



October 27, 2017

Jennifer Barrett, Chief
Bureau of Support Services
Agency for Health Care Administration
Building 2, Suite 203, Mail Stop 15
2727 Mahan Drive
Tallahassee, FL 32308-5403

RE: Response to AHCA's Invitation to Negotiate (ITN) for the Florida Statewide Medicaid Managed Care Program Specialty Plan

Dear Ms. Barrett:

Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance (Clear Health) is pleased to submit a proposal in response to the ITN for **Florida's Statewide Medicaid Managed Care Program** issued by the Agency for Health Care Administration (Agency) on July 14, 2017.

Clear Health is bidding in all 11 Florida regions as a Specialty plan for individuals with HIV/AIDS. This response is for a **Specialty Plan for individuals with HIV/AIDS in Region 1**. We authorize the Agency's release of the redacted version of the response in the event the Agency receives a public records request.

Clear Health currently offers a specialty plan for Medicaid recipients living with HIV/AIDS in nearly all regions of the state. We provide managed care services to the eligible TANF, SSI and Dual Eligible populations with a diagnosis of HIV/AIDS. We are one of the few of our kind in the country, and one of the two Florida HIV/AIDS specialty designated plans. We have maintained the largest enrollment of the two HIV/AIDS plans in Florida since the inception of the statewide Medicaid Managed Care program – ten times greater than the other Florida HIV/AIDS specialty plan.

Clear Health is backed by the knowledge and track record of Simply Healthcare Plans, Inc. (Simply). Simply continues to do business as Clear Health, and brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). Each of our legacy plans were formed to bring local health care solutions to Florida's Medicaid recipients, and have diversified to meet the varying needs of the Florida population. While each plan was strong on its own, the combined resources, capabilities, network, and community ties of our unified Simply create a far stronger whole. The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations. We bring together the leadership, resources, and capabilities of our proven health plans already in Florida. Our unified plan combines the data analytics, responsiveness, member and provider engagement, and deep local roots from Clear Health, Better Health, Amerigroup, and the original Simply with the national presence, best practices, innovations, and depth of experience from Anthem, Inc., our ultimate parent company. Together with our affiliates, Anthem is in 20 Medicaid markets

9250 W. Flagler Street
Miami, Florida 33174
(305) 921-2648



including Florida. We currently serve more than 9,300 members across Florida, and we are the largest HIV/AIDS specialty plan in the state and the nation.

Respondent Information

Respondent's name	Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance
Respondent's Address	<p>Our corporate headquarters is located at: 9250 W. Flagler Street Miami, Florida 33174</p> <p>To best serve members in our service locations throughout Florida, we also have offices in the following locations:</p> <p>4200 West Cypress Street, Suite 900 Tampa, FL 33607</p> <p>Royal Palm 1 1000 South Pine Island Road, Suite 900 Plantation, FL 33324</p> <p>200 West College Avenue Tallahassee, FL 32301</p> <p>2290 Lucien Way, Suite 210 Maitland, FL 32751</p>
Federal Employer Identification (FEID) Number	27-0945036

Contact Information

As the President and Chief Executive Officer of Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance, I will serve as the official vendor contact with authority to bind our organization to a contract. I will be available to be contacted by telephone or email and will attend meetings as appropriate.

Name	Lourdes Rivas
Title	President and Chief Executive Officer
Address	9250 W. Flagler Street Miami, Florida 33174
Email Address	LRivas@simplyhealthcareplans.com
Telephone Number	(305) 921-2648
Signature of Contact Person	

9250 W. Flagler Street
Miami, Florida 33174
(305) 921-2648



We have also included contact information for Holly Prince, our Chief Financial Officer, who will serve as an alternate contact person for Clear Health, and who also has authority to bind our organization to a contract.

Name	Holly Prince
Title	Regional Vice President of Finance / Florida Plan Chief Financial Officer
Address	9250 W. Flagler Street Miami, Florida 33174
Email Address	HPrince@simplyhealthcareplans.com
Telephone Number	(305) 921-2610
Signature of Contact Person	

We greatly appreciate the opportunity to participate in this process to continue to partner with the State to administer vitally important health care services that provide specialized care and appropriate avenues to access that care for Florida Medicaid's HIV/AIDS population. As a proud partner serving Florida Medicaid's HIV/AIDS population since 2012, we understand the needs of Floridians and the requirements and objectives of the public agencies administering programs.

We are honored and humbled to be partners with the Agency and we look forward to bringing new innovative solutions as we enter the next chapter of Florida's Medicaid program.

Sincerely,

Lourdes Rivas
President and Chief Executive Officer
Clear Health

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EXHIBIT A-2-a
QUALIFICATION OF PLAN ELIGIBILITY

RESPONDENT NAME: SIMPLY HEALTHCARE PLANS, INC. D/B/A CLEAR HEALTH ALLIANCE

1. IDENTIFICATION OF PLAN TYPES

I hereby certify that my company is submitting a response to AHCA ITN 001-17/18 to operate as one of the following plan types in Region 1:

☐ Comprehensive Plan

OR

☐ Long-Term Care Plus Plan

OR

☐ Managed Medical Assistance Plan

OR

☒ Specialty Plan

2. QUALIFICATION OF PLAN ELIGIBILITY

I hereby certify my company currently operates as one (1) of the following:

☒ HMO Health Maintenance Organization and possess a current Florida Certificate of Authority and Health Care Provider Certificate in at least one (1) Florida county.

OR

☐ PSN that possesses a Florida Third Party Administrator License or a subcontract/letter of agreement with a Florida-licensed Third Party Administrator. A copy of the Third Party Administrator license, or subcontract/letter of agreement, must be submitted with the solicitation response.

In addition, the respondent shall complete **Exhibit A-2-b**, Provider Service Network Certification of Ownership and Controlling Interest.

OR

EXHIBIT A-2-a
QUALIFICATION OF PLAN ELIGIBILITY

☐ Exclusive Provider Organization that meets the licensure requirements of Section 627.6472, Florida Statutes.

OR

☐ Accountable Care Organization authorized under federal law.

Signature below indicates the respondent's full acknowledgement of, understanding of, and agreement with the certification identified above as written and without caveat.

Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance

Respondent Name


Authorized Official Signature

10-27-2017
Date

M. Lourdes Rivas

Authorized Official Printed Name

President and CEO

Authorized Official Title

Failure to submit, Exhibit A-2-a, Qualification of Plan Eligibility, signed by an authorized official may result in the rejection of response.

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Simply Healthcare Plans, Inc., D/B/A Clear Health Alliance is submitting this response as a Managed Care Plan and therefore Exhibit A-2-b: Provider Service Network Certification of Ownership and Controlling Interest, is not applicable or required per Attachment A, Instructions and Special Conditions.

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EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

RESPONDENT NAME: SIMPLY HEALTHCARE PLANS, INC. D/B/A CLEAR HEALTH ALLIANCE

1. ACCEPTANCE OF SOLICITATION REQUIREMENTS

I hereby certify that I understand and agree that my organization has read all requirements and Agency specifications provided in this solicitation, accepts said requirements, and that this response is made in accordance with the provisions of such requirements and specifications. By my written signature below, I guarantee and certify that all items included in this response shall meet or exceed any and all such requirements and Agency specifications. I further agree, if awarded a Contract resulting from this solicitation, to deliver services that meet or exceed the requirements and specifications provided in this solicitation.

AND

2. ACCEPTANCE OF CONTRACT TERMS AND CONDITIONS

I hereby certify that should my organization be awarded a Contract resulting from this solicitation, it will comply with all terms and conditions as specified in this solicitation and in the Agency Standard Contract (**Exhibit A-8, including Attachments II - V**).

AND

3. STATEMENT OF NO-INVOLVEMENT

I hereby certify that neither my organization nor any person with an interest in the organization had any prior involvement in performing a feasibility study of the implementation of the subject Contract, in drafting of this solicitation or in developing the subject program.

AND

4. PROHIBITION OF GRATUITIES

I hereby certify that no elected official or employee of the State of Florida has or shall benefit financially or materially from such my organization's response or subsequent Contract in violation of the provisions of Chapter 112, Florida Statutes. I understand that any Contract issued as a result of this solicitation may be terminated if it is determined that gratuities of any kind were either offered or received by any of the aforementioned parties.

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

AND

5. NON-COLLUSION CERTIFICATION

I hereby certify that all persons, companies, or parties interested in the response as principals are named therein, that the response is made without collusion with any other person, persons, organization, or parties submitting a response; that it is in all respects made in good faith; and as the signer of the response, I have full authority to legally bind the prospective respondent to the provisions of this solicitation.

AND

6. PERFORMANCE OF SERVICES

I hereby certify my organization shall ensure all services, provided directly or indirectly under the Contract resulting from this solicitation, will be performed within the borders of the United States and its territories and protectorates.

AND

7. ORGANIZATIONAL CONFLICT OF INTEREST CERTIFICATION

The standards on organizational conflicts of interest in Title 48, Code of Federal Regulations, Subpart 9.5 – Organizational and Consultant Conflicts of Interest and Section 287.057(17), Florida Statutes, apply to this solicitation. A respondent with an actual or potential organizational conflict of interest shall disclose the conflict. If the respondent believes the conflict of interest can be mitigated, neutralized or avoided, the respondent shall submit a Conflict of Interest Mitigation Plan with its response, that shall, at a minimum:

- a) Identify any relationship, financial interest or other activity which may create an actual or potential organizational conflict of interest.
- b) Describe the actions the respondent intends to take to mitigate, neutralize, or avoid the identified organizational conflicts of interest.
- c) Identify the official within the respondent's organization responsible for making conflict of interest determinations.

The Conflict of Interest Mitigation Plan will be evaluated as acceptable or not acceptable. The Agency reserves the right to request additional information from the respondent or other sources, as deemed necessary, to determine whether or not the plan adequately neutralizes, mitigates, or avoids the identified conflicts.

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

Pursuant to the aforementioned requirements, I hereby certify that, to the best of my knowledge, my organization (including its subcontractors, subsidiaries and partners):

Please check the applicable paragraph below. Do not check more than one of the paragraphs below.

- ☒ Has no existing relationship, financial interest or other activity which creates any actual or potential organizational conflicts of interest relating to the award of a Contract resulting from this solicitation.
- ☐ Has included information in its response to this solicitation detailing the existence of actual or potential organizational conflicts of interest and has provided a "Conflict of Interest Mitigation Plan", as outlined above.

AND

8. RESPONDENT ATTESTATION FOR EXHIBIT A-4

I hereby certify that no modification and/or alteration has been made to the template, narrative and/or instructions contained in **Exhibit A-4**, Submission Requirements and Evaluation Criteria, including **Exhibits A-4-a, A-4-b, A-4-c and A-4-d**, including all exhibits/attachments, as applicable.

I understand the Agency may not consider supplemental response narrative for evaluation which is not contained within the Response Sections contained in **Exhibit A-4**, Submission Requirements and Evaluation Criteria.

AND

9. RESPONDENT ATTESTATION FOR ATTACHMENT C, COST PROPOSAL INSTRUCTIONS AND RATE METHODOLOGY NARRATIVE

I hereby certify that no modification and/or alteration has been made to the template, narrative and/or instructions contained in **Attachment C, Cost Proposal Instructions and Rate Methodology Narrative**, including all applicable exhibits.

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

AND

10. RESPONDENT ATTESTATION REGARDING SCRUTINIZED COMPANIES LIST

I hereby certify that my company is not listed on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, created pursuant to Section 215.473, Florida Statutes. Pursuant to Section 287.135(5), Florida Statutes, the respondent agrees the Agency may immediately terminate the resulting Contract for cause if the respondent is found to have submitted a false certification or if the respondent is placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List during the term of the resulting Contract.

AND

11. NAMES OF OPERATION

I hereby certify the following is a list of all names under which my organization has operated during the past five (5) years (since July 14, 2012).

Clear Health Alliance; Simply Healthcare Plans, Inc.; Simply Healthcare; AMERIGROUP

Florida, Inc.; Simply Healthcare Plans, Inc. d/b/a Clear Health Alliance; Better Health,

LLC; Better Health, Inc.; and Better Health d/b/a Simply Better Health;

AND

12. BUSINESS RELATIONSHIP

The respondent shall disclose any business relationship (as defined in Section 409.966(3)(e), Florida Statutes) with any other eligible Managed Care Plan that is a potential respondent to this solicitation. Such disclosure shall include identifying information for each Managed Care Plan, the nature of the business relationship, the current service area of each Managed Care Plan (by line of business), and the signature of the authorized representative for each Managed Care Plan.

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

The respondent must disclose any business relationship(s) in the space provided below:

Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance does not have any business relationship with any other eligible MCO that is a potential respondent to this solicitation.

Simply Healthcare Plans, Inc. is also responding to this ITN as a Comprehensive Plan.

AND

13. COMPLETE MEDICAID PROVIDER ENROLLMENT PACKAGE SUBMISSION

I hereby certify my organization, if awarded a Contract, shall provide the Agency with an accurate and complete Medicaid Provider Enrollment Application, including all ownership and principal fingerprint cards and processing fees, within thirty (30) days after the Contract award is complete.

AND

14. REQUIRED PLAN READINESS DOCUMENTATION

I hereby certify my organization, if awarded a Contract, shall submit to the Agency all required Plan Readiness documentation within established timeframes as required in **Attachment A**, Instructions and Special Conditions, **Section E.**, Contract Implementation.

AND

15. CERTIFICATION REGARDING TERMINATED CONTRACTS

I hereby certify that my organization (including its subsidiaries and affiliates) has not unilaterally or willfully terminated any previous contract prior to the end of the contract with a State or the Federal government and has not had a contract terminated by a State or the Federal government for cause, prior to the end of the contract, within the past five (5) years (since July 14, 2012), other than those listed on **Page 6** of this Exhibit.

AND

16. LIST OF TERMINATED CONTRACTS

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

List the terminated contracts in chronological order and provide a brief description (half-page or less) of the reason(s) for the termination. Additional pages may be submitted; however, no more than five (5) additional pages should be submitted in total.

The Agency is not responsible for confirming the accuracy of the information provided.

The Agency reserves the right within its sole discretion, to determine the respondent to be a non-responsible vendor based on any or all of the listed contracts and therefore may reject the respondent's reply.

Respondent Name: Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance

Client's Name: N/A

Term of Terminated Contract: N/A

Description of Services: N/A

Brief Summary of Reason(s) for Contract Termination: N/A

Respondent Name:

Client's Name:

Term of Terminated Contract:

Description of Services:

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

Brief Summary of Reason(s) for Contract Termination:

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

Signature below indicates the respondent's full acknowledgement of; understanding of; and agreement with all of the certifications and statements identified above in Items 1 through 16 as written and without caveat.

Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance

Respondent Name


Authorized Official Signature

10-27-2017
Date

M. Lourdes Rivas

Authorized Official Printed Name

President and CEO

Authorized Official Title

Failure to submit, Exhibit A-2-c, Additional Required Certifications and Statements, signed by an authorized official may result in the rejection of response.

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EXHIBIT A-3-a
MILLIMAN ORGANIZATIONAL
CONFLICT OF INTEREST MITIGATION PLAN

RESPONDENT NAME: SIMPLY HEALTHCARE PLANS, INC. D/B/A CLEAR HEALTH ALLIANCE

The Agency for Health Care Administration ("Agency" or "AHCA") "must avoid, neutralize, or mitigate significant potential organizational conflicts of interest (OCI) before a Contract is awarded. If the Agency elects to mitigate the significant potential organizational conflict or conflicts of interest, an adequate mitigation plan, including organizational, physical, and electronic barriers, shall be developed. [Section 287.057(17)(a)(1), Florida Statutes]

The Agency has determined that in order to evaluate proposals and negotiate a Contract that is in the best interests of the State, it is necessary to use the services of Milliman, Inc. ("Milliman") to act as an actuary and advisor throughout all stages of the "Statewide Medicaid Managed Care Program" competitive solicitation. The Agency reasonably anticipates one or more prospective respondents may also use Milliman. The Agency has determined that all reasonably anticipated OCIs relating to Milliman may be mitigated by the following mitigation plan, which has been agreed to by Milliman:

I. Milliman

- a.** All Milliman personnel who will perform services under the "Statewide Medicaid Managed Care Program" competitive solicitation shall be part of a separate internal Milliman working group (the "Milliman AHCA Group") with its own internal electronic and hard folders.
- b.** All documents or communications received or generated by the Milliman AHCA Group that relate in any way to this solicitation shall be placed only in this Group's separate files.
- c.** Each member of the Milliman AHCA Group shall submit **Exhibit A-3-b**, Milliman Employee Organizational Conflict of Interest Affidavit indicating they will provide actuarial services to the Agency.
- d.** No Milliman personnel, other than the Milliman AHCA Group personnel shall have access to the Milliman AHCA's Groups files.
- e.** The above-listed personnel shall not discuss any information relating to the SMMC ITN Services with any other Milliman personnel.

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EXHIBIT A-3-a
MILLIMAN ORGANIZATIONAL
CONFLICT OF INTEREST MITIGATION PLAN

II. Respondents

- a. Any actual or prospective respondent who is using Milliman for this procurement must disclose this fact in its initial reply to the solicitation. Specifically, a respondent wishing to use Milliman must:
 - i. Identify itself and its intent to use Milliman;
 - ii. Identify the specific Milliman personnel that will be assisting the respondent in the procurement;
 - iii. Submit **Exhibit A-3-b, Milliman Employee Organizational Conflict of Interest Affidavit** forms, completed by each identified Milliman personnel.
- b. All replies submitted in response to this solicitation must include the completed declaration in **Section IV.** of this Exhibit, signed by the authorized official who signed the reply on behalf of the respondent.
- c. Any actual or prospective respondent who learns there is a reasonable basis to believe there has or may have been a violation of the Milliman OCI Mitigation Plan shall, within seventy-two (72) hours, notify the Agency of the facts and circumstances of the possible violation.

III. Protests

- a. **Actual or prospective respondents are advised they have a burden to diligently investigate and challenge potential OCIs relating to Milliman.**
- b. All challenges to the Milliman OCI Mitigation Plan must be timely filed as a challenge to the specifications of this solicitation. Similarly, challenges to amendments to the Milliman OCI Mitigation Plan must be timely filed as specifications challenges.
- c. All challenges to Milliman-related information provided by actual or prospective respondents and posted by the Agency must be timely filed as specifications challenges.
- d. **All protests filed after a Notice of Intent to Award has been posted which allege a Milliman-related OCI shall be limited to alleged violations of the Milliman OCI Mitigation Plan.**

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EXHIBIT A-3-a
MILLIMAN ORGANIZATIONAL
CONFLICT OF INTEREST MITIGATION PLAN

IV. Declaration

Declaration of M. Lourdes Rivas
Authorized Official Printed Name

Pursuant to Section 92.525, Florida Statutes, M. Lourdes Rivas
Authorized Official Printed Name
declares that:

1. I am over the age of 21 and am competent to testify as to the matters stated in this declaration.
2. I declare that I have read the Milliman Organizational Conflict of Interest Mitigation Plan, and that Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance
Respondent Name

will directly and indirectly fully comply with the Milliman Organizational Conflict of Interest Mitigation Plan through all stages of the procurement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 27th day of Oct 2017.



Authorized Official Signature

M. Lourdes Rivas
Authorized Official Printed Name

Failure to submit, Exhibit A-3-a, Milliman Organizational Conflict of Interest Mitigation Plan, certified by an authorized official may result in the rejection of response.

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Simply Healthcare Plans, Inc., D/B/A Clear Health Alliance did not use Milliman, Inc. (“Milliman”) in the development of this response or for this procurement and therefore, Exhibit A-3-b: Milliman Employee Organizational Conflict of Interest Affidavit is not applicable or required per Attachment A, Instructions and Special Conditions.

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Financial Statements - Statutory Basis Health

Simply Healthcare Plans, Inc.

Years Ended December 31, 2016 and 2015
With Reports of Independent Auditors

Simply Healthcare Plans, Inc.

Financial Statements – Statutory Basis

Years ended December 31, 2016 and 2015

Contents

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Indianapolis, IN 46204

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Report of Independent Auditors

Board of Directors
Simply Healthcare Plans, Inc.

We have audited the accompanying statutory-basis financial statements of Simply Healthcare Plans, Inc., which comprise the balance sheets as of December 31, 2016 and 2015, and the related statements of income, changes in capital and surplus and cash flow for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation. Management also is responsible for the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

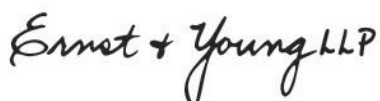
As described in Note 1, to meet the requirements of Florida, the financial statements have been prepared in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation, which practices differ from U.S. generally accepted accounting principles. The variances between such practices and U.S. generally accepted accounting principles are described in Note 1. The effects on the accompanying financial statements of these variances are not reasonably determinable but are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the effects of the matter described in the preceding paragraph, the statutory-basis financial statements referred to above do not present fairly, in conformity with U.S. generally accepted accounting principles, the financial position of Simply Healthcare Plans, Inc. at December 31, 2016 and 2015, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

However, in our opinion, the statutory basis financial statements referred to above present fairly, in all material respects, the financial position of Simply Healthcare Plans, Inc. at December 31, 2016 and 2015, and the results of its operations and its cash flows for the years then ended in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation.



March 30, 2017

Simply Healthcare Plans, Inc.

Balance Sheets – Statutory Basis

	December 31	
	2016	2015
	<i>(In Thousands)</i>	
Admitted assets		
Cash and invested assets:		
Cash, cash equivalents, and short-term investments	\$ 198,372	\$ 92,585
Bonds	65,593	64,560
Total cash and invested assets	263,965	157,145
Accrued investment income	756	698
Premiums receivable	19,246	17,402
Amounts recoverable from reinsurers	1,554	253
Amounts receivable from uninsured plans	503	433
Net deferred tax asset	4,055	3,523
Electronic data processing equipment	1,575	1,223
Health care and other receivables	1,678	2,629
Other assets	640	10
Total admitted assets	<u>\$ 293,972</u>	<u>\$ 183,316</u>
Liabilities and capital and surplus		
Liabilities:		
Unpaid claims and claims adjustment expenses	\$ 130,960	\$ 103,333
Aggregate policy reserves	22,221	3,011
Current federal income tax payable	5,543	4,559
Accounts payable and accrued expenses	1,427	10,706
Payable to affiliates	3,219	2,974
Liability for amounts held under uninsured plans	7,849	6,213
Other liabilities	9,358	6,403
Total liabilities	180,577	137,199
Capital and surplus:		
Common stock, \$.01 par value, 10,000 shares authorized, 5,700 shares issued and outstanding	—	—
Additional paid-in surplus	5,714	5,714
Unassigned surplus (deficit)	87,121	(171)
Surplus notes	20,560	20,560
Special surplus funds	—	20,014
Total capital and surplus	<u>113,395</u>	<u>46,117</u>
Total liabilities and capital and surplus	<u>\$ 293,972</u>	<u>\$ 183,316</u>

See accompanying notes.

Simply Healthcare Plans, Inc.

Statements of Income – Statutory Basis

	Year ended December 31	
	2016	2015
	<i>(In Thousands)</i>	
Premium income	\$ 1,213,860	\$ 986,205
Benefits and expenses:		
Claims and claims adjustment expenses	1,044,387	858,630
Operating expenses	74,514	85,788
Total benefits and expenses	1,118,901	944,418
Net underwriting gain (loss)	94,959	41,787
Investment gains (losses):		
Net investment income	1,544	742
Net realized capital gains (losses), net of tax (benefit)	1	6
Total net investment gains (losses)	1,545	748
Other income (expense)	(42)	(422)
Income (loss) before federal income taxes	96,462	42,113
Federal income tax (benefit)	40,877	20,302
Net income (loss)	\$ 55,585	\$ 21,811

See accompanying notes.

Simply Healthcare Plans, Inc.

Statement of Changes in Capital and Surplus – Statutory Basis

	Common Stock	Additional Paid-in Surplus	Unassigned (Deficit) Surplus	Surplus Notes	Special Surplus Funds	Total Capital and Surplus
			<i>(In Thousands)</i>			
Balance as of January 1, 2015	\$ —	\$ 5,714	\$ (2,977)	\$ 20,560	\$ 9,169	\$ 32,466
Net income (loss)	—	—	21,811	—	—	21,811
Change in net deferred income tax	—	—	47	—	—	47
Change in nonadmitted assets	—	—	(8,207)	—	—	(8,207)
Change in special surplus funds for ACA health insurer fee	—	—	(10,845)	—	10,845	—
Balance as of December 31, 2015	—	5,714	(171)	20,560	20,014	46,117
Net Income (loss)	—	—	55,585	—	—	55,585
Change in net unrealized capital gains and losses net of tax (benefit)	—	—	(229)	—	—	(229)
Change in net deferred income tax	—	—	(3,435)	—	—	(3,435)
Change in nonadmitted assets	—	—	15,357	—	—	15,357
Change in special surplus funds for ACA health insurer fee	—	—	20,014	—	(20,014)	—
Balance as of December 31, 2016	<u>\$ —</u>	<u>\$ 5,714</u>	<u>\$ 87,121</u>	<u>\$ 20,560</u>	<u>\$ —</u>	<u>\$ 113,395</u>

See accompanying notes.

Simply Healthcare Plans, Inc.

Statements of Cash Flow – Statutory Basis

	Year ended December 31	
	2016	2015
	<i>(In Thousands)</i>	
Operating activities:		
Premiums collected	\$ 1,231,225	\$ 950,214
Investment income received	2,368	616
Claims and claims adjustment expenses paid	(1,016,340)	(862,201)
General administrative and miscellaneous expenses paid	(80,556)	(72,176)
Federal income taxes (paid) recovered	(39,894)	(18,620)
Net cash provided by (used in) operating activities	96,803	(2,167)
Investment activities:		
Proceeds from investments sold, matured or repaid	3,288	19,778
Cost of investments acquired	(5,551)	(69,317)
Net cash provided by (used in) investment activities	(2,263)	(49,539)
Financing or miscellaneous activities:		
Net transfers from (to) affiliates	(714)	–
Other	11,961	(6,446)
Net cash provided by (used in) financing or miscellaneous activities	11,247	(6,446)
Change in cash, cash equivalents and short-term investments	105,787	(58,152)
Cash, cash equivalents and short-term investments at beginning of year	92,585	150,737
Cash, cash equivalents and short-term investments at end of year	<u>\$ 198,372</u>	<u>\$ 92,585</u>

See accompanying notes.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

December 31, 2016

1. Nature of Operations and Significant Accounting Policies

Simply Healthcare Plans, Inc. (the “Company”) is a Florida domiciled stock health maintenance organization (“HMO”) which is licensed in Florida. The Company is a prepaid capitated plan created primarily for an enrolled population comprised of beneficiaries of the Medicaid and Medicare programs. The Company’s current service areas include all counties of Florida. It provides Medicaid and Medicare Services in Miami-Dade, Osceola, Seminole, Orange and Polk counties and Medicaid only services in the rest of Florida counties, except for Volusia, Flagler, St. John’s, Duval and Nassau. As of December 31, 2016, the Company served 133,053 members. The Company manages healthcare services for Medicare members as a Medicare Advantage Plan, under a contract with the Centers for Medicare and Medicaid Services (“CMS”). The Company manages healthcare services for Medicaid members under a contract with the Florida Agency for Healthcare Administration (“AHCA”). The loss of these contracts would have a material effect on the Company’s operations. The Company is a wholly owned subsidiary of Simply Healthcare Holdings, Inc. (“Simply Holdings”), which is an indirect wholly-owned subsidiary of Anthem, Inc. (“Anthem”), a publicly traded company. On December 19, 2014, Simply Holdings entered into an Agreement and Plan Merger with a subsidiary of Anthem, Inc. (“Anthem”), a publicly traded company. Based on receipt of all federal and state regulatory approvals, the acquisition was finalized and closed on February 17, 2015.

On July 24, 2015, the Company’s ultimate parent company, Anthem, and Cigna Corporation (“Cigna”) entered into an Agreement and Plan of Merger dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and a direct wholly-owned subsidiary of Anthem, pursuant to which Anthem will acquire all outstanding shares of Cigna, or the Acquisition. On July 21, 2016, the U.S. Department of Justice, or DOJ, along with certain state attorneys general, filed a civil antitrust lawsuit in the U.S. District Court for the District of Columbia seeking to block the Acquisition. On January 18, 2017, Anthem provided notice to Cigna that Anthem had elected to extend the termination date under the Merger Agreement from January 31, 2017 until April 30, 2017. Following the conclusion of the trial, the Court ruled in favor of the DOJ, on February 8, 2017, and Anthem promptly filed notice that Anthem would appeal the Court’s ruling. On February 14, 2017, Cigna purported to terminate the Merger Agreement and commenced litigation against Anthem in the Delaware Court of Chancery, or Delaware Court, seeking damages and a declaratory judgment that its purported termination of the Merger Agreement was lawful, among other claims. Anthem believes Cigna’s allegations are without merit. Also on February 14, 2017, Anthem initiated its own litigation against Cigna in the Delaware Court seeking a temporary restraining order to enjoin Cigna from terminating the Merger Agreement, specific performance compelling Cigna to comply with the Merger Agreement and damages. On February 15, 2017, the Delaware Court granted Anthem’s motion for a temporary restraining order and issued an order enjoining Cigna from terminating the Merger Agreement. The temporary restraining order became effective immediately and will remain in place pending any further order from the Delaware Court. Anthem intends to vigorously defend the Acquisition in both the Circuit Court and the Delaware Court and remains committed to completing the Acquisition as soon as practicable.

Basis of Presentation

The accompanying financial statements have been prepared in accordance with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation (“Florida OIR”). The Florida OIR has adopted the accounting policies found in the National Association of Insurance Commissioners (“NAIC”) *Accounting Practices and Procedures Manual* (“NAIC SAP”) as a component of prescribed accounting practices. Additionally, the Florida OIR has adopted certain prescribed accounting practices that differ from those found in NAIC SAP, which impact the Company. Specifically, all parent and affiliate intercompany receivable balances are considered nonadmitted assets. In addition, pursuant to Section 641.35(3)(a), Florida Statutes, if an HMO, through a health risk contract, transfers to any entity the obligation to pay providers for subscriber claims, the liability for any such payment remains with the HMO until the payment is received by the provider and should be reflected in claim

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

reserves. The Company employed no permitted practices in preparing the accompanying statutory basis financial statements.

A reconciliation of the Company's statutory capital and surplus as of December 31, 2016 and 2015 between practices prescribed by the Florida OIR and NAIC SAP along with reference of Statement of Statutory Accounting Principles ("SSAP") are shown below:

	<u>SSAP No.</u>	<u>2016</u>	<u>2015</u>
Statutory capital and surplus, Florida OIR basis		\$ 113,395	\$ 46,117
State prescribed practices:			
Nonadmittance of amounts due from affiliates pursuant to 641.35 (2)(i) of the Florida Revised Statutes	25	714	–
State prescribed practices:			
Claim reserve pursuant to 641.35 (3)(a) of the Florida Revised Statutes	55	211	204
Statutory capital and surplus, NAIC SAP basis		<u>\$ 114,320</u>	<u>\$ 46,321</u>

A reconciliation of the Company's statutory net income for the years ended December 31, 2016 and 2015 between practices prescribed by the Florida OIR and NAIC SAP along with reference of SSAP is shown below:

	<u>SSAP No.</u>	<u>2016</u>	<u>2015</u>
Statutory net income, Florida OIR basis		\$ 55,585	\$ 21,811
State prescribed practices:			
Claim reserve pursuant to 641.35 (3)(a) of the Florida Revised Statutes	55	7	204
Statutory net income, NAIC SAP basis		<u>\$ 55,592</u>	<u>\$ 22,015</u>

Such practices vary from U.S. generally accepted accounting principles ("GAAP"). The more significant variances from GAAP, applicable to the Company, are as follows:

Investments: Investments in bonds, preferred stocks and unaffiliated common stocks are reported at amortized cost or fair value based on their NAIC rating. For GAAP, such fixed maturity investments are designated at purchase as available-for-sale and are reported at fair value with unrealized holding gains and losses, net of tax, reported as a separate component of capital and surplus.

For statutory purposes, all single class and multi-class mortgage-backed/asset-backed securities, such as collateralized mortgage obligations ("CMOs"), where it is determined that a decline in fair value is other-than-temporary because the Company intends to sell the security or has assessed that it does not have the intent and ability to retain the investments in the security for a period of time sufficient to recover the amortized cost basis, the amortized cost basis is written down to fair value as a realized loss in the statements of income. If deemed other-than-temporarily impaired as the Company does not expect to recover the amortized cost basis even if it

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

did not intend to sell the security and the Company has the intent and ability to hold the security, the amortized cost basis is written down to the present value of future cash flows as a realized loss in the statements of income. For impaired bonds not backed by other assets, an other-than-temporary impairment (“OTTI”) is considered to have occurred if it is probable that the Company will be unable to collect all amounts due according to the instrument’s contractual terms in effect at the date of acquisition. A decline in fair value that is other-than-temporary includes situations where the Company has made a decision to sell a security prior to its maturity at an amount below its carrying value. If it is determined that a decline in the fair value of a bond is other-than-temporary, an impairment loss is recognized as a realized loss in the statements of income equal to the entire difference between the bond’s carrying value and its fair value.

For GAAP purposes, all securities, purchased or retained, that represent beneficial interests in securitized assets, such as CMOs, mortgage-backed securities, bonds and asset-backed securities, other than high credit quality securities, whose decline in fair value is determined to be other-than-temporary, the cost basis of the security is written down to the fair value if the Company intends to sell the security or it is more likely than not that the Company will have to sell the security prior to recovery. For impaired fixed maturity securities that the Company does not intend to sell or it is more likely than not that the Company will not have to sell such securities, but the Company expects that it will not fully recover the amortized cost basis, the credit component of the OTTI is recognized in other-than-temporary losses in the income statements, and the non-credit component of the OTTI is recognized in other comprehensive income. Furthermore, unrealized losses entirely caused by non-credit factors related to fixed maturity securities for which the Company expects to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive income.

Premiums receivable: Premiums receivable are recorded at the billed amount and reduced by any amounts not deemed collectible. Generally amounts aged ninety days and older are nonadmitted assets, with the exception of government receivables. For GAAP, these amounts are recorded at the billed amount and are reported net of a valuation allowance based upon historical collection trends and management’s judgment on the collectability of these accounts.

Nonadmitted assets: Certain assets designated as nonadmitted, including deferred federal income taxes in excess of certain statutory limits, investments in unaudited subsidiaries, furniture and equipment, non-operating software, leasehold improvements, prepaid expenses, intangible assets other than goodwill, certain health care and other receivable balances, and certain premium receivable balances are excluded from the balance sheets by a direct charge to capital and surplus. These nonadmitted assets totaled \$10,111 and \$25,468 at December 31, 2016 and 2015, respectively. For GAAP, these amounts are carried as assets, net of a valuation allowance, if necessary.

Surplus notes: Surplus notes are reported as capital and surplus, surplus note interest expense is not recorded until approved by the Florida OIR and related accrued interest is reported as borrowed money. For GAAP, surplus notes are reported as long-term debt, and surplus note interest expense is accrued as incurred.

Deferred income taxes: Deferred tax assets are reduced by a statutory valuation allowance if, based on the weight of available evidence, it is more likely than not that some portion or all of the gross deferred tax assets will not be realized. Adjusted gross deferred tax assets are separated by character (ordinary and capital) and admitted in an amount equal to the sum of 1) the amount of federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the applicable carryback period, plus 2) based on Risk Based Capital (“RBC”) thresholds the lesser of the remaining adjusted gross deferred tax assets expected to be realized within the applicable period of the balance sheet date or an amount no greater than the applicable percentage of capital and surplus excluding any net deferred tax assets, electronic data processing (“EDP”) equipment and operating software and any net positive goodwill, plus 3) the amount of remaining adjusted gross deferred tax assets that can be offset against existing gross deferred tax liabilities after consideration of the reversal patterns of temporary differences. The remaining deferred tax asset is nonadmitted.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

Deferred taxes do not include amounts for state taxes. Changes in deferred income taxes are recorded as adjustments to capital and surplus. For GAAP, state income taxes are considered in the computation of deferred taxes, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years, and a valuation allowance is established for deferred tax assets estimated to be unrealizable. Excluding the tax impact of unrealized investment gains and losses and certain other items, the change in deferred income taxes is recorded in the statements of income.

Statements of cash flow: Cash, cash equivalents and short-term investments in the statements of cash flow represent cash balances, and investments with initial maturities of one year or less. If in the aggregate the Company has a negative cash balance, it is reported as a negative asset and not as a liability. For GAAP, the corresponding captions of cash and cash equivalents include cash balances and investments with initial maturities of three months or less and negative cash balances are reported separately as liabilities and short term investments.

Uninsured accident and health plans: The Company provides administrative services to AHCA on an uninsured basis. Under this arrangement, the customer retains the risk of funding payments for health benefits provided, and the Company may be subject to credit risk of the customer from the time of the Company's claim payment until the Company receives the claim reimbursement. In accordance with SSAP No. 47, Uninsured Plans, these claim payments and subsequent reimbursements are excluded from the Company's statutory basis statements of income, and administrative fees earned are deducted from general insurance expenses. For GAAP, these administrative fees are reported as revenue in the statements of income.

Reinsurance: Any reinsurance balance amounts deemed to be uncollectible have been written off through a charge to operations. In addition, a liability for reinsurance balances has been provided for unsecured policy reserves ceded to reinsurers not authorized to assume such business. Changes to the liability are credited or charged directly to unassigned surplus. Under GAAP, an allowance for amounts deemed uncollectible would be established through a charge to earnings. Policy and contract liabilities ceded to reinsurers have been reported as reductions of the related reserves rather than as assets as would be required under GAAP.

The effects of the foregoing variances from GAAP on the accompanying statutory basis financial statements have not been determined but are presumed to be material.

Other significant accounting policies are as follows:

Use of Estimates

Preparation of statutory basis financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Investments

Bonds not backed by loans are stated at amortized cost, with amortization of premium or discount calculated based on the modified scientific method, using lower of yield to call or yield to maturity. Single class and multi-class mortgage-backed/asset-backed securities are valued at amortized cost using the interest method including anticipated prepayments. Prepayment assumptions for loan-backed securities and structured securities are obtained from broker-dealer survey values or internal estimates. These assumptions are consistent with the current interest rate and economic environment. The retrospective adjustment method is used to value all loan-backed securities. Non-investment grade bonds are stated at the lower of cost or fair value as determined by the NAIC's Securities Valuation Office ("SVO"). Common stocks of unaffiliated companies are stated at fair value as determined by various third-party pricing sources.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

Unrealized gains and losses on stocks and non-investment grade bonds are reflected directly in unassigned surplus net of federal income taxes unless there is deemed to be an other-than-temporary decline in value, in which case the loss is charged to income. Realized gains and losses on investments sold are determined using the specific identification method and are included in net realized capital gains (loss), net of tax. Investment income is not accrued on bonds with interest payments in default.

Short-term investments include investments with maturities of less than one year and more than three months at the date of acquisition and are reported at amortized cost, which approximates fair value. Cash equivalent investments include investments with maturities of less than or equal to three months at the date of acquisition and are reported at amortized cost, which approximates fair value. Non-investment grade short-term and cash equivalent investments are stated at the lower of amortized cost or fair value.

Electronic Data Processing Equipment and Software

EDP equipment and software are recorded at cost less accumulated depreciation. Depreciation on EDP equipment and operating software is computed principally by the straight-line method over the lesser of the estimated useful lives of the assets or three years. Non-operating software is depreciated using the straight-line method over the lesser of its useful life or five years. Accumulated depreciation at December 31, 2016 and 2015 was \$3,728 and \$2,564, respectively. Depreciation expense in 2016 and 2015 was \$1,164 and \$995, respectively.

Furniture and Equipment

Furniture and equipment is capitalized and depreciated on a straight-line basis over its useful life. The net book value is charged in full to unassigned surplus as a nonadmitted asset. Depreciation expense in 2016 and 2015 was \$549 and \$1,023, respectively.

Health Care Receivables

Health care receivables represent amounts related to pharmacy rebate receivables and other health care related receivables other than premiums. Pharmacy rebate receivables are recorded when earned based upon actual rebate receivables and an estimate of receivables based upon current utilization of specific pharmaceuticals and provider contract terms. These health care receivables are subject to various admittance tests based on the nature of the receivable balance.

Unpaid Claims and Claims Adjustment Expenses

Unpaid claims and claims adjustment expenses include management's best estimate of amounts based on historical claim development patterns and certain individual case estimates. The established liability considers health benefit provisions, business practices, economic conditions and other factors that may materially affect the cost, frequency and severity of claims. Reserves for unpaid claims and claims adjustment expenses are based on assumptions and estimates, and while management believes such estimates are reasonable, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed and changes in estimates are incorporated into current operating results.

Risk Share and Other Reserves

The Company contracts with physicians or providers groups to provide medical services to the Company's members. The Company pays capitation or negotiated fees for defined services provided by the physicians. Under the terms of these agreements, certain providers are eligible to receive provider incentives based on qualitative and quantitative factors. Estimated risk sharing settlements are continually reviewed, and necessary adjustments are included in current operations. Claim and claim adjustment expenses include all amounts incurred by the Company under these arrangements.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

Premiums

Premiums are recognized as revenue during the period in which the Company is obligated to provide service to members. Premium payments from contracted government agencies are based on eligibility lists produced by the government agencies. Adjustments to eligibility lists produced by the government agencies result from retroactive application of enrollment or disenrollment of members or classification changes between rate categories. The Company estimates the amount of retroactive premium owed to or from the government agencies each period and adjusts premium revenue accordingly. Expenses incurred in connection with acquiring insurance business are charged to operations as incurred.

Delays in approval of annual premium rate changes require that the Company defer the recognition of any increases to the period in which the premium rates become final. The value of the impact can be significant in the period in which it is recognized dependent on the magnitude of the premium rate increase, the membership to which it applies and the length of the delay between the effective date of the rate increase and the final contract date. Premium rate decreases are recognized in the period the change in premium rate becomes effective and the change in the rate is known, which may be prior to the period when the contract amendment affecting the rate is finalized.

The State of Florida, AHCA, informed the Company on June 7, 2016 of a pricing error related to the State Fiscal Year 2015-2016 contract. AHCA indicated it underpaid the Company due to a mismatch of rates. Related to this, the Company received and recognized cash and premiums of \$6,039 from AHCA during 2016 related to 2015.

Medicare Advantage Part D Premiums and Expenses

The Company serves as a plan sponsor, offering Medicare Advantage Part D prescription drug insurance coverage under a contract with the CMS. The CMS premium, the member premium, and the low-income premium subsidy represent payments for the Company's insurance risk coverage under the Medicare Advantage Part D program and therefore are recorded as premium revenues in operations. Premium revenues are recognized ratably over the period in which eligible individuals are entitled to receive prescription drug benefits. Pharmacy benefit costs and administrative costs under the contract are expensed as incurred.

Subsidies from CMS representing cost reimbursements under the Medicare Part D program are not reflected as premium revenues, but rather are accounted for as deposits in amounts receivable for uninsured plans on the accompanying balance sheets. The related liabilities are reported in the accompanying balance sheets in liability for amounts held under uninsured plans.

Reinsurance

Reinsurance premiums, claims and claims adjustment expenses are accounted for on a basis consistent with those used in accounting for the original policies issued and the terms of the reinsurance contracts.

Retrospectively Rated Contracts

The Company's contracts with CMS and AHCA include a provision for which premiums vary based on loss experience. The Company estimates accrued retrospective premium adjustments through the review of each retrospectively rated contract, comparing the claim development with that anticipated in the contract. Any adjustment made to the estimated liability as a result of a final settlement is included in current operations. The Company uses estimates to report in the statutory basis financial statements the incurred and unpaid liability amounts for retrospectively rated contracts based on its underwriting experience; actuarial, tax, and accounting estimates and assumptions at the financial statement date and regulations and guidance available that is subject to change prior to settlement. Accordingly, the Company's use of estimates and assumptions in the preparation of the statutory basis financial statements and related footnote disclosures may differ from actual results.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

Federal Income Taxes

The Company participates in a tax sharing agreement with Anthem and its subsidiaries. Allocation of federal income taxes is based upon separate return calculations with credit for net losses that can be used on a consolidated basis. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

Health Insurer Fee

ACA Section 9010 imposed a mandatory annual fee on health insurers that write certain types of health insurance on U.S. risks for each calendar year beginning on or after January 1, 2014. The annual fee is allocated to health insurers based on the ratio of the amount of an insurer's premium written during the preceding calendar year to the amount of health insurance for all U.S. health risk for those certain lines of business that is written during the preceding calendar year. This fee is non-deductible for income tax purposes. The health insurer fee is reported in operating expenses in the same year it is paid. The health insurer fee to be paid in the following year is segregated in special surplus funds until the beginning of the year in which it is to be paid. Payment of the health insurer fee has been suspended for 2017 and will resume for 2018 and beyond.

Reclassifications

Certain prior year amounts have been reclassified to conform to the current year presentation.

2. Investments

A summary of the Company's investments in bonds is as follows:

	Statement Value	Gross Unrealized Gains	Gross Unrealized Losses		Fair Value
			Less Than 12 Months	12 Months or Greater	
<i>December 31, 2016</i>					
States, territories and political subdivisions	\$ 65,593	\$ 385	\$ (329)	\$ –	\$ 65,649
Total bonds	<u>\$ 65,593</u>	<u>\$ 385</u>	<u>\$ (329)</u>	<u>\$ –</u>	<u>\$ 65,649</u>
<i>December 31, 2015</i>					
States, territories and political subdivisions	\$ 64,560	\$ 1,140	\$ (29)	\$ –	\$ 65,671
Total bonds	<u>\$ 64,560</u>	<u>\$ 1,140</u>	<u>\$ (29)</u>	<u>\$ –</u>	<u>\$ 65,671</u>

The statement and fair values of bonds at December 31, 2016, by contractual maturity, are shown below. Actual maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Statement Value	Fair Value
Due in one year or less	\$ 6,519	\$ 6,516
Due after one through five years	14,932	14,888
Due after five through ten years	20,296	20,197
Due after ten years	23,846	24,048
	<u>\$ 65,593</u>	<u>\$ 65,649</u>

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

Proceeds from sales of bonds during 2016 and 2015 were \$1,768 and \$19,780, respectively, resulting in gross gains of \$7 and \$59, respectively, and realized gross losses of \$5 and \$51, respectively.

Cash of \$310 and \$310 was on deposit with the Florida OIR at December 31, 2016 and 2015, respectively. Bonds with a statement value of \$15,563 and \$15,555 were on deposit with AHCA at December 31, 2016 and 2015, respectively.

A significant judgment in the valuation of investments is the determination of when an other-than-temporary decline in value has occurred. The Company follows a consistent and systematic process for impairing securities that sustain other-than-temporary declines in value. The Company has established a committee responsible for the impairment review process. The decision to impair a security incorporates both quantitative criteria and qualitative information. The impairment review process considers a number of factors, including but not limited to (a) the length of time and the extent to which a security's fair value has been less than statement value; (b) the financial condition and near term prospects of the issuer; (c) the intent to sell and, for loan-backed and structured securities, the intent and ability of the Company to retain its investment for a period of time to allow for any anticipated recovery in value; (d) whether the debtor is current on interest and principal payments; and (e) general market conditions and industry or sector specific factors. For securities that are deemed to be other-than-temporarily impaired, the security is adjusted to its fair value (or its discounted cash flows for loan-backed and structured securities), and the resulting losses are recognized in net realized gains or losses in the statutory basis statements of income. The new cost basis of the impaired securities is not increased for future recoveries in fair value. The Company recorded no charges for OTTI of securities for the years ended December 31, 2016 and 2015.

A summary of unaffiliated investments with unrealized losses along with the related fair value, aggregated by the length of time that investments have been in a continuous unrealized loss position, is as follows:

	December 31, 2016			December 31, 2015		
	Number of Securities	Fair Value	Gross Unrealized Loss	Number of Securities	Fair Value	Gross Unrealized Loss
Bonds:						
Less than 12 months	34	\$ 28,984	\$ (329)	11	\$ 8,061	\$ (29)
12 months or greater	—	—	—	—	—	—
Total bonds	<u>34</u>	<u>\$ 28,984</u>	<u>(329)</u>	<u>11</u>	<u>\$ 8,061</u>	<u>(29)</u>

The Company's bond portfolio is sensitive to interest rate fluctuations, which impact the fair value of individual securities. Unrealized losses on bonds reported above were primarily caused by the effects of the interest rate environment and the widening of credit spreads on certain securities. Unrealized losses on stocks result from normal market fluctuations and are considered temporary. The Company currently has the ability and intent to hold these securities until their full cost can be recovered. Therefore, the Company does not believe the unrealized losses represent an OTTI as of December 31, 2016 or 2015.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

3. Fair Value

Assets and liabilities recorded at fair value in the statutory basis balance sheets would be categorized based upon the level of judgment associated with the inputs used to measure their fair value. Level inputs are as follows:

<u>Level Input</u>	<u>Input Definition</u>
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The following table summarizes the assets and liabilities measured at fair value and held as of December 31, 2016 and 2015, respectively:

	<u>Level I</u>	<u>Level II</u>	<u>Level III</u>	<u>Total</u>
December 31, 2016				
US special revenue bonds	\$ -	\$ 251	\$ -	\$ 251
Total bonds	-	251	-	251
Total assets at fair value	<u>\$ -</u>	<u>\$ 251</u>	<u>\$ -</u>	<u>\$ 251</u>
December 31, 2015				
Industrial and miscellaneous bonds	\$ -	\$ -	\$ -	\$ -
Total bonds	-	-	-	-
Total assets at fair value	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>

Fair values of fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level I or Level II inputs, for the determination of fair value to facilitate fair value measurements and disclosures. United States government securities represent Level I securities, while Level II securities primarily include corporate securities, securities from states, municipalities and political subdivisions and residential mortgage-backed securities. For securities not actively traded, the third party pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. As the Company is responsible for the determination of fair value, the Company performs monthly analyses on the prices received from third parties to determine whether the prices are reasonable estimates of fair value. The Company's analyses include a review of month-to-month price fluctuations and, as needed, a comparison of pricing services' valuations for the identical security.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

The following table summarizes the fair value of financial instruments by type:

December 31, 2016						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level I)	(Level II)	(Level III)	Not Practicable (Carrying Value)
Bonds	\$ 65,649	\$ 65,593	\$ –	\$ 65,649	\$ –	\$ –
Short-term investments	614	614	194	420	–	–
December 31, 2015						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level I)	(Level II)	(Level III)	Not Practicable (Carrying Value)
Bonds	\$ 65,671	\$ 64,560	\$ –	\$ 65,671	\$ –	\$ –
Short-term investments	427	426	194	233	–	–

4. Unpaid Claims and Claims Adjustment Expenses

The following table provides a reconciliation of the beginning and ending balances for unpaid claims and claims adjustment expenses:

	2016	2015
Balances at January 1	\$ 103,333	\$ 109,589
Incurred (redundancies) related to:		
Current year	1,054,746	857,116
Prior years	(10,359)	1,514
Total incurred	1,044,387	858,630
Paid related to:		
Current year	928,353	755,459
Prior years	88,407	109,427
Total paid	1,016,760	864,886
Balances at December 31	\$ 130,960	\$ 103,333

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any year end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established year end liability. The negative amounts reported for incurred related to prior years' results from claims being settled for amounts less than originally estimated. Positive amounts reported for incurred related to prior years result from claims being settled for amounts greater than originally estimated. This experience is primarily attributable to actual medical cost experience that differs from that assumed at the time the liability was established.

The Company took into account estimated anticipated subrogation and other recoveries in its determination of the liability for unpaid claims based on historical recovery patterns.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

5. Retrospectively Rated Contracts and Contracts Subject to Redetermination

The amount of net premiums written by the Company in 2016 and 2015 that was subject to retrospective rating features, including MLR rebate regulations, was \$1,230,056 and \$987,385, which represented 100% and 100%, respectively, of the total net premiums written.

6. Reinsurance

Certain premiums and benefits are ceded to other insurance companies under various reinsurance agreements. These reinsurance agreements limit the Company's exposure to losses within its capital resources. The Company remains obligated for amounts ceded in the event that the reinsurers do not meet their obligations.

The effects of reinsurance on net premium considerations are as follows:

	Year ended December 31	
	2016	2015
Direct premiums	\$ 1,214,275	\$ 987,385
Ceded premiums - non-affiliates	(415)	(1,180)
Net premiums	<u>\$ 1,213,860</u>	<u>\$ 986,205</u>

The Company's ceded reinsurance arrangements reduced certain other items in the accompanying financial statements as follows:

	Year ended December 31	
	2016	2015
Direct claims and claim adjustment expense	\$ 1,046,691	\$ 858,952
Ceded claims and claim adjustment expense	(2,304)	(322)
Net claims and claim adjustment expense	<u>\$ 1,044,387</u>	<u>\$ 858,630</u>

7. Federal Income Taxes

The Company had a federal income tax payable of \$5,543 and \$4,559 at December 31, 2016 and December 31, 2015, respectively.

The components of net deferred tax assets (liabilities) at December 31 are as follows:

	Ordinary	2016 Capital	Total
Gross deferred tax assets	\$ 5,024	\$ 117	\$ 5,141
Gross deferred tax liabilities	(1,077)	—	(1,077)
Net deferred tax asset before admissibility test	<u>\$ 3,947</u>	<u>\$ 117</u>	<u>\$ 4,064</u>

The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101 *Income Taxes* - ("SSAP No. 101") as of December 31, 2016 is:

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ 3,620	\$ 21	\$ 3,641
Admitted pursuant to paragraph 11.b	318	96	414
Admitted pursuant to paragraph 11.c	1,077	—	1,077
Admitted deferred tax asset	5,015	117	5,132
Deferred tax liability	(1,077)	—	(1,077)
Net admitted deferred tax asset	3,938	117	4,055
Nonadmitted deferred tax asset	\$ 9	\$ —	\$ 9

	Ordinary	2015 Capital	Total
Gross deferred tax assets	\$ 7,877	\$ —	\$ 7,877
Gross deferred tax liabilities	(500)	(2)	(502)
Net deferred tax asset before admissibility test	\$ 7,377	\$ (2)	\$ 7,375

The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101 as of December 31, 2015 is:

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ 3,233	\$ —	\$ 3,233
Admitted pursuant to paragraph 11.b	290	—	290
Admitted pursuant to paragraph 11.c	502	—	502
Admitted deferred tax asset	4,025	—	4,025
Deferred tax liability	(500)	(2)	(502)
Net admitted deferred tax asset	3,525	(2)	3,523
Nonadmitted deferred tax asset	\$ 3,852	\$ —	\$ 3,852

The change in the amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101 during 2016 is:

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ 387	\$ 21	\$ 408
Admitted pursuant to paragraph 11.b	28	96	124
Admitted pursuant to paragraph 11.c	575	—	575
Admitted deferred tax asset	990	117	1,107
Deferred tax liability	(577)	2	(575)
Net admitted deferred tax asset	413	119	532
Nonadmitted deferred tax asset	\$ (3,843)	\$ —	\$ (3,843)

	2016	2015
Amount of adjusted capital and surplus used to determine recovery period and threshold limitations.	\$ 107,766	\$ 41,371

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

The impact of tax planning strategies is as follows:

	2016		2015		Change	
	Ordinary	Capital	Ordinary	Capital	Ordinary	Capital
Adjusted gross deferred tax assets amount	\$ 5,024	\$ 117	\$ 7,877	\$ –	\$ (2,853)	\$ 117
Percentage of adjusted gross deferred tax assets by tax character attributable to the impact of tax planning strategies	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Net admitted adjusted gross deferred tax assets amount	\$ 5,015	\$ 117	\$ 4,025	\$ –	\$ 990	\$ 117
Percentage of net admitted adjusted gross deferred tax assets by tax character attributable to the impact of tax planning strategies	21.48%	0.00%	0.00%	0.00%	21.48%	0.00%

The Company's tax planning strategies do not include the use of reinsurance.

Current federal income taxes consist of the following major components:

	2016	2015	Change
Federal income taxes on operations	\$ 40,877	\$ 20,302	\$ 20,575
Federal income tax expense on net capital gains	1	–	1
Federal income taxes incurred	<u>\$ 40,878</u>	<u>\$ 20,302</u>	<u>\$ 20,576</u>

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

The components of deferred income taxes are as follows:

	December 31		
	2016	2015	Change
Deferred tax assets:			
Ordinary:			
Accrued future expenses	\$ 56	–	\$ 56
Amortization	1,281	1,771	(490)
Accounts receivable	1,812	1,871	(59)
Claims discount reserve	342	300	42
Fixed assets	133	3,009	(2,876)
Other insurance reserves	1,365	–	1,365
Prepaid expenses	30	268	(238)
Other adjustments	5	202	(197)
Stock compensation	–	456	(456)
Subtotal	5,024	7,877	(2,853)
Nonadmitted ordinary deferred tax assets	(9)	(3,852)	3,843
Admitted deferred tax assets	5,015	4,025	990
Capital:			
Investments in securities	117	–	117
Subtotal	117	–	117
Nonadmitted deferred tax assets			
Admitted capital deferred tax assets	117	–	117
Admitted deferred tax assets	5,132	4,025	1,107
Deferred tax liabilities:			
Ordinary:			
Surplus note interest	(1,077)	(500)	(577)
Subtotal	(1,077)	(500)	(577)
Capital:			
Investments in securities	–	(2)	2
Subtotal	–	(2)	2
Deferred tax liabilities	(1,077)	(502)	(575)
Net admitted deferred tax assets	\$ 4,055	\$ 3,523	\$ 532

The changes in deferred tax assets and deferred tax liabilities are as follows:

	December 31		
	2016	2015	Change
Total deferred tax assets	\$ 5,141	\$ 7,877	\$ (2,736)
Total deferred tax liabilities	(1,077)	(502)	(575)
Net deferred tax asset	\$ 4,064	\$ 7,375	(3,311)
Tax effect of unrealized gains			(124)
Change in net deferred income tax			\$ (3,435)

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

The Company's income tax expense and change in deferred taxes differs from the amount obtained by applying the federal statutory rate of 35% for the year ended December 31 for the following reasons:

	2016	2015
Tax expense computed using federal statutory rate	\$ 33,762	\$ 14,740
ACA health insurer fee	7,039	5,733
Change in nonadmitted assets	4,030	(1,795)
Tax exempt and dividend received income net of proration	(497)	—
Prior year true-ups and adjustments	336	—
Intercompany transfers and adjustments	(456)	—
Other	99	1,577
Total	<u>\$ 44,313</u>	<u>\$ 20,255</u>
Federal income taxes incurred	\$ 40,877	\$ 20,302
Tax on capital gain/(loss)	1	—
Change in net deferred income taxes	3,435	(47)
Total statutory income taxes	<u>\$ 44,313</u>	<u>\$ 20,255</u>

At December 31, 2016, the Company has no operating loss carryforwards or tax credit carryforwards.

The following are income taxes incurred in the current and prior years that will be available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2016	\$ 39,905	\$ 1	\$ 39,906
2015	18,713	20	18,733
2014	—	—	—

The Company is included in the consolidated federal income tax return of their parent Anthem, Inc., along with other affiliates, as of December 31, 2016. Allocation of federal income taxes with affiliates subject to the tax sharing agreement is based upon separate income tax return calculations with credit for net losses that can be used on a consolidated basis. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

The Company is a member of the IRS Compliance Assurance Program ("CAP"). The objective of CAP is to reduce taxpayer burden and uncertainty while assuring the IRS of the accuracy of tax returns prior to filing, thereby reducing or eliminating the need for post filing examinations. As of December 31, 2016, the examination of the 2016 tax year continues to be in process.

8. Health Insurer Fee

The Company had \$908,205 of premiums written subject to assessment under ACA Section 9010 as of December 31, 2015 and no premiums written subject to assessment under ACA Section 9010 as of December 31, 2016 due to the 2017 suspension of this assessment. Because no health insurer fee is to be paid in 2017, no funds have been segregated in special surplus funds for the health insurer fee at December 31, 2016. The Company's portion of the annual health insurance industry fee paid during 2016 was \$20,112 and is included in operating expenses.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

9. Capital and Surplus

The Florida OIR requires the Company to maintain a minimum statutory capital and surplus as set forth in the state statutes. Under those requirements, capital and surplus is calculated as the greater of \$1,500, or 10% of total liabilities, or 2% of total annualized premiums. The Florida OIR has not adopted the Risk-Based Capital (RBC) requirement of the NAIC. At December 31, 2016 and 2015, the Company's capital and surplus exceeded all regulatory requirements.

Per the *Florida Statue 641.365*, certain limitations exist on the Company's ability to pay dividends to its parent. The Company may pay funds only from accumulated surplus funds that were derived from realized net operating profits on its business and net realized capital gains. Prior written approval by the Florida OIR is required for payment of any dividend that would result in these accumulated surplus funds being less than zero. Florida OIR approval is not required if the dividend paid is less than the greater of 1) ten percent of the Company's accumulated surplus as of December 31st of the preceding year or 2) the Company's net income from the immediately preceding calendar year. Within the limitation above, the Company may pay dividends of \$55,585 during 2017 without prior approval.

The portion of unassigned surplus representing cumulative unrealized gains (losses) was (\$229) and \$0 as of December 31, 2016 and 2015, respectively.

10. Leases

The Company leases office space and EDP equipment and other miscellaneous items under various non-cancelable operating leases. Related lease expense for 2016 and 2015 was \$806 and \$6,133, respectively.

At December 31, 2016, future lease payments for operating leases with initial or remaining noncancelable terms of one year or more consisted of the following: 2017, \$487; 2018, \$3; 2019, \$3; 2020, \$3; and thereafter, \$225.

11. Commitments and Contingencies

Commitments:

During March 2012, the Company entered into a service agreement with a related party through common ownership, whereby a celebrity will provide certain marketing and communications services with respect to the Company's managed care services. As part of the agreement, the celebrity will be required to make public appearances on behalf of the Company. The agreement is for a term of five years, expiring in March 2017, and requires escalating monthly installments throughout the term. The Company is also required to reimburse the celebrity's reasonable out of pocket expenses including travel and meal expenses. The Company is entitled to terminate the agreement, with a thirty day written notice, under certain conditions defined in the agreement.

At December 31, 2016, future minimum payments under the service agreement consisted of \$802 for 2017.

Other Contingencies:

In February 2015, Anthem reported that it was the target of a sophisticated external cyber-attack. The attackers gained unauthorized access to certain of Anthem's information technology systems and obtained personal information related to many individuals and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that Anthem will not identify additional information that was accessed or obtained.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

Upon discovery of the cyber-attack, Anthem took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate its systems and identify solutions based on the evolving landscape. Anthem is providing credit monitoring and identity protection services to those who have been affected by this cyber-attack. Anthem has continued to implement security enhancements since this incident. Anthem has incurred expenses subsequent to the cyber-attack to investigate and remediate this matter and expects to continue to incur expenses of this nature in the foreseeable future. Anthem will recognize these expenses in the periods in which they are incurred.

Actions have been filed in various federal and state courts and other claims have been or may be asserted against Anthem on behalf of current or former members, current or former employees, other individuals, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber-attack. Federal and state agencies, including state insurance regulators, state attorneys general, the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigation, are investigating events related to the cyber-attack, including how it occurred, its consequences and Anthem's responses. The NAIC's multistate targeted market conduct and financial exam was concluded in December 2016. As part of the resolution, the NAIC asked and Anthem has agreed to provide a customized credit protection program functionally equivalent to a credit freeze for minors who were under the age of 18 on January 27, 2015. No fines or penalties were issued. Although Anthem is cooperating in these investigations, Anthem may be subject to fines or other obligations, which may have an adverse effect on how Anthem operates its business and on its results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation in February 2015 and was subsequently heard by the Panel in May 2015. In June 2015, the Panel entered its order transferring the consolidated matter to the U.S. District Court for the Northern District of California. The U.S. District Court entered its case management order in September 2015. Anthem filed a motion to dismiss ten of the counts that are before the U.S. District Court. In February 2016, the court issued an order granting in part and denying in part our motion, dismissing three counts with prejudice, four counts without prejudice and allowing three counts to proceed. Plaintiffs filed a second amended complaint in March 2016, and Anthem subsequently filed a second motion to dismiss. In May 2016, the court issued an order granting in part and denying in part our motion, dismissing one count with prejudice, dismissing certain counts asserted by specific named plaintiffs with or without prejudice depending on their individualized facts, and allowing the remaining counts to proceed. In July 2016, plaintiffs filed a third amended complaint, which Anthem answered in August 2016. Fact discovery was completed in December 2016. There remain two state court cases that are presently proceeding outside of the Multidistrict Litigation.

Anthem has contingency plans and insurance coverage for certain expenses and potential liabilities of this nature. While a loss from these matters is reasonably possible, Anthem cannot reasonably estimate a range of possible losses because the investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

The Company is involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits and reviews and administrative proceedings include routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and Federal Agencies. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on The Company's business operations. The Company believes that any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on the Company's financial position or results of operations.

At December 31, 2016 and 2015, the Company reported admitted assets of \$19,749 and \$17,835 respectively in premium receivables due from policyholders and agents and receivables due from uninsured plans. Based upon Company experience, any uncollectible receivables are not expected to exceed zero that was nonadmitted at

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

December 31, 2015; therefore, no additional provision for uncollectible amounts has been recorded. The potential for any additional loss is not believed to be material to the Company's financial condition.

12. Retirement Benefits

During 2015, the Company participated in a defined contribution plan created prior to the February 17, 2015 acquisition of Simply Healthcare by Anthem. No Company-matched amounts were contributed to the plan. Beginning on January 1, 2016, that defined contribution plan merged into the Anthem 401(k) Retirement Savings Plan, a defined contribution plan sponsored by ATH Holding Company, LLC ("ATH Holding") and covering substantially all employees. Voluntary employee contributions are matched by ATH Holding subject to certain limitations. ATH Holding allocates a share of the total accumulated costs of this plan to the Company based on the number of allocated employees. The Company has no legal obligation for benefits under this plan. During 2016, the Company was allocated \$1,246 for the defined contribution plan.

13. Uninsured Accident and Health Plans

The net loss from operations and total claim payment volume from administrative services only ("ASO") plans was:

	ASO Uninsured Plans	Uninsured Portion of Partially Insured Plans	Total ASO
For the year ended December 31, 2016			
Net reimbursement for administrative expenses (including administrative fees) in excess of actual expenses	\$ (110)	\$ —	\$ (110)
Total net other income or expenses (including interest paid to or received from plans)	—	—	—
Net loss from operations	(110)	—	(110)
Total claim payment volume	<u>\$ 3,382</u>	<u>\$ —</u>	<u>\$ 3,382</u>
For the year ended December 31, 2015			
Net reimbursement for administrative expenses (including administrative fees) in excess of actual expenses	\$ (249)	\$ —	\$ (249)
Total net other income or expenses (including interest paid to or received from plans)	—	—	—
Net loss from operations	(249)	—	(249)
Total claim payment volume	<u>\$ 7,310</u>	<u>\$ —</u>	<u>\$ 7,310</u>

The Company does not record revenue explicitly attributable to the cost share and reinsurance components of administered Medicare products.

As of December 31, 2016 and 2015, the Company recorded a receivable from CMS of \$503 and \$433, respectively, related to the cost share and reinsurance components of administered Medicare products.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

14. Health Care Receivable

Pharmaceutical rebate receivables of \$1,678 and \$1,266 were admitted at December 31, 2016 and 2015, respectively.

Pharmaceutical rebate receivables consist of reasonably estimated and billed amounts. Amounts not collected within 90 days of the invoice or confirmation date are nonadmitted. Pharmaceutical rebate receivables of \$1,585 and \$1,174 were nonadmitted as of December 31, 2016 and 2015, respectively.

The following table summarizes information about the Company's pharmaceutical rebate receivables:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More Than 180 Days After Billing
12/31/2016	\$ 1,678	\$ 1,678	\$ -	\$ -	\$ -
9/30/2016	1,921	1,585	-	-	-
6/30/2016	1,706	1,582	-	1,582	-
3/31/2016	1,470	1,445	-	1,445	-
12/31/2015	1,266	1,645	-	-	1,645
9/30/2015	991	1,863	-	-	1,863
6/30/2015	956	1,909	-	-	1,909
3/31/2015	993	1,553	-	-	1,553
12/31/2014	1,456	1,644	-	-	1,644
9/30/2014	1,264	1,611	-	-	1,611
6/30/2014	1,456	1,478	-	-	1,478
3/31/2014	1,235	1,208	-	-	1,208

Claim overpayment receivables consist of amounts that have been invoiced and meet the setoff conditions. Amounts that have not been invoiced and do not meet the setoff conditions are nonadmitted. Claim overpayment receivables and other health care receivables of \$954 and \$2,213 were nonadmitted as of December 31, 2016 and 2015, respectively.

Provider receivables of \$1,026 and \$988 at December 31, 2016 and 2015, respectively, were also nonadmitted.

15. Related Party Transactions

Effective January 1, 2016, the Company has entered into an administrative services agreement with its affiliated companies. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Costs include expenses such as salaries, benefits, communications, advertising, consulting services, rent, utilities, accounting, underwriting, and product development, which support the operations of the Company. These costs are allocated based on various utilization statistics. Net payments to affiliated companies pursuant to the 2016 administrative service agreements were \$100,869, and are included in operating expenses and claims adjustment expenses in the statutory basis statements of income.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

Prior to 2016, the Company entered into a Management Service Agreement with Better Health, Inc. (“Better Health”), a related party through common ownership, in which the Company provides services to administer a significant portion of Better Health’s benefits and business support services. In addition, the Company is entitled to receive reimbursements for reasonable expenses incurred in furtherance of operating Better Health in so much as these expenses exceed the amount of the management fee. For the year ended December 31, 2015, \$26,160 was received in relation to this agreement and has been recorded as an offset to general administrative expenses on the Company’s accompanying statutory statements of income.

At December 31, 2016 and 2015, the Company reported \$714 and \$0 due from affiliates, which were nonadmitted per Florida OIR prescribed accounting practices. At December 31, 2016 and 2015, the Company reported \$3,219 and \$2,974 due to affiliates, respectively. The receivable and payable balances represent intercompany transactions that are settled within the terms of the management and services agreement.

16. Surplus Notes and Letter of Credit

The Company entered into various promissory surplus notes in 2013 with Simply Holdings totaling \$20,560. The surplus notes bear interest at annual rates of 8%. Management determines what portion of principal of each note shall be repaid within ninety days after the end of each calendar year. The repayment of principal and any interest accrued is subordinated to the prior payment in full of all other liabilities of the Company. The repayment must also be approved by the Florida OIR and not cause the Company to fall below the minimum surplus requirements. Management does not anticipate any repayments during 2017.

During 2016 and 2015, the Company did not seek nor did the Florida OIR approve any interest payments. As of December 31, 2016 and 2015, the “unapproved” cumulative interest relating to the surplus notes is approximately \$9,424 and \$7,774, respectively.

17. Subsequent Events

Management of the Company has evaluated all other events occurring after December 31, 2016 through March 30, 2017, the date the financial statements were available to be issued, to determine whether any event required either recognition or disclosure in the financial statements. It was determined there were no other events that require recognition or disclosure in the financial statements through the report date.

FINANCIAL STATEMENTS AND SUPPLEMENTARY
INFORMATION – STATUTORY BASIS

Simply Healthcare Plans, Inc.

*Years Ended December 31, 2015 and 2014
With Reports of Independent Auditors*

Simply Healthcare Plans, Inc.

Financial Statements – Statutory Basis

Years ended December 31, 2015 and 2014

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Report of Independent Auditors

Board of Directors
Simply Healthcare Plans, Inc.

We have audited the accompanying statutory basis financial statements of Simply Healthcare Plans, Inc., which comprise the balance sheet as of December 31, 2015, and the related statements of income, changes in capital and surplus, and cash flows for the year then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation. Management also is responsible for the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 1, to meet the requirements of Florida, the financial statements have been prepared in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation, which practices differ from U.S. generally accepted accounting principles. The variances between such practices and U.S. generally accepted accounting principles are described in Note 1. The effects on the accompanying financial statements of these variances are not reasonably determinable but are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the effects of the matter described in the preceding paragraph, the statutory basis financial statements referred to above do not present fairly, in conformity with U.S. generally accepted accounting principles, the financial position of Simply Healthcare Plans, Inc. at December 31, 2015, or the results of its operations or its cash flows for the year then ended.

Opinion on Statutory Basis of Accounting

However, in our opinion, the statutory basis financial statements referred to above present fairly, in all material respects, the financial position of Simply Healthcare Plans, Inc. at December 31, 2015, and the results of its operations and its cash flows for the year then ended in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation.

Report of Other Auditors on Prior Year Financial Statements

The statutory basis financial statements of Simply Healthcare Plans, Inc. for the year ended December 31, 2014 were audited by other auditors who expressed an adverse opinion with respect to conformity with U.S. generally accepted accounting principles and an unmodified opinion with respect to conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation in their report dated March 31, 2015, except for the restatement section in Note 1 as to which the date is April 4, 2016. Their report dated March 31, 2015, except for the restatement section in Note 1 as to which the date is April 4, 2016, contained emphasis of a matter paragraphs describing the subsequent acquisition of Simply Healthcare Holdings, Inc. (parent company of Simply Healthcare Plans, Inc.) by Anthem, Inc. on February 17, 2015 and the restatement of the 2014 financial statements.



April 7, 2016

Simply Healthcare Plans, Inc.

Balance Sheets – Statutory Basis

	December 31	
	2015	2014
	<i>(In Thousands)</i>	
Admitted assets		
Cash and invested assets:		
Cash, cash equivalents, and short-term investments	\$ 92,585	\$ 150,737
Bonds	64,560	15,437
Total cash and invested assets	157,145	166,174
Accrued investment income	698	152
Premiums receivable	17,402	16,929
Reinsurance balances recoverable	253	17
Amounts receivable from uninsured plans	433	8,048
Net deferred tax asset	3,523	6,555
Electronic data processing equipment	1,223	652
Health care receivables	2,629	6,458
Other assets	10	10
Total admitted assets	<u>\$ 183,316</u>	<u>\$ 204,995</u>
Liabilities and capital and surplus		
Liabilities:		
Unpaid claims and claims adjustment expenses	\$ 103,333	\$ 109,589
Aggregate policy reserves	3,011	1,974
Premiums received in advance	—	37,952
Current federal income tax payable	4,559	5,256
Accounts payable and accrued expenses	10,706	10,133
Payables to parent and affiliates	2,974	65
Liability for amounts held under uninsured plans	6,213	1,746
Other liabilities	6,403	5,814
Total liabilities	137,199	172,529
Capital and surplus:		
Common stock, \$.01 par value, 10,000 shares authorized, 5,700 shares issued and outstanding	—	—
Additional paid-in surplus	5,714	5,714
Unassigned deficit	(171)	(2,977)
Surplus notes	20,560	20,560
Special surplus funds	20,014	9,169
Total capital and surplus	46,117	32,466
Total liabilities and capital and surplus	<u>\$ 183,316</u>	<u>\$ 204,995</u>

See accompanying notes.

Simply Healthcare Plans, Inc.

Statements of Income – Statutory Basis

	Year ended December 31	
	2015	2014
	<i>(In Thousands)</i>	
Premium income	\$ 986,205	\$ 834,607
Benefits and expenses:		
Claims and claims adjustment expenses	858,630	746,355
Operating expenses	85,788	65,804
Total benefits and expenses	944,418	812,159
Net underwriting gain	41,787	22,448
Investment gains:		
Net investment income	742	276
Net realized gains on investments, net of tax	6	11
Net investment gains	748	287
Other loss	(422)	(99)
Income before federal income taxes	42,113	22,636
Federal income taxes incurred	20,302	10,779
Net income	\$ 21,811	\$ 11,857

Simply Healthcare Plans, Inc.

Statement of Changes in Capital and Surplus – Statutory Basis

	<u>Surplus Notes</u>	<u>Paid-in Surplus</u>	<u>Unassigned (Deficit)</u> <i>(In Thousands)</i>	<u>Special Surplus Funds</u>	<u>Total Capital and Surplus</u>
Balance as of January 1, 2014	\$ 20,560	\$ 5,714	\$ (8,765)	\$ –	\$ 17,509
Net income	–	–	11,857	–	11,857
Change in net deferred income tax	–	–	1,138	–	1,138
Change in nonadmitted assets	–	–	1,962	–	1,962
ACA health insurer fee	–	–	(9,169)	9,169	–
Balance as of December 31, 2014	<u>20,560</u>	<u>5,714</u>	<u>(2,977)</u>	<u>9,169</u>	<u>32,466</u>
Net Income	–	–	21,811	–	21,811
Change in net deferred income tax	–	–	47	–	47
Change in nonadmitted assets	–	–	(8,207)	–	(8,207)
ACA health insurer fee	–	–	(10,845)	10,845	–
Balance as of December 31, 2015	<u>\$ 20,560</u>	<u>\$ 5,714</u>	<u>\$ (171)</u>	<u>\$ 20,014</u>	<u>\$ 46,117</u>

Simply Healthcare Plans, Inc.

Statements of Cash Flow – Statutory Basis

	Year ended December 31	
	2015	2014
	<i>(In Thousands)</i>	
Operating activities:		
Premiums collected, net of reinsurance	\$ 950,214	\$ 861,822
Net investment income	616	197
Claims and claims adjustment expenses	(862,201)	(699,506)
General administrative expenses paid	(72,176)	(65,890)
Federal income taxes paid	(18,620)	(5,855)
Net cash (used in) provided by operating activities	(2,167)	90,768
Investment activities:		
Proceeds from investments sold, matured or repaid	19,778	3,037
Cost of investments acquired	(69,317)	(15,077)
Net cash (used in) investment activities	(49,539)	(12,040)
Financing or miscellaneous activities:		
Other	(6,446)	8,908
Net cash provided by financing or miscellaneous activities	(6,446)	8,908
Change in cash, cash equivalents and short-term investments	(58,152)	87,636
Cash, cash equivalents and short-term investments at beginning of year	150,737	63,101
Cash and short-term investments at end of year	<u>\$ 92,585</u>	<u>\$ 150,737</u>

See accompanying notes.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

December 31, 2015

1. Nature of Operations and Significant Accounting Policies

Simply Healthcare Plans, Inc. (the “Company”) is a Florida domiciled stock health maintenance organization (“HMO”) which is licensed in Florida. The Company is a prepaid capitated plan created primarily for an enrolled population comprised of beneficiaries of the Medicaid and Medicare programs. The Company’s current service areas include all counties of Florida. As of December 31, 2015, the Company served 116,224 members. The Company manages healthcare services for Medicare members as a Medicare Advantage Plan, under a contract with the Centers for Medicare and Medicaid Services (“CMS”). The Company manages healthcare services for Medicaid members under a contract with the Florida Agency for Healthcare Administration (“AHCA”). The Company is a wholly owned subsidiary of Simply Healthcare Holdings, Inc. (“Simply Holdings”). On December 19, 2014, Simply Holdings entered into an Agreement and Plan of Merger with a subsidiary of Anthem, Inc. (“Anthem”), a publicly traded company. Based on receipt of all federal and state regulatory approvals, the acquisition was finalized and closed on February 17, 2015.

On July 24, 2015, the Company’s ultimate parent company, Anthem, and Cigna Corporation (“Cigna”) entered into an Agreement and Plan of Merger dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and a direct wholly-owned subsidiary of Anthem, pursuant to which Anthem will acquire all outstanding shares of Cigna. The acquisition is expected to close in the second half of 2016 and is subject to certain state regulatory approvals, standard closing conditions, customary approvals required under the Hart-Scott-Rodino Antitrust Improvements Act and the approval of both the Anthem, Inc. shareholders and Cigna’s stockholders.

Basis of Presentation

The accompanying financial statements have been prepared in accordance with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation (“Florida OIR”). The Florida OIR has adopted the accounting policies found in the National Association of Insurance Commissioners (“NAIC”) *Accounting Practices and Procedures Manual* (“NAIC SAP”) as a component of prescribed accounting practices. Additionally, the Florida OIR has adopted certain prescribed accounting practices that differ from those found in NAIC SAP, which impact the Company. The Company employed no permitted practices in preparing the accompanying statutory basis financial statements.

A reconciliation of the Company’s statutory capital and surplus as of December 31, 2015 and 2014 between practices prescribed by the Florida OIR and NAIC SAP is shown below:

	<u>2015</u>	<u>2014</u>
Statutory capital and surplus, Florida OIR basis	\$ 46,117	\$ 32,466
State prescribed practices:		
Nonadmittance of amounts due from affiliates pursuant to 641.35 (2)(i) of the FL Revised Statutes	—	539
Statutory capital and surplus, NAIC SAP basis	<u>\$ 46,117</u>	<u>\$ 33,005</u>

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

December 31, 2015

1. Nature of Operations and Significant Accounting Policies (continued)

For the years ended December 31, 2015 and 2014, there are no differences between the Company's net income under NAIC SAP and practices prescribed by the Florida OIR.

NAIC SAP varies from U.S. generally accepted accounting principles ("GAAP"). The more significant variances from GAAP, applicable to the Company, are as follows:

Investments: Investments in bonds are reported at amortized cost or fair value based on their NAIC rating. For GAAP, such fixed maturity investments are designated at purchase as available-for-sale and are reported at fair value with unrealized holding gains and losses reported as a separate component of capital and surplus.

For statutory purposes, all single class and multi-class mortgage-backed/asset-backed securities, such as collateralized mortgage obligations ("CMOs"), where it is determined that a decline in fair value is other-than-temporary because the Company intends to sell the security or has assessed that it does not have the intent and ability to retain the investments in the security for a period of time sufficient to recover the amortized cost basis, the amortized cost basis is written down to fair value as a realized loss in the statements of income. If deemed other-than-temporarily impaired as the Company does not expect to recover the amortized cost basis even if it did not intend to sell the security and the Company has the intent and ability to hold the security, the amortized cost basis is written down to the present value of future cash flows as a realized loss in the statements of income. For impaired bonds not backed by other assets, an other-than-temporary impairment ("OTTI") is considered to have occurred if it is probable that the Company will be unable to collect all amounts due according to the instrument's contractual terms in effect at the date of acquisition. A decline in fair value that is other-than-temporary includes situations where the Company has made a decision to sell a security prior to its maturity at an amount below its carrying value. If it is determined that a decline in the fair value of a bond is other-than-temporary, an impairment loss is recognized as a realized loss in the statements of income equal to the entire difference between the bond's carrying value and its fair value.

For GAAP purposes, all securities, purchased or retained, that represent beneficial interests in securitized assets, such as CMOs, mortgage-backed securities, bonds and asset-backed securities, other than high credit quality securities, whose decline in fair value is determined to be other-than-temporary, the cost basis of the security is written down to the fair value if the Company intends to sell the security or it is more likely than not that the Company will have to sell the security prior to recovery. For impaired fixed maturity securities that the Company does not intend to sell or it is more likely than not that the Company will not have to sell such securities, but the Company expects that it will not fully recover the amortized cost basis, the credit component of the OTTI is recognized in other-than-temporary losses in the income statements, and the non-credit component of the OTTI is recognized in other comprehensive income. Furthermore, unrealized losses entirely caused by non-credit factors related to fixed maturity securities for which the Company expects to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive income.

Premiums receivable: Premiums receivable are recorded at the billed amount and reduced by any amounts not deemed collectible. Generally amounts aged ninety days and older are excluded from the balance sheets by a direct charge to capital and surplus. For GAAP, these amounts are recorded at the billed amount and are reported net of a valuation allowance based upon historical collection trends and management's judgment on the collectability of these accounts.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

December 31, 2015

1. Nature of Operations and Significant Accounting Policies (continued)

Nonadmitted assets: Certain assets designated as nonadmitted, including furniture and equipment, receivables from affiliates, leasehold improvements, prepaid expenses, goodwill, intangibles, and certain health care and other receivable balances, are excluded from the balance sheets by a direct charge to capital and surplus. These nonadmitted assets totaled \$25,468 and \$17,261 at December 31, 2015 and 2014, respectively. For GAAP, these amounts are carried as assets, net of a valuation allowance, if necessary.

Surplus notes: Surplus notes are reported as capital and surplus, and surplus note interest expense is not recorded until approved by the Florida OIR. For GAAP, surplus notes are reported as long-term debt, and surplus note interest expense is accrued as incurred.

Deferred income taxes: Deferred tax assets are reduced by a statutory valuation allowance if, based on the weight of available evidence, it is more likely than not that some portion or all of the gross deferred tax assets will not be realized. Adjusted gross deferred tax assets are separated by character (ordinary and capital) and admitted in an amount equal to the sum of 1) the amount of federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the applicable carryback period, plus 2) based on Risk Based Capital (“RBC”) thresholds the lesser of the remaining adjusted gross deferred tax assets expected to be realized within the applicable period of the balance sheet date or an amount no greater than the applicable percentage of capital and surplus excluding any net deferred tax assets, electronic data processing (“EDP”) equipment and operating software and any net positive goodwill, plus 3) the amount of remaining adjusted gross deferred tax assets that can be offset against existing gross deferred tax liabilities after consideration of the reversal patterns of temporary differences. The remaining deferred tax asset is nonadmitted.

Deferred taxes do not include amounts for state taxes. Changes in deferred income taxes are recorded as adjustments to capital and surplus. For GAAP, state income taxes are considered in the computation of deferred taxes, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years, and a valuation allowance is established for deferred tax assets estimated to be unrealizable. Excluding the tax impact of unrealized investment gains and losses and certain other items, the change in deferred income taxes is recorded in the statements of income.

Statements of cash flow: Cash, cash equivalents and short-term investments in the statements of cash flow represent cash balances, and investments with initial maturities of one year or less. If in the aggregate the Company has a negative cash balance, it is reported as a negative asset and not as a liability. For GAAP, the corresponding captions of cash include cash balances and investments with initial maturities of three months or less and negative cash balances are reported separately as liabilities.

Reinsurance: Any reinsurance balance amounts deemed to be uncollectible have been written off through a charge to operations. In addition, a liability for reinsurance balances has been provided for unsecured policy reserves ceded to reinsurers not authorized to assume such business. Changes to the liability are credited or charged directly to unassigned surplus. Under GAAP, an allowance for amounts deemed uncollectible would be established through a charge to earnings. Policy and contract liabilities ceded to reinsurers have been reported as reductions of the related reserves rather than as assets as would be required under GAAP.

The effects of the foregoing variances from GAAP on the accompanying statutory basis financial statements have not been determined but are presumed to be material.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

1. Nature of Operations and Significant Accounting Policies (continued)

Other significant accounting policies are as follows:

Use of Estimates

Preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Investments

Bonds not backed by loans are stated at amortized cost, with amortization of premium or discount calculated based on the modified scientific method, using lower of yield to call or yield to maturity. Single class and multi-class mortgage-backed/asset-backed securities are valued at amortized cost using the interest method including anticipated prepayments. Prepayment assumptions for loan-backed securities and structured securities are obtained from broker-dealer survey values or internal estimates. These assumptions are consistent with the current interest rate and economic environment. The retrospective adjustment method is used to value all loan-backed securities. Non-investment grade bonds are stated at the lower of cost or fair value as determined by the NAIC's Securities Valuation Office ("SVO").

Short-term investments include investments with maturities of less than one year and more than three months at the date of acquisition and are reported at amortized cost, which approximates fair value. Non-investment grade short-term investments are stated at the lower of amortized cost or fair value.

Electronic Data Processing Equipment and Software

EDP equipment and software are recorded at cost less accumulated depreciation. Depreciation on EDP equipment and operating software is computed principally by the straight-line method over the lesser of the estimated useful lives of the assets or three years. Non-operating software is depreciated using the straight-line method over the lesser of its useful life or five years. Accumulated depreciation at December 31, 2015 and 2014 was \$2,564 and \$1,561, respectively. Depreciation expense in 2015 and 2014 was \$995 and \$847, respectively.

Furniture and Equipment

Furniture and equipment is capitalized and depreciated on a straight-line basis over its useful life. The net book value is charged in full to unassigned surplus as a nonadmitted asset. Depreciation expense in 2015 and 2014 was \$1,023 and \$980, respectively.

Health Care Receivables

Health care receivables represent amounts related to pharmacy rebate receivables and other health care related receivables other than premiums. Pharmacy rebate receivables are recorded when earned based upon actual rebate receivables and an estimate of receivables based upon current utilization of specific pharmaceuticals and provider contract terms. These health care receivables are subject to various admittance tests based on the nature of the receivable balance.

Unpaid Claims and Claims Adjustment Expenses

Unpaid claims and claims adjustment expenses include management's best estimate of amounts based on historical claim development patterns and certain individual case estimates. The established liability considers health benefit provisions, business practices, economic conditions and other factors that may materially affect the cost, frequency and severity of claims. Reserves for unpaid claims and claim adjustment expenses are based on assumptions and estimates, and while management believes such estimates are reasonable, the ultimate liability may be in excess of

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

December 31, 2015

1. Nature of Operations and Significant Accounting Policies (continued)

or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed and changes in estimates are incorporated into current operating results.

Premiums

Premiums are recognized as revenue during the period in which the Company is obligated to provide service to members. Premium payments from contracted government agencies are based on eligibility lists produced by the government agencies. Adjustments to eligibility lists produced by the government agencies result from retroactive application of enrollment or disenrollment of members or classification changes between rate categories. The Company estimates the amount of retroactive premium owed to or from the government agencies each period and adjusts premium revenue accordingly. Expenses incurred in connection with acquiring insurance business are charged to operations as incurred.

Delays in approval of annual premium rate changes require that the Company defer the recognition of any increases to the period in which the premium rates become final. The value of the impact can be significant in the period in which it is recognized dependent on the magnitude of the premium rate increase, the membership to which it applies and the length of the delay between the effective date of the rate increase and the final contract date. Premium rate decreases are recognized in the period the change in premium rate becomes effective and the change in the rate is known, which may be prior to the period when the contract amendment affecting the rate is finalized.

Medicare Advantage Part D Premiums and Expenses

The Company serves as a plan sponsor, offering Medicare Advantage Part D prescription drug insurance coverage under a contract with the Centers for Medicare & Medicaid Services (“CMS”). The CMS premium, the member premium, and the low-income premium subsidy represent payments for the Company’s insurance risk coverage under the Medicare Advantage Part D program and therefore are recorded as premium revenues in operations. Premium revenues are recognized ratably over the period in which eligible individuals are entitled to receive prescription drug benefits. Pharmacy benefit costs and administrative costs under the contract are expensed as incurred.

Subsidies from CMS representing cost reimbursements under the Medicare Part D program are not reflected as premium revenues, but rather are accounted for as deposits, with the related liabilities reported in the balance sheets with other liabilities.

Reinsurance

Reinsurance premiums, claims and claims adjustment expenses are accounted for on a basis consistent with those used in accounting for the original policies issued and the terms of the reinsurance contracts.

Retrospectively Rated Contracts

The Company’s contracts with CMS and the State Medicaid Agency include a provision for which premiums vary based on loss experience. The Company estimates accrued retrospective premium adjustments through the review of each retrospectively rated contract, comparing the claim development with that anticipated in the contract. Any adjustment made to the estimated liability as a result of a final settlement is included in current operations. The Company uses estimates to report in the statutory basis financial statements the incurred and unpaid liability amounts for retrospectively rated contracts based on its underwriting experience; actuarial, tax, and accounting estimates and assumptions at the financial statement date and regulations and guidance available that is subject to

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

December 31, 2015

1. Nature of Operations and Significant Accounting Policies (continued)

change prior to settlement. Accordingly, the Company's use of estimates and assumptions in the preparation of the statutory basis financial statements and related footnote disclosures may differ from actual results. The Company records accrued retrospective premium as an adjustment to earned premium.

The amount of net premiums written by the Company in 2015 and 2014 that was subject to retrospective rating features, including MLR rebates regulations, was \$987,385 and \$449,461, which represented 100% and 53.8%, respectively, of the total net premiums written.

Federal Income Taxes

The Company participates in a tax sharing agreement with Anthem and its subsidiaries. Allocation of federal income taxes is based upon separate return calculations with credit for net losses that can be used on a consolidated basis. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

Patient Protection and Affordable Care Act

In 2010, the U.S. Congress passed and the President signed into law ACA. ACA has created significant changes and will continue to create significant changes for health insurance markets. Certain requirements include changes to Medicare Advantage payments and the minimum MLR provision that requires insurers to pay rebates to customers when insurers do not meet or exceed the specified MLR thresholds. Most of the provisions of ACA with more significant effects on the health insurance marketplace, both state and federal, went into effect on January 1, 2014, including a requirement that insurers guarantee the issuance of coverage to all individuals regardless of health status, strict rules on how health insurance is rated, the assessment of new taxes and fees (including annual fees on health insurance companies), the creation of new insurance exchanges for individuals and small groups, the availability of premium subsidies for certain individual products, and substantial expansions in eligibility for Medicaid.

Implementation of ACA brings with it significant oversight responsibilities by health insurers that may result in increased governmental audits, increased assertions of *False Claims Act* violations, and an increased risk of other litigation.

Health Insurer Fee

ACA Section 9010 imposed a mandatory annual fee on health insurers that write certain types of health insurance on U.S. risks for each calendar year beginning on or after January 1, 2014. The annual fee is allocated to health insurers based on the ratio of the amount of an insurer's premium written during the preceding calendar year to the amount of health insurance for all U.S. health risk for those certain lines of business that is written during the preceding calendar year. This fee is non-deductible for income tax purposes. The health insurer fee paid in 2015 is included in 2015 operating expenses. The estimated health insurer fee payable in 2016 is segregated in special surplus funds at December 31, 2015. For statutory accounting purposes, the entire fee expected to be paid during the year is recorded as a general and administrative expense on January 1st, as the first policy is underwritten for the calendar year.

Reclassifications

Certain prior year amounts have been reclassified to conform to the current year presentation.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

December 31, 2015

2. Investments

A summary of the Company's investments in bonds is as follows:

	Statement Value	Gross Unrealized Gains	Gross Unrealized Losses Less Than 12 Months	12 Months or Greater	Fair Value
<i>December 31, 2015</i>					
States, territories and political subdivisions	\$ 64,560	\$ 1,140	\$ (29)	\$ –	\$ 65,671
Total bonds	<u>\$ 64,560</u>	<u>\$ 1,140</u>	<u>\$ (29)</u>	<u>\$ –</u>	<u>\$ 65,671</u>
<i>December 31, 2014</i>					
States, territories and political subdivisions	\$ 3,936	\$ –	\$ (4)	\$ –	\$ 3,932
Industrial and miscellaneous	11,501	1	(10)	–	11,492
Total bonds	<u>\$ 15,437</u>	<u>\$ 1</u>	<u>\$ (14)</u>	<u>\$ –</u>	<u>\$ 15,424</u>

The statement and fair values of bonds at December 31, 2015, by contractual maturity, are shown below. Actual maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Statement Value	Fair Value
Due in one year or less	\$ 1,440	\$ 1,444
Due after one through five years	19,250	19,296
Due after five through ten years	20,726	21,096
Due after ten years	23,144	23,835
	<u>\$ 64,560</u>	<u>\$ 65,671</u>

Proceeds from sales of bonds during 2015 and 2014 were \$19,780 and \$1,862, respectively, resulting in realized gross gains of \$59 and \$11, respectively, and realized gross losses of \$51 in 2015.

Cash of \$300 and \$300 were on deposit with the Florida OIR at December 31, 2015 and 2014, respectively.

A significant judgment in the valuation of investments is the determination of when an other-than-temporary decline in value has occurred. The Company follows a consistent and systematic process for impairing securities that sustain other-than-temporary declines in value. The Company has established a committee responsible for the impairment review process. The decision to impair a security incorporates both quantitative criteria and qualitative information. The impairment review process considers a number of factors, including but not limited to (a) the length of time and the extent to which a security's fair value has been less than statement value; (b) the financial condition and near term prospects of the issuer; (c) the intent to sell and, for loan-backed and structured securities, the intent and ability of the Company to retain its investment for a period of time to allow for any anticipated recovery in value; (d) whether the debtor is current on interest and principal payments; and (e) general market conditions and industry or sector specific factors. For securities that are deemed to be other-than-temporarily impaired, the security is adjusted to its fair value (or its discounted cash flows for loan-backed and structured securities), and the resulting losses are recognized in net realized gains or losses in the statutory basis statements of income. The new cost basis of the impaired securities is not increased for future recoveries in fair value. The Company recorded no charges OTTI of securities for the years ended December 31, 2015 and 2014.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

2. Investments (continued)

A summary of unaffiliated investments with unrealized losses along with the related fair value, aggregated by the length of time that investments have been in a continuous unrealized loss position, is as follows:

	December 31, 2015			December 31, 2014		
	Number of Securities	Fair Value	Gross Unrealized Loss	Number of Securities	Fair Value	Gross Unrealized Loss
Bonds:						
Less than 12 months	11	\$ 8,061	\$ (29)	8	\$ 6,372	\$ (14)
12 months or greater	—	—	—	—	—	—
Total bonds	11	\$ 8,061	(29)	8	\$ 6,372	(14)

The Company's bond portfolio is sensitive to interest rate fluctuations, which impact the fair value of individual securities. Unrealized losses on bonds reported above were primarily caused by the effects of the interest rate environment and the widening of credit spreads on certain securities. Unrealized losses on stocks result from normal market fluctuations and are considered temporary. The Company currently has the ability and intent to hold these securities until their full cost can be recovered. Therefore, the Company does not believe the unrealized losses represent an OTTI as of December 31, 2015 or 2014.

3. Fair Value

Assets and liabilities recorded at fair value in the statutory basis balance sheets would be categorized based upon the level of judgment associated with the inputs used to measure their fair value. Level inputs are as follows:

<u>Level Input</u>	<u>Input Definition</u>
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

At December 31, 2015 and 2014, the Company did not have any assets or liabilities measured at fair value.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

December 31, 2015

3. Fair Value (continued)

The following table summarizes the fair value of financial instruments by type as of December 31, 2015 and 2014, respectively:

December 31, 2015						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level I)	(Level II)	(Level III)	Not Practicable (Carrying Value)
Bonds	\$ 65,671	\$ 64,560	\$ –	\$ 65,671	\$ –	\$ –
Short-term investments	427	426	194	233	–	–

December 31, 2014						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level I)	(Level II)	(Level III)	Not Practicable (Carrying Value)
Bonds	\$ 15,424	\$ 15,437	\$ 3,500	\$ 11,924		
Short-term investments	48,546	48,552		48,546		

4. Unpaid Claims and Claims Adjustment Expenses

The following table provides a reconciliation of the beginning and ending balances for unpaid claims and claims adjustment expenses:

	2015	2014
Balances at January 1	\$ 109,589	\$ 53,924
Incurred (redundancies) related to:		
Current year	857,116	742,064
Prior years	1,514	4,291
Total incurred	858,630	746,355
Paid related to:		
Current year	755,459	633,193
Prior years	109,427	57,497
Total paid	864,886	690,690
Balances at December 31	\$ 103,333	\$ 109,589

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any year end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established year end liability. The negative amounts reported for incurred related to prior years' results from claims being settled for amounts less than originally estimated. Positive amounts reported for incurred related to prior years result from claims being settled for amounts greater than originally estimated. This experience is primarily attributable to actual medical cost experience that differs from that assumed at the time the liability was established.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

4. Unpaid Claims and Claims Adjustment Expenses (continued)

The Company took into account estimated anticipated subrogation and other recoveries in its determination of the liability for unpaid claims based on historical recovery patterns.

5. Reinsurance

Certain premiums and benefits are ceded to other insurance companies under various reinsurance agreements. These reinsurance agreements limit the Company's exposure to losses within its capital resources. The Company remains obligated for amounts ceded in the event that the reinsurers do not meet their obligations. Effective January 1, 2014 the reinsurance activity includes the transitional reinsurance program required by ACA and disclosed in Note 8.

The effects of reinsurance on net premium considerations are as follows:

	Year ended December 31	
	2015	2014
Direct premiums	\$ 987,385	\$ 835,894
Ceded premiums - non-affiliates	(1,180)	(1,287)
Net premiums	<u>\$ 986,205</u>	<u>\$ 834,607</u>

The Company's ceded reinsurance arrangements reduced certain other items in the accompanying financial statements as follows:

	Year ended December 31	
	2015	2014
Direct claims and claim adjustment expense	\$ 858,952	\$ 747,016
Ceded claims and claim adjustment expense	(322)	(661)
Net claims and claim adjustment expense	<u>\$ 858,630</u>	<u>\$ 746,355</u>

6. Federal Income Taxes

The Company had a federal income tax payable of \$4,559 and \$5,256 at December 31, 2015 and December 31, 2014, respectively.

The components of net deferred tax assets (liabilities) at December 31 are as follows:

	Ordinary	2015 Capital	Total
Gross deferred tax assets	\$ 7,877	\$ –	\$ 7,877
Gross deferred tax liabilities	(500)	(2)	(502)
Net deferred tax asset before admissibility test	<u>\$ 7,377</u>	<u>\$ (2)</u>	<u>\$ 7,375</u>

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

6. Federal Income Taxes (continued)

The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101 *Income Taxes - A Replacement of SSAP No. 10R and SSAP 10* ("SSAP No. 101") as of December 31, 2015 is:

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ 3,233	\$ –	\$ 3,233
Admitted pursuant to paragraph 11.b	290	–	290
Admitted pursuant to paragraph 11.c	502	–	502
Admitted deferred tax asset	4,025	–	4,025
Deferred tax liability	(500)	(2)	(502)
Net admitted deferred tax asset	3,525	(2)	3,523
Nonadmitted deferred tax asset	\$ 3,852	\$ –	\$ 3,852

	Ordinary	2014 Capital	Total
Gross deferred tax assets	\$ 7,328	\$ –	\$ 7,328
Gross deferred tax liabilities	–	–	–
Net deferred tax asset before admissibility test	\$ 7,328	\$ –	\$ 7,328

The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101 as of December 31, 2014 is:

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ 6,336	\$ –	\$ 6,336
Admitted pursuant to paragraph 11.b	219	–	219
Admitted pursuant to paragraph 11.c	–	–	–
Admitted deferred tax asset	6,555	–	6,555
Deferred tax liability	–	–	–
Net admitted deferred tax asset	6,555	–	6,555
Nonadmitted deferred tax asset	\$ 773	\$ –	\$ 773

The change in the amount of admitted adjusted gross deferred tax assets under each component during 2015 is:

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ (3,103)	\$ –	\$ (3,103)
Admitted pursuant to paragraph 11.b	71	–	71
Admitted pursuant to paragraph 11.c	502	–	502
Admitted deferred tax asset	(2,530)	–	(2,530)
Deferred tax liability	(500)	(2)	(502)
Net admitted deferred tax asset	(3,030)	(2)	(3,032)
Nonadmitted deferred tax asset	\$ 3,079	\$ –	\$ 3,079

	2015	2014
Amount of adjusted capital and surplus used to determine recovery period and threshold limitations.	\$ 41,371	\$ 25,259

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

6. Federal Income Taxes (continued)

The impact of tax planning strategies is as follows:

	2015		2014		Change	
	Ordinary	Capital	Ordinary	Capital	Ordinary	Capital
Adjusted gross deferred tax assets amount	\$ 7,877	\$ –	\$ 7,328	\$ –	\$ 549	\$ –
Percentage of adjusted gross deferred tax assets by tax character attributable to the impact of tax planning strategies	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Net admitted adjusted gross deferred tax assets amount	\$ 4,025	\$ –	\$ 6,555	\$ –	\$ (2,530)	\$ –
Percentage of net admitted adjusted gross deferred tax assets by tax character attributable to the impact of tax planning strategies	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

The Company's tax planning strategies do not include the use of reinsurance.

Current federal income taxes consist of the following major components:

	2015	2014	Change
Federal income taxes on operations	\$ 20,302	\$ 10,779	\$ 9,523
Federal income tax expense on net capital gains	–	–	–
Federal income taxes incurred	<u>\$ 20,302</u>	<u>\$ 10,779</u>	<u>\$ 9,523</u>

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

6. Federal Income Taxes (continued)

The components of deferred income taxes are as follows:

	December 31		
	2015	2014	Change
Deferred tax assets:			
Ordinary:			
Amortization	\$ 1,771	\$ 882	\$ 889
Accounts receivable	1,871	2,367	(496)
Fixed assets	3,009	701	2,308
Stock compensation	456	–	456
Claims discount reserve	300	266	34
Prepaid expenses	268	342	(74)
Other	202	113	89
Unearned premium reserve	-	2,657	(2,657)
Subtotal	7,877	7,328	549
Nonadmitted ordinary deferred tax assets	(3,852)	(773)	(3,079)
Admitted deferred tax assets	4,025	6,555	(2,530)
Deferred tax liabilities:			
Ordinary:			
Surplus Note Interest	(500)	-	(500)
Subtotal	(500)	-	(500)
Capital:			
Investments in securities	(2)	-	(2)
Subtotal	(2)	-	(2)
Deferred tax liabilities	(502)	-	(502)
Net admitted deferred tax assets	\$ 3,523	\$ 6,555	\$ (3,032)

The changes in deferred tax assets and deferred tax liabilities are as follows:

	December 31		
	2015	2014	Change
Total deferred tax assets	\$ 7,877	\$ 7,328	\$ 549
Total deferred tax liabilities	(502)	-	(502)
Net deferred tax asset	\$ 7,375	\$ 7,328	47
Tax effect of unrealized gains			-
Change in net deferred income tax			\$ 47

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

6. Federal Income Taxes (continued)

The Company's income tax expense and change in deferred taxes differs from the amount obtained by applying the federal statutory rate of 35% for the year ended December 31 for the following reasons:

	2015	2014
Tax expense computed using federal statutory rate	\$ 14,740	\$ 7,923
Change in nonadmitted assets	(1,795)	493
ACA health insurer fee	5,733	1,221
Other	1,577	4
Total	<u>\$ 20,255</u>	<u>\$ 9,641</u>
 Federal income taxes incurred	 \$ 20,302	 \$ 10,779
Change in net deferred income taxes	(47)	(1,138)
Total statutory income taxes	<u>\$ 20,255</u>	<u>\$ 9,641</u>

At December 31, 2015, the Company has no operating loss carryforwards or tax credit carryforwards.

The following are income taxes incurred in the current and prior years that will be available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2015	\$ 19,395	\$ 20	\$ 19,415
2014	11,931	—	11,931

The Company is a member of the IRS Compliance Assurance Program ("CAP"). The objective of CAP is to reduce taxpayer burden and uncertainty while assuring the IRS of the accuracy of tax returns prior to filing, thereby reducing or eliminating the need for post filing examinations. As of December 31, 2015, the examination of the 2015 tax year continues to be in process.

7. Health Insurer Fee

The Company has \$908,205 and \$834,608 of premiums written subject to assessment under ACA Section 9010 as of December 31, 2015 and 2014, respectively. The Company's estimated portion of the annual health insurance industry fee to be paid by September 30, 2016 is \$20,014 as segregated in special surplus funds on the balance sheet. The Company's portion of the annual health insurance industry fee paid during 2015 was \$18,706 and is included in operating expenses. Total Adjusted Capital ("TAC") and Authorized Control Level ("ACL") were \$46,117 and \$35,244, respectively, as of December 31, 2015. Had the assessment, based upon 2015 premiums written, been accrued on December 31, 2015, TAC would have been reduced to \$26,103, which would continue to exceed all capital and surplus requirements as described in Note 8.

8. Capital and Surplus

The State of Florida requires Company to maintain a minimum statutory capital and surplus as set forth in the State. Under those requirements, capital and surplus is calculated as the greater of \$1,500, or 10% of total liabilities, or 2% of total annualized premiums. The Florida OIR has not adopted the Risk-Based Capital (RBC) requirement of the NAIC. At December 31, 2015 and 2014, the Company's capital and surplus exceeded all regulatory requirements.

Per the *Florida Statue 641.365*, certain limitations exist on the Company's ability to pay dividends to its parent. The Company may pay funds only from accumulated surplus funds that were derived from realized net operating profits on its business and net realized capital gains. Prior written approval by the Florida OIR is required for payment of

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

December 31, 2015

8. Capital and Surplus (continue)

any dividend that would result in these accumulated surplus funds being less than zero. Florida OIR approval is not required if the dividend paid is less than the greater of 1) ten percent of the Company's accumulated surplus as of December 31st of the preceding year or 2) the Company's net income from the immediately preceding calendar year.

Within the limitation above, the Company may not pay dividends during 2016 without prior approval.

There was no portion of unassigned surplus representing cumulative unrealized gains as of December 31, 2015 and 2014, respectively.

9. Leases

The Company leases office space and EDP equipment and other miscellaneous items under various non-cancelable operating leases. Related lease expense for 2015 and 2014 was \$6,133 and \$6,060, respectively.

At December 31, 2015, future lease payments for operating leases with initial or remaining noncancelable terms of one year or more consisted of the following: 2016, \$1,818; 2017, \$2,475; 2018, \$2,335; 2019, \$2,406; and thereafter, \$2,478.

10. Commitments and Contingencies

Commitments:

During March 2012, the Company entered into a service agreement with a related party through common ownership, whereby a celebrity will provide certain marketing and communications services with respect to the Company's managed care services. As part of the agreement, the celebrity will be required to make public appearances on behalf of the Company. The agreement is for a term of five years, expiring in March 2017, and requires escalating monthly installments throughout the term. The Company is also required to reimburse the celebrity's reasonable out of pocket expenses including travel and meal expenses. The Company is entitled to terminate the agreement, with a thirty day written notice, under certain conditions defined in the agreement.

At December 31, 2015, future minimum payments under the service agreement consisted of the following: 2016, \$3,500; and 2017, \$802.

Other Contingencies:

In February 2015, Anthem reported that it was the target of a sophisticated external cyber-attack. The attackers gained unauthorized access to certain of Anthem's information technology systems and obtained personal information related to many individuals and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that Anthem will not identify additional information that was accessed or obtained.

Anthem has continued to implement security enhancements since this incident and is supporting federal law enforcement efforts to identify the responsible parties. Upon discovery of the cyber-attack, Anthem took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate its systems and identify

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

December 31, 2015

10. Commitments and Contingencies (continued)

solutions based on the evolving landscape. Anthem is providing credit monitoring and identity protection services to those who have been affected by this cyber-attack. Anthem has incurred expenses subsequent to the cyber-attack to investigate and remediate this matter and expects to continue to incur expenses of this nature in the foreseeable future. Anthem will recognize these expenses in the periods in which they are incurred.

The Company is involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental and administrative proceedings. These investigations, audits and reviews include routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and Federal Agencies. Such investigations could result in the imposition of civil or criminal fines, penalties and other sanctions. The Company believes that any liability that may result from any one of these actions is unlikely to have a material adverse effect on the Company's financial position or results of operations.

Actions have been filed in various federal and state courts, and other claims have been or may be asserted against Anthem on behalf of current or former members, current or former employees, other individuals, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber-attack. State and federal agencies, including state insurance regulators, state attorneys general, the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigation, are investigating events related to the cyber-attack, including how it occurred, its consequences and Anthem's responses. Although Anthem is cooperating in these investigations, Anthem may be subject to fines or other obligations, which may have an adverse effect on how Anthem operates its business and results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation in February 2015 and was subsequently heard by the Panel in May 2015. In June 2015, the Panel entered its order transferring the consolidated matter to the U.S. District Court for the Northern District of California. The U.S. District Court entered its Case Management Order in September 2015. Anthem has filed a Motion to Dismiss several of the counts that are before the U.S. District Court. There remain a few state court cases that are presently proceeding outside of the Multidistrict Litigation.

Anthem has contingency plans and insurance coverage for certain expenses and potential liabilities of this nature. The coverage has been sufficient to cover the majority of claims and liabilities incurred to date. While a loss from these matters is reasonably possible, Anthem cannot reasonably estimate a range of possible losses because the investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

The Company is involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental and administrative proceedings. These investigations, audits and reviews include routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and Federal Agencies. Such investigations could result in the imposition of civil or criminal fines, penalties and other sanctions. The Company believes that any liability that may result from any one of these actions is unlikely to have a material adverse effect on the Company's financial position or results of operations.

At December 31, 2015 and 2014, the Company reported admitted assets of \$17,835 and \$24,977 respectively in premium receivables due from policyholders and agents and receivables due from uninsured plans. Based upon Company experience, any uncollectible receivables are not expected to exceed zero that was nonadmitted at December 31, 2015; therefore, no additional provision for uncollectible amounts has been recorded. The potential for any additional loss is not believed to be material to the Company's financial condition.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

11. Health Care Receivable

Admitted health care receivables consist of pharmacy rebate receivables of \$1,266 and \$1,456, claims overpayments of \$1,312 and \$1,971, and other receivables of \$51 and \$3,031 at December 31, 2015 and 2014, respectively.

Pharmaceutical rebate receivables at December 31, 2015 and 2014 consist of reasonably estimated and billed amounts. Amounts not collected within 90 days of the invoice or confirmation date are nonadmitted. Pharmaceutical rebate receivables of \$1,174 and \$3,955 were nonadmitted as of December 31, 2015 and 2014, respectively.

The following table summarizes information about the Company's pharmaceutical rebate receivables:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More Than 180 Days After Billing
4th Qtr 2015	\$ 1,266	\$ 1,266	\$ —	\$ —	\$ —
3rd Qtr 2015	991	1,174	—	—	—
2nd Qtr 2015	956	1,318	—	—	1,318
1st Qtr 2015	993	1,211	—	—	1,211
4th Qtr 2014	\$ 1,456	\$ 1,656	\$ —	\$ —	\$ 1,656
3rd Qtr 2014	1,264	1,607	—	—	1,607
2nd Qtr 2014	1,456	1,469	—	—	1,469
1st Qtr 2014	1,235	1,175	—	—	1,175
4th Qtr 2013	\$ 565	\$ 867	\$ —	\$ —	\$ 867
3rd Qtr 2013	496	686	—	—	686
2nd Qtr 2013	402	501	—	—	501
1st Qtr 2013	343	406	—	—	406

Claim overpayment receivables consist of amounts that have been invoiced and meet the setoff conditions. Amounts that have not been invoiced and do not meet the setoff conditions are nonadmitted. Claim overpayment receivables and other health care receivables of \$2,206 and \$1,794 were nonadmitted as of December 31, 2015 and 2014, respectively.

Provider receivables of \$988 and zero and other receivables of \$6 and \$12 at December 31, 2015 and 2014, respectively, were also nonadmitted.

12. Related Party Transactions

The Company entered into a Management Service Agreement with Better Health, Inc. ("Better Health"), a related party through common ownership, in which the Company provides services to administer a significant portion of Better Health's benefits and business support services. In addition, the Company is entitled to receive reimbursements for reasonable expenses incurred in furtherance of operating Better Health in so much as these expenses exceed the amount of the management fee. For the years ended December 31, 2015 and 2014, \$26,160 and \$36,493 was received in relation to this agreement and has been recorded as an offset to general administrative expenses on the Company's accompanying statutory statements of income.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

13. Related Party Transactions (continue)

For the years ended December 31, 2015 and 2014, approximately \$167 and \$1,600, respectively, was paid to a related party for management fees and reimbursable expenses. There is no formal agreement between the parties and as a result, the reimbursement amounts are based on expenses paid by the related party, which are approved by the Company's executives.

At December 31, 2015 and 2014, the Company reported \$2,975 and \$64 due to affiliates, respectively. The receivable and payable balances represent intercompany transactions that are settled within the terms of the management and services agreement.

14. Surplus Notes and Letter of Credit

The Company entered into various promissory surplus notes in 2013 with Simply Holdings totaling \$20,560. The surplus notes bear interest at annual rates of 8%. Management determines what portion of principal of each note shall be repaid within ninety days after the end of each calendar year. The repayment of principal and any interest accrued is subordinated to the prior payment in full of all other liabilities of the Company. The repayment must also be approved by the Florida OIR and not cause the Company to fall below the minimum surplus requirements. Management does not anticipate any repayments during 2016.

During 2015 and 2014, the Company did not seek nor did the Florida OIR approve any interest payments. As of December 31, 2015 and 2014, the "unapproved" cumulative interest relating to the surplus notes is approximately \$7,774 and \$6,130, respectively.

At December 31, 2014, the Company had an outstanding letter of credit of \$99,529 that matured December 31, 2015 and was collateralized by certain assets of the Parent.

Simply Healthcare Plans, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

15. Reconciliation to the Statutory Annual Statements

The 2014 audited net income and surplus amounts presented in the 2015 audited financial statements were adjusted as compared to the presentation in the 2014 Annual Statement as follows:

	Year ended December 31	
	2015	2014
Total capital and surplus reported in the Annual Statement	\$ 46,117	\$ 27,319
Increase in net deferred tax asset	–	5,147
Total capital and surplus reported in the accompanying statutory basis balance sheets	<u>\$ 46,117</u>	<u>\$ 32,466</u>
	Year ended December 31	
	2015	2014
Total net income as reported in the Annual Statement	\$ 21,811	\$ 11,857
Total net income as reported in the accompanying statutory basis statements of income	<u>\$ 21,811</u>	<u>\$ 11,857</u>

16. Subsequent Events

The annual health insurer fee under section 9010 of the ACA, discussed in Note 1, has been suspended for 2017 and will resume for 2018 and beyond.

Management of the Company has evaluated all other events occurring after December 31, 2015 through April 07, 2016, the date the financial statements were available to be issued, to determine whether any event required either recognition or disclosure in the financial statements. It was determined there were no other events that require recognition or disclosure in the financial statements through the report date.

FINANCIAL STATEMENTS – STATUTORY BASIS

Better Health, Inc.

*Years Ended December 31, 2016 and 2015
with Reports of Independent Auditors*

Better Health, Inc.

Financial Statements – Statutory Basis

Years ended December 31, 2016 and 2015

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Report of Independent Auditors

Board of Directors
Better Health, Inc.

We have audited the accompanying statutory-basis financial statements of Better Health, Inc., which comprise the balance sheets as of December 31, 2016 and 2015, and the related statements of operations, changes in capital and surplus and cash flow for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation. Management also is responsible for the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 1, to meet the requirements of Florida, the financial statements have been prepared in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation, which practices differ from U.S. generally accepted accounting principles. The variances between such practices and U.S. generally accepted accounting principles are described in Note 1. The effects on the accompanying financial statements of these variances are not reasonably determinable but are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the effects of the matter described in the preceding paragraph, the statutory-basis financial statements referred to above do not present fairly, in conformity with U.S. generally accepted accounting principles, the financial position of Better Health, Inc. at December 31, 2016 and 2015, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

However, in our opinion, the statutory basis financial statements referred to above present fairly, in all material respects, the financial position of Better Health, Inc. at December 31, 2016 and 2015, and the results of its operations and its cash flows for the years then ended in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation.



March 30, 2017

Better Health, Inc.

Balance Sheets – Statutory Basis

	December 31	
	2016	2015
	<i>(In Thousands)</i>	
Admitted assets		
Cash, cash equivalents and short-term investments	\$ 65,720	\$ 43,761
Accrued investment income	—	1
Premiums receivable	3,168	4,017
Reinsurance balances recoverable	1,262	98
Current federal income tax recoverable	558	2,024
Net deferred tax asset	2,044	—
Health care receivables	—	835
Total admitted assets	<u>\$ 72,752</u>	<u>\$ 50,736</u>
Liabilities and capital and surplus		
Liabilities:		
Unpaid claims and claims adjustment expenses	\$ 37,236	\$ 34,877
Aggregate policy reserves	2,827	307
Accounts payable and accrued expenses	200	220
Payables to parent and affiliates	909	56
Liability relating to uninsured plans	51	—
Other liabilities	614	—
Total liabilities	<u>41,837</u>	<u>35,460</u>
Capital and surplus:		
Common stock, \$.01 par value, 1,000 shares authorized, 1,000 shares issued and outstanding	—	—
Additional paid-in surplus	995	995
Unassigned (deficit) surplus	19,420	(1,094)
Surplus notes	10,500	10,500
Special surplus funds	—	4,875
Total capital and surplus	<u>30,915</u>	<u>15,276</u>
Total liabilities and capital and surplus	<u>\$ 72,752</u>	<u>\$ 50,736</u>

See accompanying notes.

Better Health, Inc.

Statements of Operations – Statutory Basis

	Year ended December 31	
	2016	2015
	<i>(In Thousands)</i>	
Premium income	\$ 319,170	\$ 267,120
Benefits and expenses:		
Claims and claims adjustment expenses	276,651	244,490
Operating expenses	20,412	23,717
Total benefits and expenses	297,063	268,207
Net underwriting gain (loss)	22,107	(1,087)
Investment gains (loss)		
Net investment income	10	10
Other income (expense)	(24)	(124)
Income (loss) before federal income taxes	22,093	(1,201)
Federal income taxes (benefit)	8,968	(896)
Net income (loss)	\$ 13,125	\$ (305)

See accompanying notes.

Better Health, Inc.

Statements of Changes in Capital and Surplus – Statutory Basis

	Surplus Notes	Paid-in Surplus	Unassigned (Deficit) Surplus	Special Surplus Funds	Total Capital and Surplus
			<i>(In Thousands)</i>		
Balance as of January 1, 2015	\$ 10,500	\$ 995	\$ 4,498	\$ –	\$ 15,993
Net income (loss)	–	–	(305)	–	(305)
Change in nonadmitted assets	–	–	(412)	–	(412)
Change in special surplus funds for ACA health insurer fee	–	–	(4,875)	4,875	–
Balance as of December 31, 2015	10,500	995	(1,094)	4,875	15,276
Net income (loss)	–	–	13,125	–	13,125
Change in net deferred income tax	–	–	2,117	–	2,117
Change in nonadmitted assets	–	–	397	–	397
Change in special surplus funds for ACA health insurer fee	–	–	4,875	(4,875)	–
Balance as of December 31, 2016	\$ 10,500	\$ 995	\$ 19,420	\$ –	\$ 30,915

See accompanying notes.

Better Health, Inc.

Statement of Cash Flow – Statutory Basis

	Year ended December 31	
	2016	2015
	<i>(In Thousands)</i>	
Operating activities:		
Premiums collected	\$ 322,540	\$ 262,028
Investment income received	10	9
Claims and claims adjustment expenses paid	(274,288)	(237,263)
General administrative and miscellaneous expenses paid	(20,406)	(23,982)
Federal income taxes (paid) recovered	(7,501)	(378)
Net cash provided by (used in) operating activities	20,355	414
Financing or miscellaneous activities:		
Net transfer from (to) affiliates	854	56
Other	750	(521)
Net cash provided by (used in) financing or miscellaneous activities	1,604	(465)
Change in cash, cash equivalents and short-term investments	21,959	(51)
Cash, cash equivalents and short-term investments at beginning of year	43,761	43,812
Cash, cash equivalents and short-term investments at end of year	<u>\$ 65,720</u>	<u>\$ 43,761</u>

See accompanying notes.

Better Health, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

December 31, 2016

1. Nature of Operations and Significant Accounting Policies

Better Health, Inc. (the “Company”) was originally formed in 2006 as Better Health, LLC. (a Limited Liability Company) and organized as a Provider Services Network (“PSN”) to provide health insurance coverage for Florida’s Medicaid recipients. Effective February 26, 2014, the Company filed a Certificate of Conversion to change its corporate structure from a Limited Liability Company to C Corporation and is currently operating as Better Health, Inc. The company also converted from a PSN and became a licensed HMO in the state of Florida effective February 1, 2015. The Company operates as a prepaid capitated plan created primarily for an enrolled population comprised of beneficiaries of the Medicaid program. The Company’s current service areas include Broward, Hardee, Highlands, Hillsborough, Manatee and Polk counties of Florida. The Company manages healthcare services for Medicaid members under a contract with the Florida Agency for Healthcare Administration (“AHCA”). The loss of this contract would have a material effect on the Company’s operations. The Company is a wholly owned subsidiary of Simply Healthcare Holdings, Inc. (“Simply Holdings”). On December 19, 2014, Simply Holdings entered into an Agreement and Plan Merger with a subsidiary of Anthem, Inc. (“Anthem”), a publicly traded company. Based on receipt of all federal and state regulatory approvals, the acquisition was finalized and closed on February 17, 2015.

On July 24, 2015, the Company’s ultimate parent company, Anthem, and Cigna Corporation (“Cigna”) entered into an Agreement and Plan of Merger dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and a direct wholly-owned subsidiary of Anthem, pursuant to which Anthem will acquire all outstanding shares of Cigna, or the Acquisition. On July 21, 2016, the U.S. Department of Justice, or DOJ, along with certain state attorneys general, filed a civil antitrust lawsuit in the U.S. District Court for the District of Columbia seeking to block the Acquisition. On January 18, 2017, Anthem provided notice to Cigna that Anthem had elected to extend the termination date under the Merger Agreement from January 31, 2017 until April 30, 2017. Following the conclusion of the trial, the Court ruled in favor of the DOJ, on February 8, 2017, and Anthem promptly filed notice that Anthem would appeal the Court’s ruling. On February 14, 2017, Cigna purported to terminate the Merger Agreement and commenced litigation against Anthem in the Delaware Court of Chancery, or Delaware Court, seeking damages and a declaratory judgment that its purported termination of the Merger Agreement was lawful, among other claims. Anthem believes Cigna’s allegations are without merit. Also on February 14, 2017, Anthem initiated its own litigation against Cigna in the Delaware Court seeking a temporary restraining order to enjoin Cigna from terminating the Merger Agreement, specific performance compelling Cigna to comply with the Merger Agreement and damages. On February 15, 2017, the Delaware Court granted Anthem’s motion for a temporary restraining order and issued an order enjoining Cigna from terminating the Merger Agreement. The temporary restraining order became effective immediately and will remain in place pending any further order from the Delaware Court. Anthem intends to vigorously defend the Acquisition in both the Circuit Court and the Delaware Court and remains committed to completing the Acquisition as soon as practicable.

Basis of Presentation

The accompanying financial statements have been prepared in accordance with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation (“Florida OIR”). The Florida OIR has adopted the accounting policies found in the National Association of Insurance Commissioners (“NAIC”) *Accounting Practices and Procedures Manual* (“NAIC SAP”) as a component of prescribed accounting practices. Additionally, the Florida OIR has adopted certain prescribed accounting practices that differ from those found in NAIC SAP, which impact the Company. Specifically, all parent and affiliate intercompany receivable balances are considered nonadmitted assets. In addition, pursuant to Section 641.35(3)(a), Florida Statutes, if an HMO, through a health risk contract, transfers to any entity the obligation to pay providers for subscriber claims, the liability for any such payment remains with the HMO until the payment is received by the provider and should be reflected in claim reserves. The Company employed no permitted practices in preparing the accompanying statutory basis financial statements.

Better Health, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

A reconciliation of the Company's statutory capital and surplus as of December 31, 2016 and 2015 between practices prescribed by the Florida OIR and NAIC SAP along with reference of Statement of Statutory Accounting Principles ("SSAP") are shown below:

	<u>SSAP No.</u>	<u>2016</u>	<u>2015</u>
Statutory capital and surplus, Florida OIR basis		\$ 30,915	\$ 15,276
State prescribed practices:			
Claim reserve pursuant to 641.35 3(a) of the FL Revised Statutes	55	350	307
Nonadmittance of amounts due from affiliates pursuant to 641.35 (2)(i) of the FL Revised Statutes	25	5	132
Statutory capital and surplus, NAIC SAP basis		<u>\$ 31,270</u>	<u>\$ 15,715</u>

A reconciliation of the Company's net income (loss) for the years ended December 31, 2016 and 2015 between practices prescribed by the Florida OIR and NAIC SAP along with reference of Statement of Statutory Accounting Principles ("SSAP") are shown below:

	<u>SSAP No.</u>	<u>2016</u>	<u>2015</u>
Statutory net income (loss), Florida OIR basis		\$ 13,125	\$ (305)
State prescribed practices:			
Claim reserve pursuant to 641.35 3(a) of the FL Revised Statutes	55	43	307
Statutory net income (loss), NAIC SAP basis		<u>\$ 13,168</u>	<u>\$ 2</u>

Such practices vary from U.S. generally accepted accounting principles ("GAAP"). The more significant variances from GAAP, applicable to the Company, are as follows:

Premiums receivable: Premiums receivable are recorded at the billed amount and reduced by any amounts not deemed collectible. Generally amounts aged ninety days and older are non admitted assets, with the exception of government receivables. For GAAP, these amounts are recorded at the billed amount and are reported net of a valuation allowance based upon historical collection trends and management's judgment on the collectability of these accounts.

Nonadmitted assets: Certain assets designated as nonadmitted, including deferred federal income taxes in excess of certain statutory limits, investments in unaudited subsidiaries, furniture and equipment, non-operating software, leasehold improvements, prepaid expenses, intangible assets other than goodwill, certain health care and other receivable balances, and certain premium receivable balances are excluded from the balance sheets by a direct charge to capital and surplus. These nonadmitted assets totaled \$309 and \$706 at December 31, 2016 and 2015, respectively. For GAAP, these amounts are carried as assets, net of a valuation allowance, if necessary.

Surplus notes: Surplus notes are reported as capital and surplus, surplus note interest expense is not recorded until approved by the Florida OIR and related accrued interest is reported as borrowed money. For GAAP, surplus notes are reported as long-term debt, and surplus note interest expense is accrued as incurred.

Better Health, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

Deferred income taxes: Deferred tax assets are reduced by a statutory valuation allowance if, based on the weight of available evidence, it is more likely than not that some portion or all of the gross deferred tax assets will not be realized. Adjusted gross deferred tax assets are separated by character (ordinary and capital) and admitted in an amount equal to the sum of 1) the amount of federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the applicable carryback period, plus 2) based on Risk Based Capital (“RBC”) thresholds the lesser of the remaining adjusted gross deferred tax assets expected to be realized within the applicable period of the balance sheet date or an amount no greater than the applicable percentage of capital and surplus excluding any net deferred tax assets, electronic data processing (“EDP”) equipment and operating software and any net positive goodwill, plus 3) the amount of remaining adjusted gross deferred tax assets that can be offset against existing gross deferred tax liabilities after consideration of the reversal patterns of temporary differences. The remaining deferred tax asset is nonadmitted.

Deferred taxes do not include amounts for state taxes. Changes in deferred income taxes are recorded as adjustments to capital and surplus. For GAAP, state income taxes are considered in the computation of deferred taxes, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years, and a valuation allowance is established for deferred tax assets estimated to be unrealizable. Excluding the tax impact of unrealized investment gains and losses and certain other items, the change in deferred income taxes is recorded in the statements of operations.

Statements of cash flow: Cash, cash equivalents and short-term investments in the statements of cash flow represent cash balances, and investments with initial maturities of one year or less. If in the aggregate the Company has a negative cash balance, it is reported as a negative asset and not as a liability. For GAAP, the corresponding captions of cash and cash equivalents include cash balances and investments with initial maturities of three months or less and negative cash balances are reported separately as liabilities and short term investments.

Uninsured accident and health plans: The Company provides administrative services to AHCA on an uninsured basis. Under this arrangement, the customer retains the risk of funding payments for health benefits provided, and the Company may be subject to credit risk of the customer from the time the Company’s claim payment until the Company receives the claim reimbursement. In accordance with the Statement of Statutory Accounting Principles (“SSAP”) No. 47, *Uninsured Plans*, these claim payments and subsequent reimbursements are excluded from the Company’s statutory basis statements of income, and administrative fees earned are deducted from operating expenses. For GAAP these administrative fees are reported as revenue in the statements of operations.

Reinsurance: Any reinsurance balance amounts deemed to be uncollectible have been written off through a charge to operations. In addition, a liability for reinsurance balances has been provided for unsecured policy reserves ceded to reinsurers not authorized to assume such business. Changes to the liability are credited or charged directly to unassigned surplus. Under GAAP, an allowance for amounts deemed uncollectible would be established through a charge to earnings. Policy and contract liabilities ceded to reinsurers have been reported as reductions of the related reserves rather than as assets as would be required under GAAP.

The effects of the foregoing variances for GAAP on the accompanying statutory basis financial statements have not been determined but are presumed to be material.

Other significant accounting policies are as follows:

Use of Estimates

Preparation of statutory basis financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Better Health, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

Health Care Receivables

Health care receivables represent amounts related to claim overpayments and other health care related receivables other than premiums. These health care receivables are subject to various admittance tests based on the nature of the receivable balance.

Unpaid Claims and Claims Adjustment Expenses

Unpaid claims and claims adjustment expenses include management's best estimate of amounts based on historical claim development patterns and certain individual case estimates. The established liability considers health benefit provisions, business practices, economic conditions and other factors that may materially affect the cost, frequency and severity of claims. Reserves for unpaid claims and claim adjustment expenses are based on assumptions and estimates, and while management believes such estimates are reasonable, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed and changes in estimates are incorporated into current operating results.

Risk Share and Other Reserves

The Company contracts with physicians or provider groups to provide medical services to the Company's members. The Company pays capitation or negotiated fees for defined services provided by the physicians. Under the terms of these agreements, certain providers are eligible to receive provider incentives based on qualitative and quantitative factors. Estimated risk-sharing settlements are continually reviewed, and necessary adjustments are included in current operations. Claim and claim adjustment expenses include all amounts incurred by the Company under these arrangements.

Premiums

Premiums are recognized as revenue during the period in which the Company is obligated to provide service to members. Premium payments from contracted government agencies are based on eligibility lists produced by the government agencies. Adjustments to eligibility lists produced by the government agencies result from retroactive application of enrollment or disenrollment of members or classification changes between rate categories. The Company estimates the amount of retroactive premium owed to or from the government agencies each period and adjusts premium revenue accordingly. Expenses incurred in connection with acquiring insurance business are charged to operations as incurred.

Delays in approval of annual premium rate changes require that the Company defer the recognition of any increases to the period in which the premium rates become final. The value of the impact can be significant in the period in which it is recognized dependent on the magnitude of the premium rate increase, the membership to which it applies and the length of the delay between the effective date of the rate increase and the final contract date. Premium rate decreases are recognized in the period the change in premium rate becomes effective and the change in the rate is known, which may be prior to the period when the contract amendment affecting the rate is finalized.

The State of Florida, AHCA, informed the Company on June 7, 2016 of a pricing error related to the State Fiscal Year 2015-2016 contract. AHCA indicated it underpaid the Company due to a mismatch of rates. Related to this, the Company received and recognized cash and premiums of \$3,686 from AHCA during 2016 related to 2015.

Reinsurance

Reinsurance premiums, claims and claims adjustment expenses are accounted for on a basis consistent with those used in accounting for the original policies issued and the terms of the reinsurance contracts.

Better Health, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

Retrospectively Rated Contracts

The Company's contract with AHCA includes a provision for which premiums vary based on loss experience. The Company estimates accrued retrospective premium adjustments through the review of each retrospectively rated contract, comparing the claim development with that anticipated in the contract. Any adjustment made to the estimated liability as a result of a final settlement is included in current operations. The Company uses estimates to report in the statutory basis financial statements the incurred and unpaid liability amounts for retrospectively rated contracts based on its underwriting experience; actuarial, tax, and accounting estimates and assumptions at the financial statement date and regulations and guidance available that is subject to change prior to settlement. Accordingly, the Company's use of estimates and assumptions in the preparation of the statutory basis financial statements and related footnote disclosures may differ from actual results.

Federal Income Tax

The Company participates in a tax sharing agreement with Anthem and its subsidiaries. Allocation of federal income tax is based upon separate return calculations with credit for net losses that can be used on a consolidated basis. Intercompany tax balances are settled based on the Internal Revenue Service due dates.

Health Insurer Fee

ACA Section 9010 imposed a mandatory annual fee on health insurers that write certain types of health insurance on U.S. risks for each calendar year beginning on or after January 1, 2014. The annual fee is allocated to health insurers based on the ratio of the amount of an insurer's premium written during the preceding calendar year to the amount of health insurance for all U.S. health risk for those certain lines of business that is written during the preceding calendar year. This fee is non-deductible for income tax purposes. The health insurer fee is reported in operating expenses in the same year it is paid. The health insurer fee to be paid in the following year is segregated in special surplus funds until the beginning of the year in which it is to be paid. Payment of the health insurer fee has been suspended for 2017 and will resume for 2018 and beyond.

Reclassification

Certain prior year amounts have been reclassified to conform to the current year presentation.

2. Unpaid Claims and Claims Adjustment Expenses

The following table provides a reconciliation of the beginning and ending balances for unpaid claims and claims adjustment expenses:

	<u>2016</u>	<u>2015</u>
Balances at January 1, net of reinsurance	\$ 34,877	\$ 27,325
Incurred (redundancies) related to:		
Current year	282,390	245,853
Prior years	<u>(5,739)</u>	<u>(1,363)</u>
Total incurred	276,651	244,490
Paid related to:		
Current year	246,097	214,305
Prior years	<u>28,195</u>	<u>22,633</u>
Total paid	274,292	236,938
Balances at December 31, gross of reinsurance	<u>\$ 37,236</u>	<u>\$ 34,877</u>

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any year end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established year end liability. The

Better Health, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

negative amounts reported for incurred related to prior years' results from claims being settled for amounts less than originally estimated. Positive amounts reported for incurred related to prior years result from claims being settled for amounts greater than originally estimated. This experience is primarily attributable to actual medical cost experience that differs from that assumed at the time the liability was established.

The Company took into account estimated anticipated subrogation and other recoveries in its determination of the liability for unpaid claims based on historical recovery patterns.

3. Retrospectively Rated Contracts and Contracts Subject to Redetermination

The amount of net premiums written by the Company in 2016 and 2015 that was subject to retrospective rating features, including MLR rebate regulations, was \$322,105 and \$267,831, which represented 100% and 100%, respectively, of the total net premiums written.

4. Reinsurance

Certain premiums and benefits are ceded to other insurance companies under various reinsurance agreements. These reinsurance agreements limit the Company's exposure to losses within its capital resources. The Company remains obligated for amounts ceded in the event that the reinsurers do not meet their obligations.

The effects of reinsurance on net premium considerations are as follows:

	Year ended December 31	
	2016	2015
Direct premiums	\$ 319,585	\$ 267,831
Ceded premiums	(415)	(711)
Net premiums	<u>\$ 319,170</u>	<u>\$ 267,120</u>

The Company's ceded reinsurance arrangements reduced certain other items in the accompanying financial statements as follows:

	2016	2015
Direct claims and claim adjustment expense	\$ 278,140	\$ 244,593
Ceded claims and claim adjustment expense	(1,489)	(103)
Net claims and claim adjustment expense	<u>\$ 276,651</u>	<u>\$ 244,490</u>

Better Health, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

5. Federal Income Taxes

The Company had a federal income tax recoverable of \$558 and \$2,024 as of December 31, 2016 and 2015, respectively.

The components of net deferred tax assets (liabilities) at December 31 are as follows:

	Ordinary	2016 Capital	Total
Gross deferred tax assets	\$ 2,667	\$ –	\$ 2,667
Statutory valuation allowance	–	–	–
Adjusted gross deferred tax assets	2,667	–	2,667
Gross deferred tax liabilities	(550)	–	(550)
Net deferred tax asset before admissibility test	<u>\$ 2,117</u>	<u>\$ –</u>	<u>\$ 2,117</u>

The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101 Income Taxes (“SSAP No. 101”) as of December 31, 2016 is:

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ 771	\$ –	\$ 771
Admitted pursuant to paragraph 11.b	1,273	–	1,273
Admitted pursuant to paragraph 11.c	550	–	550
Admitted deferred tax asset	2,594	–	2,594
Deferred tax liability	550	–	550
Net admitted deferred tax asset	<u>2,044</u>	<u>–</u>	<u>2,044</u>
Nonadmitted deferred tax asset	<u>\$ 73</u>	<u>\$ –</u>	<u>\$ 73</u>

	Ordinary	2015 Capital	Total
Gross deferred tax assets	\$ 3,202	\$ –	\$ 3,202
Statutory valuation allowance	2,908	–	2,908
Adjusted gross deferred tax assets	294	–	294
Gross deferred tax liabilities	294	–	294
Adjusted gross deferred tax assets	<u>\$ –</u>	<u>\$ –</u>	<u>\$ –</u>

Better Health, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101 as of December 31, 2015 is:

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ —	\$ —	\$ —
Admitted pursuant to paragraph 11.b	—	—	—
Admitted pursuant to paragraph 11.c	294	—	294
Admitted deferred tax asset	294	—	294
Deferred tax liability	294	—	294
Net admitted deferred tax asset	—	—	—
Nonadmitted deferred tax asset	\$ —	\$ —	\$ —

The change in the amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101 during 2016 is:

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ 771	\$ —	\$ 771
Admitted pursuant to paragraph 11.b	1,273	—	1,273
Admitted pursuant to paragraph 11.c	256	—	256
Admitted deferred tax asset	2,300	—	2,300
Deferred tax liability	256	—	256
Net admitted deferred tax asset	2,044	—	2,044
Nonadmitted deferred tax asset	\$ 73	\$ —	\$ 73

	2016	2015
Amount of adjusted capital and surplus used to determine recovery period and threshold limitations.	\$ 28,871	\$ 15,276

The impact of tax planning strategies is as follows:

	2016		2015		Change	
	Ordinary	Capital	Ordinary	Capital	Ordinary	Capital
Adjusted gross deferred tax assets amount	\$ 2,667	\$ —	\$ 294	\$ —	\$ 2,373	\$ —
Percentage of adjusted gross deferred tax assets by tax character attributable to the impact of tax planning strategies	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Net admitted adjusted gross deferred tax assets amount	\$ 2,594	\$ —	\$ 294	\$ —	\$ 2,300	\$ —
Percentage of net admitted adjusted gross deferred tax assets by tax character attributable to the impact of tax planning strategies	20.77%	0.00%	0.00%	0.00%	20.77%	0.00%

Better Health, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

The Company's tax planning strategies do not include the use of reinsurance.

Current federal income taxes consist of the following major components:

	2016	2015	Change
Federal income taxes (benefit) on operations	\$ 9,418	\$ (832)	\$ 10,250
Utilization of net operating loss and capital loss carryforwards	(450)	(64)	(386)
Federal income taxes (benefit) incurred	<u>\$ 8,968</u>	<u>\$ (896)</u>	<u>\$ 9,864</u>

The components of deferred income taxes are as follows:

	December 31 2016	2015	Change
Deferred tax assets:			
Ordinary:			
Accrued future expenses	\$ —	\$ 35	(35)
Amortization	827	896	(69)
Accounts receivable	75	236	(161)
Claims discount reserve	97	101	(4)
Net operating loss carryover	1,205	1,923	(718)
Other insurance reserves	455	—	455
Prepaid expenses	8	11	(3)
Subtotal	<u>2,667</u>	<u>3,202</u>	<u>(535)</u>
Statutory valuation allowance adjustment	—	2,908	(2,908)
Nonadmitted ordinary deferred tax assets	<u>73</u>	<u>—</u>	<u>73</u>
Net admitted deferred tax assets	<u>\$ 2,594</u>	<u>\$ 294</u>	<u>\$ 2,300</u>
Deferred tax liabilities:			
Ordinary:			
Write-ins	550	294	256
Subtotal	<u>\$ 550</u>	<u>\$ 294</u>	<u>\$ 256</u>
Net admitted deferred tax assets/liabilities	<u>\$ 2,044</u>	<u>\$ —</u>	<u>\$ 2,044</u>

The changes in deferred tax assets and deferred tax liabilities are as follows:

	December 31 2016	2015	Change
Total deferred tax assets	\$ 2,667	\$ 294	\$ 2,373
Total deferred tax liabilities	550	294	256
Net deferred tax asset	<u>\$ 2,117</u>	<u>\$ —</u>	<u>\$ 2,117</u>
Tax effect of unrealized gains			—
Change in net deferred income tax			<u>\$ 2,117</u>

Better Health, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

The Company's income tax expense and change in deferred income tax differs from the amount obtained by applying the federal statutory rate of 35% for the year ended December 31 for the following reasons:

	2016	2015
Tax expense computed using federal statutory rate	\$ 7,732	\$ (421)
ACA health insurer fee	1,851	897
Change in nonadmitted assets	165	(247)
Prior year true-ups and adjustments	2	355
Valuation allowance	(2,908)	(1,480)
Other	9	-
Total	<u>\$ 6,851</u>	<u>\$ (896)</u>
Federal income taxes (benefit) incurred	\$ 8,968	\$ (896)
Change in net deferred income taxes	(2,117)	-
Total statutory income taxes	<u>\$ 6,851</u>	<u>\$ (896)</u>

At December 31, 2016, the Company had \$3,444 of unused net operating loss or tax credit carryforwards available to offset future taxable income. The losses or credits will begin to expire in 2033.

The following are income taxes incurred in the current and prior years that will be available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2016	\$ 8,678	\$ -	\$ 8,678
2015	-	-	-
2014	-	-	-

Better Health, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

The Company is included in the consolidated federal income tax return of their parent Anthem, Inc., along with other affiliates, as of December 31, 2016. Allocation of federal income taxes with affiliates subject to the tax sharing agreement is based upon separate income tax return calculations with credit for net losses that can be used on a consolidated basis. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

The Company is a member of the IRS Compliance Assurance Program (“CAP”). The objective of CAP is to reduce taxpayer burden and uncertainty while assuring the IRS of the accuracy of tax returns prior to filing, thereby reducing or eliminating the need for post filing examinations. As of December 31, 2016, the examination of the 2016 tax year continues to be in process.

6. Health Insurer Fee

The Company had \$267,831 of premiums written subject to assessment under ACA Section 9010 as of December 31, 2015 and no premiums written subject to assessment under ACA Section 9010 as of December 31, 2016 due to the 2017 suspension of this assessment. Because no health insurer fee is to be paid in 2017, no funds have been segregated in special surplus funds for the health insurer fee at December 31, 2016. The Company’s portion of the annual health industry fee paid during 2016 was \$5,289 and is included in the operating expenses.

7. Capital and Surplus

The Florida OIR requires the Company to maintain a minimum statutory capital and surplus as set forth in the state statutes. Under those requirements, capital and surplus is calculated as the greater of \$1,500, or 10% of total liabilities, or 2% of total annualized premiums. In addition, a consent order filed with the Florida OIR, requires the Company to maintain surplus at 125% of the minimum statute requirement. The Florida OIR has not adopted the Risk-Based Capital (RBC) requirement of the NAIC. At December 31, 2016 and 2015, the Company’s capital and surplus exceeded all regulatory requirements.

Per the Florida Statute 641.365, certain limitations exist on the Company’s ability to pay dividends to its parent. The Company may pay funds only from accumulated surplus funds that were derived from realized net operating profits on its business and net realized capital gains. Prior written approval by the Florida OIR is required for payment of any dividend that would result in these accumulated surplus funds being less than zero. Florida OIR approval is not required if the dividend paid is less than the greater of 1) ten percent of the Company’s accumulated surplus as of December 31st of the preceding year or 2) the Company’s net income from the immediately preceding calendar year. Within these limitations, the Company may pay \$13,125 in dividends during 2016 without prior approval.

There was no portion of unassigned surplus representing cumulative unrealized gains (losses) as of December 31, 2016 and 2015, respectively.

8. Contingencies

In February 2015, Anthem reported that it was the target of a sophisticated external cyber-attack. The attackers gained unauthorized access to certain of Anthem’s information technology systems and obtained personal information related to many individuals and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that Anthem will not identify additional information that was accessed or obtained.

Better Health, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

Upon discovery of the cyber-attack, Anthem took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate its systems and identify solutions based on the evolving landscape. Anthem is providing credit monitoring and identity protection services to those who have been affected by this cyber-attack. Anthem has continued to implement security enhancements since this incident. Anthem has incurred expenses subsequent to the cyber-attack to investigate and remediate this matter and expects to continue to incur expenses of this nature in the foreseeable future. Anthem will recognize these expenses in the periods in which they are incurred.

Actions have been filed in various federal and state courts and other claims have been or may be asserted against Anthem on behalf of current or former members, current or former employees, other individuals, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber-attack. Federal and state agencies, including state insurance regulators, state attorneys general, the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigation, are investigating events related to the cyber-attack, including how it occurred, its consequences and Anthem's responses. The NAIC's multistate targeted market conduct and financial exam was concluded in December 2016. As part of the resolution, the NAIC asked and Anthem has agreed to provide a customized credit protection program functionally equivalent to a credit freeze for minors who were under the age of 18 on January 27, 2015. No fines or penalties were issued. Although Anthem is cooperating in these investigations, Anthem may be subject to fines or other obligations, which may have an adverse effect on how Anthem operates its business and on its results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation in February 2015 and was subsequently heard by the Panel in May 2015. In June 2015, the Panel entered its order transferring the consolidated matter to the U.S. District Court for the Northern District of California. The U.S. District Court entered its case management order in September 2015. Anthem filed a motion to dismiss ten of the counts that are before the U.S. District Court. In February 2016, the court issued an order granting in part and denying in part our motion, dismissing three counts with prejudice, four counts without prejudice and allowing three counts to proceed. Plaintiffs filed a second amended complaint in March 2016, and Anthem subsequently filed a second motion to dismiss. In May 2016, the court issued an order granting in part and denying in part our motion, dismissing one count with prejudice, dismissing certain counts asserted by specific named plaintiffs with or without prejudice depending on their individualized facts, and allowing the remaining counts to proceed. In July 2016, plaintiffs filed a third amended complaint, which Anthem answered in August 2016. Fact discovery was completed in December 2016. There remain two state court cases that are presently proceeding outside of the Multidistrict Litigation.

Anthem has contingency plans and insurance coverage for certain expenses and potential liabilities of this nature. While a loss from these matters is reasonably possible, Anthem cannot reasonably estimate a range of possible losses because the investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

The Company is involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits and reviews and administrative proceedings include routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and Federal Agencies. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on The Company's business operations. The Company believes that any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on the Company's financial position or results of operations.

At December 31, 2016 and 2015, the Company reported admitted assets of \$3,168, and \$4,017, respectively, in premiums receivable and amounts receivable from uninsured plans. The receivables are not deemed to be uncollectible; therefore, no provisions for uncollectable amounts have been recorded. The potential for any additional loss is not believed to be material to the Company's financial condition.

Better Health, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

9. Retirement Benefits

During 2015, the Company participated in a defined contribution plan created prior to the February 17, 2015 acquisition of Better Healthcare by Anthem. No Company-matched amounts were contributed to the plan. Beginning on January 1, 2016, that defined contribution plan merged into the Anthem 401(k) Retirement Savings Plan, a defined contribution plan sponsored by ATH Holding Company, LLC (“ATH Holding”) and covering substantially all employees. Voluntary employee contributions are matched by ATH Holding subject to certain limitations. ATH Holding allocates a share of the total accumulated costs of this plan to the Company based on the number of allocated employees. The Company has no legal obligation for benefits under this plan. During 2016, the Company was allocated \$307 for the defined contribution plan.

	2016	2015
Defined contribution plan	\$ 373	\$ –

10. Uninsured Accident and Health Plans

The net gain (loss) from operations from administrative service contract (“ASO”) plan was:

	ASO Uninsured Plans	Uninsured Portion of Partially Insured Plans	Total ASO
For the year ended December 31, 2016			
Net reimbursement for administrative expenses (including administrative fees in excess of actual expenses)	\$ (7)	\$ –	\$ (7)
Total net other income or expenses (including interest paid to or received from plans)	–	–	–
Net gain (loss) from operations	(7)	–	(7)
Total claim payment volume	\$ 201	\$ –	\$ 201

	ASO Uninsured Plans	Uninsured Portion of Partially Insured Plans	Total ASO
For the year ended December 31, 2015			
Net reimbursement for administrative expenses (including administrative fees in excess of actual expenses)	\$ (204)	\$ –	\$ (204)
Total net other income or expenses (including interest paid to or received from plans)	–	–	–
Net gain (loss) from operations	(204)	–	(204)
Total claim payment volume	\$ 5,987	\$ –	\$ 5,987

Better Health, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

11. Health Care Receivable

Claim overpayment receivables consist of amounts that have been invoiced and meet the setoff conditions. Amounts that have not been invoiced and do not meet the setoff conditions are nonadmitted. Claim overpayment receivables and other health care receivables of \$209 and \$543 were nonadmitted as of December 31, 2016 and 2015, respectively.

12. Related Party Transactions

Effective January 1, 2016, the Company has entered into an administrative services agreement with Anthem and its affiliated companies. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Costs include expenses such as salaries, benefits, communications, advertising, consulting services, rent, utilities, accounting, underwriting, and product development, which support the operations of the Company. These costs are allocated based on various utilization statistics. Net payments to affiliated companies pursuant to the 2016 administrative service agreements were \$33,708, and are included in operating expenses and claims adjustment expenses in the statutory basis statements of income.

Prior to 2016, the Company entered into a Management Service Agreement with Simply Healthcare Plans, Inc. (“Simply”), a related party through common ownership, in which the Company provides services to administer a significant portion of the Company’s benefits and business support services. In addition, the Company is required to pay reimbursements for reasonable expenses incurred in furtherance of operating the Company in so much as these expenses exceed the amount of the management fee. For the year ended December 31, 2015, \$26,160 was paid in relation to this agreement and are included in operating expenses and claims adjustment expenses in the statutory basis statements of operations.

At December 31, 2016 and 2015, the Company reported \$5 and \$132 due from affiliates, which were nonadmitted per Florida OIR prescribed accounting practices. At December 31, 2016 and 2015, the Company reported \$909 and \$56 due to affiliates, respectively. The receivable and payable balances represent intercompany transactions that are settled within the terms of the management and services agreement.

Better Health, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

13. Reconciliation to the Statutory Annual Statements

The 2016 and 2015 audited net income and surplus amounts were adjusted as compared to the Annual Statement as follows:

	Year ended December 31	
	2016	2015
Total capital and surplus reported in the Annual Statement	\$ 30,915	\$ 15,214
Increase in federal income tax benefits	–	62
Total capital and surplus reported in the accompanying statutory basis statement of operations	<u>\$ 30,915</u>	<u>\$ 15,276</u>

	Year ended December 31	
	2016	2015
Total net income (loss) reported in the Annual Statement	\$ 13,187	\$ (192)
Increase in premium income	–	(219)
Decrease in claims and claims adjustment expenses	–	44
Increase in federal income tax benefits	(62)	62
Total net income (loss) reported in the accompanying statutory basis statement of operations	<u>\$ 13,125</u>	<u>\$ (305)</u>

14. Subsequent Events

Management of the Company has evaluated all other events occurring after December 31, 2016 through March 30, 2017, the date the financial statements were available to be issued, to determine whether any event required either recognition or disclosure in the financial statements. It was determined there were no events that require recognition or disclosure in the financial statements through the report date.

FINANCIAL STATEMENTS AND SUPPLEMENTARY
INFORMATION – STATUTORY BASIS

Better Health, Inc.

*Years Ended December 31, 2015 and 2014
With Reports of Independent Auditors*

Better Health, Inc.

Financial Statements – Statutory Basis

Years ended December 31, 2015 and 2014

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Report of Independent Auditors

Board of Directors
Better Health, Inc.

We have audited the accompanying statutory basis financial statements of Better Health, Inc., which comprise the balance sheet as of December 31, 2015, and the related statements of income, changes in capital and surplus, and cash flow for the year then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation. Management also is responsible for the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 1, to meet the requirements of Florida, the financial statements have been prepared in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation, which practices differ from U.S. generally accepted accounting principles. The variances between such practices and U.S. generally accepted accounting principles are described in Note 1. The effects on the accompanying financial statements of these variances are not reasonably determinable but are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the effects of the matter described in the preceding paragraph, the statutory basis financial statements referred to above do not present fairly, in conformity with U.S. generally accepted accounting principles, the financial position of Better Health, Inc. at December 31, 2015, or the results of its operations or its cash flows for the year then ended.

Opinion on Statutory Basis of Accounting

However, in our opinion, the statutory basis financial statements referred to above present fairly, in all material respects, the financial position of Better Health, Inc. at December 31, 2015, and the results of its operations and its cash flows for the year then ended in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation.

Report of Other Auditors on 2014 Financial Statements

The statutory basis financial statements of Better Health, Inc. for the year ended December 31, 2014 were audited by other auditors who expressed an adverse opinion with respect to conformity with U.S. generally accepted accounting principles and an unmodified opinion with respect to conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation in their report dated March 31, 2015, except for the restatement section in Note 1 as to which the date is March 31, 2016. Their report dated March 31, 2015, except for the restatement section in Note 1 as to which the date is March 31, 2016, contained emphasis of a matter paragraphs describing the subsequent acquisition of Simply Healthcare Holdings, Inc. (parent company of Better Health, Inc.) by Anthem, Inc. on February 17, 2015, the conversion of its status from an administrative provider to a Health Maintenance Organization in July 2014, and the restatement of the 2014 financial statements.



April 5, 2016

Better Health, Inc.

Balance Sheets – Statutory Basis

	December 31	
	2015	2014
	<i>(In Thousands)</i>	
Admitted assets		
Cash	\$ 43,761	\$ 43,812
Accrued investment income	1	—
Premiums receivable	4,017	18,182
Reinsurance balances recoverable	98	22
Current federal income tax recoverable	2,024	750
Health care receivables	835	141
Total admitted assets	<u>\$ 50,736</u>	<u>\$ 62,907</u>
Liabilities and capital and surplus		
Liabilities:		
Unpaid claims and claims adjustment expenses	\$ 34,877	\$ 27,325
Aggregate policy reserves	307	—
Premiums received in advance	—	18,848
Accounts payable and accrued expenses	220	361
Payables to parent and affiliates	56	380
Total liabilities	<u>35,460</u>	<u>46,914</u>
Capital and surplus:		
Common stock, \$.01 par value, 1,000 shares authorized, 1,000 shares issued and outstanding	—	—
Additional paid-in surplus	995	995
Unassigned (deficit) surplus	(1,094)	4,498
Surplus notes	10,500	10,500
Special surplus funds	4,875	—
Total capital and surplus	<u>15,276</u>	<u>15,993</u>
Total liabilities and capital and surplus	<u>\$ 50,736</u>	<u>\$ 62,907</u>

See accompanying notes.

Better Health, Inc.

Statements of Operations— Statutory Basis

	Year ended December 31	
	2015	2014
	<i>(In Thousands)</i>	
Premium income	\$ 267,120	\$ 158,828
Benefits and expenses:		
Claims and claims adjustment expenses	244,490	131,605
Operating expenses	23,717	35,485
Total benefits and expenses	268,207	167,090
Net underwriting loss	(1,087)	(8,262)
Investment gains:		
Net investment income	10	5
Other loss	(124)	(50)
Loss before federal income taxes	(1,201)	(8,307)
Federal income taxes benefit	(896)	—
Net loss	\$ (305)	\$ (8,307)

See accompanying notes.

Better Health, Inc.

Statements of Changes in Capital and Surplus – Statutory Basis

	Surplus Notes	Paid-in Surplus	Unassigned Surplus (Deficit) <i>(In Thousands)</i>	Special Surplus Funds	Total Capital and Surplus
Balance as of January 1, 2014	\$ 10,500	\$ 995	\$ 6,784	\$ –	\$ 18,279
Net loss	–	–	(8,307)	–	(8,307)
Change in nonadmitted assets	–	–	6,021	–	6,021
Balance as of December 31, 2014	10,500	995	4,498	–	15,993
Net loss	–	–	(305)	–	(305)
Change in nonadmitted assets	–	–	(412)	–	(412)
ACA health insurer fee	–	–	(4,875)	4,875	–
Balance as of December 31, 2015	<u><u>\$ 10,500</u></u>	<u><u>\$ 995</u></u>	<u><u>\$ (1,094)</u></u>	<u><u>\$ 4,875</u></u>	<u><u>\$ 15,276</u></u>

See accompanying notes.

Better Health, Inc.

Statements of Cash Flow – Statutory Basis

	Year ended December 31	
	2015	2014
	<i>(In Thousands)</i>	
Operating activities:		
Premiums collected, net of reinsurance	\$ 262,028	\$ 180,947
Net investment income	9	5
Claims and claims adjustment expenses	(237,263)	(105,796)
General administrative expenses paid	(23,982)	(38,891)
Federal income taxes paid	(378)	(931)
Net cash provided by operating activities	414	35,334
Financing or miscellaneous activities:		
Other	(465)	6,436
Net cash (used in) provided by financing or miscellaneous activities	(465)	6,436
Change in cash	(51)	41,770
Cash beginning of the year	43,812	2,042
Cash at end of year	<u>\$ 43,761</u>	<u>\$ 43,812</u>

See accompanying notes.

Better Health, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

December 31, 2015

1. Nature of Operations and Significant Accounting Policies

Better Health, Inc. (the “Company”) was originally formed in 2006 as Better Health, LLC. (a Limited Liability Company) and organized as a Provider Services Network (“PSN”) to provide health insurance coverage for Florida’s Medicaid recipients. Effective February 26, 2014, the Company filed a Certificate of Conversion to change its corporate structure from a Limited Liability Company to C Corporation and is currently operating as Better Health, Inc. The company also converted from a PSN and became a licensed HMO in the state of Florida effective February 1, 2015. The Company operates as a prepaid capitated plan created primarily for an enrolled population comprised of beneficiaries of the Medicaid program. The Company’s current service areas include Broward, Hardee, Highlands, Hillsborough, Manatee and Polk counties of Florida. As of December 31, 2015, the Company served 95,517 members. The Company manages healthcare services for Medicaid members under a contract with the Florida Agency for Healthcare Administration (“AHCA”). The Company is a wholly owned subsidiary of Simply Healthcare Holdings, Inc. (“Simply Holdings”). On December 19, 2014, Simply Holdings entered into an Agreement and Plan of Merger with a subsidiary of Anthem, Inc. (“Anthem”), a publicly traded company. Based on receipt of all federal and state regulatory approvals, the acquisition was finalized and closed on February 17, 2015. The shareholders of Anthem approved a proposal to amend its articles of incorporation to change the name to Anthem, Inc. from WellPoint, Inc. The name change was effective December 2, 2014.

On July 24, 2015, the Company’s ultimate parent company, Anthem, and Cigna Corporation (“Cigna”) entered into an Agreement and Plan of Merger dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and a direct wholly-owned subsidiary of Anthem, pursuant to which Anthem will acquire all outstanding shares of Cigna. The acquisition is expected to close in the second half of 2016 and is subject to certain state regulatory approvals, standard closing conditions, customary approvals required under the Hart-Scott-Rodino Antitrust Improvements Act and the approval of both the Anthem, Inc. shareholders and Cigna’s stockholders.

Basis of Presentation

The accompanying financial statements have been prepared in accordance with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation (“Florida OIR”). The Florida OIR has adopted the accounting policies found in the National Association of Insurance Commissioners (“NAIC”) *Accounting Practices and Procedures Manual* (“NAIC SAP”) as a component of prescribed accounting practices. Additionally, the Florida OIR has adopted certain prescribed accounting practices that differ from those found in NAIC SAP, which impact the Company. The Company employed no permitted practices in preparing the accompanying statutory basis financial statements.

Better Health, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

1. Nature of Operations and Significant Accounting Policies (continued)

A reconciliation of the Company's statutory capital and surplus as of December 31, 2015 and 2014 between practices prescribed by the Florida OIR and NAIC SAP is shown below:

	<u>2015</u>	<u>2014</u>
Statutory capital and surplus, Florida OIR basis	\$ 15,276	\$ 15,993
State prescribed practices:		
Nonadmittance of amounts due from affiliates pursuant to 641.35 (2)(i) of the FL Revised Statutes	<u>132</u>	<u>64</u>
Statutory capital and surplus, NAIC SAP basis	<u>\$ 15,408</u>	<u>\$ 16,057</u>

For the years ended December 31, 2015 and 2014 there are no differences between the Company's net income under NAIC SAP and practices prescribed by the Florida OIR.

NAIC SAP varies from U.S. generally accepted accounting principles ("GAAP"). The more significant variances from GAAP, applicable to the Company, are as follows:

Premiums receivable: Premiums receivable are recorded at the billed amount and reduced by any amounts not deemed collectible. Generally non-government receivable amounts aged ninety days and older are excluded from the balance sheets by a direct charge to capital and surplus. For GAAP, these amounts are recorded at the billed amount and are reported net of a valuation allowance based upon historical collection trends and management's judgment on the collectability of these accounts.

Nonadmitted assets: Certain assets designated as nonadmitted, receivables from affiliates, certain health care and other receivable balances, are excluded from the balance sheets by a direct charge to capital and surplus. These nonadmitted assets totaled \$706 and \$294 at December 31, 2015 and 2014, respectively. For GAAP, these amounts are carried as assets, net of a valuation allowance, if necessary.

Deferred income taxes: Deferred tax assets are reduced by a statutory valuation allowance if, based on the weight of available evidence, it is more likely than not that some portion or all of the gross deferred tax assets will not be realized. Adjusted gross deferred tax assets are separated by character (ordinary and capital) and admitted in an amount equal to the sum of 1) the amount of federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the applicable carryback period, plus 2) based on Risk Based Capital ("RBC") thresholds the lesser of the remaining adjusted gross deferred tax assets expected to be realized within the applicable period of the balance sheet date or an amount no greater than the applicable percentage of capital and surplus excluding any net deferred tax assets, electronic data processing ("EDP") equipment and operating software and any net positive goodwill, plus 3) the amount of remaining adjusted gross deferred tax assets that can be offset against existing gross deferred tax liabilities after consideration of the reversal patterns of temporary differences. The remaining deferred tax asset is nonadmitted.

Deferred taxes do not include amounts for state taxes. Changes in deferred income taxes are recorded as adjustments to capital and surplus. For GAAP, state income taxes are considered in the computation of deferred taxes, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in

Better Health, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

1. Nature of Operations and Significant Accounting Policies (continued)

future years, and a valuation allowance is established for deferred tax assets estimated to be unrealizable. Excluding the tax impact of unrealized investment gains and losses and certain other items, the change in deferred income taxes is recorded in the statements of income.

Statements of cash flow: Cash and short-term investments in the statements of cash flow represent cash balances, and investments with initial maturities of one year or less. If in the aggregate the Company has a negative cash balance, it is reported as a negative asset and not as a liability. For GAAP, the corresponding captions of cash include cash balances and investments with initial maturities of three months or less and negative cash balances are reported separately as liabilities.

Reinsurance: Any reinsurance balance amounts deemed to be uncollectible have been written off through a charge to operations. In addition, a liability for reinsurance balances has been provided for unsecured policy reserves ceded to reinsurers not authorized to assume such business. Changes to the liability are credited or charged directly to unassigned surplus. Under GAAP, an allowance for amounts deemed uncollectible would be established through a charge to earnings. Policy and contract liabilities ceded to reinsurers have been reported as reductions of the related reserves rather than as assets as would be required under GAAP.

The effects of the foregoing variances from GAAP on the accompanying statutory basis financial statements have not been determined but are presumed to be material.

Other significant accounting policies are as follows:

Use of Estimates

Preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Health Care Receivables

Health care receivables represent amounts related to claim overpayments and other health care related receivables other than premiums. These health care receivables are subject to various admittance tests based on the nature of the receivable balance.

Unpaid Claims and Claims Adjustment Expenses

Unpaid claims and claims adjustment expenses include management's best estimate of amounts based on historical claim development patterns and certain individual case estimates. The established liability considers health benefit provisions, business practices, economic conditions and other factors that may materially affect the cost, frequency and severity of claims. Reserves for unpaid claims and claim adjustment expenses are based on assumptions and estimates, and while management believes such estimates are reasonable, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed and changes in estimates are incorporated into current operating results.

The Company records a liability for future policy benefits relating to certain individual product contracts. The liability represents the present value of future benefits to be paid to or on behalf of policy holders and related

Better Health, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

1. Nature of Operations and Significant Accounting Policies (continued)

expenses less the present value of future net premiums. Changes in the liability for future benefits are recognized in the accompanying statutory basis statements in the period in which the change occurs.

Premiums

Premiums are recognized as revenue during the period in which the Company is obligated to provide service to members. Premium payments from contracted government agencies are based on eligibility lists produced by the government agencies. Adjustments to eligibility lists produced by the government agencies result from retroactive application of enrollment or disenrollment of members or classification changes between rate categories. The Company estimates the amount of retroactive premium owed to or from the government agencies each period and adjusts premium revenue accordingly. Expenses incurred in connection with acquiring insurance business are charged to operations as incurred.

Delays in approval of annual premium rate changes require that the Company defer the recognition of any increases to the period in which the premium rates become final. The value of the impact can be significant in the period in which it is recognized dependent on the magnitude of the premium rate increase, the membership to which it applies and the length of the delay between the effective date of the rate increase and the final contract date. Premium rate decreases are recognized in the period the change in premium rate becomes effective and the change in the rate is known, which may be prior to the period when the contract amendment affecting the rate is finalized.

Under the MediPass contract, approximately twelve months after the end of each contract year, AHCA will compare the aggregated actual Medicaid payments for the Company's covered services to an aggregate comprised of the total sum of all Per Capita Capitation Benchmark's ("PCCB") for all enrollees as calculated by AHCA for the year. If the aggregate adjusted actual costs for the period are less than the aggregated PCCB, a savings pool results ("Savings Pool"). The Savings Pool will be compared to the administrative fee paid to the Company for the year. To the extent that the Savings Pool exceeds the amount remitted to the Company for the period, 100% of the excess will be due to the Company. However, if the Savings Pool is less than the fee paid to the Company for the year, the Company will be required to refund the difference, not to exceed more than 50% of the administrative fee received for the year. Management is provided with cost statistics on an ongoing basis. As a result of the Savings Pool, for the year ended December 31, 2015 and 2014, the Company recorded approximately \$2,379 and \$6,676, respectively, of additional revenues relating to the reconciliation with AHCA and is included in the caption net premiums earned on the accompanying statement of income. As of December 31, 2015 and 2014, approximately \$2,379 and \$12,207, respectively, is due from AHCA in relation to the Savings Pool.

Reinsurance

Reinsurance premiums, claims and claims adjustment expenses are accounted for on a basis consistent with those used in accounting for the original policies issued and the terms of the reinsurance contracts.

Retrospectively Rated Contracts

The Company's contracts with the State Medicaid Agency include a provision for which premiums vary based on loss experience. The Company estimates accrued retrospective premium adjustments through the review of each retrospectively rated contract, comparing the claim development with that anticipated in the contract. Any adjustment made to the estimated liability as a result of a final settlement is included in current operations. The Company uses estimates to report in the statutory basis financial statements the incurred and unpaid liability

Better Health, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

1. Nature of Operations and Significant Accounting Policies (continued)

amounts for retrospectively rated contracts based on its underwriting experience; actuarial, tax, and accounting estimates and assumptions at the financial statement date and regulations and guidance available that is subject to change prior to settlement. Accordingly, the Company's use of estimates and assumptions in the preparation of the statutory basis financial statements and related footnote disclosures may differ from actual results. The Company records accrued retrospective premium as an adjustment to earned premium.

The amount of net premiums written by the Company in 2015 and 2014 that was subject to retrospective rating features was \$267,831 and \$159,153, which represented 100% of the total net premiums written.

Federal Income Taxes

The Company participates in a tax sharing agreement with Anthem and its subsidiaries. Allocation of federal income taxes is based upon separate return calculations with credit for net losses that can be used on a consolidated basis. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

Patient Protection and Affordable Care Act

In 2010, the U.S. Congress passed and the President signed into law ACA. ACA has created significant changes and will continue to create significant changes for health insurance markets. Certain requirements include changes to Medicare Advantage payments and the minimum MLR provision that requires insurers to pay rebates to customers when insurers do not meet or exceed the specified MLR thresholds. Most of the provisions of ACA with more significant effects on the health insurance marketplace, both state and federal, went into effect on January 1, 2014, including a requirement that insurers guarantee the issuance of coverage to all individuals regardless of health status, strict rules on how health insurance is rated, the assessment of new taxes and fees (including annual fees on health insurance companies), the creation of new insurance exchanges for individuals and small groups, the availability of premium subsidies for certain individual products, and substantial expansions in eligibility for Medicaid.

Implementation of ACA brings with it significant oversight responsibilities by health insurers that may result in increased governmental audits, increased assertions of *False Claims Act* violations, and an increased risk of other litigation.

Health Insurer Fee

ACA Section 9010 imposed a mandatory annual fee on health insurers that write certain types of health insurance on U.S. risks for each calendar year beginning on or after January 1, 2014. The annual fee is allocated to health insurers based on the ratio of the amount of an insurer's premium written during the preceding calendar year to the amount of health insurance for all U.S. health risk for those certain lines of business that is written during the preceding calendar year. This fee is non-deductible for income tax purposes. The Company was not subject to the health insurer fee in 2014. The estimated health insurer fee payable in 2016 is segregated in special surplus funds at December 31, 2015. For statutory accounting purposes, the entire fee expected to be paid during the year is recorded as a general and administrative expense on January 1st, as the first policy is underwritten for the calendar year.

Reclassifications

Certain prior year amounts have been reclassified to conform to the current year presentation.

Better Health, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

2. Unpaid Claims and Claims Adjustment Expenses

The following table provides a reconciliation of the beginning and ending balances for unpaid claims and claims adjustment expenses:

	<u>2015</u>	<u>2014</u>
Balances at January 1	\$ 27,325	\$ 3,978
Incurred (redundancies) related to:		
Current year	245,853	131,194
Prior years	<u>(1,363)</u>	<u>411</u>
Total incurred	244,490	131,605
Paid related to:		
Current year	214,305	107,038
Prior years	<u>22,633</u>	<u>1,220</u>
Total paid	236,938	108,258
Balances at December 31	<u><u>\$ 34,877</u></u>	<u><u>\$ 27,325</u></u>

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any year end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established year end liability. The negative amounts reported for incurred related to prior years' results from claims being settled for amounts less than originally estimated. Positive amounts reported for incurred related to prior years result from claims being settled for amounts greater than originally estimated. This experience is primarily attributable to actual medical cost experience that differs from that assumed at the time the liability was established.

The Company took into account estimated anticipated subrogation and other recoveries in its determination of the liability for unpaid claims based on historical recovery patterns.

3. Reinsurance

Certain premiums and benefits are ceded to other insurance companies under various reinsurance agreements. These reinsurance agreements limit the Company's exposure to losses within its capital resources. The Company remains obligated for amounts ceded in the event that the reinsurers do not meet their obligations.

The effects of reinsurance on net premium considerations are as follows:

	<u>Year ended December 31</u>	
	<u>2015</u>	<u>2014</u>
Direct premiums	\$ 267,831	\$ 159,153
Ceded premiums - non-affiliates	<u>(711)</u>	<u>(325)</u>
Net premiums	<u><u>\$ 267,120</u></u>	<u><u>\$ 158,828</u></u>

Better Health, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

3. Reinsurance (continued)

The Company's ceded reinsurance arrangements reduced certain other items in the accompanying financial statements as follows:

	Year ended December 31	
	2015	2014
Direct claims and claim adjustment expense	\$ 244,593	\$ 131,627
Ceded claims and claim adjustment expense	(103)	(22)
Net claims and claim adjustment expense	<u>\$ 244,490</u>	<u>\$ 131,605</u>

4. Federal Income Taxes

The Company had a federal income tax recoverable of \$2,024 and \$750 at December 31, 2015 December 31, 2014, respectively.

Through February 25, 2014, the Company was a limited liability company and was treated as a partnership for federal income tax purposes. Accordingly, it would not incur income taxes or have any unrecognized tax benefits. Instead, its earnings and losses are included in the tax return of its members and taxed depending on the members' tax situation. As a result, the statutory financial statements do not reflect a provision for income taxes.

Upon conversion to a corporation on February 25, 2014, the Company's results of operations are included in the federal consolidated tax return of Simply Holdings. Income taxes are accounted for under the asset and liability method. Deferred income taxes are recognized, subject to statutory limitations, for temporary differences between the financial reporting basis and the income tax basis of assets and liabilities based on enacted tax laws and statutory tax rates applicable to the periods in which the temporary difference are expected to reverse. Gross deferred tax assets are first reduced by a statutory valuation allowance adjustment if, based on the weight of available evidence, it is more likely than not that some portion of the gross deferred tax asset will not be realized.

The components of net deferred tax assets (liabilities) at December 31 are as follows:

	Ordinary	2015 Capital	Total
Gross deferred tax assets	\$ 3,202	\$ –	\$ 3,202
Statutory valuation allowance	2,908	–	2,908
Adjusted gross deferred tax assets	294	–	294
Gross deferred tax liabilities	(294)	–	(294)
Net deferred tax asset before admissibility test	<u>\$ –</u>	<u>\$ –</u>	<u>\$ –</u>

Better Health, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

4. Federal Income Taxes (continued)

The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101 *Income Taxes - A Replacement of SSAP No. 10R and SSAP 10* ("SSAP No. 101") as of December 31, 2015 is:

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ —	\$ —	\$ —
Admitted pursuant to paragraph 11.b	—	—	—
Admitted pursuant to paragraph 11.c	<u>294</u>	<u>—</u>	<u>294</u>
Admitted deferred tax asset	<u>294</u>	<u>—</u>	<u>294</u>
Deferred tax liability	<u>(294)</u>	<u>—</u>	<u>(294)</u>
Net admitted deferred tax asset	<u>—</u>	<u>—</u>	<u>—</u>
Nonadmitted deferred tax asset	<u>\$ —</u>	<u>\$ —</u>	<u>\$ —</u>

	Ordinary	2014 Capital	Total
Gross deferred tax assets	\$ <u>4,389</u>	\$ —	\$ <u>4,389</u>
Statutory valuation allowance	<u>(4,389)</u>	<u>—</u>	<u>(4,389)</u>
Adjusted gross deferred tax assets	<u>\$ —</u>	<u>\$ —</u>	<u>\$ —</u>

The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101 as of December 31, 2014

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ —	\$ —	\$ —
Admitted pursuant to paragraph 11.b	—	—	—
Admitted pursuant to paragraph 11.c	<u>—</u>	<u>—</u>	<u>—</u>
Admitted deferred tax asset	<u>—</u>	<u>—</u>	<u>—</u>
Deferred tax liability	<u>—</u>	<u>—</u>	<u>—</u>
Net admitted deferred tax asset	<u>—</u>	<u>—</u>	<u>—</u>
Nonadmitted deferred tax asset	<u>\$ —</u>	<u>\$ —</u>	<u>\$ —</u>

The change in the amount of admitted adjusted gross deferred tax assets under each component during 2015 is:

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ —	\$ —	\$ —
Admitted pursuant to paragraph 11.b	—	—	—
Admitted pursuant to paragraph 11.c	<u>294</u>	<u>—</u>	<u>294</u>
Admitted deferred tax asset	<u>294</u>	<u>—</u>	<u>294</u>
Deferred tax liability	<u>(294)</u>	<u>—</u>	<u>(294)</u>
Net admitted deferred tax asset	<u>—</u>	<u>—</u>	<u>—</u>
Nonadmitted deferred tax asset	<u>\$ —</u>	<u>\$ —</u>	<u>\$ —</u>

	2015	2014
Amount of adjusted capital and surplus used to determine recovery period and threshold limitations.	\$ <u>15,276</u>	\$ <u>15,993</u>

Better Health, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

4. Federal Income Taxes (continued)

The impact of tax planning strategies is as follows:

	2015		2014		Change	
	Ordinary	Capital	Ordinary	Capital	Ordinary	Capital
Adjusted gross deferred tax assets amount	\$ 294	\$ –	\$ –	\$ –	\$ 294	\$ –
Percentage of adjusted gross deferred tax assets by tax character attributable to the impact of tax planning strategies	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Net admitted adjusted gross deferred tax assets amount	\$ 294	\$ –	\$ –	\$ –	\$ 294	\$ –
Percentage of net admitted adjusted gross deferred tax assets by tax character attributable to the impact of tax planning strategies	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

The Company's tax planning strategies do not include the use of reinsurance.

Current federal income taxes consist of the following major components:

	2015	2014	Change
Federal income taxes (benefit) on operations	\$ (832)	\$ –	\$ (832)
Utilization of net operating loss and capital loss carryforwards	(64)	–	(64)
Federal income taxes (benefit) incurred	<u>\$ (896)</u>	<u>\$ –</u>	<u>\$ (896)</u>

Better Health, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

4. Federal Income Taxes (continued)

The components of deferred income taxes are as follows:

	December 31		
	2015	2014	Change
Deferred tax assets:			
Ordinary:			
Accrued future expenses	\$ 35	\$ –	35
Amortization	896	1,062	(166)
Accounts receivable	236	133	103
Net operating loss carryforward	1,923	1,661	262
Other insurance reserves	–	–	–
Claims discount reserve	101	79	22
Prepaid expenses	11	–	11
Unearned premium reserve	–	1,454	(1,454)
Subtotal	3,202	4,389	(1,187)
Statutory valuation allowance adjustment	(2,908)	(4,389)	–
Admitted deferred tax assets	294	–	294
Deferred tax liabilities:			
Ordinary:			
Surplus note interest	(294)	–	(294)
Deferred tax liabilities	(294)	–	(294)
Net admitted deferred tax assets	\$ –	\$ –	\$ –

The changes in deferred tax assets and deferred tax liabilities are as follows:

	December 31		
	2015	2014	Change
Total deferred tax assets	\$ 294	\$ –	\$ 294
Total deferred tax liabilities	(294)	–	(294)
Net deferred tax asset	\$ –	\$ –	\$ –
Tax effect of unrealized gains			–
Change in net deferred income tax			\$ –

Better Health, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

4. Federal Income Taxes (continued)

The Company's income tax benefit and change in deferred taxes differs from the amount obtained by applying the federal statutory rate of 35% for the year ended December 31 for the following reasons:

	2015	2014
Tax expense computed using federal statutory rate	\$ (421)	\$ (2,908)
Change in nonadmitted assets	(247)	–
Valuation adjustment	(1,480)	4,389
ACA health insurer fee	897	–
Prior year adjustments	355	–
Change in taxable status	–	(621)
Other	–	(860)
Total	<u>\$ (896)</u>	<u>\$ –</u>
Federal income taxes (benefit) incurred	\$ (896)	\$ –
Change in net deferred income taxes	–	–
Total statutory income taxes (benefit)	<u>\$ (896)</u>	<u>\$ –</u>

At December 31, 2015, the Company had \$5,495 of unused net operating loss or tax credit carryforwards available to offset future taxable income. The losses or credits will begin to expire in 2034.

The Company is a member of the IRS Compliance Assurance Program (“CAP”). The objective of CAP is to reduce taxpayer burden and uncertainty while assuring the IRS of the accuracy of tax returns prior to filing, thereby reducing or eliminating the need for post filing examinations. As of December 31, 2015, the examination of the 2015 tax year continues to be in process.

5. Health Insurer Fee

The Company has \$267,831 of premiums written subject to assessment under ACA Section 9010 as of December 31, 2015. The Company's estimated portion of the annual health insurance industry fee to be paid by September 30, 2016 is \$4,875 as segregated in special surplus funds on the balance sheet. The Company portion of annual health insurer fee paid in 2015 was \$2,562 and is included in operating expenses. Total Adjusted Capital (“TAC”) and Authorized Control Level (“ACL”) were \$15,276 and \$10,624, respectively, as of December 31, 2015. Had the assessment, based upon 2015 premiums written, been accrued on December 31, 2015, TAC would have been reduced to \$10,401, which would continue to exceed all capital and surplus requirements as described in Note 6.

6. Capital and Surplus

The State of Florida requires Company to maintain a minimum statutory capital and surplus as set forth in the State. Under those requirements, capital and surplus is calculated as the greater of \$1,500, or 10% of total liabilities, or 2% of total annualized premiums. The Florida OIR has not adopted the Risk-Based Capital (RBC) requirement of the NAIC. At December 31, 2015 and 2014, the Company's capital and surplus exceeded all regulatory requirements.

Per the Florida Statue 641.365, certain limitations exist on the Company's ability to pay dividends to its parent. The Company may pay funds only from accumulated surplus funds that were derived from realized net operating profits

Better Health, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

6. Capital and Surplus (continued)

on its business and net realized capital gains. Prior written approval by the Florida OIR is required for payment of any dividend that would result in these accumulated surplus funds being less than zero. Florida OIR approval is not required if the dividend paid is less than the greater of 1) ten percent of the Company's accumulated surplus as of December 31st of the preceding year or 2) the Company's net income from the immediately preceding calendar year. Within these limitations, the Company may not pay any dividends during 2016 without prior approval.

There was no portion of unassigned surplus representing cumulative unrealized gains as of December 31, 2015 and 2014, respectively.

7. Contingencies

Other Contingencies:

In February 2015, Anthem reported that it was the target of a sophisticated external cyber-attack. The attackers gained unauthorized access to certain of Anthem's information technology systems and obtained personal information related to many individuals and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that Anthem will not identify additional information that was accessed or obtained.

Anthem has continued to implement security enhancements since this incident and is supporting federal law enforcement efforts to identify the responsible parties. Upon discovery of the cyber-attack, Anthem took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate its systems and identify solutions based on the evolving landscape. Anthem is providing credit monitoring and identity protection services to those who have been affected by this cyber-attack. Anthem has incurred expenses subsequent to the cyber-attack to investigate and remediate this matter and expects to continue to incur expenses of this nature in the foreseeable future. Anthem will recognize these expenses in the periods in which they are incurred.

The Company is involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental and administrative proceedings. These investigations, audits and reviews include routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and Federal Agencies. Such investigations could result in the imposition of civil or criminal fines, penalties and other sanctions. The Company believes that any liability that may result from any one of these actions is unlikely to have a material adverse effect on the Company's financial position or results of operations.

Actions have been filed in various federal and state courts, and other claims have been or may be asserted against Anthem on behalf of current or former members, current or former employees, other individuals, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber-attack. State and federal agencies, including state insurance regulators, state attorneys general, the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigation, are investigating events related to the cyber-attack, including how it occurred, its consequences and Anthem's responses. Although Anthem is cooperating in these investigations, Anthem may be subject to fines or other obligations, which may have an adverse effect on how Anthem operates its business and results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation in February 2015 and was subsequently heard by the Panel in May 2015. In June

Better Health, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

7. Contingencies (continued)

2015, the Panel entered its order transferring the consolidated matter to the U.S. District Court for the Northern District of California. The U.S. District Court entered its Case Management Order in September 2015. Anthem has filed a Motion to Dismiss several of the counts that are before the U.S. District Court. There remain a few state court cases that are presently proceeding outside of the Multidistrict Litigation.

Anthem has contingency plans and insurance coverage for certain expenses and potential liabilities of this nature. The coverage has been sufficient to cover the majority of claims and liabilities incurred to date. While a loss from these matters is reasonably possible, Anthem cannot reasonably estimate a range of possible losses because the investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

At December 31, 2015 and 2014, the Company reported admitted assets of \$4,017 and \$18,182 respectively in premium receivables due from the state Medicaid agency. The receivables are not deemed to be uncollectible, therefore, no provisions for uncollectable amounts have been recorded. The potential for any additional loss is not believed to be material to the Company's financial condition.

8. Health Care Receivable

Admitted health care receivables consist of claims overpayments of \$835 and \$141 at December 31, 2015 and 2014, respectively.

Claim overpayment receivables consist of amounts that have been invoiced and meet the setoff conditions. Amounts that have not been invoiced and do not meet the setoff conditions are nonadmitted. Claim overpayment receivables and other health care receivables of \$424 and \$170 were nonadmitted as of December 31, 2015 and 2014, respectively.

Provider receivables of \$119 and \$49 were nonadmitted at December 31, 2015 and 2014, respectively.

9. Related Party Transactions

The Company has entered into administrative services agreements with its affiliated companies. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Costs include expenses such as salaries, benefits, communications, advertising, consulting services, rent, utilities, accounting, underwriting, and product development, which support the operations of the Company. These costs are allocated based on various utilization statistics.

Net payments to affiliated companies pursuant to the above administrative service agreements were \$26,160 and \$36,493 in 2015 and 2014, respectively, and are included in operating expenses and claims adjustment expenses in the statutory basis statements of operations.

Better Health, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

9. Related Party Transactions (continued)

At December 31, 2015 and 2014, the Company reported \$56 and \$380 due to affiliates, respectively. The payable balances represent intercompany transactions that are settled within the terms of the management and services agreement.

The Company paid no dividends and received no capital contributions for the years ended December 31, 2015 and 2014 respectively.

10. Surplus Notes

During December of 2012, the Company entered into two promissory surplus notes with Simply Holdings totaling \$5,000. During February of 2013, the Company entered into an additional promissory surplus note with Simply Holdings totaling \$5,500. The surplus notes bear interest at annual rates of 8%. Management determines what portion of principal of each note shall be repaid within ninety days after the end of each calendar year. The repayment of principal and any interest accrued is subordinated to the prior payment in full of all other liabilities of the Company. The repayment must also be approved by the AHCA and not cause the Company to fall below the minimum surplus requirements. Management does not anticipate any repayments during 2016.

During 2015 and 2014, the Company did not seek nor did the AHCA approve any interest payments. As of December 31, 2015 and 2014, the “unapproved” cumulative interest relating to the surplus notes is approximately \$2,459 and \$1,619, respectively.

11. Restricted Assets

Cash with a statement value of \$300 was on deposit with the Florida OIR at December 31, 2015 and 2014. Cash with a statement value of \$10,243 and \$7,213 was on deposit with Florida AHCA at December 31, 2015 and 2014.

Better Health, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

12. Reconciliation to the Statutory Annual Statements

The 2015 audited net income and surplus amounts were adjusted as compared to the 2015 Annual Statement as follows:

	Year ended December 31	
	2015	2014
Total capital and surplus reported in the Annual Statement	\$ 15,214	\$ 15,818
Increase in premium income	-	219
Decrease in claims and claims adjustment expenses	-	(44)
Increase in federal income tax benefit	62	-
Total capital and surplus reported in the accompanying statutory basis balance sheets	<u>\$ 15,276</u>	<u>\$ 15,993</u>

	Year ended December 31	
	2015	2014
Total net loss as reported in the Annual Statement	\$ (192)	\$ (8,482)
Increase in premium income	(219)	219
Decrease in claims and claims adjustment expenses	44	(44)
Increase in federal income tax benefit	62	-
Total net loss as reported in the accompanying statutory basis statements of operations	<u>\$ (305)</u>	<u>\$ (8,307)</u>

13. Subsequent Events

The annual health insurer fee under section 9010 of the ACA, discussed in Note 1, has been suspended for 2017 and will resume for 2018 and beyond.

Management of the Company has evaluated all other events occurring after December 31, 2015 through April 5, 2016, the date the financial statements were available to be issued, to determine whether any event required either recognition or disclosure in the financial statements. It was determined there were no other events that require recognition or disclosure in the financial statements through the report date.

Financial Statements - Statutory Basis

AMERIGROUP Florida, Inc.

Years Ended December 31, 2016 and 2015
With Reports of Independent Auditors

AMERIGROUP Florida, Inc.
Financial Statements - Statutory Basis

Years ended December 31, 2016 and 2015

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Report of Independent Auditors

Board of Directors
AMERIGROUP Florida, Inc.

We have audited the accompanying statutory basis financial statements of AMERIGROUP Florida, Inc., which comprise the balance sheets as of December 31, 2016 and 2015, and the related statements of operations, changes in capital and surplus, and cash flow for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation. Management also is responsible for the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 1, to meet the requirements of Florida, the financial statements have been prepared in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation, which practices differ from U.S. generally accepted accounting principles. The variances between such practices and U.S. generally accepted accounting principles are described in Note 1. The effects on the accompanying financial statements of these variances are not reasonably determinable but are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the effects of the matter described in the preceding paragraph, the statutory basis financial statements referred to above do not present fairly, in conformity with U.S. generally accepted accounting principles, the financial position of AMERIGROUP Florida, Inc. at December 31, 2016 and 2015, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

However, in our opinion, the statutory basis financial statements referred to above present fairly, in all material respects, the financial position of AMERIGROUP Florida, Inc. at December 31, 2016 and 2015, and the results of its operations and its cash flows for the years then ended in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation.

Ernst + Young LLP

March 30, 2017

AMERIGROUP Florida, Inc.

Balance Sheets – Statutory Basis

	December 31	
	2016	2015
	<i>(In Thousands)</i>	
Admitted assets		
Cash and invested assets:		
Cash, cash equivalents and short-term investments	\$ 50,126	\$ 62,453
Bonds	147,035	110,896
Unaffiliated common stocks	—	13,826
Receivable for securities	—	6
Securities lending collateral	948	6,809
Total cash and invested assets	198,109	193,990
Accrued investment income	858	800
Premiums receivable	20,096	6,923
Amounts receivable from uninsured plans	835	330
Net deferred tax asset	9,146	5,576
Electronic data processing equipment and software	—	13
Health care and other receivables	—	461
Other assets	—	300
Total admitted assets	<u>\$ 229,044</u>	<u>\$ 208,393</u>
Liabilities and capital and surplus		
Liabilities:		
Unpaid claims and claims adjustment expenses	\$ 122,226	\$ 103,067
Aggregate policy reserves	480	334
Accounts payable and accrued expenses	2,202	890
Current federal income tax payable	2,351	369
Remittances and items not allocated	4,926	8,257
Payable to affiliates	3,235	9,877
Payable for securities lending	948	6,809
Liability for amounts held under uninsured plans	559	403
Other liabilities	5,987	2,703
Total liabilities	142,914	132,709
Capital and surplus:		
Common stock, \$1 par value, 1,000 shares authorized, 100 shares issued and outstanding	—	—
Additional paid-in surplus	80,185	70,185
Unassigned surplus (deficit)	5,945	(15,466)
Special surplus funds	—	20,965
Total capital and surplus	86,130	75,684
Total liabilities and capital and surplus	<u>\$ 229,044</u>	<u>\$ 208,393</u>

See accompanying notes.

AMERIGROUP Florida, Inc.

Statements of Operations – Statutory Basis

	Year ended December 31	
	2016	2015
	<i>(In Thousands)</i>	
Premium income	\$ 1,432,591	\$ 1,309,826
Benefits and expenses:		
Claims and claims adjustment expenses	1,359,034	1,242,703
Operating expenses	67,938	65,959
Change in reserves for accident and health contracts	—	(1,536)
Total benefits and expenses	<u>1,426,972</u>	<u>1,307,126</u>
Net underwriting gain (loss)	5,619	2,700
Investment gains (losses):		
Net investment income	3,065	3,474
Net realized capital gains (losses), net of tax (benefit)	<u>3,218</u>	<u>(412)</u>
Total net investment gains (losses)	6,283	3,062
Income (loss) before federal income taxes	11,902	5,762
Federal income tax (benefit)	<u>13,870</u>	<u>7,698</u>
Net income (loss)	<u>\$ (1,968)</u>	<u>\$ (1,936)</u>

See accompanying notes.

AMERIGROUP Florida, Inc.

Statements of Changes in Capital and Surplus – Statutory Basis

	<u>Common Stock</u>	<u>Additional Paid-in Surplus</u>	<u>Unassigned (Deficit) Surplus</u> <i>(In Thousands)</i>	<u>Special Surplus Funds</u>	<u>Total Capital and Surplus</u>
Balance as of January 1, 2015	\$ —	\$ 70,185	\$ (8,072)	\$ 21,493	83,606
Net income (loss)	—	—	(1,936)	—	(1,936)
Change in unrealized capital losses, net of benefit	—	—	(271)	—	(271)
Change in net deferred income tax	—	—	528	—	528
Change in nonadmitted assets	—	—	(6,243)	—	(6,243)
Change in special surplus funds for ACA health insurer fee	—	—	528	(528)	—
Balance as of December 31, 2015	<u>—</u>	<u>70,185</u>	<u>(15,466)</u>	<u>20,965</u>	<u>75,684</u>
Net income (loss)	—	—	(1,968)	—	(1,968)
Change in unrealized capital losses, net of tax (benefit)	—	—	(2,779)	—	(2,779)
Change in net deferred income tax	—	—	2,576	—	2,576
Change in nonadmitted assets	—	—	2,617	—	2,617
Capital contributions from parent	—	10,000	—	—	10,000
Change in special surplus funds for ACA health insurer fee	—	—	20,965	(20,965)	—
Balance as of December 31, 2016	<u><u>\$ —</u></u>	<u><u>\$ 80,185</u></u>	<u><u>\$ 5,945</u></u>	<u><u>\$ —</u></u>	<u><u>\$ 86,130</u></u>

See accompanying notes.

AMERIGROUP Florida, Inc.

Statements of Cash Flow – Statutory Basis

	Year ended December 31	
	2016	2015
	<i>(In Thousands)</i>	
Operating activities:		
Premiums collected	\$ 1,419,564	\$ 1,285,809
Investment income received	4,290	4,745
Claims and claims adjustment expenses paid	(1,334,461)	(1,230,480)
General administrative and miscellaneous expenses paid	(66,400)	(63,711)
Federal income taxes (paid) recovered	(13,618)	227
Net cash provided by (used in) operating activities	9,375	(3,410)
Investment activities:		
Proceeds from investments sold, matured or repaid	60,486	46,456
Cost of investments acquired	(77,537)	(45,057)
Net cash provided by (used in) investment activities	(17,051)	1,399
Financing or miscellaneous activities:		
Capital contribution from parent	10,000	—
Net transfers from (to) affiliates	(6,642)	5,168
Other	(8,009)	(195)
Net cash (used in) provided by financing or miscellaneous activities	(4,651)	4,973
Change in cash, cash equivalents and short-term investments	(12,327)	2,962
Cash, cash equivalents and short-term investments at the beginning of year	62,453	59,491
Cash, cash equivalents and short-term investments at end of year	<u>\$ 50,126</u>	<u>\$ 62,453</u>

See accompanying notes.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

December 31, 2016

1. Nature of Operations and Significant Accounting Policies

AMERIGROUP Florida, Inc. (the “Company”) is a Florida domiciled stock health maintenance organization (“HMO”), which is licensed in Florida. The Company is a prepaid capitated plan created primarily for an enrolled population comprised of beneficiaries of the Medicaid, Florida Healthy Kids (“FHK”), and Long-term Care Community Diversion (“LTC”) programs. The Company’s current service areas include the counties of Brevard, Broward, Hardee, Highlands, Hillsborough, Lake, Manatee, Miami-Dade, Monroe, Pasco, Palm Beach, Pinellas, Polk, Orange, Osceola, Sarasota, Seminole, and Volusia in Florida. The loss of the Medicaid contract with the Florida Agency for Health Care Administration (“AHCA”) would have a material effect on the company’s operations. Prior to 2016, the Company also managed healthcare services for members as a Medicare Advantage Plan, under a contract with the Centers for Medicare and Medicaid Services (“CMS”). The Company is a wholly owned subsidiary of Physicians Healthcare Plan Holding, Inc. (“PHP Holdings, Inc.”), which is an indirect wholly-owned subsidiary of Anthem, Inc. (“Anthem”), a publicly traded company.

On July 24, 2015, the Company’s ultimate parent company, Anthem, and Cigna Corporation (“Cigna”) entered into an Agreement and Plan of Merger dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and a direct wholly-owned subsidiary of Anthem, pursuant to which Anthem will acquire all outstanding shares of Cigna, or the Acquisition. On July 21, 2016, the U.S. Department of Justice, or DOJ, along with certain state attorneys general, filed a civil antitrust lawsuit in the U.S. District Court for the District of Columbia seeking to block the Acquisition. On January 18, 2017, Anthem provided notice to Cigna that Anthem had elected to extend the termination date under the Merger Agreement from January 31, 2017 until April 30, 2017. Following the conclusion of the trial, the Court ruled in favor of the DOJ, on February 8, 2017, and Anthem promptly filed notice that Anthem would appeal the Court’s ruling. On February 14, 2017, Cigna purported to terminate the Merger Agreement and commenced litigation against Anthem in the Delaware Court of Chancery, or Delaware Court, seeking damages and a declaratory judgment that its purported termination of the Merger Agreement was lawful, among other claims. Anthem believes Cigna’s allegations are without merit. Also on February 14, 2017, Anthem initiated its own litigation against Cigna in the Delaware Court seeking a temporary restraining order to enjoin Cigna from terminating the Merger Agreement, specific performance compelling Cigna to comply with the Merger Agreement and damages. On February 15, 2017, the Delaware Court granted Anthem’s motion for a temporary restraining order and issued an order enjoining Cigna from terminating the Merger Agreement. The temporary restraining order became effective immediately and will remain in place pending any further order from the Delaware Court. Anthem intends to vigorously defend the Acquisition in both the Circuit Court and the Delaware Court and remains committed to completing the Acquisition as soon as practicable.

Basis of Presentation

The accompanying financial statements have been prepared in accordance with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation (“Florida OIR”). The Florida OIR has adopted the accounting policies found in the National Association of Insurance Commissioners’ (“NAIC”) *Accounting Practices and Procedures Manual* (“NAIC SAP”) as a component of prescribed accounting practices. Additionally, the Florida OIR has adopted certain prescribed accounting practices that differ from those found in NAIC SAP, which impact the Company. Specifically, all parent and affiliate intercompany receivable balances are considered nonadmitted assets. In addition, pursuant to Section 641.35(3)(a), Florida Statutes, if an HMO, through a health risk contract, transfers to any entity the obligation to pay providers for subscriber claims, the liability for any such payment remains with the HMO until the payment is received by the provider and should be reflected in loss reserves.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

A reconciliation of the Company's statutory capital and surplus as of December 31, 2016 and 2015 between practices prescribed by the Florida OIR and NAIC SAP along with reference of Statement of Statutory Accounting Principles ("SSAP") is shown below:

	<u>SSAP No.</u>	<u>2016</u>	<u>2015</u>
Statutory capital and surplus, Florida OIR basis		\$ 86,130	\$ 75,684
State prescribed practices:			
Nonadmittance of amounts due from affiliates			
pursuant to 641.35 (2)(i) of the Florida Revised Statutes	25	1,958	189
Claim reserve			
pursuant to 641.35 (3)(a) of the Florida Revised Statutes	55	11,218	—
Statutory capital and surplus, NAIC SAP basis		<u>\$ 99,306</u>	<u>\$ 75,873</u>

A reconciliation of the Company's statutory net income (loss) as of December 31, 2016 and 2015 between practices prescribed by the Florida OIR and NAIC SAP along with reference of SSAP is shown below:

	<u>SSAP No.</u>	<u>2016</u>	<u>2015</u>
Statutory net income (loss), Florida OIR basis		\$ (1,968)	\$ (1,936)
State prescribed practices:			
Claim reserve			
pursuant to 641.35 (3)(a) of the Florida Revised Statutes	55	11,218	—
Statutory net income (loss), NAIC SAP basis		<u>\$ 9,250</u>	<u>\$ (1,936)</u>

Such practices vary from U.S. generally accepted accounting principles ("GAAP"). The more significant variances from GAAP, applicable to the Company, are as follows:

Investments: Investments in bonds and preferred stocks are reported at amortized cost or fair value based on their NAIC rating. For GAAP, such fixed maturity investments are designated at purchase as available-for-sale and are reported at fair value with unrealized holding gains and losses, net of tax, reported as a separate component of capital and surplus.

For statutory purposes, all single class and multi-class mortgage-backed/asset-backed securities, such as collateralized mortgage obligations ("CMOs"), where it is determined that a decline in fair value is other-than-temporary because the Company intends to sell the security or has assessed that it does not have the intent and ability to retain the investments in the security for a period of time sufficient to recover the amortized cost basis, the amortized cost basis is written down to fair value as a realized loss in the statements of operations. If deemed other-than-temporarily impaired as the Company does not expect to recover the amortized cost basis even if it did not intend to sell the security and the Company has the intent and ability to hold the security, the amortized cost basis is written down to the present value of future cash flows as a realized loss in the statements of operations. For impaired bonds not backed by other assets, an other-than temporary impairment ("OTTI") is considered to have occurred if it is probable that the Company will be unable to collect all amounts due according to the instrument's contractual terms in effect at the date of acquisition. A decline in fair value that is other-than-temporary includes situations where the Company has made a decision to sell a security prior to its maturity at an amount below its carrying value. If it is determined that a decline in the fair value of a bond is other-than-temporary, an impairment loss is recognized as a realized loss in the statements of operations equal to the entire difference between the bond's carrying value and its fair value.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

For GAAP purposes, all securities, purchased or retained, that represent beneficial interests in securitized assets, such as CMOs, mortgage-backed securities, bonds and asset-backed securities, other than high credit quality securities, whose decline in fair value is determined to be other-than-temporary, the cost basis of the security is written down to the fair value if the Company intends to sell the security or it is more likely than not that the Company will have to sell the security prior to recovery. For impaired fixed maturity securities that the Company does not intend to sell or it is more likely than not that the Company will not have to sell such securities, but the Company expects that it will not fully recover the amortized cost basis, the credit component of the OTTI is recognized in other-than-temporary losses in the income statements, and the non-credit component of the OTTI is recognized in other comprehensive income. Furthermore, unrealized losses entirely caused by non-credit factors related to fixed maturity securities for which the Company expects to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive income.

Premiums receivable: Premiums receivable are recorded at the billed amount and reduced by any amounts not deemed collectible. Generally amounts aged ninety days and older are nonadmitted assets, with the exception of government receivables. For GAAP, these amounts are recorded at the billed amount and are reported net of a valuation allowance based upon historical collection trends and management's judgment on the collectability of these accounts.

Nonadmitted assets: Certain assets designated as nonadmitted, including furniture and equipment, receivables from affiliates, leasehold improvements, prepaid expenses, goodwill, intangibles, and certain health care and other receivable balances, are excluded from the balance sheets by a direct charge to capital and surplus. These nonadmitted assets totaled \$18,311 and \$20,928 at December 31, 2016 and 2015, respectively. For GAAP, these amounts are carried as assets, net of a valuation allowance, if necessary.

Deferred income taxes: Deferred tax assets are reduced by a statutory valuation allowance if, based on the weight of available evidence, it is more likely than not that some portion or all of the gross deferred tax assets will not be realized. Adjusted gross deferred tax assets are separated by character (ordinary and capital) and admitted in an amount equal to the sum of 1) the amount of federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the applicable carryback period, plus 2) based on Risk Based Capital ("RBC") thresholds the lesser of the remaining adjusted gross deferred tax assets expected to be realized within the applicable period of the balance sheet date or an amount no greater than the applicable percentage of capital and surplus excluding any net deferred tax assets, electronic data processing ("EDP") equipment and operating software and any net positive goodwill, plus 3) the amount of remaining adjusted gross deferred tax assets that can be offset against existing gross deferred tax liabilities after consideration of the reversal patterns of temporary differences. The remaining deferred tax asset is nonadmitted.

Deferred taxes do not include amounts for state taxes. Changes in deferred income taxes are recorded as adjustments to capital and surplus. For GAAP, state income taxes are considered in the computation of deferred taxes, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years, and a valuation allowance is established for deferred tax assets estimated to be unrealizable. Excluding the tax impact of unrealized investment gains and losses and certain other items, the change in deferred income taxes is recorded in the statements of operations.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

Statements of cash flow: Cash, cash equivalents and short-term investments in the statements of cash flow represent cash balances, and investments with initial maturities of one year or less. If in the aggregate the Company has a negative cash balance, it is reported as a negative asset and not as a liability. For GAAP, the corresponding captions of cash and cash equivalents include cash balances and investments with initial maturities of three months or less and negative cash balances are reported separately as liabilities and short term investments.

Uninsured accident and health plans: The Company provides administrative services to AHCA on an uninsured basis. Under these arrangements, the customer retains the risk of funding payments for health benefits provided, and the Company may be subject to credit risk of the customer from the time of the Company's claim payment until the Company receives the claim reimbursement. In accordance with SSAP No. 47, Uninsured Plans, these claim payments and subsequent reimbursements are excluded from the Company's statutory basis statements of income, and administrative fees earned are deducted from general insurance expenses. For GAAP, these administrative fees are reported as revenue in the statements of income.

The effects of the foregoing variances from GAAP on the accompanying statutory basis financial statements have not been determined but are presumed to be material.

Other significant accounting policies are as follows:

Use of Estimates

Preparation of statutory basis financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Investments

Bonds not backed by loans are stated at amortized cost, with amortization of premium or discount calculated based on the modified scientific method, using lower of yield to call or yield to maturity. Single class and multi-class mortgage-backed/asset-backed securities are valued at amortized cost using the interest method including anticipated prepayments. Prepayment assumptions for loan-backed securities and structured securities are obtained from broker-dealer survey values or internal estimates. These assumptions are consistent with the current interest rate and economic environment. The retrospective adjustment method is used to value all loan-backed securities. Non-investment grade bonds are stated at the lower of cost or fair value as determined by the NAIC's Securities Valuation Office ("SVO"). Common stocks of unaffiliated companies are stated at fair value as determined by various third-party pricing sources.

The Company participates in a securities lending program whereby marketable securities in its investment portfolio are transferred to independent brokers or dealers based on, among other things, their creditworthiness in exchange for collateral initially equal to at least 102% of the fair value of the securities on loan, and is thereafter maintained at a minimum of 100% of the fair value of the securities loaned. The fair value of the securities on loan to each borrower is monitored daily and the borrower is required to deliver additional collateral if the fair value of the collateral falls below 100% of the fair value of the securities on loan. The Company has no loaned portfolio securities with terms exceeding one year.

Unrealized gains and losses on stocks and non-investment grade bonds are reflected directly in unassigned surplus net of federal income taxes unless there is deemed to be an other-than-temporary decline in value, in which case the loss is charged to income. Realized gains and losses on investments sold are determined using the specific

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

identification method and are included in net realized capital gains (loss), net of tax. Investment income is not accrued on bonds with interest payments in default.

Short-term investments include investments with maturities of less than one year and more than three months at the date of acquisition and are reported at amortized cost, which approximates fair value. Cash equivalent investments include investments with maturities of less than or equal to three months at the date of acquisition and are reported at amortized cost, which approximates fair value. Non-investment grade short-term and cash equivalent investments are stated at the lower of amortized cost or fair value.

Electronic Data Processing Equipment and Software

EDP equipment and software are recorded at cost less accumulated depreciation. Depreciation on EDP equipment and operating software is computed principally by the straight-line method over the lesser of the estimated useful lives of the assets or three years. Non-operating software is depreciated using the straight-line method over the lesser of its useful life or five years. Accumulated depreciation at December 31, 2016 and 2015 was \$209 and \$1,431, respectively. Depreciation expense in 2016 and 2015 was \$13 and \$28, respectively.

Furniture and Equipment

Furniture and equipment is capitalized and depreciated on a straight-line basis over its useful life. The net book value is charged in full to unassigned surplus as a nonadmitted asset. Depreciation expense in 2016 and 2015 was \$569 and \$434, respectively.

Health Care Receivables

Health care receivables represent amounts related to pharmacy rebate receivables and other health care related receivables other than premiums. Pharmacy rebate receivables are recorded when earned based upon actual rebate receivables and an estimate of receivables based upon current utilization of specific pharmaceuticals and provider contract terms. These health care receivables are subject to various admittance tests based on the nature of the receivable balance.

Unpaid Claims and Claims Adjustment Expenses

Unpaid claims and claims adjustment expenses include management's best estimate of amounts based on historical claim development patterns and certain individual case estimates. The established liability considers health benefit provisions, business practices, economic conditions and other factors that may materially affect the cost, frequency and severity of claims. Reserves for unpaid claims and claims adjustment expenses are based on assumptions and estimates, and while management believes such estimates are reasonable, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed and changes in estimates are incorporated into current operating results.

Premiums

Premiums are recognized as revenue during the period in which the Company is obligated to provide service to members. Premium payments from contracted government agencies are based on eligibility lists produced by the government agencies. Adjustments to eligibility lists produced by the government agencies result from retroactive application of enrollment or disenrollment of members or classification changes between rate categories. The Company estimates the amount of retroactive premium owed to or from the government agencies each period and adjusts premium revenue accordingly. Expenses incurred in connection with acquiring insurance business are charged to operations as incurred.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

Delays in approval of annual premium rate changes require that the Company defer the recognition of any increases to the period in which the premium rates become final. The value of the impact can be significant in the period in which it is recognized dependent on the magnitude of the premium rate increase, the membership to which it applies and the length of the delay between the effective date of the rate increase and the final contract date. Premium rate decreases are recognized in the period the change in premium rate becomes effective and the change in the rate is known, which may be prior to the period when the contract amendment affecting the rate is finalized.

The State of Florida, AHCA, informed the Company on June 7, 2016 of a pricing error related to the State Fiscal Year 2015-2016 contract. AHCA indicated it under paid the Company due to a mismatch of rates. Related to this, the Company received and recognized cash and premiums of \$9,113 from AHCA during 2016 related to 2015.

Medicare Advantage Part D Premiums and Expenses

Prior to 2016, the Company served as a plan sponsor, offering Medicare Advantage Part D prescription drug insurance coverage under a contract with CMS. The CMS premium, the member premium, and the low-income premium subsidy represent payments for the Company's insurance risk coverage under the Medicare Advantage Part D program and therefore are recorded as premium revenues in operations. Premium revenues are recognized ratably over the period in which eligible individuals are entitled to receive prescription drug benefits. Pharmacy benefit costs and administrative costs under the contract are expensed as incurred.

Subsidies from CMS representing cost reimbursements under the Medicare Part D program are not reflected as premium revenues, but rather are accounted for as deposits in amounts receivable for uninsured plans on the accompanying balance sheets. The related liabilities are reported in the accompanying balance sheets in liability for amounts held under uninsured plans.

Retrospectively Rated Contracts

The Company's contracts with CMS and AHCA include a provision for which premiums vary based on loss experience. The Company estimates accrued retrospective premium adjustments through the review of each retrospectively rated contract, comparing the claim development with that anticipated in the contract. Any adjustment made to the estimated liability as a result of a final settlement is included in current operations. The Company uses estimates to report in the statutory basis financial statements the incurred and unpaid liability amounts for retrospectively rated contracts based on its underwriting experience; actuarial, tax, and accounting estimates and assumptions at the financial statement date and regulations and guidance available that is subject to change prior to settlement. Accordingly, the Company's use of estimates and assumptions in the preparation of the statutory basis financial statements and related footnote disclosures may differ from actual results.

Federal Income Taxes

The Company participates in a tax sharing agreement with Anthem and its subsidiaries. Allocation of federal income taxes is based upon separate return calculations with credit for net losses that can be used on a consolidated basis. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

Health Insurer Fee

ACA Section 9010 imposed a mandatory annual fee on health insurers that write certain types of health insurance on U.S. risks for each calendar year beginning on or after January 1, 2014. The annual fee is allocated to health insurers based on the ratio of the amount of an insurer's premium written during the preceding calendar year to the amount of health insurance for all U.S. health risk for those certain lines of business that is written during the preceding calendar year. This fee is nondeductible for income tax purposes. The health insurer fee is reported in operating expenses in the same year it is paid. The health insurer fee to be paid in the following year is segregated in special

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

surplus funds until the beginning of the year in which it is to be paid. Payment of the health insurer fee has been suspended for 2017 and is currently scheduled to resume for 2018 and beyond.

Reclassifications

Certain prior year amounts have been reclassified to conform to the current year presentation.

2. Investments

A summary of the Company's investments in bonds is as follows:

	Statement Value	Gross Unrealized Gains	Gross Unrealized Losses Less Than 12 Months	12 Months or Greater	Fair Value
December 31, 2016					
United States government securities	\$ 30,460	\$ –	\$ (226)	\$ –	\$ 30,234
States, territories and political subdivisions	31,868	1,088	(23)	–	32,933
Industrial and miscellaneous	49,276	206	(299)	–	49,183
Loan-backed and structured securities	35,431	176	(306)	(38)	35,263
Total bonds	<u>\$ 147,035</u>	<u>\$ 1,470</u>	<u>\$ (854)</u>	<u>\$ (38)</u>	<u>\$ 147,613</u>
December 31, 2015					
States, territories and political subdivisions	\$ 31,132	\$ 1,875	\$ –	\$ –	\$ 33,007
Industrial and miscellaneous	50,346	87	(397)	(30)	50,006
Loan-backed and structured securities	29,418	207	(133)	(83)	29,409
Total bonds	<u>\$ 110,896</u>	<u>\$ 2,169</u>	<u>\$ (530)</u>	<u>\$ (113)</u>	<u>\$ 112,422</u>

The statement and fair values of bonds at December 31, 2016 by contractual maturity are shown below. Actual maturities may differ from contractual maturities because borrowers may have the right to call or repay obligations with or without call or prepayment penalties.

	Statement Value	Fair Value
Due in one year or less	\$ 10,703	\$ 10,713
Due after one through five years	71,939	71,684
Due after five through ten years	17,074	17,356
Due after ten years	11,888	12,597
Loan-backed and structured securities	35,431	35,263
	<u>\$ 147,035</u>	<u>\$ 147,613</u>

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

Proceeds from sales of bonds during 2016 and 2015 were \$27,076 and \$37,261, respectively, resulting in realized gross gains of \$138 and \$106, respectively, and realized gross losses of (\$2) and (\$741) in 2016 and 2015, respectively.

Cash of \$300 and \$300 were on deposit with the Florida OIR at December 31, 2016 and 2015, respectively.

Investments with a statement value of \$38,782 and \$38,546 were on deposit with AHCA at December 31, 2016 and 2015, respectively.

A summary of the Company's investment in unaffiliated common stocks is as follows:

	Cost	Gross Unrealized Gains	Gross Unrealized Losses Less Than 12 Months	12 Months or Greater	Fair Value
<i>December 31, 2015</i>					
Common stocks	\$ 9,590	\$ 4,248	\$ (12)	\$ –	\$ 13,826

Proceeds from sales of unaffiliated common stocks during 2016 and 2015 were \$14,394 and \$0, respectively. The Company realized gross gains of \$4,804 and \$0 during 2016 and 2015, respectively. All common stock was sold as of December 31, 2016.

A significant judgment in the valuation of investments is the determination of when an other-than temporary decline in value has occurred. The Company follows a consistent and systematic process for impairing securities that sustain other-than-temporary declines in value. The Company has established a committee responsible for the impairment review process. The decision to impair a security incorporates both quantitative criteria and qualitative information. The impairment review process considers a number of factors, including but not limited to (a) the length of time and the extent to which a security's fair value has been less than statement value; (b) the financial condition and near term prospects of the issuer; (c) the intent to sell and, for loan-backed and structured securities, the intent and ability of the Company to retain its investment for a period of time to allow for any anticipated recovery in value; (d) whether the debtor is current on interest and principal payments; and (e) general market conditions and industry or sector specific factors. For securities that are deemed to be other-than-temporarily impaired, the security is adjusted to its fair value (or its discounted cash flows for loan-backed and structured securities), and the resulting losses are recognized in net realized gains or losses in the statutory basis statements of operations. The new cost basis of the impaired securities is not increased for future recoveries in fair value. There were no charges for OTTI of securities for the years ended December 31, 2016 and 2015.

A summary of unaffiliated investments with unrealized losses along with the related fair value, aggregated by the length of time that investments have been in a continuous unrealized loss position, is as follows:

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

	December 31, 2016			December 31, 2015		
	Number of		Gross	Number of		Gross
	Securities	Fair Value	Unrealized	Securities	Fair Value	Unrealized
			Loss			Loss
Bonds:						
Less than 12 months	81	\$ 74,926	\$ (854)	77	\$ 39,063	\$ (530)
12 months or greater	4	1,420	(38)	14	6,829	(113)
Total bonds	85	\$ 76,346	\$ (892)	91	\$ 45,892	\$ (643)
Common stocks:						
Less than 12 months	–	\$ –	\$ –	–	\$ 485	\$ (12)
Total common stocks	–	\$ –	\$ –	–	\$ 485	\$ (12)

The Company's bond portfolio is sensitive to interest rate fluctuations, which impact the fair value of individual securities. Unrealized losses on bonds reported above were primarily caused by the effects of the interest rate environment and the widening of credit spreads on certain securities. Unrealized losses on stocks result from normal market fluctuations and are considered temporary. The Company currently has the ability and intent to hold these securities until their full cost can be recovered. Therefore, the Company does not believe the unrealized losses represent an OTTI as of December 31, 2016 or 2015.

The Company's investment portfolio included loaned securities with carrying values of \$916 and \$6,722 at December 31, 2016 and 2015, respectively. The fair value of the loaned securities was \$928 and \$6,809 at December 31, 2016 and 2015, respectively.

The Company reinvests the collateral received under the securities lending program. The aggregate amount of cash collateral reinvested at December 31, 2016, categorized by the contractual maturity of the investment, is as follows:

	Amortized	
	Cost	Fair Value
30 days or less	\$ 948	\$ 949
Securities received	–	–
Total collateral reinvested	\$ 948	\$ 949

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

3. Fair Value

Assets and liabilities recorded at fair value in the statutory basis balance sheets would be categorized based upon the level of judgment associated with the inputs used to measure their fair value. Level inputs are as follows:

<u>Level Input</u>	<u>Input Definition</u>
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The following table summarizes the assets and liabilities measured at fair value and held as of December 31, 2016 and 2015, respectively:

	<u>Level I</u>	<u>Level II</u>	<u>Level III</u>	<u>Total</u>
December 31, 2016				
Industrial and miscellaneous bonds	\$ —	\$ 916	\$ —	\$ 916
Total bonds	—	916	—	916
Total assets at fair value	<u>\$ —</u>	<u>\$ 916</u>	<u>\$ —</u>	<u>\$ 916</u>
December 31, 2015				
Industrial and miscellaneous common stocks	\$ 13,826	\$ —	\$ —	\$ 13,826
Total stocks	13,826	—	—	13,826
Total assets at fair value	<u>\$ 13,826</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 13,826</u>

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

Fair values of fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level I or Level II inputs, for the determination of fair value to facilitate fair value measurements and disclosures. United States government securities represent Level I securities, while Level II securities primarily include corporate securities, securities from states, municipalities and political subdivisions and residential mortgage-backed securities. For securities not actively traded, the third party pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. As the Company is responsible for the determination of fair value, the Company performs monthly analyses on the prices received from third parties to determine whether the prices are reasonable estimates of fair value. The Company's analyses include a review of month-to-month price fluctuations and, as needed, a comparison of pricing services' valuations for the identical security.

Fair values of equity securities are generally designated as Level I and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated as Level II.

The Company's policy is to recognize transfers between levels, if any, as of the beginning of the reporting period. There were no transfers between levels during the years ended December 31, 2016 and 2015.

The following table summarizes the fair value of financial instruments by type:

December 31, 2016						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level I)	(Level II)	(Level III)	Not Practicable (Carrying Value)
Bonds	\$ 147,613	\$ 147,035	\$ 30,234	\$ 117,379	\$ –	\$ –
Securities lending collateral	949	948	949	–	–	–
Short-term investments	36,288	36,288	36,288	–	–	–
December 31, 2015						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level I)	(Level II)	(Level III)	Not Practicable (Carrying Value)
Bonds	\$ 112,422	\$ 110,896	\$ –	\$ 112,422	\$ –	\$ –
Common stocks	13,826	13,826	13,826	–	–	–
Securities lending collateral	6,809	6,809	6,709	100	–	–
Short-term investments	39,238	39,237	38,739	499	–	–

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

4. Unpaid Claims and Claims Adjustment Expenses

The following table provides a reconciliation of the beginning and ending balances for unpaid claims and claims adjustment expenses:

	<u>2016</u>	<u>2015</u>
Balances at January 1	\$ 103,067	\$ 86,932
Incurred (redundancies) related to:		
Current year	1,350,614	1,238,412
Prior years	8,420	4,291
Total incurred	<u>1,359,034</u>	<u>1,242,703</u>
Paid related to:		
Current year	1,228,870	1,136,058
Prior years	111,005	90,510
Total paid	<u>1,339,875</u>	<u>1,226,568</u>
Balances at December 31	<u><u>\$ 122,226</u></u>	<u><u>\$ 103,067</u></u>

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any year end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established year end liability. The negative amounts reported for incurred related to prior years' results from claims being settled for amounts less than originally estimated. Positive amounts reported for incurred related to prior years result from claims being settled for amounts greater than originally estimated. This experience is primarily attributable to actual medical cost experience that differs from that assumed at the time the liability was established.

The Company took into account estimated anticipated subrogation and other recoveries in its determination of the liability for unpaid claims based on historical recovery patterns.

5. Retrospectively Rated Contracts and Contracts Subject to Redetermination

The amount of net premiums written by the Company in 2016 and 2015 that was subject to retrospective rating features, including MLR rebate regulations, was \$1,431,823 and \$1,309,626, which represented 100.0%, and 100.0%, respectively, of the total net premiums written.

6. Federal Income Taxes

The Company has a federal income tax payable of \$2,351 and \$369 as of December 31, 2016 and 2015, respectively.

The components of net deferred tax assets (liabilities) at December 31 are as follows:

	<u>Ordinary</u>	<u>2016 Capital</u>	<u>Total</u>
Gross deferred tax assets	\$ 9,662	\$ –	\$ 9,662
Gross deferred tax liabilities	(3)	(10)	(13)
Net deferred tax asset before admissibility test	<u><u>\$ 9,659</u></u>	<u><u>\$ (10)</u></u>	<u><u>\$ 9,649</u></u>

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101 *Income Taxes* ("SSAP No. 101") as of December 31, 2016 is:

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ 8,642	\$ –	\$ 8,642
Admitted pursuant to paragraph 11.b	504	–	504
Admitted pursuant to paragraph 11.c	13	–	13
Admitted deferred tax asset	9,159	–	9,159
Deferred tax liability	(3)	(10)	(13)
Net admitted deferred tax asset	9,156	(10)	9,146
Nonadmitted deferred tax asset	\$ 503	\$ –	\$ 503

	Ordinary	2015 Capital	Total
Gross deferred tax assets	\$ 7,070	\$ –	\$ 7,070
Gross deferred tax liabilities	(2)	(1,492)	(1,494)
Net deferred tax asset before admissibility test	\$ 7,068	\$ (1,492)	\$ 5,576

The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101 as of December 31, 2015 is:

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ 6,215	\$ –	\$ 6,215
Admitted pursuant to paragraph 11.b	164	–	164
Admitted pursuant to paragraph 11.c	691	–	691
Admitted deferred tax asset	7,070	–	7,070
Deferred tax liability	(2)	(1,492)	(1,494)
Net admitted deferred tax asset	7,068	(1,492)	5,576
Nonadmitted deferred tax asset	\$ –	\$ –	\$ –

The change in the amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101 during 2016 is:

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ 2,427	\$ –	\$ 2,427
Admitted pursuant to paragraph 11.b	340	–	340
Admitted pursuant to paragraph 11.c	(678)	–	(678)
Admitted deferred tax asset	2,089	–	2,089
Deferred tax liability	(1)	1,482	1,481
Net admitted deferred tax asset	2,088	1,482	3,570
Nonadmitted deferred tax asset	\$ 503	\$ –	\$ 503

	2016	2015
Amount of adjusted capital and surplus used to determine recovery period and threshold limitations.	\$ 76,984	\$ 70,096

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

The impact of tax planning strategies is as follows:

	2016		2015		Change	
	Ordinary	Capital	Ordinary	Capital	Ordinary	Capital
Adjusted gross deferred tax assets amount	\$ 9,662	\$ –	\$ 7,070	\$ –	\$ 2,592	\$ –
Percentage of adjusted gross deferred tax assets by tax character attributable to the impact of tax planning strategies	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Net admitted adjusted gross deferred tax assets amount	\$ 9,158	\$ –	\$ 7,070	\$ –	\$ 2,088	\$ –
Percentage of net admitted adjusted gross deferred tax assets by tax character attributable to the impact of tax planning strategies	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

The Company's tax planning strategies do not include the use of reinsurance.

Current federal income taxes consist of the following major components:

	2016	2015	Change
Federal income taxes on operations	\$ 13,870	\$ 7,698	\$ 6,172
Federal income taxes (benefit) expense on net capital gains (losses)	1,730	(223)	1,953
Federal income taxes	<u>\$ 15,600</u>	<u>\$ 7,475</u>	<u>\$ 8,125</u>

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

The components of deferred income taxes are as follows:

	December 31		
	2016	2015	Change
Deferred tax assets:			
Ordinary:			
Amortization	\$ 308	\$ 516	\$ (208)
Accounts receivable	2,796	3,610	(814)
Fixed assets	791	878	(87)
Other insurance reserves	5,651	1,992	3,659
Prepaid expenses	22	18	4
Other	94	56	38
Subtotal	9,662	7,070	2,592
Nonadmitted deferred tax assets	503	—	503
Admitted ordinary deferred tax assets	9,159	7,070	2,089
Admitted deferred tax assets	9,159	7,070	2,089
Deferred tax liabilities:			
Ordinary:			
Discount of coordination of benefits	(3)	(2)	(1)
Subtotal	(3)	(2)	(1)
Capital:			
Investments in securities	(10)	(1,492)	1,482
Subtotal	(10)	(1,492)	1,482
Deferred tax liabilities	(13)	(1,494)	1,481
Net admitted deferred tax assets	\$ 9,146	\$ 5,576	\$ 3,570

The changes in deferred tax assets and deferred tax liabilities are as follows:

	December 31		
	2016	2015	Change
Total deferred tax assets	\$ 9,662	\$ 7,070	\$ 2,592
Total deferred tax liabilities	(13)	(1,494)	1,481
Net deferred tax asset	\$ 9,649	\$ 5,576	4,073
Tax effect of unrealized gains (losses)			(1,497)
Change in net deferred income tax			\$ 2,576

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

The Company's income tax expense and change in deferred taxes differs from the amount obtained by applying the federal statutory rate of 35% for the year ended December 31 for the following reasons:

	2016	2015
Tax expense computed using federal statutory rate	\$ 4,771	\$ 1,939
Change in nonadmitted assets	1,092	(2,185)
Permanent differences	(340)	(391)
ACA health insurer fee	7,394	7,441
Other	107	143
Total	<u>\$ 13,024</u>	<u>\$ 6,947</u>
Federal income taxes	\$ 15,600	\$ 7,475
Change in net deferred income taxes	(2,576)	(528)
Total statutory income taxes	<u>\$ 13,024</u>	<u>\$ 6,947</u>

At December 31, 2016, the Company has no operating loss carryforwards or tax credit carryforwards.

The following are income taxes incurred in the current and prior years that will be available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2016	\$ 13,815	\$ 1,730	\$ 15,545
2015	6,943	—	6,943
2014	NA	—	—

The Company is included in the consolidated federal income tax return of their parent Anthem, Inc., along with other affiliates, as of December 31, 2016. Allocation of federal income taxes with affiliates subject to the tax sharing agreement is based upon separate income tax return calculations with credit for net losses that can be used on a consolidated basis. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

The Company is a member of the IRS Compliance Assurance Program ("CAP"). The objective of CAP is to reduce taxpayer burden and uncertainty while assuring the IRS of the accuracy of tax returns prior to filing, thereby reducing or eliminating the need for post filing examinations. As of December 31, 2016, the examination of the 2016 tax year continues to be in process.

7. Health Insurer Fee

The Company had \$1,156,733 of premiums written subject to assessment under ACA Section 9010 as of December 31, 2015 and no premiums written subject to assessment under ACA Section 9010 as of December 31, 2016 due to the 2017 suspension of this assessment. Because no health insurer fee is to be paid in 2017, no funds have been segregated in special surplus funds for the health insurer fee at December 31, 2016. The Company's portion of the annual health insurance industry fee paid during 2016 was \$21,127 and is included in operating expenses.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

8. Capital and Surplus

The Florida OIR requires the Company to maintain a minimum surplus as set forth in the state statutes. Under those requirements, capital and surplus is calculated as the greater of \$1,500, or 10% of total liabilities, or 2% of total annualized premiums. Additionally, the Department requires the Company to maintain \$3,000 in excess surplus over the statutory requirement per the Department's *Consent Order* pursuant to the approved merger between the Company and PHP Holdings, Inc. The Florida OIR has not adopted the RBC requirement of the NAIC. At December 31, 2016 and 2015, the Company's capital and surplus exceeded all regulatory requirements.

Per the *Florida Statute 641.365*, certain limitations exist on the Company's ability to pay dividends to its parent. The Company may pay funds only from accumulated surplus funds that were derived from realized net operating profits on its business and net realized capital gains. Prior written approval by the Florida OIR is required for payment of any dividend that would result in these accumulated surplus funds being less than zero. Florida OIR approval is not required if the dividend paid is less than the greater of 1) ten percent of the Company's accumulated surplus as of December 31st of the preceding year or 2) the Company's net income from the immediately preceding calendar year.

Within these limitations, the Company may pay \$594 in dividends during 2016 without prior approval.

The portion of unassigned surplus representing cumulative unrealized (losses) gains net of tax was \$(26) and \$2,753 as December 31, 2016 and 2015, respectively.

9. Leases

The Company leases office space and EDP equipment and other miscellaneous items under various non-cancelable operating leases. Related lease expense for 2016 and 2015 was \$3,115 and \$2,564, respectively.

At December 31, 2016, future lease payments for operating leases with initial or remaining non-cancelable terms of one year or more consisted of the following: 2017, \$1,139; 2018, \$1,149 ; 2019, \$486 , and 2020, \$145..

10. Contingencies

In March 2016, Anthem filed a lawsuit against its vendor for pharmacy benefit management ("PBM") services, captioned Anthem, Inc. v. Express Scripts, Inc., in the U.S. District Court for the Southern District of New York. The lawsuit seeks to recover damages for pharmacy pricing that is higher than competitive benchmark pricing, damages related to operational breaches and seeks various declarations under the PBM agreement between the parties. Anthem's suit asserts that Express Scripts, Inc.'s ("Express Scripts") current pricing exceeds the competitive benchmark pricing required by the PBM agreement over the remaining term of the PBM agreement and through the post-termination transition period. Further, Anthem believes that Express Scripts' excessive pricing has caused Anthem to lose existing customers and prevented the Company from gaining new business. In addition to the amounts associated with competitive benchmark pricing, Anthem is seeking damages associated with operational breaches incurred to date, together with a declaratory judgment that Express Scripts: (1) breached its obligation to negotiate in good faith and to agree in writing to new pricing terms; (2) is required to provide competitive benchmark pricing to Anthem through the term of the PBM agreement; (3) has breached the PBM agreement, and that Anthem can terminate the PBM agreement either due to Express Scripts' breaches or because Anthem has determined that Express Scripts' performance with respect to the delegated Medicare Part D functions has been unsatisfactory; and (4) is required under the PBM agreement to provide post-termination services, at competitive benchmark pricing, for one year following any termination. In April 2016, Express Scripts filed an answer to the lawsuit disputing Anthem's contractual claims and alleging various defenses and counterclaims. Express Scripts contends that Anthem breached the PBM agreement by failing to negotiate proposed new pricing terms in good faith and that Anthem breached the implied covenant of good faith and fair dealing by disregarding the terms of the transaction. In addition, Express Scripts is seeking declaratory judgments: (1) regarding the timing of the periodic

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

pricing review under the PBM agreement; (2) that it has no obligation to ensure that Anthem receives any specific level of pricing, that Anthem has no contractual right to any change in pricing under the PBM agreement and that its sole obligation is to negotiate proposed pricing terms in good faith; and (3) that Anthem does not have the right to terminate the PBM agreement. In the alternative, Express Scripts claims that Anthem has been unjustly enriched by its payment of \$4.675 billion at the time of the PBM agreement. Anthem believes that Express Scripts' defenses and counterclaims are without merit. Anthem filed a motion to dismiss Express Scripts' counterclaims, which is pending. Anthem intends to vigorously pursue these claims and defend against any counterclaims; however, the ultimate outcome cannot be presently determined.

Anthem and Express Scripts were also named as defendants in a purported class action lawsuit filed in June 2016 in the Southern District of New York by three members of ERISA plans alleging ERISA violations captioned Karen Burnett, Brendan Farrell, and Robert Shullich, individually and on behalf of all others similarly situated vs. Express Scripts, Inc. and Anthem, Inc. The lawsuit was then consolidated with a similar lawsuit that was previously filed against Express Scripts. A first amended consolidated complaint was filed in the consolidated lawsuit, which is captioned In Re Express Scripts/Anthem ERISA Litigation. The first amended consolidated complaint was filed by six individual plaintiffs against Anthem and Express Scripts on behalf of all persons who are participants in or beneficiaries of any ERISA or non-ERISA health care plan from December 1, 2009 to the present in which Anthem provided prescription drug benefits through a PBM agreement with Express Scripts and who paid a percentage bases on co-insurance payment in the course of using that prescription drug benefit. As to the ERISA members, the plaintiffs allege that Anthem breached its duties under ERISA (i) by failing to adequately monitor Express Scripts' pricing under the PBM agreement and (ii) by trading off the best interests of Anthem insureds for its own pecuniary interest by allegedly agreeing to higher pricing in the PBM agreement in exchange for the \$4.675 billion purchase price for Anthem's NextRX PBM business. As to the non-ERISA members, the plaintiffs assert that Anthem breached the implied covenant of good faith and fair dealing implied in the health plans under which the non-ERISA members are covered by (i) negotiating and entering into the PBM agreement with Express Scripts that was detrimental to the interests of the such non-ERISA members, (ii) failing to adequately monitor the activities of Express Scripts, including failing to timely monitor and correct the prices charged by Express Scripts for prescription medications, and (iii) acting in Anthem's self-interests instead of the interests of the non-ERISA members when it accepted the \$4.675 billion purchase price for NextRx. Plaintiffs seek to hold Anthem and Express Scripts jointly and severally liable and to recover all losses suffered by the proposed class, equitable relief, disgorgement of alleged ill-gotten gains, injunctive relief, attorney's fees and costs and interest. Anthem filed a motion to dismiss all of the claims brought against Anthem, which is pending. Express Scripts filed a motion to transfer the case to a federal court in Missouri and Anthem intends to oppose this transfer. Anthem intends to vigorously defend this suit; however, its ultimate outcome cannot be presently determined.

In February 2015, Anthem reported that it was the target of a sophisticated external cyber-attack. The attackers gained unauthorized access to certain of Anthem's information technology systems and obtained personal information related to many individuals and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that Anthem will not identify additional information that was accessed or obtained.

Upon discovery of the cyber-attack, Anthem took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate its systems and identify solutions based on the evolving landscape. Anthem is providing credit monitoring and identity protection services to those who have been affected by this cyber-attack. Anthem has continued to implement security enhancements since this incident. Anthem has incurred expenses subsequent to the cyber-attack to investigate and remediate this matter and expects to continue to incur expenses of

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

this nature in the foreseeable future. Anthem will recognize these expenses in the periods in which they are incurred.

Actions have been filed in various federal and state courts and other claims have been or may be asserted against Anthem on behalf of current or former members, current or former employees, other individuals, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber-attack. Federal and state agencies, including state insurance regulators, state attorneys general, the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigation, are investigating events related to the cyber-attack, including how it occurred, its consequences and Anthem's responses. The NAIC's multistate targeted market conduct and financial exam was concluded in December 2016. As part of the resolution, the NAIC asked and Anthem has agreed to provide a customized credit protection program functionally equivalent to a credit freeze for minors who were under the age of 18 on January 27, 2015. No fines or penalties were issued. Although Anthem is cooperating in these investigations, Anthem may be subject to fines or other obligations, which may have an adverse effect on how Anthem operates its business and on its results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation in February 2015 and was subsequently heard by the Panel in May 2015. In June 2015, the Panel entered its order transferring the consolidated matter to the U.S. District Court for the Northern District of California. The U.S. District Court entered its case management order in September 2015. Anthem filed a motion to dismiss ten of the counts that are before the U.S. District Court. In February 2016, the court issued an order granting in part and denying in part our motion, dismissing three counts with prejudice, four counts without prejudice and allowing three counts to proceed. Plaintiffs filed a second amended complaint in March 2016, and Anthem subsequently filed a second motion to dismiss. In May 2016, the court issued an order granting in part and denying in part our motion, dismissing one count with prejudice, dismissing certain counts asserted by specific named plaintiffs with or without prejudice depending on their individualized facts, and allowing the remaining counts to proceed. In July 2016, plaintiffs filed a third amended complaint, which Anthem answered in August 2016. Fact discovery was completed in December 2016. There remain two state court cases that are presently proceeding outside of the Multidistrict Litigation.

Anthem has contingency plans and insurance coverage for certain expenses and potential liabilities of this nature. While a loss from these matters is reasonably possible, Anthem cannot reasonably estimate a range of possible losses because the investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

The Company is involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits and reviews and administrative proceedings include routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and Federal Agencies. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on The Company's business operations. The Company believes that any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on the Company's financial position or results of operations.

At December 31, 2016 and 2015, the Company reported admitted assets of \$20,931 and \$7,253, respectively, in premiums receivable and amounts receivable from uninsured plans. Based upon Company experience, receivables from the government have been fully collected; therefore, no additional provision for uncollectible amounts has been recorded. The potential for any additional loss is not believed to be material to the Company's financial condition.

The Company has no other known contingencies.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

11. Retirement Benefits

The Company participates in various deferred compensation plans sponsored by Anthem that cover certain employees. The deferred amounts are payable according to the terms and subject to the conditions of said deferred compensation agreements. Anthem allocates a share of the total costs of these plans to the Company based on the number of allocated employees participating in the plans. The Company has no legal obligation for benefits under these plans.

The Company participates in the Anthem 401(k) Retirement Savings Plan, a defined contribution plan, sponsored by ATH Holding and covering substantially all employees. Voluntary employee contributions are matched by ATH Holding subject to certain limitations. ATH Holding allocates a share of the total costs of the plan to the Company based on the number of allocated employees.

During 2016 and 2015, the Company was allocated the following costs for these retirement benefits:

	2016	2015
Deferred compensation plan	\$ 51	\$ 51
Defined contribution plan	1,747	1,715

12. Uninsured Accident and Health Plans

The net loss from operations and total claim payment volume from administrative services only (“ASO”) plans was:

	ASO Uninsured Plans	Uninsured Portion of Partially Insured Plans	Total ASO
For the year ended December 31, 2016			
Net reimbursement for administrative expenses (including administrative fees) less than actual expenses	\$ (112)	\$ –	\$ (112)
Total net other income or expenses (including interest paid to or received from plans)	–	–	–
Net loss from operations	<u>(112)</u>	<u>–</u>	<u>(112)</u>
Total claim payment volume	<u>\$ 3,432</u>	<u>\$ –</u>	<u>\$ 3,432</u>
For the year ended December 31, 2015			
Net reimbursement for administrative expenses (including administrative fees) less than actual expenses	\$ (675)	\$ –	\$ (675)
Total net other income or expenses (including interest paid to or received from plans)	–	–	–
Net loss from operations	<u>(675)</u>	<u>–</u>	<u>(675)</u>
Total claim payment volume	<u>\$ 19,853</u>	<u>\$ –</u>	<u>\$ 19,853</u>

The Company did not record revenue explicitly attributable to the cost share and reinsurance components of administered Medicare products in 2015.

As of December 31, 2016 and 2015, the Company recorded a receivable from CMS of \$835 and \$330, respectively, related to the cost share and reinsurance components of administered Medicare products.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

13. Health Care Receivable

Pharmaceutical rebate receivables of \$0 and \$461 were admitted at December 31, 2016 and 2015, respectively.

Pharmaceutical rebate receivables consist of reasonably estimated and billed amounts. Amounts not collected within 90 days of the invoice or confirmation date are nonadmitted. Pharmaceutical rebate receivables of \$56 and \$1,824 were nonadmitted at December 31, 2016 and 2015, respectively.

Claim overpayment receivables consist of amounts that have been invoiced and meet the setoff conditions. Amounts that have not been invoiced and do not meet the setoff conditions are nonadmitted. Claim overpayment receivables and other health care receivables of \$3,483 and \$4,407 were nonadmitted as of December 31, 2016 and 2015, respectively.

Provider advances of \$298 and \$298 were nonadmitted at December 31, 2016 and 2015, respectively. Capitation agreement receivables of \$1,332 and \$2,684 were nonadmitted as of December 31, 2016 and 2015, respectively, as amounts did not meet the setoff conditions.

14. Related Party Transactions

The Company has entered into administrative services agreements with its affiliated companies. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Costs include expenses such as salaries, benefits, communications, advertising, consulting services, rent, utilities, accounting, underwriting, and product development, which support the operations of the Company. These costs are allocated based on various utilization statistics.

Net payments to affiliated companies pursuant to the above administrative service agreements were \$124,803 and \$125,804 in 2016 and 2015, respectively, and are included in operating expenses and claims adjustment expenses in the statutory basis statements of operations.

At December 31, 2016 and 2015, the Company reported \$1,958 and \$189 due from affiliates, which were nonadmitted per Florida OIR prescribed accounting practices. At December 31, 2016 and 2015, the Company reported \$3,235 and \$9,877 due to affiliates, respectively. The receivable and payable balances represent intercompany transactions that are settled within the terms of the management and services agreement.

The Company paid no dividends for the years ended December 31, 2016 and 2015.

The Company received a \$10,000 capital contribution from its parent company on September 30, 2016. The Company received no capital contributions from its parent for the year ended December 31, 2015.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis (continued)

(Dollars In Thousands)

15. Subsequent Events

Management of the Company has evaluated all other events occurring after December 31, 2016 through March 30, 2017, the date the financial statements were available to be issued, to determine whether any event required either recognition or disclosure in the financial statements. It was determined there were no events that require recognition or disclosure in the financial statements through the report date.

FINANCIAL STATEMENTS AND SUPPLEMENTARY
INFORMATION – STATUTORY BASIS

AMERIGROUP Florida, Inc.

*Years Ended December 31, 2015 and 2014
With Reports of Independent Auditors*

AMERIGROUP Florida, Inc.

Financial Statements – Statutory Basis

Years ended December 31, 2015 and 2014

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Report of Independent Auditors

Board of Directors
AMERIGROUP Florida, Inc.

We have audited the accompanying statutory basis financial statements of AMERIGROUP Florida, Inc., which comprise the balance sheets as of December 31, 2015 and 2014, and the related statements of operations, changes in capital and surplus, and cash flow for the years then ended, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation. Management also is responsible for the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Basis for Adverse Opinion on U.S. Generally Accepted Accounting Principles

As described in Note 1, to meet the requirements of Florida the financial statements have been prepared in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation, which practices differ from U.S. generally accepted accounting principles. The variances between such practices and U.S. generally accepted accounting principles are described in Note 1. The effects on the accompanying financial statements of these variances are not reasonably determinable but are presumed to be material.

Adverse Opinion on U.S. Generally Accepted Accounting Principles

In our opinion, because of the effects of the matter described in the preceding paragraph, the statutory basis financial statements referred to above do not present fairly, in conformity with U.S. generally accepted accounting principles, the financial position of AMERIGROUP Florida, Inc. at December 31, 2015 and 2014, or the results of its operations or its cash flows for the years then ended.

Opinion on Statutory Basis of Accounting

However, in our opinion, the statutory basis financial statements referred to above present fairly, in all material respects, the financial position of AMERIGROUP Florida, Inc. at December 31, 2015 and 2014, and the results of its operations and its cash flows for the years then ended in conformity with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation.

Ernst + Young LLP

March 28, 2016

AMERIGROUP Florida, Inc.

Balance Sheets – Statutory Basis

	December 31	
	2015	2014
	<i>(In Thousands)</i>	
Admitted assets		
Cash and invested assets:		
Cash and short-term investments	\$ 62,453	\$ 59,491
Bonds	110,896	115,841
Common stocks	13,826	13,943
Receivable for securities	6	—
Securities lending collateral	6,809	5,498
Total cash and invested assets	193,990	194,773
Accrued investment income	800	778
Premiums receivable	6,923	7,128
Amounts receivable relating to uninsured plans	330	1,702
Current federal income tax recoverable	—	7,334
Net deferred tax asset	5,576	4,902
Electronic data processing equipment	13	40
Receivables from parent and affiliates	—	22
Health care receivables	461	1,121
Other assets	300	1,633
Total admitted assets	\$ 208,393	\$ 219,433
Liabilities and capital and surplus		
Liabilities:		
Unpaid claims and claims adjustment expenses	\$ 103,067	\$ 86,932
Aggregate policy reserves	334	2,062
Premiums received in advance	—	24,029
Accounts payable and accrued expenses	890	866
Current federal income tax payable	369	—
Remittances and items not allocated	8,257	8,656
Payables to parent and affiliates	9,877	4,708
Payable for securities lending	6,809	5,498
Liability relating to uninsured plans	403	13
Other liabilities	2,703	3,063
Total liabilities	132,709	135,827
Capital and surplus:		
Common stock, \$1 par value, 1,000 shares authorized, 100 shares issued and outstanding	—	—
Additional paid-in surplus	70,185	70,185
Unassigned deficit	(15,466)	(8,072)
Special surplus funds	20,965	21,493
Total capital and surplus	75,684	83,606
Total liabilities and capital and surplus	\$ 208,393	\$ 219,433

See accompanying notes.

AMERIGROUP Florida, Inc.

Statements of Operations – Statutory Basis

	Year ended December 31	
	2015	2014
	<i>(In Thousands)</i>	
Premium income	\$ 1,309,826	\$ 938,255
Benefits and expenses:		
Claims and claims adjustment expenses	1,242,703	916,010
Operating expenses	65,959	56,823
Change in reserves for life and accident and health contracts	<u>(1,536)</u>	<u>1,536</u>
Total benefits and expenses	<u>1,307,126</u>	<u>974,369</u>
Net underwriting gain (loss)	2,700	(36,114)
Investment gains:		
Net investment income	3,474	3,032
Net realized (losses) gains on investments, net of tax	<u>(412)</u>	<u>151</u>
Net investment gains	<u>3,062</u>	<u>3,183</u>
Income (loss) before federal income taxes	5,762	(32,931)
Federal income taxes incurred (benefit)	<u>7,698</u>	<u>(6,279)</u>
Net loss	<u>\$ (1,936)</u>	<u>\$ (26,652)</u>

See accompanying notes.

AMERIGROUP Florida, Inc.

Statements of Changes in Capital and Surplus – Statutory Basis

	<u>Common Stock</u>	<u>Paid-in Surplus</u>	<u>Unassigned Surplus (Deficit)</u> <i>(In Thousands)</i>	<u>Special Surplus Funds</u>	<u>Total Capital and Surplus</u>
Balance as of January 1, 2014	\$ —	\$ 35,185	\$ 38,236	\$ —	\$ 73,421
Net loss	—	—	(26,652)	—	(26,652)
Change in unrealized capital gains	—	—	685	—	685
Change in net deferred income tax	—	—	1,793	—	1,793
Change in nonadmitted assets	—	—	(641)	—	(641)
Capital contributions from parent	—	35,000	—	—	35,000
ACA health insurer fee	—	—	(21,493)	21,493	—
Balance as of December 31, 2014	<u>—</u>	<u>70,185</u>	<u>(8,072)</u>	<u>21,493</u>	<u>83,606</u>
Net loss	—	—	(1,936)	—	(1,936)
Change in unrealized capital gains	—	—	(271)	—	(271)
Change in net deferred income tax	—	—	528	—	528
Change in nonadmitted assets	—	—	(6,243)	—	(6,243)
ACA health insurer fee	—	—	528	(528)	—
Balance as of December 31, 2015	<u><u>\$ —</u></u>	<u><u>\$ 70,185</u></u>	<u><u>\$ (15,466)</u></u>	<u><u>\$ 20,965</u></u>	<u><u>\$ 75,684</u></u>

See accompanying notes.

AMERIGROUP Florida, Inc.

Statements of Cash Flow – Statutory Basis

	Year ended December 31	
	2015	2014
	<i>(In Thousands)</i>	
Operating activities:		
Premiums collected	\$ 1,285,809	\$ 953,562
Net investment income	4,745	4,441
Claims and claims adjustment expenses	(1,230,480)	(883,201)
General administrative expenses paid	(63,711)	(56,809)
Federal income taxes recovered (paid)	227	(1,479)
Net cash (used in) provided by operating activities	<u>(3,410)</u>	<u>16,514</u>
Investment activities:		
Proceeds from investments sold, matured or repaid	46,456	25,146
Cost of investments acquired	<u>(45,057)</u>	<u>(23,395)</u>
Net cash provided by investment activities	<u>1,399</u>	<u>1,751</u>
Financing or miscellaneous activities:		
Capital contribution from parent	–	35,000
Dividend to shareholder	–	(11,500)
Other	4,973	6,195
Net cash provided by financing or miscellaneous activities	<u>4,973</u>	<u>29,695</u>
Change in cash and short-term investments	2,962	47,960
Cash and short-term investments at beginning of year	<u>59,491</u>	<u>11,531</u>
Cash and short-term investments at end of year	<u><u>\$ 62,453</u></u>	<u><u>\$ 59,491</u></u>

See accompanying notes.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

December 31, 2015

1. Nature of Operations and Significant Accounting Policies

AMERIGROUP Florida, Inc. (the “Company”) is a Florida domiciled stock health maintenance organization (“HMO”), which is licensed in Florida. The Company is a prepaid capitated plan created primarily for an enrolled population comprised of beneficiaries of the Medicaid, Florida Healthy Kids (“FHK”), and Long-term Care Community Diversion (“LTC”) programs. The Company’s current service areas include the counties of Brevard, Broward, Hardee, Highlands, Hillsborough, Lake, Manatee, Miami-Dade, Monroe, Pasco, Palm Beach, Pinellas, Polk, Orange, Osceola, Sarasota, Seminole, and Volusia in Florida. As of December 31, 2015, the Company served 392,725 members. The Company also manages healthcare services for members as a Medicare Advantage Plan, under a contract with the Centers for Medicare and Medicaid Services (“CMS”). The Company is a wholly owned subsidiary of Physicians Healthcare Plan Holding, Inc. (“PHP Holdings, Inc.”), which is an indirect wholly-owned subsidiary of Anthem, Inc. (“Anthem”), a publicly traded company. The shareholders of Anthem approved a proposal to amend its articles of incorporation to change the name to Anthem, Inc. from WellPoint, Inc. The name change was effective December 2, 2014.

On July 24, 2015, the Company’s ultimate parent company, Anthem, and Cigna Corporation (“Cigna”) entered into an Agreement and Plan of Merger dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and a direct wholly-owned subsidiary of Anthem, pursuant to which Anthem will acquire all outstanding shares of Cigna. The acquisition is expected to close in the second half of 2016 and is subject to certain state regulatory approvals, standard closing conditions, customary approvals required under the Hart-Scott-Rodino Antitrust Improvements Act and the approval of both the Anthem, Inc. shareholders and Cigna’s stockholders.

Basis of Presentation

The accompanying financial statements have been prepared in accordance with accounting practices prescribed or permitted by the Florida Office of Insurance Regulation (“Florida OIR”). The Florida OIR has adopted the accounting policies found in the National Association of Insurance Commissioners (“NAIC”) *Accounting Practices and Procedures Manual* (“NAIC SAP”) as a component of prescribed accounting practices. Additionally, the Florida OIR has adopted certain prescribed accounting practices that differ from those found in NAIC SAP, which impact the Company. The Company employed no permitted practices in preparing the accompanying statutory basis financial statements.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

1. Nature of Operations and Significant Accounting Policies (continued)

A reconciliation of the Company's statutory capital and surplus as of December 31, 2015 and 2014 between practices prescribed by the Florida OIR and NAIC SAP is shown below:

	<u>2015</u>	<u>2014</u>
Statutory capital and surplus, Florida OIR basis	\$ 75,684	\$ 83,606
State prescribed practices:		
Nonadmittance of amounts due from affiliates pursuant to 641.35 (2)(i) of the FL Revised Statutes effective June 30, 2015	<u>189</u>	<u>—</u>
Statutory capital and surplus, NAIC SAP basis	<u>\$ 75,873</u>	<u>\$ 83,606</u>

For the years ended December 31, 2015 and 2014 there are no differences between the Company's net income under NAIC SAP and practices prescribed by the Florida OIR.

NAIC SAP varies from U.S. generally accepted accounting principles ("GAAP"). The more significant variances from GAAP, applicable to the Company, are as follows:

Investments: Investments in bonds and unaffiliated common stocks are reported at amortized cost or fair value based on their NAIC rating. For GAAP, such fixed maturity investments are designated at purchase as available-for-sale and are reported at fair value with unrealized holding gains and losses reported as a separate component of capital and surplus.

For statutory purposes, all single class and multi-class mortgage-backed/asset-backed securities, such as collateralized mortgage obligations ("CMOs"), where it is determined that a decline in fair value is other-than-temporary because the Company intends to sell the security or has assessed that it does not have the intent and ability to retain the investments in the security for a period of time sufficient to recover the amortized cost basis, the amortized cost basis is written down to fair value as a realized loss in the statements of operations. If deemed other-than-temporarily impaired as the Company does not expect to recover the amortized cost basis even if it did not intend to sell the security and the Company has the intent and ability to hold the security, the amortized cost basis is written down to the present value of future cash flows as a realized loss in the statements of operations. For impaired bonds not backed by other assets, an other-than-temporary impairment is considered to have occurred if it is probable that the Company will be unable to collect all amounts due according to the instrument's contractual terms in effect at the date of acquisition. A decline in fair value that is other-than-temporary includes situations where the Company has made a decision to sell a security prior to its maturity at an amount below its carrying value. If it is determined that a decline in the fair value of a bond is other-than-temporary, an impairment loss is recognized as a realized loss in the statements of operations equal to the entire difference between the bond's carrying value and its fair value.

For GAAP purposes, all securities, purchased or retained, that represent beneficial interests in securitized assets, such as CMOs, mortgage-backed securities, bonds and asset-backed securities, other than high credit quality securities, whose decline in fair value is determined to be other-than-temporary, the cost basis of the security is written down to the fair value if the Company intends to sell the security or it is more likely than not that the Company will have to sell the security prior to recovery. For impaired fixed maturity securities that the Company does not intend to sell or it is more likely than not that the Company will not have to sell such securities, but the Company expects that it will not fully recover the amortized cost basis, the credit component of the other-than-

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

1. Nature of Operations and Significant Accounting Policies (continued)

temporary impairment is recognized in other-than-temporary losses in the income statements, and the non-credit component of the other-than-temporary impairment is recognized in other comprehensive income. Furthermore, unrealized losses entirely caused by non-credit factors related to fixed maturity securities for which the Company expects to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive income.

Premiums receivable: Premiums receivable are recorded at the billed amount and reduced by any amounts not deemed collectible. Generally non-government receivable amounts aged ninety days and older are excluded from the balance sheets by a direct charge to capital and surplus. For GAAP, these amounts are recorded at the billed amount and are reported net of a valuation allowance based upon historical collection trends and management's judgment on the collectability of these accounts.

Nonadmitted assets: Certain assets designated as nonadmitted, including furniture and equipment, receivables from affiliates, leasehold improvements, prepaid expenses, goodwill, intangibles, and certain health care and other receivable balances, are excluded from the balance sheets by a direct charge to capital and surplus. These nonadmitted assets totaled \$20,928 and \$14,685 at December 31, 2015 and 2014, respectively. For GAAP, these amounts are carried as assets, net of a valuation allowance, if necessary.

Deferred income taxes: Deferred tax assets are reduced by a statutory valuation allowance if, based on the weight of available evidence, it is more likely than not that some portion or all of the gross deferred tax assets will not be realized. Adjusted gross deferred tax assets are separated by character (ordinary and capital) and admitted in an amount equal to the sum of 1) the amount of federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the applicable carryback period, plus 2) based on Risk Based Capital ("RBC") thresholds the lesser of the remaining adjusted gross deferred tax assets expected to be realized within the applicable period of the balance sheet date or an amount no greater than the applicable percentage of capital and surplus excluding any net deferred tax assets, electronic data processing ("EDP") equipment and operating software and any net positive goodwill, plus 3) the amount of remaining adjusted gross deferred tax assets that can be offset against existing gross deferred tax liabilities after consideration of the reversal patterns of temporary differences. The remaining deferred tax asset is nonadmitted.

Deferred taxes do not include amounts for state taxes. Changes in deferred income taxes are recorded as adjustments to capital and surplus. For GAAP, state income taxes are considered in the computation of deferred taxes, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years, and a valuation allowance is established for deferred tax assets estimated to be unrealizable. Excluding the tax impact of unrealized investment gains and losses and certain other items, the change in deferred income taxes is recorded in the statements of operations.

Statements of cash flow: Cash and short-term investments in the statements of cash flow represent cash balances, and investments with initial maturities of one year or less. If in the aggregate the Company has a negative cash balance, it is reported as a negative asset and not as a liability. For GAAP, the corresponding captions of cash include cash balances and investments with initial maturities of three months or less and negative cash balances are reported separately as liabilities.

The effects of the foregoing variances from GAAP on the accompanying statutory basis financial statements have not been determined but are presumed to be material.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

1. Nature of Operations and Significant Accounting Policies (continued)

Other significant accounting policies are as follows:

Use of Estimates

Preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Investments

Bonds not backed by loans are stated at amortized cost, with amortization of premium or discount calculated based on the modified scientific method, using lower of yield to call or yield to maturity. Single class and multi-class mortgage-backed/asset-backed securities are valued at amortized cost using the interest method including anticipated prepayments. Prepayment assumptions for loan-backed securities and structured securities are obtained from broker-dealer survey values or internal estimates. These assumptions are consistent with the current interest rate and economic environment. The retrospective adjustment method is used to value all loan-backed securities. Non-investment grade bonds are stated at the lower of cost or fair value as determined by the NAIC's Securities Valuation Office ("SVO"). Common stocks of unaffiliated companies are stated at fair value as determined by various third-party pricing sources.

The Company participates in a securities lending program whereby marketable securities in its investment portfolio are transferred to independent brokers or dealers based on, among other things, their creditworthiness in exchange for collateral initially equal to at least 102% of the fair value of the securities on loan, and is thereafter maintained at a minimum of 100% of the fair value of the securities loaned. The fair value of the securities on loan to each borrower is monitored daily and the borrower is required to deliver additional collateral if the fair value of the collateral falls below 100% of the fair value of the securities on loan. The Company has no loaned portfolio securities with terms exceeding one year.

Unrealized gains and losses on stocks and non-investment grade bonds are reflected directly in unassigned surplus net of federal income taxes unless there is deemed to be an other-than-temporary decline in value, in which case the loss is charged to income. Realized gains and losses on investments sold are determined using the specific identification method and are included in net realized gains, net of tax. Investment income is not accrued on bonds with interest payments in default.

Short-term investments include investments with maturities of less than one year and more than three months at the date of acquisition and are reported at amortized cost, which approximates fair value. Non-investment grade short-term investments are stated at the lower of amortized cost or fair value.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

1. Nature of Operations and Significant Accounting Policies (continued)

Electronic Data Processing Equipment and Software

EDP equipment and software are recorded at cost less accumulated depreciation. Depreciation on EDP equipment and operating software is computed principally by the straight-line method over the lesser of the estimated useful lives of the assets or three years. Non-operating software is depreciated using the straight-line method over the lesser of its useful life or five years. Accumulated depreciation at December 31, 2015 and 2014 was \$1,431 and \$1,403, respectively. Depreciation expense in 2015 and 2014 was \$28 and \$28, respectively.

Furniture and Equipment

Furniture and equipment is capitalized and depreciated on a straight-line basis over its useful life. The net book value is charged in full to unassigned surplus as a nonadmitted asset. Depreciation expense in 2015 and 2014 was \$434 and \$222, respectively.

Health Care Receivables

Health care receivables represent amounts related to pharmacy rebate receivables and other health care related receivables other than premiums. Pharmacy rebate receivables are recorded when earned based upon actual rebate receivables and an estimate of receivables based upon current utilization of specific pharmaceuticals and provider contract terms. These health care receivables are subject to various admittance tests based on the nature of the receivable balance.

Unpaid Claims and Claims Adjustment Expenses

Unpaid claims and claims adjustment expenses include management's best estimate of amounts based on historical claim development patterns and certain individual case estimates. The established liability considers health benefit provisions, business practices, economic conditions and other factors that may materially affect the cost, frequency and severity of claims. Reserves for unpaid claims and claim adjustment expenses are based on assumptions and estimates, and while management believes such estimates are reasonable, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed and changes in estimates are incorporated into current operating results.

The Company records a liability for future policy benefits relating to certain individual product contracts. The liability represents the present value of future benefits to be paid to or on behalf of policy holders and related expenses less the present value of future net premiums. Changes in the liability for future benefits are recognized in the accompanying statutory basis statements in the period in which the change occurs.

Premium Deficiency Reserves

Premium deficiency reserves are established for the amount of the anticipated claims and claims adjustment expenses that have not been previously expensed in excess of the recorded unearned premium reserve and future premiums on existing policies. The Company does not use anticipated investment income as a factor in the premium deficiency reserve calculation. The Company recorded premium deficiency reserves of \$1,536 as of December 31, 2014. The Company did not have any premium deficiency reserves as of December 31, 2015.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

1. Nature of Operations and Significant Accounting Policies (continued)

Premiums

Premiums are recognized as revenue during the period in which the Company is obligated to provide service to members. Premium payments from contracted government agencies are based on eligibility lists produced by the government agencies. Adjustments to eligibility lists produced by the government agencies result from retroactive application of enrollment or disenrollment of members or classification changes between rate categories. The Company estimates the amount of retroactive premium owed to or from the government agencies each period and adjusts premium revenue accordingly. Expenses incurred in connection with acquiring insurance business are charged to operations as incurred.

Delays in approval of annual premium rate changes require that the Company defer the recognition of any increases to the period in which the premium rates become final. The value of the impact can be significant in the period in which it is recognized dependent on the magnitude of the premium rate increase, the membership to which it applies and the length of the delay between the effective date of the rate increase and the final contract date. Premium rate decreases are recognized in the period the change in premium rate becomes effective and the change in the rate is known, which may be prior to the period when the contract amendment affecting the rate is finalized.

Medicare Advantage Part D Premiums and Expenses

The Company serves as a plan sponsor, offering Medicare Advantage Part D prescription drug insurance coverage under a contract with the CMS. The CMS premium, the member premium, and the low-income premium subsidy represent payments for the Company's insurance risk coverage under the Medicare Advantage Part D program and therefore are recorded as premium revenues in operations. Premium revenues are recognized ratably over the period in which eligible individuals are entitled to receive prescription drug benefits. Pharmacy benefit costs and administrative costs under the contract are expensed as incurred.

Subsidies from CMS representing cost reimbursements under the Medicare Part D program are not reflected as premium revenues, but rather are accounted for as deposits, with the related liabilities reported in the balance sheets with other liabilities.

Retrospectively Rated Contracts

The Company's contracts with CMS and the State Medicaid Agency include a provision for which premiums vary based on loss experience. The Company estimates accrued retrospective premium adjustments through the review of each retrospectively rated contract, comparing the claim development with that anticipated in the contract. Any adjustment made to the estimated liability as a result of a final settlement is included in current operations. The Company uses estimates to report in the statutory basis financial statements the incurred and unpaid liability amounts for retrospectively rated contracts based on its underwriting experience; actuarial, tax, and accounting estimates and assumptions at the financial statement date and regulations and guidance available that is subject to change prior to settlement. Accordingly, the Company's use of estimates and assumptions in the preparation of the statutory basis financial statements and related footnote disclosures may differ from actual results. The Company records accrued retrospective premium as an adjustment to earned premium.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

1. Nature of Operations and Significant Accounting Policies (continued)

Federal Income Taxes

The Company participates in a tax sharing agreement with Anthem and its subsidiaries. Allocation of federal income taxes is based upon separate return calculations with credit for net losses that can be used on a consolidated basis. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

Patient Protection and Affordable Care Act

In 2010, the U.S. Congress passed and the President signed into law the Patient Protection and Affordable Care Act (“ACA”). ACA has created significant changes and will continue to create significant changes for health insurance markets. Certain requirements include changes to Medicare Advantage payments and the minimum medical loss ratio (“MLR”) provision that requires insurers to pay rebates to customers when insurers do not meet or exceed the specified MLR thresholds. Most of the provisions of ACA with more significant effects on the health insurance marketplace, both state and federal, went into effect on January 1, 2014, including a requirement that insurers guarantee the issuance of coverage to all individuals regardless of health status, strict rules on how health insurance is rated, the assessment of new taxes and fees (including annual fees on health insurance companies), the creation of new insurance exchanges for individuals and small groups, the availability of premium subsidies for certain individual products, and substantial expansions in eligibility for Medicaid.

Implementation of ACA brings with it significant oversight responsibilities by health insurers that may result in increased governmental audits, increased assertions of *False Claims Act* violations, and an increased risk of other litigation.

Health Insurer Fee

ACA Section 9010 imposed a mandatory annual fee on health insurers that write certain types of health insurance on U.S. risks for each calendar year beginning on or after January 1, 2014. The annual fee is allocated to health insurers based on the ratio of the amount of an insurer's premium written during the preceding calendar year to the amount of health insurance for all U.S. health risk for those certain lines of business that is written during the preceding calendar year. This fee is non-deductible for income tax purposes. The health insurer fee paid in 2015 is included in 2015 operating expenses. The estimated health insurer fee payable in 2016 is segregated in special surplus funds at December 31, 2015. For statutory accounting purposes, the entire fee expected to be paid during the year is recorded as a general and administrative expense on January 1st, as the first policy is underwritten for the calendar year.

Reclassifications

Certain prior year amounts have been reclassified to conform to the current year presentation.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

2. Investments

A summary of the Company's investments in bonds is as follows:

			<u>Gross Unrealized Losses</u>		
	Statement	Gross	Less	12 Months	Fair
	Value	Unrealized	Than	or	Value
		Gains	12 Months	Greater	
<i>December 31, 2015</i>					
States, territories and political subdivisions	\$ 31,132	\$ 1,875	\$ –	\$ –	\$ 33,007
Industrial and miscellaneous	50,346	87	(397)	(30)	50,006
Loan-backed and structured securities	29,418	207	(133)	(83)	29,409
Total bonds	<u>\$ 110,896</u>	<u>\$ 2,169</u>	<u>\$ (530)</u>	<u>\$ (113)</u>	<u>\$ 112,422</u>
<i>December 31, 2014</i>					
States, territories and political subdivisions	\$ 29,863	\$ 1,630	\$ –	\$ –	\$ 31,493
Industrial and miscellaneous	56,455	194	(95)	(107)	56,447
Loan-backed and structured securities	29,523	303	(12)	(130)	29,684
Total bonds	<u>\$ 115,841</u>	<u>\$ 2,127</u>	<u>\$ (107)</u>	<u>\$ (237)</u>	<u>\$ 117,624</u>

The statement and fair values of bonds at December 31, 2015, by contractual maturity, are shown below. Actual maturities may differ from contractual maturities because borrowers may have the right to call or prepay obligations with or without call or prepayment penalties.

	Statement Value	Fair Value
Due in one year or less	\$ 9,280	\$ 9,286
Due after one through five years	42,361	42,154
Due after five through ten years	18,164	18,907
Due after ten years	11,673	12,666
Loan-backed and structured securities	29,418	29,409
	<u>\$ 110,896</u>	<u>\$ 112,422</u>

Proceeds from sales of bonds during 2015 and 2014 were \$37,261 and \$25,390, respectively, resulting in realized gross gains of \$106 and \$230, respectively, and realized gross losses of \$741 in 2015. There were no realized gross losses in 2014.

Bonds with a statement value of \$38,846 and \$40,084 were on deposit with the Florida OIR at December 31, 2015 and 2014, respectively.

There were no sales of stocks during 2015 and 2014.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

2. Investments (continued)

A summary of the Company's investment in unaffiliated common stocks is as follows:

	Cost	Gross Unrealized Gains	Gross Unrealized Losses Less Than 12 Months	12 Months or Greater	Fair Value
December 31, 2015					
Common stocks	<u>\$ 9,590</u>	<u>\$ 4,248</u>	<u>\$ (12)</u>	<u>\$ –</u>	<u>\$ 13,826</u>
December 31, 2014					
Common stocks	<u>\$ 9,094</u>	<u>\$ 4,849</u>	<u>\$ –</u>	<u>\$ –</u>	<u>\$ 13,943</u>

A significant judgment in the valuation of investments is the determination of when an other-than-temporary decline in value has occurred. The Company follows a consistent and systematic process for impairing securities that sustain other-than-temporary declines in value. The Company has established a committee responsible for the impairment review process. The decision to impair a security incorporates both quantitative criteria and qualitative information. The impairment review process considers a number of factors, including but not limited to (a) the length of time and the extent to which a security's fair value has been less than statement value; (b) the financial condition and near term prospects of the issuer; (c) the intent to sell and, for loan-backed and structured securities, the intent and ability of the Company to retain its investment for a period of time to allow for any anticipated recovery in value; (d) whether the debtor is current on interest and principal payments; and (e) general market conditions and industry or sector specific factors. For securities that are deemed to be other-than-temporarily impaired, the security is adjusted to its fair value (or its discounted cash flows for loan-backed and structured securities), and the resulting losses are recognized in net realized gains or losses in the statutory basis statements of operations. The new cost basis of the impaired securities is not increased for future recoveries in fair value. There were no charges recorded for other-than-temporary impairment ("OTTI") of securities for the years ended December 31, 2015 and 2014.

A summary of unaffiliated investments with unrealized losses along with the related fair value, aggregated by the length of time that investments have been in a continuous unrealized loss position, is as follows:

	December 31, 2015			December 31, 2014		
	Number of Securities	Fair Value	Gross Unrealized Loss	Number of Securities	Fair Value	Gross Unrealized Loss
Bonds:						
Less than 12 months	77	\$ 39,063	\$ (530)	45	\$ 27,211	\$ (107)
12 months or greater	14	6,829	(113)	28	16,089	(237)
Total bonds	<u>91</u>	<u>\$ 45,892</u>	<u>\$ (643)</u>	<u>73</u>	<u>\$ 43,300</u>	<u>\$ (344)</u>
Common stocks:						
Less than 12 months	-	\$ 485	\$ (12)	-	\$ –	\$ –
Total common stocks	<u>-</u>	<u>\$ 485</u>	<u>\$ (12)</u>	<u>-</u>	<u>\$ –</u>	<u>\$ –</u>

The Company's bond portfolio is sensitive to interest rate fluctuations, which impact the fair value of individual securities. Unrealized losses on bonds reported above were primarily caused by the effects of the interest rate environment and the widening of credit spreads on certain securities. Unrealized losses on stocks result from normal market fluctuations and are considered temporary. The Company currently has the ability and intent to hold these

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

2. Investments (continued)

securities until their full cost can be recovered. Therefore, the Company does not believe the unrealized losses represent an OTTI as of December 31, 2015 or 2014.

The Company's investment portfolio included loaned securities with carrying values of \$6,722 and \$5,340 at December 31, 2015 and 2014, respectively. The fair value of the invested collateral was \$6,809 and \$5,498 at December 31, 2015 and 2014, respectively.

The Company reinvests the collateral received under the securities lending program. The aggregate amount of cash collateral reinvested at December 31, 2015, categorized by the contractual maturity of the investment, is as follows:

	Amortized Cost	Fair Value
30 days or less	\$ 4,400	\$ 4,400
31 to 60 days	100	100
61 to 90 days	125	125
Subtotal	4,625	4,625
Securities received	2,184	2,184
Total collateral reinvested	<u>\$ 6,809</u>	<u>\$ 6,809</u>

3. Fair Value

Assets and liabilities recorded at fair value in the statutory basis balance sheets would be categorized based upon the level of judgment associated with the inputs used to measure their fair value. Level inputs are as follows:

<u>Level Input</u>	<u>Input Definition</u>
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

3. Fair Value (continued)

The following table summarizes the assets and liabilities measured at fair value and held as of December 31, 2015 and 2014, respectively:

	<u>Level I</u>	<u>Level II</u>	<u>Level III</u>	<u>Total</u>
December 31, 2015				
Industrial and miscellaneous common stocks	<u>\$ 13,826</u>	<u>\$ –</u>	<u>\$ –</u>	<u>\$ 13,826</u>
Total stocks	<u>13,826</u>	<u>–</u>	<u>–</u>	<u>13,826</u>
Total assets at fair value	<u><u>\$ 13,826</u></u>	<u><u>\$ –</u></u>	<u><u>\$ –</u></u>	<u><u>\$ 13,826</u></u>
December 31, 2014				
Industrial and miscellaneous bonds	<u>\$ –</u>	<u>\$ 3,803</u>	<u>\$ –</u>	<u>\$ 3,803</u>
Total bonds	<u>–</u>	<u>3,803</u>	<u>–</u>	<u>3,803</u>
Industrial and miscellaneous common stocks	<u>13,943</u>	<u>–</u>	<u>–</u>	<u>13,943</u>
Total stocks	<u>13,943</u>	<u>–</u>	<u>–</u>	<u>13,943</u>
Total assets at fair value	<u><u>\$ 13,943</u></u>	<u><u>\$ 3,803</u></u>	<u><u>\$ –</u></u>	<u><u>\$ 17,746</u></u>

Fair values of fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level I or Level II inputs, for the determination of fair value to facilitate fair value measurements and disclosures. United States government securities represent Level I securities, while Level II securities primarily include corporate securities, securities from states, municipalities and political subdivisions and residential mortgage-backed securities. For securities not actively traded, the third party pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. As the Company is responsible for the determination of fair value, the Company performs monthly analyses on the prices received from third parties to determine whether the prices are reasonable estimates of fair value. The Company's analyses include a review of month-to-month price fluctuations and, as needed, a comparison of pricing services' valuations for the identical security.

Fair values of equity securities are generally designated as Level I and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated as Level II.

The Company's policy is to recognize transfers between levels, if any, as of the beginning of the reporting period. There were no transfers between levels during the years ended December 31, 2015 and 2014.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

3. Fair Value (continued)

The following table summarizes the fair value of financial instruments by type as of December 31, 2015 and 2014, respectively:

December 31, 2015						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level I)	(Level II)	(Level III)	Not Practicable (Carrying Value)
Bonds	\$ 112,422	\$ 110,896	\$ –	\$ 112,422	\$ –	\$ –
Common stock	13,826	13,826	13,826	–	–	–
Securities lending collateral	6,809	6,809	6,709	100	–	–
Short-term investments	39,238	39,237	38,739	499	–	–

December 31, 2014						
Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level I)	(Level II)	(Level III)	Not Practicable (Carrying Value)
Bonds	\$ 117,624	\$ 115,841	\$ –	\$ 117,624	\$ –	\$ –
Common stock	13,943	13,943	13,943	–	–	–
Securities lending collateral	5,498	5,498	5,498	–	–	–
Short-term investments	36,754	36,754	36,754	–	–	–

4. Unpaid Claims and Claims Adjustment Expenses

The following table provides a reconciliation of the beginning and ending balances for unpaid claims and claims adjustment expenses:

	2015	2014
Balances at January 1	\$ 86,932	\$ 53,215
Incurred (redundancies) related to:		
Current year	1,238,412	918,106
Prior years	4,291	(2,096)
Total incurred	1,242,703	916,010
Paid related to:		
Current year	1,136,058	830,188
Prior years	90,510	52,105
Total paid	1,226,568	882,293
Balances at December 31	\$ 103,067	\$ 86,932

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any year end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established year end liability. The negative amounts reported for incurred related to prior years' results from claims being settled for amounts less than originally estimated. Positive amounts reported for incurred related to prior years result from claims being settled for

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

4. Unpaid Claims and Claims Adjustment Expenses (continued)

amounts greater than originally estimated. This experience is primarily attributable to actual medical cost experience that differs from that assumed at the time the liability was established.

The Company took into account estimated anticipated subrogation and other recoveries in its determination of the liability for unpaid claims based on historical recovery patterns.

5. Retrospectively Rated Contracts and Contracts Subject to Redetermination

The amount of net premiums written by the Company in 2015 and 2014 that was subject to retrospective rating features, including MLR rebates regulations, was \$1,309,626 and \$105,214, which represented 100.0% and 11.2%, respectively, of the total net premiums written.

6. Federal Income Taxes

The Company had a federal income tax payable of \$369 at December 31, 2015 and a federal income tax recoverable of \$7,334 at December 31, 2014.

The components of net deferred tax assets (liabilities) at December 31 are as follows:

	Ordinary	2015 Capital	Total
Gross deferred tax assets	\$ 7,070	\$ –	\$ 7,070
Gross deferred tax liabilities	(2)	(1,492)	(1,494)
Net deferred tax asset before admissibility test	\$ 7,068	\$ (1,492)	\$ 5,576

The amount of admitted adjusted gross deferred tax assets under each component of Statement of Statutory Accounting Principles (“SSAP”) No. 101 *Income Taxes - A Replacement of SSAP No. 10R and SSAP 10* (“SSAP No. 101”) as of December 31, 2015 is:

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ 6,215	\$ –	\$ 6,215
Admitted pursuant to paragraph 11.b	164	–	164
Admitted pursuant to paragraph 11.c	691	–	691
Admitted deferred tax asset	7,070	–	7,070
Deferred tax liability	(2)	(1,492)	(1,494)
Net admitted deferred tax asset	7,068	(1,492)	5,576
Nonadmitted deferred tax asset	\$ –	\$ –	\$ –

	Ordinary	2014 Capital	Total
Gross deferred tax assets	\$ 6,522	\$ –	\$ 6,522
Gross deferred tax liabilities	(3)	(1,617)	(1,620)
Net deferred tax asset before admissibility test	\$ 6,519	\$ (1,617)	\$ 4,902

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

6. Federal Income Taxes (continued)

The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101 as of December 31, 2014 is:

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ 4,238	\$ –	\$ 4,238
Admitted pursuant to paragraph 11.b	1,620	–	1,620
Admitted pursuant to paragraph 11.c	664	–	664
Admitted deferred tax asset	6,522	–	6,522
Deferred tax liability	(3)	(1,617)	(1,620)
Net admitted deferred tax asset	6,519	(1,617)	4,902
Nonadmitted deferred tax asset	\$ –	\$ –	\$ –

The change in the amount of admitted adjusted gross deferred tax assets under each component during 2015 is:

	Ordinary	Capital	Total
Admitted pursuant to paragraph 11.a	\$ 1,977	\$ –	\$ 1,977
Admitted pursuant to paragraph 11.b	(1,456)	–	(1,456)
Admitted pursuant to paragraph 11.c	27	–	27
Admitted deferred tax asset	548	–	548
Deferred tax liability	1	125	126
Net admitted deferred tax asset	549	125	674
Nonadmitted deferred tax asset	\$ –	\$ –	\$ –

	2015	2014
Amount of adjusted capital and surplus used to determine recovery period and threshold limitations.	\$ 70,096	\$ 78,664

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

6. Federal Income Taxes (continued)

The impact of tax planning strategies is as follows:

	2015		2014		Change	
	Ordinary	Capital	Ordinary	Capital	Ordinary	Capital
Adjusted gross deferred tax assets amount	\$ 7,070	\$ –	\$ 6,522	\$ –	\$ 548	\$ –
Percentage of adjusted gross deferred tax assets by tax character attributable to the impact of tax planning strategies	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Net admitted adjusted gross deferred tax assets amount	\$ 7,070	\$ –	\$ 6,522	\$ –	\$ 548	\$ –
Percentage of net admitted adjusted gross deferred tax assets by tax character attributable to the impact of tax planning strategies	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

The Company's tax planning strategies do not include the use of reinsurance.

Current federal income taxes consist of the following major components:

	2015	2014	Change
Federal income taxes expense (benefit) on operations	\$ 7,698	\$ (6,279)	\$ 13,977
Federal income taxes (benefit) expense on net capital (losses) gains	(223)	80	(303)
Federal income taxes incurred (benefit)	<u>\$ 7,475</u>	<u>\$ (6,199)</u>	<u>\$ 13,674</u>

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

6. Federal Income Taxes (continued)

The components of deferred income taxes are as follows:

	December 31		
	2015	2014	Change
Deferred tax assets:			
Ordinary:			
Amortization	\$ 516	\$ 725	\$ (209)
Accounts receivable	3,610	1,840	1,770
Fixed assets	878	560	318
Other insurance reserves	1,992	1,164	828
Premium deficiency reserves	—	537	(537)
Prepaid expenses	18	14	4
Unearned premium reserve	—	1,682	(1,682)
Other	56	—	56
Subtotal	7,070	6,522	548
Admitted deferred tax assets	7,070	6,522	548
Deferred tax liabilities:			
Ordinary:			
Discount of coordination of benefits	(2)	(3)	1
Subtotal	(2)	(3)	1
Capital:			
Investments in securities	(1,492)	(1,617)	125
Subtotal	(1,492)	(1,617)	125
Deferred tax liabilities	(1,494)	(1,620)	126
Net admitted deferred tax assets	\$ 5,576	\$ 4,902	\$ 674

The changes in deferred tax assets and deferred tax liabilities are as follows:

	December 31		
	2015	2014	Change
Total deferred tax assets	\$ 7,070	\$ 6,522	\$ 548
Total deferred tax liabilities	(1,494)	(1,620)	126
Net deferred tax asset	\$ 5,576	\$ 4,902	674
Tax effect of unrealized losses			(146)
Change in net deferred income tax			\$ 528

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

6. Federal Income Taxes (continued)

The Company's income tax expense and change in deferred taxes differs from the amount obtained by applying the federal statutory rate of 35% for the year ended December 31 for the following reasons:

	2015	2014
Tax expense (benefit) computed		
using federal statutory rate	\$ 1,939	\$ (11,498)
Change in nonadmitted assets	(2,185)	(224)
Permanent differences	(391)	(302)
ACA health insurer fee	7,441	3,969
Tax settlements and contingency reserve	–	(94)
Other	143	157
Total	<u>\$ 6,947</u>	<u>\$ (7,992)</u>
Federal income taxes incurred (benefit)	\$ 7,475	\$ (6,199)
Change in net deferred income taxes	(528)	(1,793)
Total statutory income taxes (benefit)	<u>\$ 6,947</u>	<u>\$ (7,992)</u>

At December 31, 2015, the Company has no operating loss carryforwards or tax credit carryforwards.

The following are income taxes incurred in the current and prior years that will be available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2015	\$ 6,887	\$ –	\$ 6,887
2014	–	–	–
2013	N/A	3,079	3,079

The Company is a member of the IRS Compliance Assurance Program (“CAP”). The objective of CAP is to reduce taxpayer burden and uncertainty while assuring the IRS of the accuracy of tax returns prior to filing, thereby reducing or eliminating the need for post filing examinations. As of December 31, 2015, the examination of the 2015 tax year continues to be in process.

7. Health Insurer Fee

The Company has \$1,156,733 and \$805,328 of premiums written subject to assessment under ACA Section 9010 as of December 31, 2015 and 2014, respectively. The Company's estimated portion of the annual health insurance industry fee to be paid by September 30, 2016 is \$20,965 as segregated in special surplus funds on the balance sheet. The Company's portion of the annual health insurance industry fee paid during 2015 was \$21,259 and is included in operating expenses. Total Adjusted Capital (“TAC”) and Authorized Control Level (“ACL”) were \$75,684 and \$39,030, respectively, as of December 31, 2015. Had the assessment, based upon 2015 premiums written, been accrued on December 31, 2015, TAC would have been reduced to \$54,719, which would continue to exceed all capital and surplus requirements as described in Note 8.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

8. Capital and Surplus

The Florida OIR requires the Company to maintain a minimum statutory capital and surplus as set forth in the state statutes. Under those requirements, capital and surplus is calculated as the greater of \$1,500, or 10% of total liabilities, or 2% of total annualized premiums. Additionally, the Department requires the Company to maintain \$3,000 in excess surplus over the statutory requirement per the Department's *Consent Order* pursuant to the approved merger between the Company and PHP Holdings, Inc. The Florida OIR has not adopted the RBC requirement of the NAIC. At December 31, 2015 and 2014, the Company's capital and surplus exceeded all regulatory requirements.

Per the *Florida Statute 641.365*, certain limitations exist on the Company's ability to pay dividends to its parent. The Company may pay funds only from accumulated surplus funds that were derived from realized net operating profits on its business and net realized capital gains. Prior written approval by the Florida OIR is required for payment of any dividend that would result in these accumulated surplus funds being less than zero. Florida OIR approval is not required if the dividend paid is less than the greater of 1) ten percent of the Company's accumulated surplus as of December 31st of the preceding year or 2) the Company's net income from the immediately preceding calendar year. Within these limitations, the Company may pay no dividends during 2016 without prior approval.

The portion of unassigned deficit representing cumulative unrealized gains was \$4,236 and \$4,653 as December 31, 2015 and 2014, respectively.

9. Leases

The Company leases office space and EDP equipment and other miscellaneous items under various non-cancelable operating leases. Related lease expense for 2015 and 2014 was \$2,564 and \$426, respectively.

At December 31, 2015, future lease payments for operating leases with initial or remaining non-cancelable terms of one year or more consisted of the following: 2016, \$2,719; 2017, \$2,856; 2018, \$2,906; 2019, \$2,286; 2020, \$1,367 and thereafter, \$521.

10. Contingencies

In February 2015, Anthem reported that it was the target of a sophisticated external cyber-attack. The attackers gained unauthorized access to certain of Anthem's information technology systems and obtained personal information related to many individuals and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that Anthem will not identify additional information that was accessed or obtained.

Anthem has continued to implement security enhancements since this incident and is supporting federal law enforcement efforts to identify the responsible parties. Upon discovery of the cyber-attack, Anthem took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate its systems and identify solutions based on the evolving landscape. Anthem is providing credit monitoring and identity protection services to those who have been affected by this cyber-attack. Anthem has incurred expenses subsequent to the cyber-attack to investigate and remediate this matter and expects to continue to incur expenses of this nature in the foreseeable future. Anthem will recognize these expenses in the periods in which they are incurred.

Actions have been filed in various federal and state courts, and other claims have been or may be asserted against Anthem on behalf of current or former members, current or former employees, other individuals, shareholders or

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

10. Contingencies (continued)

others seeking damages or other related relief, allegedly arising out of the cyber-attack. State and federal agencies, including state insurance regulators, state attorneys general, the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigation, are investigating events related to the cyber-attack, including how it occurred, its consequences and Anthem's responses. Although Anthem is cooperating in these investigations, Anthem may be subject to fines or other obligations, which may have an adverse effect on how Anthem operates its business and results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation in February 2015 and was subsequently heard by the Panel in May 2015. In June 2015, the Panel entered its order transferring the consolidated matter to the U.S. District Court for the Northern District of California. The U.S. District Court entered its Case Management Order in September 2015. Anthem has filed a Motion to Dismiss several of the counts that are before the U.S. District Court. There remain a few state court cases that are presently proceeding outside of the Multidistrict Litigation.

Anthem has contingency plans and insurance coverage for certain expenses and potential liabilities of this nature. The coverage has been sufficient to cover the majority of claims and liabilities incurred to date. While a loss from these matters is reasonably possible, Anthem cannot reasonably estimate a range of possible losses because the investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

The Company is involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental and administrative proceedings. These investigations, audits and reviews include routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and Federal Agencies. Such investigations could result in the imposition of civil or criminal fines, penalties and other sanctions. The Company believes that any liability that may result from any one of these actions is unlikely to have a material adverse effect on the Company's financial position or results of operations.

At December 31, 2015 and 2014, the Company reported admitted assets of \$7,253 and \$8,830, respectively, in premium receivables due from policyholders and agents and receivables due from uninsured plans. The receivables are not deemed to be uncollectible, therefore, no provisions for uncollectible amounts have been recorded. The potential for any additional loss is not believed to be material to the Company's financial condition.

The Company has no other known contingencies.

11. Retirement Benefits

The Company participates in various deferred compensation plans sponsored by Anthem that cover certain employees. The deferred amounts are payable according to the terms and subject to the conditions of said deferred compensation agreements. Anthem allocates a share of the total costs of these plans to the Company based on the number of allocated employees participating in the plans. During 2015 and 2014, these costs totaled \$51 and \$15. The Company has no legal obligation for benefits under this plan.

The Company participates in the Anthem 401(k) Retirement Savings Plan, sponsored by ATH Holding and covering substantially all employees. Voluntary employee contributions are matched by ATH Holding subject to certain limitations. ATH Holding allocates a share of the total accumulated costs of this plan to the Company based on the number of allocated employees. During 2015 and 2014, these costs totaled \$1,715 and \$1,466, respectively. The Company has no legal obligation for benefits under these plans.

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

12. Health Care Receivable

Admitted health care receivables consist of pharmacy rebate receivables of \$461 and \$1,121 at December 31, 2015 and 2014, respectively.

Pharmaceutical rebate receivables at December 31, 2015 and 2014 consist of reasonably estimated and billed amounts. Amounts not collected within 90 days of the invoice or confirmation date are nonadmitted. Pharmaceutical rebate receivables of \$1,824 and \$2,375 were nonadmitted as of December 31, 2015 and 2014, respectively.

The following table summarizes information about the Company's pharmaceutical rebate receivables:

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More Than 180 Days After Billing
12/31/2015	\$ 176	\$ 623	\$ —	\$ —	\$ —
9/30/2015	162	758	—	—	—
6/30/2015	83	515	—	701	—
3/31/2015	237	282	—	552	39
12/31/2014	\$ 570	\$ 649	\$ —	\$ 359	\$ 339
9/30/2014	706	690	—	396	292
6/30/2014	923	864	—	606	257
3/31/2014	916	980	—	732	248
12/31/2013	\$ 789	\$ 903	\$ —	\$ 690	\$ 214
9/30/2013	760	897	—	698	199
6/30/2013	749	812	—	645	167
3/31/2013	724	804	—	627	177

Claim overpayment receivables consist of amounts that have been invoiced and meet the setoff conditions. Amounts that have not been invoiced and do not meet the setoff conditions are nonadmitted. Claim overpayment receivables and other health care receivables of \$4,407 and \$1,876 were nonadmitted as of December 31, 2015 and 2014, respectively.

Provider advances of \$298 and \$999 were nonadmitted as of December 31, 2015 and 2014, respectively. Capitation agreement receivables of \$2,684 were nonadmitted as of December 31, 2015, as amounts did not meet the setoff conditions. The Company did not have capitation agreement receivables as of December 31, 2014.

13. Related Party Transactions

The Company has entered into administrative services agreements with its affiliated companies. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Costs include expenses such as salaries, benefits, communications, advertising, consulting services, rent, utilities,

AMERIGROUP Florida, Inc.

Notes to Financial Statements – Statutory Basis

(Dollars In Thousands)

13. Related Party Transactions (continued)

accounting, underwriting, and product development, which support the operations of the Company. These costs are allocated based on various utilization statistics.

Net payments to affiliated companies pursuant to the above administrative service agreements were \$125,804 and \$96,344 in 2015 and 2014, respectively, and are included in operating expenses and claims adjustment expenses in the statutory basis statements of operations.

At December 31, 2015 and 2014, the Company reported zero and \$22 due from affiliates and \$9,877 and \$4,708 due to affiliates, respectively. The receivable and payable balances represent intercompany transactions that are settled within the terms of the management and services agreement.

The Company paid no dividends for the years ended December 31, 2015 and 2014.

The Company received \$35,000 of capital contributions on December 31, 2014 from its parent company, PHP Holding, Inc. The Company received no capital contributions from its parent for the year ended December 31, 2015.

15. Subsequent Events

The Company will no longer serve Medicare members effective January 1, 2016. That line of business, which comprises 37,131 members as of December 31, 2015, was transferred to our affiliate, Simply Healthcare Plans, Inc.

The annual health insurer fee under section 9010 of the ACA, discussed in Note 1, has been suspended for 2017 and will resume for 2018 and beyond.

Management of the Company has evaluated all other events occurring after December 31, 2015 through March 28, 2016, the date the financial statements were available to be issued, to determine whether any event required either recognition or disclosure in the financial statements. It was determined there were no other events that require recognition or disclosure in the financial statements through the report date.

FOR THE YEAR ENDING
DECEMBER 31, 2016

2016

2016



HEALTH ANNUAL STATEMENT
FOR THE YEAR ENDED DECEMBER 31, 2016
OF THE CONDITION AND AFFAIRS OF THE
Simply Healthcare Plans, Inc.

NAIC Group Code 0671 0671 NAIC Company Code 13726 Employer's ID Number 27-0945036
(Current) (Prior)

Organized under the Laws of Florida, State of Domicile or Port of Entry _____

Country of Domicile United States of America

Licensed as business type: Health Maintenance Organization

Is HMO Federally Qualified? Yes [] No [X]

Incorporated/Organized 09/10/2009 Commenced Business 01/07/2010

Statutory Home Office 9250 W Flagler Street, Suite 600, Miami, FL, US 33174
(Street and Number) (City or Town, State, Country and Zip Code)

Main Administrative Office 4425 Corporation Lane
(Street and Number)
Virginia Beach, VA, US 23462 757-490-6900
(City or Town, State, Country and Zip Code) (Area Code) (Telephone Number)

Mail Address 4425 Corporation Lane Virginia Beach, VA, US 23462
(Street and Number or P.O. Box) (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 4425 Corporation Lane
(Street and Number)
Virginia Beach, VA, US 23462 757-490-4900
(City or Town, State, Country and Zip Code) (Area Code) (Telephone Number)

Internet Website Address www.simplyhealthcareplans.com

Statutory Statement Contact Bette Lou Gronseth, 757-518-3638
(Name) (Area Code) (Telephone Number)
Bette.Gronseth@amerigroup.com 757-557-6742
(E-mail Address) (FAX Number)

OFFICERS

CEO & President Maria Lourdes Rivas Secretary Kathleen Susan Kiefer
CFO Holly Jean Prince Treasurer Robert David Kretschmer

OTHER

Vincent Pantone, Chief Medical Officer Eric (Rick) Kenneth Noble, Assistant Treasurer

DIRECTORS OR TRUSTEES

Maria Lourdes Rivas Catherine Irene Kelaghan Carter Allen Beck

State of Florida SS:
County of Miami-Dade

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

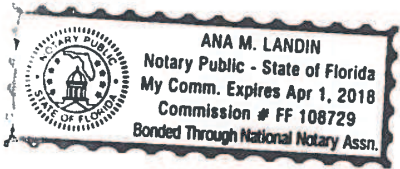
Maria Lourdes Rivas
CEO & President

Kathleen S Kiefer
Secretary

Holly J Prince
CFO

Subscribed and sworn to before me this 23rd day of March, 2017
ANA M. LANDIN

- a. Is this an original filing? _____ Yes [X] No []
- b. If no,
1. State the amendment number _____
2. Date filed _____
3. Number of pages attached _____



ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

ASSETS

	Current Year			Prior Year
	1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 Net Admitted Assets
1. Bonds (Schedule D)	65,592,752		65,592,752	64,559,757
2. Stocks (Schedule D):				
2.1 Preferred stocks			0	0
2.2 Common stocks			0	0
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens			0	0
3.2 Other than first liens			0	0
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less \$				
encumbrances)			0	0
4.2 Properties held for the production of income (less				
\$ encumbrances)			0	0
4.3 Properties held for sale (less \$ encumbrances)			0	0
5. Cash (\$197,758,510 , Schedule E - Part 1), cash equivalents				
(\$, Schedule E - Part 2) and short-term				
investments (\$613,757 , Schedule DA)	198,372,267		198,372,267	92,585,051
6. Contract loans, (including \$ premium notes)			0	0
7. Derivatives (Schedule DB)			0	0
8. Other invested assets (Schedule BA)			0	0
9. Receivables for securities			0	0
10. Securities lending reinvested collateral assets (Schedule DL)			0	0
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	263,965,019	0	263,965,019	157,144,808
13. Title plants less \$ charged off (for Title insurers				
only)			0	0
14. Investment income due and accrued	755,880		755,880	697,751
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	7,901,620		7,901,620	10,759,189
15.2 Deferred premiums and agents' balances and installments booked but				
deferred and not yet due (including \$ earned but unbilled premiums)			0	0
15.3 Accrued retrospective premiums (\$) and				
contracts subject to redetermination (\$11,344,162)	11,344,162		11,344,162	6,642,793
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers	1,553,954		1,553,954	252,686
16.2 Funds held by or deposited with reinsured companies			0	0
16.3 Other amounts receivable under reinsurance contracts			0	0
17. Amounts receivable relating to uninsured plans	502,605		502,605	432,708
18.1 Current federal and foreign income tax recoverable and interest thereon			0	0
18.2 Net deferred tax asset	4,064,208	9,493	4,054,715	3,523,223
19. Guaranty funds receivable or on deposit			0	0
20. Electronic data processing equipment and software	2,430,086	854,973	1,575,113	1,223,472
21. Furniture and equipment, including health care delivery assets				
(\$)	855,016	855,016	0	0
22. Net adjustment in assets and liabilities due to foreign exchange rates			0	0
23. Receivables from parent, subsidiaries and affiliates	713,672	713,672	0	0
24. Health care (\$1,678,499) and other amounts receivable	5,243,085	3,564,586	1,678,499	2,629,425
25. Aggregate write-ins for other than invested assets	4,753,362	4,113,535	639,827	10,000
26. Total assets excluding Separate Accounts, Segregated Accounts and				
Protected Cell Accounts (Lines 12 to 25)	304,082,669	10,111,275	293,971,394	183,316,055
27. From Separate Accounts, Segregated Accounts and Protected Cell				
Accounts			0	0
28. Total (Lines 26 and 27)	304,082,669	10,111,275	293,971,394	183,316,055
DETAILS OF WRITE-INS				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	0	0	0	0
2501. Goodwill	3,128,663	3,128,663	0	0
2502. Deposits	855,498	845,498	10,000	10,000
2503. Prepaid Expenses-	85,386	85,386	0	0
2598. Summary of remaining write-ins for Line 25 from overflow page	683,815	53,988	629,827	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	4,753,362	4,113,535	639,827	10,000

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

LIABILITIES, CAPITAL AND SURPLUS

	Current Year			Prior Year
	1	2	3	4
	Covered	Uncovered	Total	Total
1. Claims unpaid (less \$0 reinsurance ceded)	104,094,964		104,094,964	83,129,310
2. Accrued medical incentive pool and bonus amounts	23,257,284		23,257,284	17,426,184
3. Unpaid claims adjustment expenses.....	3,319,239		3,319,239	2,777,079
4. Aggregate health policy reserves, including the liability of \$0 for medical loss ratio rebate per the Public Health Service Act	22,220,518		22,220,518	3,011,007
5. Aggregate life policy reserves.....			0	0
6. Property/casualty unearned premium reserves.....			0	0
7. Aggregate health claim reserves.....	288,653		288,653	0
8. Premiums received in advance.....			0	0
9. General expenses due or accrued.....	1,426,657		1,426,657	10,706,031
10.1 Current federal and foreign income tax payable and interest thereon (including \$ on realized capital gains (losses))	5,542,526		5,542,526	4,558,726
10.2 Net deferred tax liability.....			0	0
11. Ceded reinsurance premiums payable.....			0	0
12. Amounts withheld or retained for the account of others.....			0	0
13. Remittances and items not allocated.....			0	0
14. Borrowed money (including \$ current) and interest thereon \$ (including \$ current).....			0	0
15. Amounts due to parent, subsidiaries and affiliates.....	3,218,895		3,218,895	2,974,679
16. Derivatives.....			0	0
17. Payable for securities.....			0	0
18. Payable for securities lending.....			0	0
19. Funds held under reinsurance treaties (with \$ authorized reinsurers, \$0 unauthorized reinsurers and \$0 certified reinsurers).....			0	0
20. Reinsurance in unauthorized and certified (\$) companies.....			0	0
21. Net adjustments in assets and liabilities due to foreign exchange rates			0	0
22. Liability for amounts held under uninsured plans.....	7,849,460		7,849,460	6,212,617
23. Aggregate write-ins for other liabilities (including \$221,770 current).....	9,358,454	0	9,358,454	6,403,204
24. Total liabilities (Lines 1 to 23).....	180,576,650	0	180,576,650	137,198,837
25. Aggregate write-ins for special surplus funds.....	XXX	XXX	0	20,013,754
26. Common capital stock.....	XXX	XXX	57	57
27. Preferred capital stock.....	XXX	XXX		
28. Gross paid in and contributed surplus.....	XXX	XXX	5,714,050	5,714,050
29. Surplus notes.....	XXX	XXX	20,559,808	20,559,808
30. Aggregate write-ins for other than special surplus funds.....	XXX	XXX	0	0
31. Unassigned funds (surplus).....	XXX	XXX	87,120,829	(170,451)
32. Less treasury stock, at cost:				
32.1 shares common (value included in Line 26 \$).....	XXX	XXX		
32.2 shares preferred (value included in Line 27 \$).....	XXX	XXX		
33. Total capital and surplus (Lines 25 to 31 minus Line 32).....	XXX	XXX	113,394,744	46,117,218
34. Total liabilities, capital and surplus (Lines 24 and 33)	XXX	XXX	293,971,394	183,316,055
DETAILS OF WRITE-INS				
2301. ACA Health Insurer Fee Liability	6,227,459	0	6,227,459	6,227,459
2302. Escheat Liability	2,596,955	0	2,596,955	175,745
2303. Other Premium Liability	534,040	0	534,040	0
2398. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399. Totals (Lines 2301 thru 2303 plus 2398)(Line 23 above)	9,358,454	0	9,358,454	6,403,204
2501. 2015 Fee Year / 2014 Data Year ACA tax liability	XXX	XXX	0	20,013,754
2502.	XXX	XXX		
2503.	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	XXX	XXX	0	20,013,754
3001.	XXX	XXX		
3002.	XXX	XXX		
3003.	XXX	XXX		
3098. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099. Totals (Lines 3001 thru 3003 plus 3098)(Line 30 above)	XXX	XXX	0	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

STATEMENT OF REVENUE AND EXPENSES

	Current Year		Prior Year
	1 Uncovered	2 Total	3 Total
1. Member Months.....	XXX	1,538,368	1,366,614
2. Net premium income (including \$ non-health premium income)	XXX	1,229,640,802	985,291,150
3. Change in unearned premium reserves and reserve for rate credits	XXX	(15,781,231)	913,509
4. Fee-for-service (net of \$ medical expenses)	XXX		0
5. Risk revenue	XXX		0
6. Aggregate write-ins for other health care related revenues	XXX	0	0
7. Aggregate write-ins for other non-health revenues	XXX	0	0
8. Total revenues (Lines 2 to 7)	XXX	1,213,859,571	986,204,659
Hospital and Medical:			
9. Hospital/medical benefits		373,332,977	289,246,910
10. Other professional services		176,109,687	196,317,298
11. Outside referrals			0
12. Emergency room and out-of-area		26,879,355	0
13. Prescription drugs		333,940,986	294,950,327
14. Aggregate write-ins for other hospital and medical.....	0	0	0
15. Incentive pool, withhold adjustments and bonus amounts		82,302,654	52,849,209
16. Subtotal (Lines 9 to 15)	0	992,565,659	833,363,744
Less:			
17. Net reinsurance recoveries		2,303,806	321,986
18. Total hospital and medical (Lines 16 minus 17)	0	990,261,853	833,041,758
19. Non-health claims (net)			0
20. Claims adjustment expenses, including \$33,021,130 cost containment expenses		54,124,675	25,588,128
21. General administrative expenses		74,514,230	85,788,144
22. Increase in reserves for life and accident and health contracts (including \$ increase in reserves for life only)		0	0
23. Total underwriting deductions (Lines 18 through 22).....	0	1,118,900,758	944,418,030
24. Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	94,958,813	41,786,629
25. Net investment income earned (Exhibit of Net Investment Income, Line 17)		1,544,450	742,319
26. Net realized capital gains (losses) less capital gains tax of \$744		1,065	6,242
27. Net investment gains (losses) (Lines 25 plus 26)	0	1,545,515	748,561
28. Net gain or (loss) from agents' or premium balances charged off [(amount recovered \$) (amount charged off \$0)]			
29. Aggregate write-ins for other income or expenses	0	(42,336)	(422,334)
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	96,461,992	42,112,856
31. Federal and foreign income taxes incurred	XXX	40,877,131	20,301,937
32. Net income (loss) (Lines 30 minus 31)	XXX	55,584,861	21,810,919
DETAILS OF WRITE-INS			
0601.	XXX		
0602.	XXX		
0603.	XXX		
0698. Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0
0699. Totals (Lines 0601 thru 0603 plus 0698)(Line 6 above)	XXX	0	0
0701.	XXX		
0702.	XXX		
0703.	XXX		
0798. Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0
0799. Totals (Lines 0701 thru 0703 plus 0798)(Line 7 above)	XXX	0	0
1401.			
1402.			
1403.			
1498. Summary of remaining write-ins for Line 14 from overflow page	0	0	0
1499. Totals (Lines 1401 thru 1403 plus 1498)(Line 14 above)	0	0	0
2901. Miscellaneous (expense) income		(42,336)	(422,334)
2902.			
2903.			
2998. Summary of remaining write-ins for Line 29 from overflow page	0	0	0
2999. Totals (Lines 2901 thru 2903 plus 2998)(Line 29 above)	0	(42,336)	(422,334)

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

STATEMENT OF REVENUE AND EXPENSES (Continued)

	1 Current Year	2 Prior Year
CAPITAL AND SURPLUS ACCOUNT		
33. Capital and surplus prior reporting year.....	46,117,218	27,319,293
34. Net income or (loss) from Line 32	55,584,861	21,810,919
35. Change in valuation basis of aggregate policy and claim reserves		
36. Change in net unrealized capital gains (losses) less capital gains tax of \$ (123,470)	(229,302)	0
37. Change in net unrealized foreign exchange capital gain or (loss)		
38. Change in net deferred income tax	(3,435,194)	5,967,785
39. Change in nonadmitted assets	15,357,161	(8,980,779)
40 Change in unauthorized and certified reinsurance	0	0
41. Change in treasury stock	0	0
42. Change in surplus notes	0	0
43. Cumulative effect of changes in accounting principles.....		
44. Capital Changes:		
44.1 Paid in	0	0
44.2 Transferred from surplus (Stock Dividend).....	0	0
44.3 Transferred to surplus.....		
45. Surplus adjustments:		
45.1 Paid in	0	0
45.2 Transferred to capital (Stock Dividend)		
45.3 Transferred from capital		
46. Dividends to stockholders		
47. Aggregate write-ins for gains or (losses) in surplus	0	0
48. Net change in capital and surplus (Lines 34 to 47)	67,277,526	18,797,925
49. Capital and surplus end of reporting period (Line 33 plus 48)	113,394,744	46,117,218
DETAILS OF WRITE-INS		
4701.		
4702.		
4703.		
4798. Summary of remaining write-ins for Line 47 from overflow page	0	0
4799. Totals (Lines 4701 thru 4703 plus 4798)(Line 47 above)	0	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

CASH FLOW

	1	2
	Current Year	Prior Year
Cash from Operations		
1. Premiums collected net of reinsurance	1,231,225,282	950,213,598
2. Net investment income	2,367,762	616,112
3. Miscellaneous income	0	0
4. Total (Lines 1 through 3)	1,233,593,044	950,829,710
5. Benefit and loss related payments	962,757,448	838,487,707
6. Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts		
7. Commissions, expenses paid and aggregate write-ins for deductions	134,138,628	95,888,944
8. Dividends paid to policyholders		
9. Federal and foreign income taxes paid (recovered) net of \$744 tax on capital gains (losses)	39,894,075	18,620,102
10. Total (Lines 5 through 9)	1,136,790,151	952,996,753
11. Net cash from operations (Line 4 minus Line 10)	96,802,893	(2,167,043)
Cash from Investments		
12. Proceeds from investments sold, matured or repaid:		
12.1 Bonds	3,288,239	19,779,859
12.2 Stocks	0	0
12.3 Mortgage loans	0	0
12.4 Real estate	0	0
12.5 Other invested assets	0	0
12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	0	(1,746)
12.7 Miscellaneous proceeds	0	0
12.8 Total investment proceeds (Lines 12.1 to 12.7)	3,288,239	19,778,113
13. Cost of investments acquired (long-term only):		
13.1 Bonds	5,551,297	69,316,874
13.2 Stocks	0	0
13.3 Mortgage loans	0	0
13.4 Real estate	0	0
13.5 Other invested assets	0	0
13.6 Miscellaneous applications	0	0
13.7 Total investments acquired (Lines 13.1 to 13.6)	5,551,297	69,316,874
14. Net increase (decrease) in contract loans and premium notes	0	0
15. Net cash from investments (Line 12.8 minus Line 13.7 minus Line 14)	(2,263,058)	(49,538,761)
Cash from Financing and Miscellaneous Sources		
16. Cash provided (applied):		
16.1 Surplus notes, capital notes	0	0
16.2 Capital and paid in surplus, less treasury stock	0	0
16.3 Borrowed funds	0	0
16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	0
16.5 Dividends to stockholders	0	0
16.6 Other cash provided (applied)	11,247,381	(6,446,552)
17. Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6)	11,247,381	(6,446,552)
RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS		
18. Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	105,787,216	(58,152,356)
19. Cash, cash equivalents and short-term investments:		
19.1 Beginning of year	92,585,051	150,737,407
19.2 End of year (Line 18 plus Line 19.1)	198,372,267	92,585,051
Note: Supplemental disclosures of cash flow information for non-cash transactions:		
20.0001. Depreciation	1,713,170	1,715,176

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Net premium income	1,229,640,802						555,069,773	674,571,029		
2. Change in unearned premium reserves and reserve for rate credit	(15,781,231)						(2,839,151)	(12,942,080)		
3. Fee-for-service (net of \$0 medical expenses)	0									XXX
4. Risk revenue	0									XXX
5. Aggregate write-ins for other health care related revenues	0	0	0	0	0	0	0	0	0	XXX
6. Aggregate write-ins for other non-health care related revenues	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
7. Total revenues (Lines 1 to 6)	1,213,859,571	0	0	0	0	0	552,230,622	661,628,949	0	0
8. Hospital/medical benefits	373,332,977						221,240,180	152,092,797		XXX
9. Other professional services	176,109,687						91,732,980	84,376,707		XXX
10. Outside referrals	0									XXX
11. Emergency room and out-of-area	26,879,355						8,153,556	18,725,799		XXX
12. Prescription drugs	333,940,986						76,660,027	257,280,959		XXX
13. Aggregate write-ins for other hospital and medical	0	0	0	0	0	0	0	0	0	XXX
14. Incentive pool, withhold adjustments and bonus amounts	82,302,654						44,624,156	37,678,498		XXX
15. Subtotal (Lines 8 to 14)	992,565,659	0	0	0	0	0	442,410,899	550,154,760	0	XXX
16. Net reinsurance recoveries	2,303,806						212,948	2,090,858		XXX
17. Total medical and hospital (Lines 15 minus 16).....	990,261,853	0	0	0	0	0	442,197,951	548,063,902	0	XXX
18. Non-health claims (net)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
19. Claims adjustment expenses including \$33,021,130 cost containment expenses	54,124,675						27,603,235	26,521,440		
20. General administrative expenses	74,514,230						38,002,618	36,511,612		
21. Increase in reserves for accident and health contracts	0									XXX
22. Increase in reserves for life contracts	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
23. Total underwriting deductions (Lines 17 to 22)	1,118,900,758	0	0	0	0	0	507,803,804	611,096,954	0	0
24. Total underwriting gain or (loss) (Line 7 minus Line 23)	94,958,813	0	0	0	0	0	44,426,818	50,531,995	0	0
DETAILS OF WRITE-INS										
0501. Other health	0								0	XXX
0502.	0									XXX
0503.	0									XXX
0598. Summary of remaining write-ins for Line 5 from overflow page	0	0	0	0	0	0	0	0	0	XXX
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above)	0	0	0	0	0	0	0	0	0	XXX
0601. Other non health	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
0602.	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0603.	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0698. Summary of remaining write-ins for Line 6 from overflow page	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
1301. Miscellaneous	0								0	XXX
1302.	0									XXX
1303.	0									XXX
1398. Summary of remaining write-ins for Line 13 from overflow page	0	0	0	0	0	0	0	0	0	XXX
1399. Totals (Lines 1301 thru 1303 plus 1398) (Line 13 above)	0	0	0	0	0	0	0	0	0	XXX

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT
PART 1 - PREMIUMS

Line of Business	1 Direct Business	2 Reinsurance Assumed	3 Reinsurance Ceded	4 Net Premium Income (Cols. 1 + 2 - 3)
1. Comprehensive (hospital and medical)				0
2. Medicare Supplement				0
3. Dental only				0
4. Vision only				0
5. Federal Employees Health Benefits Plan	0			0
6. Title XVIII - Medicare	555,069,677		(96)	555,069,773
7. Title XIX - Medicaid	674,986,491		415,462	674,571,029
8. Other health				0
9. Health subtotal (Lines 1 through 8)	1,230,056,168	0	415,366	1,229,640,802
10. Life	0			0
11. Property/casualty	0			0
12. Totals (Lines 9 to 11)	1,230,056,168	0	415,366	1,229,640,802

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2 - CLAIMS INCURRED DURING THE YEAR

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Payments during the year:										
1.1 Direct	887,247,690						382,865,062	504,382,628		
1.2 Reinsurance assumed	0									
1.3 Reinsurance ceded	1,002,538						218,782	783,756		
1.4 Net	886,245,152	0	0	0	0	0	382,646,280	503,598,872	0	0
2. Paid medical incentive pools and bonuses	76,471,554						41,294,426	35,177,128		
3. Claim liability December 31, current year from Part 2A:										
3.1 Direct	104,094,964	0	0	0	0	0	47,408,829	56,686,135	0	0
3.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
3.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
3.4 Net	104,094,964	0	0	0	0	0	47,408,829	56,686,135	0	0
4. Claim reserve December 31, current year from Part 2D:										
4.1 Direct	288,653						115,672	172,981		
4.2 Reinsurance assumed	0									
4.3 Reinsurance ceded	0									
4.4 Net	288,653	0	0	0	0	0	115,672	172,981	0	0
5. Accrued medical incentive pools and bonuses, current year	23,257,284						9,945,484	13,311,800		
6. Net healthcare receivables (a)	(1,761,008)						47,602	(1,808,610)		
7. Amounts recoverable from reinsurers December 31, current year	1,553,954							1,553,954		
8. Claim liability December 31, prior year from Part 2A:										
8.1 Direct	83,129,310	0	0	0	0	0	32,555,218	50,574,092	0	0
8.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
8.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
8.4 Net	83,129,310	0	0	0	0	0	32,555,218	50,574,092	0	0
9. Claim reserve December 31, prior year from Part 2D:										
9.1 Direct	0									
9.2 Reinsurance assumed	0									
9.3 Reinsurance ceded	0									
9.4 Net	0	0	0	0	0	0	0	0	0	0
10. Accrued medical incentive pools and bonuses, prior year	17,426,184	0	0	0	0	0	6,615,754	10,810,430	0	0
11. Amounts recoverable from reinsurers December 31, prior year	252,686	0	0	0	0	0	5,834	246,852	0	0
12. Incurred Benefits:										
12.1 Direct	910,263,005	0	0	0	0	0	397,786,743	512,476,262	0	0
12.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
12.3 Reinsurance ceded	2,303,806	0	0	0	0	0	212,948	2,090,858	0	0
12.4 Net	907,959,199	0	0	0	0	0	397,573,795	510,385,404	0	0
13. Incurred medical incentive pools and bonuses	82,302,654	0	0	0	0	0	44,624,156	37,678,498	0	0

(a) Excludes \$ 297,531 loans or advances to providers not yet expensed.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2A - CLAIMS LIABILITY END OF CURRENT YEAR

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Reported in Process of Adjustment:										
1.1 Direct	34,913,291						14,564,307	20,348,984		
1.2 Reinsurance assumed	0									
1.3 Reinsurance ceded	0									
1.4 Net	34,913,291	0	0	0	0	0	14,564,307	20,348,984	0	0
2. Incurred but Unreported:										
2.1 Direct	69,181,673						32,844,522	36,337,151		
2.2 Reinsurance assumed	0									
2.3 Reinsurance ceded	0									
2.4 Net	69,181,673	0	0	0	0	0	32,844,522	36,337,151	0	0
3. Amounts Withheld from Paid Claims and Capitulations:										
3.1 Direct	0									
3.2 Reinsurance assumed	0									
3.3 Reinsurance ceded	0									
3.4 Net	0	0	0	0	0	0	0	0	0	0
4. TOTALS:										
4.1 Direct	104,094,964	0	0	0	0	0	47,408,829	56,686,135	0	0
4.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
4.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
4.4 Net	104,094,964	0	0	0	0	0	47,408,829	56,686,135	0	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2B - ANALYSIS OF CLAIMS UNPAID - PRIOR YEAR - NET OF REINSURANCE

Line of Business	Claims Paid During the Year		Claim Reserve and Claim Liability December 31 of Current Year		5 Claims Incurred In Prior Years (Columns 1 + 3)	6 Estimated Claim Reserve and Claim Liability December 31 of Prior Year
	1	2	3	4		
	On Claims Incurred Prior to January 1 of Current Year	On Claims Incurred During the Year	On Claims Unpaid December 31 of Prior Year	On Claims Incurred During the Year		
1. Comprehensive (hospital and medical)					0	0
2. Medicare Supplement					0	0
3. Dental Only					0	0
4. Vision Only					0	0
5. Federal Employees Health Benefits Plan					0	0
6. Title XVIII - Medicare	20,428,695	367,015,594	123,530	47,400,970	20,552,225	32,555,218
7. Title XIX - Medicaid	37,963,740	466,539,948	908,718	55,950,399	38,872,458	50,574,092
8. Other health					0	0
9. Health subtotal (Lines 1 to 8)	58,392,435	833,555,542	1,032,248	103,351,369	59,424,683	83,129,310
10. Healthcare receivables (a)		5,243,085			0	0
11. Other non-health					0	0
12. Medical incentive pools and bonus amounts	23,288,147	53,183,407	3,501,842	19,755,442	26,789,989	17,426,184
13. Totals (Lines 9 - 10 + 11 + 12)	81,680,582	881,495,864	4,534,090	123,106,811	86,214,672	100,555,494

(a) Excludes \$ 0 loans or advances to providers not yet expensed.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Title XVIII

Year in Which Losses Were Incurred		Cumulative Net Amounts Paid				
		1 2012	2 2013	3 2014	4 2015	5 2016
1.	Prior .....	.0	.0	.0	.0	
2.	2012	40,373	47,474	47,196	47,269	47,229
3.	2013 .....	.XXX	192,479	225,978	226,367	225,943
4.	2014 .....	.XXX	.XXX	356,725	403,379	405,503
5.	2015 .....	.XXX	.XXX	.XXX	282,453	314,681
6.	2016 .....	.XXX	.XXX	.XXX	.XXX	390,010

Section B - Incurred Health Claims - Title XVIII

Year in Which Losses Were Incurred		Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
		1 2012	2 2013	3 2014	4 2015	5 2016
1.	Prior .....	.0	.0	.0	.0	.0
2.	2012	47,891	47,474	47,196	47,269	47,229
3.	2013 .....	.XXX	226,262	226,202	226,591	225,943
4.	2014 .....	.XXX	.XXX	396,723	403,626	405,503
5.	2015 .....	.XXX	.XXX	.XXX	321,377	315,098
6.	2016 .....	.XXX	.XXX	.XXX	.XXX	447,063

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Title XVIII

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2012 .....	.61,183	.47,229	.555	1.2	47,784	78.1			47,784	78.1
2. 2013	254,014	225,943	2,519	1.1	228,462	89.9			228,462	89.9
3. 2014	448,681	405,503	4,670	1.2	410,173	91.4			410,173	91.4
4. 2015	378,269	314,681	11,881	3.8	326,562	86.3	.417	.11	326,990	86.4
5. 2016	552,231	390,010	23,513	6.0	413,523	74.9	57,053	1,503	472,079	85.5

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Title XIX

Year in Which Losses Were Incurred		Cumulative Net Amounts Paid				
		1 2012	2 2013	3 2014	4 2015	5 2016
1.	Prior	6,709	6,831	6,626	6,670	6,670
2.	2012	57,956	66,651	66,314	66,274	66,103
3.	2013	XXX	122,702	145,927	146,622	146,378
4.	2014	XXX	XXX	279,658	339,214	339,764
5.	2015	XXX	XXX	XXX	467,494	515,151
6.	2016	XXX	XXX	XXX	XXX	491,486

Section B - Incurred Health Claims - Title XIX

Year in Which Losses Were Incurred		Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
		1 2012	2 2013	3 2014	4 2015	5 2016
1.	Prior	14,401	6,831	6,626	6,670	6,670
2.	2012	67,878	66,651	66,313	66,274	66,103
3.	2013	XXX	141,269	146,410	146,622	146,378
4.	2014	XXX	XXX	337,752	339,521	339,764
5.	2015	XXX	XXX	XXX	527,560	519,268
6.	2016	XXX	XXX	XXX	XXX	557,540

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Title XIX

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2012	87,228	66,103	408	0.6	66,511	76.2			66,511	76.2
2. 2013	169,427	146,378	1,535	1.0	147,913	87.3			147,913	87.3
3. 2014	385,937	339,764	4,760	1.4	344,524	89.3			344,524	89.3
4. 2015	607,022	515,151	15,337	3.0	530,488	87.4	4,117	106	534,711	88.1
5. 2016	661,629	491,486	22,903	4.7	514,389	77.7	66,054	1,700	582,143	88.0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Grand Total

Year in Which Losses Were Incurred		Cumulative Net Amounts Paid				
		1 2012	2 2013	3 2014	4 2015	5 2016
1.	Prior	6,709	6,831	6,626	6,670	6,670
2.	2012	98,329	114,125	113,510	113,543	113,332
3.	2013	XXX	315,181	371,905	372,989	372,321
4.	2014	XXX	XXX	636,383	742,593	745,267
5.	2015	XXX	XXX	XXX	749,947	829,832
6.	2016	XXX	XXX	XXX	XXX	881,496

Section B - Incurred Health Claims - Grand Total

Year in Which Losses Were Incurred		Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
		1 2012	2 2013	3 2014	4 2015	5 2016
1.	Prior	14,401	6,831	6,626	6,670	6,670
2.	2012	115,769	114,125	113,509	113,543	113,332
3.	2013	XXX	367,531	372,612	373,213	372,321
4.	2014	XXX	XXX	734,475	743,147	745,267
5.	2015	XXX	XXX	XXX	848,937	834,366
6.	2016	XXX	XXX	XXX	XXX	1,004,603

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Grand Total

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2012	148,411	113,332	963	0.8	114,295	77.0	0	0	114,295	77.0
2. 2013	423,441	372,321	4,054	1.1	376,375	88.9	0	0	376,375	88.9
3. 2014	834,618	745,267	9,430	1.3	754,697	90.4	0	0	754,697	90.4
4. 2015	985,291	829,832	27,218	3.3	857,050	87.0	4,534	117	861,701	87.5
5. 2016	1,213,860	881,496	46,416	5.3	927,912	76.4	123,107	3,203	1,054,222	86.8

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2D - AGGREGATE RESERVE FOR ACCIDENT AND HEALTH CONTRACTS ONLY

	1	2	3	4	5	6	7	8	9
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
1. Unearned premium reserves	0								
2. Additional policy reserves (a)	0								
3. Reserve for future contingent benefits	0								
4. Reserve for rate credits or experience rating refunds (including \$) for investment income	20,087,431						4,286,778	15,800,653	
5. Aggregate write-ins for other policy reserves	2,133,087	0	0	0	0	0	2,133,087	0	0
6. Totals (gross)	22,220,518	0	0	0	0	0	6,419,865	15,800,653	0
7. Reinsurance ceded	0								
8. Totals (Net)(Page 3, Line 4)	22,220,518	0	0	0	0	0	6,419,865	15,800,653	0
9. Present value of amounts not yet due on claims	0								
10. Reserve for future contingent benefits	288,653						115,672	172,981	
11. Aggregate write-ins for other claim reserves	0	0	0	0	0	0	0	0	0
12. Totals (gross)	288,653	0	0	0	0	0	115,672	172,981	0
13. Reinsurance ceded	0								
14. Totals (Net)(Page 3, Line 7)	288,653	0	0	0	0	0	115,672	172,981	0
DETAILS OF WRITE-INS									
0501. Risk Adjustment Retermination	2,133,087						2,133,087		
0502.									
0503.									
0598. Summary of remaining write-ins for Line 5 from overflow page.....	0	0	0	0	0	0	0	0	0
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above)	2,133,087	0	0	0	0	0	2,133,087	0	0
1101.									
1102.									
1103.									
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0	0	0	0	0	0
1199. Totals (Lines 1101 thru 1103 plus 1198) (Line 11 above)	0	0	0	0	0	0	0	0	0

(a) Includes \$ premium deficiency reserve.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.
UNDERWRITING AND INVESTMENT EXHIBIT

	PART 3 - ANALYSIS OF EXPENSES		3	4	5
	1	2			
	Claim Adjustment Expenses				
	1	2	3	4	5
	Cost	Other Claim	General	Investment	Total
	Containment	Adjustment	Administrative	Expenses	
	Expenses	Expenses	Expenses		
1. Rent (\$ for occupancy of own building)	9	11,508	2,008,076	4,041	2,023,634
2. Salary, wages and other benefits	28,194,767	11,581,590	20,542,507	41,344	60,360,208
3. Commissions (less \$ ceded plus \$ assumed)	0	0	4,426,106	0	4,426,106
4. Legal fees and expenses	39,364	410	31,478	63	71,315
5. Certifications and accreditation fees					0
6. Auditing, actuarial and other consulting services	782,211	554,937	526,817	1,060	1,865,025
7. Traveling expenses	309,734	29,121	720,803	1,451	1,061,109
8. Marketing and advertising	49,339	36,408	8,669,994	17,449	8,773,190
9. Postage, express and telephone	517,102	230,586	1,322,103	2,661	2,072,452
10. Printing and office supplies	57,105	814,272	143,558	289	1,015,224
11. Occupancy, depreciation and amortization					0
12. Equipment	(1,430)	(19,570)	439,796	885	419,681
13. Cost or depreciation of EDP equipment and software	291,919	1,219,778	3,668,091	7,382	5,187,170
14. Outsourced services including EDP, claims, and other services	913,471	1,185,753	1,331,990	2,681	3,433,895
15. Boards, bureaus and association fees	0		52,340	105	52,445
16. Insurance, except on real estate	0	77	418,329	842	419,248
17. Collection and bank service charges	0		103,168	209	103,377
18. Group service and administration fees					0
19. Reimbursements by uninsured plans					0
20. Reimbursements from fiscal intermediaries					0
21. Real estate expenses	21	0	801,966	1,614	803,601
22. Real estate taxes					0
23. Taxes, licenses and fees:					
23.1 State and local insurance taxes	557	0	6,554,370	0	6,554,927
23.2 State premium taxes					0
23.3 Regulatory authority licenses and fees	70,729	117	96,302	0	167,148
23.4 Payroll taxes	1,793,690	736,102	1,118,776	0	3,648,568
23.5 Other (excluding federal income and real estate taxes)	0	0	20,149,748	0	20,149,748
24. Investment expenses not included elsewhere				92,669	92,669
25. Aggregate write-ins for expenses	2,542	4,722,456	1,387,912	2,793	6,115,703
26. Total expenses incurred (Lines 1 to 25)	33,021,130	21,103,545	74,514,230	177,538	(a) .....128,816,443
27. Less expenses unpaid December 31, current year ..		3,319,239	1,426,657		4,745,896
28. Add expenses unpaid December 31, prior year	2,035,598	741,481	10,706,031	0	13,483,110
29. Amounts receivable relating to uninsured plans, prior year	0	0	432,708	0	432,708
30. Amounts receivable relating to uninsured plans, current year			502,605		502,605
31. Total expenses paid (Lines 26 minus 27 plus 28 minus 29 plus 30)	35,056,728	18,525,787	83,863,501	177,538	137,623,554
DETAILS OF WRITE-INS					
2501. Pharmacy Admin Fee		4,050,231			4,050,231
2502. Non Income Tax Penalties			1,087,188		1,087,188
2503. Miscellaneous	2,542	672,225	300,724	2,793	978,284
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	2,542	4,722,456	1,387,912	2,793	6,115,703

(a) Includes management fees of \$100,869,002 to affiliates and \$ to non-affiliates.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

EXHIBIT OF NET INVESTMENT INCOME

		1	2
		Collected During Year	Earned During Year
1.	U.S. government bonds	(a) .....	.....
1.1	Bonds exempt from U.S. tax	(a) .....	.....
1.2	Other bonds (unaffiliated)	(a) .....1,633,186	.....1,682,426
1.3	Bonds of affiliates	(a) .....	.....
2.1	Preferred stocks (unaffiliated)	(b) .....	.....
2.11	Preferred stocks of affiliates	(b) .....	.....
2.2	Common stocks (unaffiliated) .....	.....	.....
2.21	Common stocks of affiliates .....	.....	.....
3.	Mortgage loans	(c) .....	.....
4.	Real estate	(d) .....	.....
5	Contract Loans .....	.....	.....
6	Cash, cash equivalents and short-term investments	(e) .....18,422	.....28,872
7	Derivative instruments	(f) .....	.....
8.	Other invested assets .....	.....	.....
9.	Aggregate write-ins for investment income .....	.....10,690	.....10,690
10.	Total gross investment income	1,662,298	1,721,988
11.	Investment expenses	(g) .....177,538	
12.	Investment taxes, licenses and fees, excluding federal income taxes	(g) .....0	
13.	Interest expense	(h)	
14.	Depreciation on real estate and other invested assets	(i)	
15.	Aggregate write-ins for deductions from investment income .....	.....0	
16.	Total deductions (Lines 11 through 15) .....	.....177,538	
17.	Net investment income (Line 10 minus Line 16)	1,544,450	
DETAILS OF WRITE-INS			
0901.	Miscellaneous Income .....	.....10,690	.....10,690
0902.	.....	.....	.....
0903.	.....	.....	.....
0998.	Summary of remaining write-ins for Line 9 from overflow page .....	.....0	.....0
0999.	Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)	10,690	10,690
1501.	.....	
1502.	.....	
1503.	.....	
1598.	Summary of remaining write-ins for Line 15 from overflow page .....		.....0
1599.	Totals (Lines 1501 thru 1503 plus 1598) (Line 15, above)		0

- (a) Includes \$11,083 accrual of discount less \$890,181 amortization of premium and less \$22,792 paid for accrued interest on purchases.
- (b) Includes \$ accrual of discount less \$ amortization of premium and less \$ paid for accrued dividends on purchases.
- (c) Includes \$ accrual of discount less \$ amortization of premium and less \$ paid for accrued interest on purchases.
- (d) Includes \$ for company's occupancy of its own buildings; and excludes \$ interest on encumbrances.
- (e) Includes \$0 accrual of discount less \$1,818 amortization of premium and less \$ paid for accrued interest on purchases.
- (f) Includes \$ accrual of discount less \$ amortization of premium.
- (g) Includes \$. investment expenses and \$ investment taxes, licenses and fees, excluding federal income taxes, attributable to segregated and Separate Accounts.
- (h) Includes \$ interest on surplus notes and \$ interest on capital notes.
- (i) Includes \$ depreciation on real estate and \$ depreciation on other invested assets.

EXHIBIT OF CAPITAL GAINS (LOSSES)

		1	2	3	4	5
		Realized Gain (Loss) On Sales or Maturity	Other Realized Adjustments	Total Realized Capital Gain (Loss) (Columns 1 + 2)	Change in Unrealized Capital Gain (Loss)	Change in Unrealized Foreign Exchange Capital Gain (Loss)
1.	U.S. Government bonds .....	.....0	.....0	.....0	.....0	.....0
1.1	Bonds exempt from U.S. tax .....	.....	.....	.....0	.....	.....
1.2	Other bonds (unaffiliated) .....	.....1,809	.....0	.....1,809	.....(352,772)	.....0
1.3	Bonds of affiliates .....	.....0	.....0	.....0	.....0	.....0
2.1	Preferred stocks (unaffiliated) .....	.....0	.....0	.....0	.....0	.....0
2.11	Preferred stocks of affiliates .....	.....0	.....0	.....0	.....0	.....0
2.2	Common stocks (unaffiliated) .....	.....0	.....0	.....0	.....0	.....0
2.21	Common stocks of affiliates .....	.....0	.....0	.....0	.....0	.....0
3.	Mortgage loans .....	.....	.....0	.....0	.....0	.....0
4.	Real estate .....	.....	.....0	.....0	.....	.....0
5.	Contract loans .....	.....	.....	.....0	.....	.....
6.	Cash, cash equivalents and short-term investments .....	.....	.....	.....0	.....	.....
7.	Derivative instruments .....	.....	.....	.....0	.....	.....
8.	Other invested assets .....	.....	.....0	.....0	.....0	.....0
9.	Aggregate write-ins for capital gains (losses) .....	.....0	.....0	.....0	.....0	.....0
10.	Total capital gains (losses)	1,809	0	1,809	(352,772)	0
DETAILS OF WRITE-INS						
0901.	.....				
0902.	.....				
0903.	.....				
0998.	Summary of remaining write-ins for Line 9 from overflow page .....	.....0	.....0	.....0	.....0	.....0
0999.	Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)	0	0	0	0	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

EXHIBIT OF NON-ADMITTED ASSETS

	1	2	3
	Current Year Total Nonadmitted Assets	Prior Year Total Nonadmitted Assets	Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
1. Bonds (Schedule D)		0	0
2. Stocks (Schedule D):			
2.1 Preferred stocks		0	0
2.2 Common stocks		0	0
3. Mortgage loans on real estate (Schedule B):			
3.1 First liens		0	0
3.2 Other than first liens		0	0
4. Real estate (Schedule A):			
4.1 Properties occupied by the company		0	0
4.2 Properties held for the production of income		0	0
4.3 Properties held for sale		0	0
5. Cash (Schedule E - Part 1), cash equivalents (Schedule E - Part 2) and short-term investments (Schedule DA)		0	0
6. Contract loans		0	0
7. Derivatives (Schedule DB)		0	0
8. Other invested assets (Schedule BA)		0	0
9. Receivables for securities		0	0
10. Securities lending reinvested collateral assets (Schedule DL)		0	0
11. Aggregate write-ins for invested assets	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	0	0	0
13. Title plants (for Title insurers only)		0	0
14. Investment income due and accrued		2,054	2,054
15. Premiums and considerations:			
15.1 Uncollected premiums and agents' balances in the course of collection		0	0
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due		0	0
15.3 Accrued retrospective premiums and contracts subject to redetermination		0	0
16. Reinsurance:			
16.1 Amounts recoverable from reinsurers		0	0
16.2 Funds held by or deposited with reinsured companies		0	0
16.3 Other amounts receivable under reinsurance contracts		0	0
17. Amounts receivable relating to uninsured plans		0	0
18.1 Current federal and foreign income tax recoverable and interest thereon		0	0
18.2 Net deferred tax asset	9,493	3,852,709	3,843,216
19. Guaranty funds receivable or on deposit		0	0
20. Electronic data processing equipment and software	854,973	3,047,274	2,192,301
21. Furniture and equipment, including health care delivery assets	855,016	9,325,353	8,470,337
22. Net adjustment in assets and liabilities due to foreign exchange rates		0	0
23. Receivable from parent, subsidiaries and affiliates	713,672	0	(713,672)
24. Health care and other amounts receivable	3,564,586	4,374,668	810,082
25. Aggregate write-ins for other than invested assets	4,113,535	4,866,378	752,843
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	10,111,275	25,468,436	15,357,161
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts		0	0
28. Total (Lines 26 and 27)	10,111,275	25,468,436	15,357,161
DETAILS OF WRITE-INS			
1101.			
1102.			
1103.			
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0
1199. Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	0	0	0
2501. Goodwill	3,128,663	3,128,663	0
2502. Deposits	845,498	972,419	126,921
2503. Prepaid Expenses-	85,386	765,296	679,910
2598. Summary of remaining write-ins for Line 25 from overflow page	53,988	0	(53,988)
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	4,113,535	4,866,378	752,843

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

EXHIBIT 1 - ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS ONLY

Source of Enrollment	Total Members at End of					6 Current Year Member Months
	1 Prior Year	2 First Quarter	3 Second Quarter	4 Third Quarter	5 Current Year	
1. Health Maintenance Organizations	116,224	126,060	125,831	129,161	133,053	1,538,368
2. Provider Service Organizations						
3. Preferred Provider Organizations						
4. Point of Service						
5. Indemnity Only						
6. Aggregate write-ins for other lines of business.....	0	0	0	0	0	0
7. Total	116,224	126,060	125,831	129,161	133,053	1,538,368
DETAILS OF WRITE-INS						
0601.						
0602.						
0603.						
0698. Summary of remaining write-ins for Line 6 from overflow page	0	0	0	0	0	0
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	0	0	0	0	0

EXHIBIT 2 - ACCIDENT AND HEALTH PREMIUMS DUE AND UNPAID

[illegible]

EXHIBIT 3 - HEALTH CARE RECEIVABLES

1 Name of Debtor	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 Over 90 Days	6 Nonadmitted	7 Admitted
0199998. Aggregate Pharmaceutical Rebate Receivables Not Individually Listed	3,263,845				1,585,346	1,678,499
0199999. Total Pharmaceutical Rebate Receivables	3,263,845	0	0	0	1,585,346	1,678,499
0299998. Aggregate Claim Overpayment Receivables Not Individually Listed	132,959	58,356	34,001	722,908	948,224	
0299999. Total Claim Overpayment Receivables	132,959	58,356	34,001	722,908	948,224	0
0399998. Aggregate Loans and Advances to Providers Not Individually Listed						
0399999. Total Loans and Advances to Providers	0	0	0	0	0	0
0499998. Aggregate Capitation Arrangement Receivables Not Individually Listed						
0499999. Total Capitation Arrangement Receivables	0	0	0	0	0	0
0599998. Aggregate Risk Sharing Receivables Not Individually Listed	22,908	19,204		983,585	1,025,697	
0599999. Total Risk Sharing Receivables	22,908	19,204	0	983,585	1,025,697	0
0699998. Aggregate Other Receivables Not Individually Listed	5,319				5,319	
0699999. Total Other Receivables	5,319	0	0	0	5,319	0
0799999 Gross health care receivables	3,425,031	77,560	34,001	1,706,493	3,564,586	1,678,499

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

EXHIBIT 3A - ANALYSIS OF HEALTH CARE RECEIVABLES COLLECTED AND ACCRUED

Type of Health Care Receivable	Health Care Receivables Collected During the Year		Health Care Receivables Accrued as of December 31 of Current Year		5	6
	1 On Amounts Accrued Prior to January 1 of Current Year	2 On Amounts Accrued During the Year	3 On Amounts Accrued December 31 of Prior Year	4 On Amounts Accrued During the Year	Health Care Receivables in Prior Years (Columns 1 + 3)	Estimated Health Care Receivables Accrued as of December 31 of Prior Year
1. Pharmaceutical rebate receivables	2,439,913	4,094,143		3,263,845	2,439,913	2,439,913
2. Claim overpayment receivables	3,518,721	3,983,370		948,224	3,518,721	3,518,721
3. Loans and advances to providers					0	0
4. Capitation arrangement receivables					0	0
5. Risk sharing receivables	987,711			1,025,697	987,711	987,711
6. Other health care receivables.....	57,748			5,319	57,748	57,748
7. Totals (Lines 1 through 6)	7,004,093	8,077,513	0	5,243,085	7,004,093	7,004,093

Note that the accrued amounts in Columns 3, 4, and 6 are the total health care receivables, not just the admitted portion.

EXHIBIT 4 - CLAIMS UNPAID AND INCENTIVE POOL, WITHHOLD AND BONUS (Reported and Unreported)

[illegible]

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

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EXHIBIT 7 PART 1- SUMMARY OF TRANSACTIONS WITH PROVIDERS

	1	2	3	4	5	6
Payment Method	Direct Medical Expense Payment	Column 1 as a % of Total Payments	Total Members Covered	Column 3 as a % of Total Members	Column 1 Expenses Paid to Affiliated Providers	Column 1 Expenses Paid to Non-Affiliated Providers
Capitation Payments:						
1. Medical groups	87,785,839	9.1	133,053	100.0		87,785,839
2. Intermediaries	0	0.0		0.0		
3. All other providers	47,068,108	4.9	133,053	100.0		47,068,108
4. Total capitation payments	134,853,947	14.0	266,106	200.0	0	134,853,947
Other Payments:						
5. Fee-for-service	0	0.0	XXX	XXX		
6. Contractual fee payments	754,154,751	78.1	XXX	XXX		754,154,751
7. Bonus/withhold arrangements - fee-for-service	0	0.0	XXX	XXX		
8. Bonus/withhold arrangements - contractual fee payments	76,471,555	7.9	XXX	XXX		76,471,555
9. Non-contingent salaries	0	0.0	XXX	XXX		
10. Aggregate cost arrangements	0	0.0	XXX	XXX		
11. All other payments	0	0.0	XXX	XXX		
12. Total other payments	830,626,306	86.0	XXX	XXX	0	830,626,306
13. TOTAL (Line 4 plus Line 12)	965,480,253	100%	XXX	XXX	0	965,480,253

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1	2	3	4	5	6
NAIC Code	Name of Intermediary	Capitation Paid	Average Monthly Capitation	Intermediary's Total Adjusted Capital	Intermediary's Authorized Control Level RBC
NONE					
9999999 Totals			XXX	XXX	XXX

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

EXHIBIT 8 - FURNITURE, EQUIPMENT AND SUPPLIES OWNED

Description	1 Cost	2 Improvements	3 Accumulated Depreciation	4 Book Value Less Encumbrances	5 Assets Not Admitted	6 Net Admitted Assets
1. Administrative furniture and equipment	4,713,436		(3,858,421)	855,016	855,016	
2. Medical furniture, equipment and fixtures						
3. Pharmaceuticals and surgical supplies						
4. Durable medical equipment						
5. Other property and equipment						
6. Total	4,713,436	0	(3,858,421)	855,016	855,016	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies and Going Concern

A. Accounting Practices

The accompanying financial statements of Simply Healthcare Plans, Inc. (the “Company”) have been prepared in conformity with the National Association of Insurance Commissioners’ (“NAIC”) *Annual Statement Instructions* and in accordance with accounting practices prescribed by the NAIC *Accounting Practice and Procedures Manual* (“NAIC SAP”), subject to any deviations prescribed or permitted by the Florida Office of Insurance Regulation (“Florida OIR”).

The Florida OIR state prescribed practice does not allow parent and affiliate receivables to be admitted assets. A reconciliation of the Company’s net income and capital and surplus between NAIC SAP and practices prescribed and permitted by the Florida OIR is shown below:

	SSAP #	F/S Page	F/S Line #	2016	2015
<u>Net Income</u>					
(1) Simply Healthcare Plans, Inc. state basis (Page 4, Line 32, Columns 2 & 3)	XXX	XXX	XXX	\$ 55,584,861	\$ 21,810,919
(2) States Prescribed Practices that increase(decrease) NAIC SAP:	Florida statute 641.35 (3)(a)	4	13	(6,998)	(204,308)
(3) State Permitted Practices that increase(decrease) NAIC SAP:				-	-
(4) NAIC SAP (1 - 2 - 3 = 4)	XXX	XXX	XXX	\$ 55,591,859	\$ 22,015,227
<u>Surplus</u>					
(5) Simply Healthcare Plans, Inc. state basis (Page 3, Line 33, Columns 3 & 4)	XXX	XXX	XXX	\$ 113,394,744	\$ 46,117,218
(6) States Prescribed Practices that increase(decrease) NAIC SAP:	Florida statute 641.35 (2)(i)	2	23	(713,672)	-
(7) State Permitted Practices that increase(decrease) NAIC SAP:	Florida statute 641.35 (3)(a)	4	13	(211,306)	(204,308)
(8) NAIC SAP (5 - 6 - 7 = 8)	XXX	XXX	XXX	\$ 114,319,722	\$ 46,321,526

B. Use of Estimates in the Preparation of the Financial Statements

Preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

C. Accounting Policies

Health premium revenues, based on membership records and premiums rates for each membership category within each county, are recognized as revenue during the period in which the Company is obligated to provide service to members. Premiums are reported net of excess loss reinsurance ceded and experience rating refunds. Premiums paid before the effective service month are recorded on the balance sheet as premiums received in advance and are subsequently credited to income as earned during the coverage period. Premium rates are subject to approval by Florida OIR and the Centers for Medicare and Medicaid Services (“CMS”). Costs, such as premium taxes and other underwriting expenses are charged to operations as incurred.

In addition, the Company uses the following accounting policies:

- (1)

Short-term investments include investments with maturities of less than one year at the date of acquisition and are reported at amortized cost, which approximates fair value. Non-investment grade short-term investments are stated at the lower of amortized cost or fair value
- (2)

Investment grade bonds not backed by other loans are stated at amortized cost, with amortization calculated based on the modified scientific method, using lower of yield to call or yield to maturity. Non-investment grade bonds are stated at the lower of amortized cost or fair value as determined by various third-party pricing sources.
- (3)

The Company has no investments in common stocks of unaffiliated companies.
- (4)

The Company has no preferred stocks.
- (5)

The Company has no mortgage loans – real estate.
- (6)

Loan-backed securities are stated at amortized cost. Prepayment assumptions for loan-backed securities and structured securities were obtained from broker-dealer survey values or internal estimates. These assumptions are consistent with the current interest rate and economic environment. The retrospective adjustment method is used to value all loan-backed securities. Non-investment grade loan-backed securities are stated at the lower of amortized cost or fair value.
- (7)

The Company has no investment in subsidiaries, controlled and affiliated companies.
- (8)

The Company has no investment in joint ventures, partnerships and limited liability companies.
- (9)

The Company has no derivative instruments.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

- (10) The Company does not anticipate investment income as a factor in premium deficiency calculations.
- (11) Unpaid claims and claims adjustment expenses include management’s best estimate of amounts based on historical claim development patterns and certain individual case estimates. The established liability considers health benefit provisions, business practices, economic conditions and other factors that may materially affect the cost, frequency and severity of claims. Liabilities for unpaid claims and claim adjustment expenses are based on assumptions and estimates, and while management believes such estimates are reasonable, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed and changes in estimates are incorporated into current period estimates.
- (12) The Company has not modified its capitalization policy from the prior period.
- (13) Pharmacy rebate receivables are recorded when earned based upon actual rebate receivables billed and an estimate of receivables based upon current utilization of specific pharmaceuticals and provider contract terms.

D. Going Concern

Not applicable.

2. Accounting Changes and Corrections of Errors

There were no accounting changes or corrections of errors during the years ended December 31, 2016 and 2015.

3. Business Combinations and Goodwill

- | | |
|------------------------------|-----------------|
| A. Statutory Purchase Method | Not applicable. |
| B. Statutory Merger | Not applicable. |
| C. Assumption Reinsurance | Not applicable. |
| D. Impairment Loss | Not applicable. |

4. Discontinued Operations

The Company had no operations that were discontinued during 2016 or 2015.

5. Investments

A. Mortgage Loans, including Mezzanine Real Estate Loans

The Company did not have investments in mortgage loans at December 31, 2016 or 2015.

B. Debt Restructuring

The Company did not have invested assets that were restructured debt at December 31, 2016 or 2015.

C. Reverse Mortgages

The Company did not have investments in reverse mortgages at December 31, 2016 or 2015.

D. Loan-Backed Securities

- (1) Prepayment assumptions for single-class and multi-class mortgage-backed and asset-backed securities were obtained from broker-dealer survey values or internal estimates. The Company used various third-party pricing sources in determining the market value of its loan-back securities.
- (2) The Company did not recognize other-than-temporary impairments on its loan-backed securities during the years ended December 31, 2016 and 2015.
- (3) The Company did not recognize other-than-temporarily impairments on its loan-backed securities at December 31, 2016 and 2015.
- (4) The Company had no impaired securities for which an other-than-temporary impairment had not been recognized in earnings as a realized loss at December 31, 2016 and 2015.
- (5) The Company had no impaired loan-backed securities at December 31, 2016 and 2015.

E. Repurchase Agreements and/or Securities Lending Transactions

The Company did not enter into repurchase agreements or securities lending transactions at December 31, 2016 or 2015.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

F. Real Estate

The Company did not have investments in real estate and did not engage in retail land sales operations during 2016 or 2015.

G. Investments in Low-Income Housing Tax Credits

The Company did not invest in properties generating low-income housing tax credits during 2016 or 2015.

H. Restricted Assets

(1) Restricted assets (including pledged)

	1	2	3	4	5	6	7
Restricted Asset Category	Total Gross (Admitted & Nonadmitted) Restricted From Current Year	Total Gross (Admitted & Nonadmitted) Restricted From Prior Year	Increase/ (Decrease) (1 minus 2)	Total Current Year Nonadmitted Restricted	Total Current Year Admitted Restricted (1 minus 4)	Gross Admitted and Nonadmitted Restricted to Total Assets (a)	Admitted Restricted to Total Admitted Assets (b)
a. Subject to contractual obligation for which liability is not shown	\$ -	\$ -	\$ -	\$ -	-	-	-
b. Collateral held under security lending agreements	-	-	-	-	-	-	-
c. Subject to repurchase agreements	-	-	-	-	-	-	-
d. Subject to reverse repurchase agreements	-	-	-	-	-	-	-
e. Subject to dollar repurchase agreements	-	-	-	-	-	-	-
f. Subject to dollar reverse repurchase agreements	-	-	-	-	-	-	-
g. Placed under option contracts	-	-	-	-	-	-	-
h. Letter stock or securities restricted as to sale - excluding FHLB capital stock	-	-	-	-	-	-	-
i. FHLB capital stock	-	-	-	-	-	-	-
j. On deposit with states	310,000	310,000	-	-	310,000	0.10%	0.11%
k. On deposit with other regulatory bodies	15,562,916	15,562,916	-	-	15,562,916	5.12%	5.29%
l. Pledged collateral to FHLB (including assets backing funding agreements)	-	-	-	-	-	-	-
m. Pledged as collateral not captured in other categories	-	-	-	-	-	-	-
n. Other restricted assets	-	-	-	-	-	-	-
o. Total Restricted Assets	\$ 15,872,916	\$ 15,872,916	\$ -	\$ -	\$ 15,872,916	5.22%	5.40%

(a) Column 1 divided by Asset Page, Column 1, Line 28
(b) Column 5 divided by Asset Page, Column 3, Line 28

- (2) Not applicable.
- (3) Not applicable.
- (4) Not applicable.

I. Working Capital Finance Investments

The Company did not have any working capital finance investments as December 31, 2016 and 2015.

J. Offsetting and Netting of Assets and Liabilities

The Company did not have any offsetting and netting of assets and liabilities at December 31, 2016 and 2015.

K. Structured Notes

The Company did not have any structured notes at December 31, 2016 and 2015.

L. 5*Securities

The Company has no 5* Securities as of December 31, 2016 and 2015.

6. Joint Ventures, Partnerships and Limited Liability Companies

- A. The Company has no investments in joint ventures, partnerships, or limited liability companies that exceeded 10% of its admitted assets at December 31, 2016 or 2015.
- B. The Company did not recognize impairment write downs for its investments in joint ventures, partnerships or limited liability companies during 2016 or 2015.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

7. Investment Income

- A. All investment income due and accrued with amounts that are over 90 days past due is non-admitted.
- B. At December 31, 2016 and 2015, there was no non-admitted accrued investment interest income.

8. Derivative Instruments

The Company has no derivative instruments.

9. Income Taxes

- A. The components of net deferred tax assets (liabilities):

(1) The components of net deferred tax asset (liabilities) at December 31 are as follows:

12/31/2016			
(1)	(2)	(3)	
Ordinary	Capital	(Col 1+2) Total	
(a) Gross deferred tax assets	\$ 5,024,036	117,394	\$ 5,141,430
(b) Statutory valuation allowance adjustments	-	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	5,024,036	117,394	5,141,430
(d) Deferred tax assets nonadmitted	9,493	-	9,493
(e) Subtotal net admitted deferred tax asset (1c - 1d)	5,014,543	117,394	5,131,937
(f) Deferred tax liabilities	1,077,222	-	1,077,222
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	\$ 3,937,321	\$ 117,394	\$ 4,054,715

12/31/2015			
(4)	(5)	(6)	
Ordinary	Capital	(Col 4+5) Total	
(a) Gross deferred tax assets	\$ 7,877,363	\$ -	\$ 7,877,363
(b) Statutory valuation allowance adjustments	-	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	7,877,363	-	7,877,363
(d) Deferred tax assets nonadmitted	3,852,086	-	3,852,086
(e) Subtotal net admitted deferred tax asset (1c - 1d)	4,025,277	-	4,025,277
(f) Deferred tax liabilities	499,970	2,084	502,054
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	\$ 3,525,307	\$ (2,084)	\$ 3,523,223

Change			
(7)	(8)	(9)	
(Col 1-4) Ordinary	(Col 2-5) Capital	(Col 7+8) Total	
(a) Gross deferred tax assets	\$ (2,853,327)	\$ 117,394	\$ (2,735,933)
(b) Statutory valuation allowance adjustments	-	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	(2,853,327)	117,394	(2,735,933)
(d) Deferred tax assets nonadmitted	(3,842,593)	-	(3,842,593)
(e) Subtotal net admitted deferred tax asset (1c - 1d)	989,266	117,394	1,106,660
(f) Deferred tax liabilities	577,252	(2,084)	575,168
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	\$ 412,014	\$ 119,478	\$ 531,492

(2) The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101, *Income Taxes - A Replacement of SSAP No. 10R and SSAP 10* ("SSAP No. 101") as of December 31 is as follows:

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				12/31/2016		
				(1)	(2)	(3)
				Ordinary	Capital	(Col 1+2) Total
Admission Calculation Components SSAP No. 101						
(a)	Federal income taxes paid in prior years recoverable through loss carrybacks	\$	3,619,893	\$	20,605	\$ 3,640,498
(b)	Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation (the lesser of 2(b)1 and 2(b)2 below)		317,428		96,789	414,217
	1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date		317,428		96,789	414,217
	2. Adjusted gross deferred tax assets allowed per limitation threshold		XXX		XXX	16,164,737
(c)	Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities		1,077,222		-	1,077,222
(d)	Deferred tax assets admitted as the result of application of SSAP No. 101. Total 2(a) + 2(b) + 2(c))	\$	5,014,543	\$	117,394	\$ 5,131,937

				12/31/2015		
				(4)	(5)	(6)
				Ordinary	Capital	(Col 4+5) Total
Admission Calculation Components SSAP No. 101						
(a)	Federal income taxes paid in prior years recoverable through loss carrybacks	\$	3,233,312	\$	-	\$ 3,233,312
(b)	Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation (the lesser of 2(b)1 and 2(b)2 below)		289,911		-	289,911
	1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date		289,911		-	289,911
	2. Adjusted gross deferred tax assets allowed per limitation threshold		XXX		XXX	6,205,578
(c)	Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities		502,054		-	502,054
(d)	Deferred tax assets admitted as the result of application of SSAP No. 101. Total 2(a) + 2(b) + 2(c))	\$	4,025,277	\$	-	\$ 4,025,277

				Change		
				(7)	(8)	(9)
				(Col 1-4) Ordinary	(Col 2-5) Capital	(Col 7+8) Total

Admission Calculation Components SSAP No. 101

(a)	Federal income taxes paid in prior years recoverable through loss carrybacks	\$	386,581	\$	20,605	\$	407,186
(b)	Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation (the lesser of 2(b)1 and 2(b)2 below)		27,517		96,789		124,306
	1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date		27,517		96,789		124,306
	2. Adjusted gross deferred tax assets allowed per limitation threshold		XXX		XXX		9,959,159
(c)	Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities		575,168		-		575,168
(d)	Deferred tax assets admitted as the result of application of SSAP No. 101. Total 2(a) + 2(b) + 2(c))	\$	989,266	\$	117,394	\$	1,106,660

(3)	2016	2015
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)2 above	\$ 107,764,916	\$ 41,370,523

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

(4) Impact of tax planning strategies

	12/31/2016		12/31/2015		Change	
	(1)	(2)	(3)	(4)	(5)	(6)
	Ordinary	Capital	Ordinary	Capital	(Col 1-3) Ordinary	(Col 2-4) Capital
(a) Determination of adjusted gross deferred tax assets and net admitted deferred tax assets by tax character as a percentage						
1 Adjusted gross DTAs amount from Note 9A1(c)	\$ 5,024,036	\$ 117,394	\$ 7,877,363	\$ -	\$ (2,853,327)	\$ 117,394
2 Percentage of adjusted gross DTAs by tax character attributable to the impact of tax planning strategies	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
3 Net admitted adjusted gross DTAs amount from Note 9A1(e)	\$ 5,014,543	\$ 117,394	\$ 4,025,277	\$ -	\$ 989,266	\$ 117,394
4 Percentage of net admitted adjusted gross DTAs by tax character admitted because of the impact of tax planning strategies	21.48%	0.00%	0.00%	0.00%	21.48%	0.00%
(b) Does the Company's tax-planning strategies include the use of reinsurance?			Yes		No	X

B. The Company has no unrecognized deferred tax liabilities at December 31, 2016 and 2015.

C. Current income taxes incurred consist of the following major components:

	(1)	(2)	(3)
	12/31/2016	12/31/2015	(Col 1-2) Change
(1) Current Income Tax			
(a) Federal	\$ 40,877,131	\$ 20,301,937	\$ 20,575,194
(b) Foreign	-	-	-
(c) Subtotal	40,877,131	20,301,937	20,575,194
(d) Federal income tax expense on net capital gains	744	-	744
(e) Utilization of capital loss carry-forwards	-	-	-
(f) Other	-	-	-
(g) Federal and foreign income taxes incurred	\$ 40,877,875	\$ 20,301,937	\$ 20,575,938
(2) Deferred Tax Assets:			
(a) Ordinary			
(1) Discounting of unpaid losses	\$ 342,321	\$ 300,037	\$ 42,284
(2) Unearned premium reserve	-	-	-
(3) Policyholder reserves	1,365,000	-	1,365,000
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	133,129	3,009,524	(2,876,395)
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables - nonadmitted	1,812,210	1,871,480	(59,270)
(11) Net operating loss carryforward	-	-	-
(12) Tax credit carry-forward	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	4,935	202,386	(197,451)
(14) Accrued future expenses	55,650	-	55,650
(15) Amortization	1,280,906	1,770,705	(489,799)
(16) Partnership income	-	-	-
(17) Premium deficiency reserves	-	-	-
(18) Prepaid expenses	29,885	267,854	(237,969)
(19) Stock Compensation	-	456,000	(456,000)
(99) Subtotal	5,024,036	7,877,986	(2,853,950)
(b) Statutory valuation allowance adjustment	-	-	-
(c) Nonadmitted	9,493	3,852,709	(3,843,216)
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	\$ 5,014,543	\$ 4,025,277	\$ 989,266
(e) Capital:			
(1) Investments	\$ 117,394	\$ -	\$ 117,394
(2) Net capital loss carryforward	-	-	-
(3) Real estate	-	-	-
(4) Other (including items <5% of total capital tax assets)	-	-	-
(5) Investment Partnership	-	-	-
(99) Subtotal	117,394	-	117,394
(f) Statutory valuation allowance adjustment	-	-	-
(g) Nonadmitted	-	-	-
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	117,394	-	117,394
(i) Admitted deferred tax assets (2d + 2h)	\$ 5,131,937	\$ 4,025,277	\$ 1,106,660

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

(3) Deferred Tax Liabilities:			
(a) Ordinary:			
(1) Investments	\$	-	\$ -
(2) Fixed assets		-	-
(3) Deferred and uncollected premium		-	-
(4) Policyholder reserves		-	-
(5) Other (including items <5% of total ordinary tax liabilities)		-	-
(6) Amortization		-	-
(7) Discount of coordination of benefits		-	-
(8) Surplus Notes Interest	1,077,221	499,970	577,251
(9) Write-ins	-	-	-
(99) Subtotal	1,077,221	499,970	577,251
(b) Capital:			
(1) Investments	-	2,084	(2,084)
(2) Real estate	-	-	-
(3) Other (including items <5% of total capital tax liabilities)	-	-	-
(99) Subtotal	-	2,084	(2,084)
(c) Deferred tax liabilities (3a99 + 3b99)	1,077,221	502,054	575,167
(4) Net deferred tax assets/liabilities (2i - 3C)	\$ 4,054,715	\$ 3,523,223	\$ 531,492

D. The Company’s income tax expense and change in deferred income taxes differs from the amount obtained by applying the federal statutory income tax rate of 35% for the year ended December 31 as follows:

	2016	2015
Tax expense computed using federal statutory rate	\$ 33,761,958	\$ 14,739,500
ACA health insurer fee	7,039,362	5,733,375
Change in nonadmitted assets	4,029,881	(7,565,504)
Tax exempt income and dividend received	(497,174)	(186,655)
Prior year true-ups and adjustments	336,283	1,491,841
Intercompany transfers and adjustments	(456,443)	-
Other	98,582	117,681
Total	\$ 44,312,449	\$ 14,330,238
Federal income taxes incurred	\$ 40,877,875	\$ 20,297,748
Change in net deferred income taxes	3,434,571	(5,967,510)
Total statutory income taxes	\$ 44,312,446	\$ 14,330,238

E. Operating loss carryforwards:

- (1) The Company has no operating loss carryforwards and no tax credit carryforwards as of December 31, 2016 or 2015.
- (2) The following are income taxes incurred in the current and prior year(s) that will be available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2016	\$ 39,905,172	\$ 744	\$ 39,905,917
2015	18,712,890	19,860	18,693,030
2014	-	-	-

- (3) The Company has no protective tax deposits reported as admitted assets under Section 6603 of the Internal Revenue Code as of December 31, 2016 and 2015.

F. The following companies will be included in the consolidated federal income tax return with their parent Anthem, Inc. as of December 31, 2016 and either are current members of the consolidated tax sharing agreement or are in the process of being added to the consolidated tax sharing agreement. Allocation of federal income taxes with affiliates subject to the tax sharing agreement is based upon separate income tax return calculations with credit for net losses that can be used on a consolidated basis. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

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American Imaging Management, Inc.	DeCare Dental Health International, LLC
AMERIGROUP Community Care of New Mexico, Inc.	DeCare Dental Networks, LLC
AMERIGROUP Corporation	DeCare Dental, LLC
AMERIGROUP District of Columbia, Inc.	Designated Agent Company, Inc.
AMERIGROUP Florida, Inc.	EHC Benefits Agency, Inc.
Amerigroup Insurance Company	Empire HealthChoice Assurance, Inc.
AMERIGROUP Iowa, Inc.	Empire HealthChoice HMO, Inc.
Amerigroup Kansas, Inc.	Federal Government Solutions, LLC (fka
AMERIGROUP Maryland, Inc.	Government Health Services, LLC)
AMERIGROUP Mississippi, Inc.	Forty-Four Forty-Four Forest Park Redevelopment Corp
AMERIGROUP Nevada, Inc.	Golden West Health Plan, Inc.
AMERIGROUP New Jersey, Inc.	Greater Georgia Life Insurance Company
AMERIGROUP Ohio, Inc.	Health Core, Inc.
AMERIGROUP Oklahoma, Inc.	Health Management Corporation
Amerigroup Services, Inc.	HealthKeepers, Inc.
AMERIGROUP Tennessee, Inc.	HealthLink HMO, Inc.
AMERIGROUP Texas, Inc.	HealthLink, Inc.
AMERIGROUP Washington, Inc.	HealthPlus HP, LLC
AMGP Georgia Managed Care Company, Inc.	Healthy Alliance Life Insurance Company
Anthem Blue Cross Life and Health Insurance Company	HMO Colorado, Inc.
Anthem Financial, Inc.	HMO Missouri, Inc.
Anthem Health Insurance Company of Nevada	Imaging Management Holdings, LLC
Anthem Health Plans of Kentucky, Inc.	Imaging Providers of Texas
Anthem Health Plans of Maine, Inc.	Living Complete Technologies, Inc. (fka
Anthem Health Plans of New Hampshire, Inc.	Tidgewell Associates, Inc.)
Anthem Health Plans of Virginia, Inc.	Matthew Thornton Health Plan, Inc.
Anthem Health Plans, Inc.	National Government Services, Inc.
Anthem Holding Corp.	Park Square Holdings, Inc.
Anthem Insurance Companies, Inc.	Park Square I, Inc.
Anthem Kentucky Managed Care Plan, Inc.	Park Square II, Inc.
Anthem Life & Disability Insurance Company	PHP Holdings, Inc.
Anthem Southeast, Inc.	R&P Realty, Inc.
Anthem UM Services, Inc.	Resolution Health, Inc.
Anthem, Inc.	RightCHOICE Managed Care, Inc.
Arcus Enterprises, Inc.	Rocky Mountain Hospital and Medical Service, Inc.
ARCUS HealthyLiving Services, Inc.	SellCore, Inc.
Associated Group, Inc.	Simply Healthcare Holdings, Inc.
Better Health, Inc.	Simply Healthcare Plans, Inc.
Blue Cross and Blue Shield of Georgia, Inc.	Southeast Services, Inc.
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	State Sponsored Business UM Services, Inc.
Blue Cross Blue Shield of Wisconsin	The Anthem Companies of California, Inc.
Blue Cross of California	The Anthem Companies, Inc.
Blue Cross of California Partnership Plan, Inc.	TrustSolutions, LLC
CareMore Health Group, Inc.	UNICARE Health Plan of West Virginia, Inc.
CareMore Health Plan	UNICARE Health Plans of Texas, Inc.
CareMore Health Plan of Arizona, Inc.	UNICARE Illinois Services, Inc.
CareMore Health Plan of Georgia, Inc.	UNICARE Life & Health Insurance Company
CareMore Health Plan of Nevada	UNICARE National Services, Inc.
CareMore Health Plan of Texas, Inc.	UNICARE Specialty Services, Inc.
CareMore Health System	UtiliMed IPA, Inc.
CareMore Holdings, Inc.	WellPoint Behavioral Health, Inc.
Cerulean Companies, Inc.	WellPoint California Services, Inc.
Claim Management Services, Inc.	WellPoint Dental Services, Inc.
Community Care Health Plan of Louisiana, Inc. (fka	WellPoint Health Solutions, Inc.
AMERIGROUP Louisiana, Inc.)	WellPoint Holding Corporation
Community Insurance Company	WellPoint Information Technology Services, Inc.
Compcare Health Services Insurance Corporation	WellPoint Insurance Services, Inc.
Crossroads Acquisition Corp	WellPoint Military Care Corporation
DeCare Analytics, LLC	

G. Not applicable.

10. Information Concerning Parent, Subsidiaries, Affiliates, and Other Related Parties

A. Nature of the Relationship

The Company is a Florida domiciled stock insurance company and is a wholly-owned subsidiary of Simply Healthcare Holdings, Inc. (“Simply Holdings”), which is owned by ATH Holding Company, LLC (“ATH Holding”), which is an indirect wholly-owned subsidiary of Anthem, Inc. (“Anthem”), a publicly traded company owning 100% of the outstanding shares of the Simply Holdings.

On December 19, 2014, Simply Healthcare Holdings, the parent company of Simply, entered into an Agreement and Plan of Merger (“Purchase Agreement”) with a subsidiary of Anthem, Inc. Based on receipt of all federal and state regulatory approvals, the acquisition was finalized and closed on February 17th, 2015.

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On July 24, 2015, the Company's ultimate parent company, Anthem, and Cigna Corporation ("Cigna") entered into an Agreement and Plan of Merger dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and a direct wholly-owned subsidiary of Anthem, pursuant to which Anthem will acquire all outstanding shares of Cigna, or the Acquisition. On July 21, 2016, the U.S. Department of Justice, or DOJ, along with certain state attorneys general, filed a civil antitrust lawsuit in the U.S. District Court for the District of Columbia seeking to block the Acquisition. On January 18, 2017, Anthem provided notice to Cigna that Anthem had elected to extend the termination date under the Merger Agreement from January 31, 2017 until April 30, 2017. On January 18, 2017, Anthem provided notice to Cigna that Anthem had elected to extend the termination date under the Merger Agreement from January 31, 2017 until April 30, 2017. Following the conclusion of the trial, the Court ruled in favor of the DOJ, on February 8, 2017, and Anthem promptly filed notice that Anthem would appeal the Court's ruling. On February 14, 2017, Cigna purported to terminate the Merger Agreement and commenced litigation against Anthem in the Delaware Court of Chancery, or Delaware Court, seeking damages and a declaratory judgment that its purported termination of the Merger Agreement was lawful, among other claims. Anthem believes Cigna's allegations are without merit. Also on February 14, 2017, Anthem initiated its own litigation against Cigna in the Delaware Court seeking a temporary restraining order to enjoin Cigna from terminating the Merger Agreement, specific performance compelling Cigna to comply with the Merger Agreement and damages. On February 15, 2017, the Delaware Court granted Anthem's motion for a temporary restraining order and issued an order enjoining Cigna from terminating the Merger Agreement. The temporary restraining order became effective immediately and will remain in place pending any further order from the Delaware Court. Anthem intends to vigorously defend the Acquisition in both the Circuit Court and the Delaware Court and remains committed to completing the Acquisition as soon as practicable.

B. Significant Transactions for Each Period

The following significant transactions took place between the Company and its affiliates:

There were no significant transactions that took place between the Company and its affiliates during the years ended December 31, 2016 or 2015.

C. Intercompany Management and Service Arrangements

There were no changes to the intercompany management and service arrangements, and there were no additional arrangements entered into during 2015. Effective January 1, 2016, the Company entered into the Anthem, Inc. Master Services agreement. The amounts of transactions under such agreements are presented in Schedule Y, Part 2.

D. Amounts Due to or from Related Parties

At December 31, 2016 and 2015, the Company reported \$713,672 and \$0 due from affiliates which were nonadmitted per Florida OIR. The Company reported \$3,218,895 and \$2,974,679 due to affiliates, respectively. The receivable and payable balances represent intercompany transactions that will be settled in accordance with the settlement terms of the intercompany agreement.

E. Guarantees or Contingencies for Related Parties

The Company did not enter into guarantees or undertakings for the benefit of an affiliate which would result in a material contingent exposure of the Company's or any affiliated insurer's assets or liabilities.

F. Management and Service Contracts and Cost Sharing Arrangements

The Company has entered into administrative services agreements with its affiliated companies. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The costs and expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Costs include expenses such as salaries, employee benefits, communications, advertising, consulting services, rent, utilities, billing, accounting, underwriting, and product development, which support the Company's operations. These costs are allocated based on various utilization statistics.

The Company is party to a cash concentration agreement with its affiliated companies. Under this agreement, any of the Company's affiliates may be designated as a cash manager to handle the collection and/or payment of funds on behalf of the Company. Conversely, the Company may be designated as a cash manager to handle the collection and/or payment of funds on behalf of its affiliates. Cash services covered under this agreement include the collection of premiums and other revenue, the collection of benefit and administrative expense reimbursements, the payment of policy benefits, payroll expense, general and administrative expense, and accounts payable disbursements.

G. Nature of Control Relationships that Could Affect Operations or Financial Position

ATH Holding owns all the outstanding shares of the Company. The Company's ultimate parent is Anthem, Inc.

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H. Amount deducted for Investment in Upstream Company

The Company does not own shares of upstream intermediate entities or Anthem.

I. Detail of Investments in Affiliates Greater than 10% of Admitted Assets

The Company does not have investment in affiliates greater than 10% of admitted assets.

J. Write-down for Impairments of Investments in Subsidiaries, Controlled or Affiliated (“SCA”) Companies

The Company did not write-down any investments in subsidiaries, controlled or affiliated SCA companies as of December 31, 2016 and 2015.

K. Investment in a Foreign Insurance Subsidiary

The Company does not have investments in foreign insurance subsidiaries.

L. Investment in Downstream Non-insurance Holding Companies

The Company does not have investments in downstream non-insurance holding companies.

M. All SCA Investments

The Company has no SCA Investments.

N. Investment in Insurance SCAs

The Company does not have investments in Insurance SCAs.

11. Debt

A. Capital Notes

The Company had no capital notes outstanding at December 31, 2016 and 2015.

B. All Other Debt

The Company had no other debt outstanding at December 31, 2016 and 2015.

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefits Plans

A. Defined Benefit Plan

Not applicable – See Note 12G.

B. Not applicable – See Note 12G.

C. Not applicable – See Note 12G.

D. Not applicable – See Note 12G.

E. Defined Contribution Plan

Not applicable – See Note 12G.

F. Multiemployer Plan

The Company does not participate in a multiemployer plan.

G. Consolidated/Holding Company Plans

During 2015, the Company participated in a defined contribution plan created prior to the February 17, 2015 acquisition of Simply Healthcare by Anthem. No Company-matched amounts were contributed to the plan. Beginning on January 1, 2016, that defined contribution plan merged into the Anthem 401(k) Retirement Savings Plan, a defined contribution plan sponsored by ATH Holding Company, LLC (“ATH Holding”) and covering substantially all employees. Voluntary employee contributions are matched by ATH Holding subject to certain limitations. ATH Holding allocates a share of the total accumulated costs

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of this plan to the Company based on the number of allocated employees. The Company has no legal obligation for benefits under this plan.

During 2016 and 2015, the Company was allocated the following costs or (credits) for these retirement benefits:

	2016	2015
Defined contribution plan	1,246,049	-

H. Post Employment Benefits and Compensated Absences

Not applicable.

I. Impact of Medicare Modernization Act on Postretirement Benefits (INT 04-17)

Not applicable.

13. Capital and Surplus, Shareholder's Dividend Restrictions and Quasi-Reorganizations

(1) Outstanding Shares

As of December 31, 2016, the Company has 1,000 shares authorized of \$1 par value common stock authorized, issued and outstanding. The number of shares issued and outstanding is 57.

(2) Preferred Stock

The Company has no preferred stock outstanding.

(3) Dividend Restrictions

Per the *Florida Statute 641.365*, there are certain limitations exist on the Company’s ability to pay dividends to its parent. The Company may pay funds only from accumulated surplus funds that were derived from realized net operating profits on its business and net realized capital gains. Prior written approval by the Florida DFS is required for payment of any dividend which would result in these accumulated surplus funds being less than zero. Florida DFS approval is not required if the dividend to be paid is less than the greater of 1) ten percent of the Company’s accumulated surplus or 2) the Company’s entire net operating profit, including realized capital gains, for the immediately preceding calendar year.

(4) Dividends Paid

See Footnote 10B.

(5) Maximum Ordinary Dividends During 2017

Within the limitations of (3) above, the Company may pay \$55,584,861 in dividends during 2017 without prior approval.

(6) Unassigned Surplus Restrictions

Unassigned surplus funds are not restricted at December 31, 2016.

(7) Mutual Surplus Advances

Not applicable.

(8) Company Stock Held for Special Purpose

There are no shares of stock held for special purposes at December 31, 2016.

(9) Changes in Special Surplus Funds

The changes in balances of special surplus funds from the prior year are due to changes in the amounts segregated for the estimated Affordable Care Act (“ACA”) health insurer fee. The annual fee under section 9010 of the ACA has been suspended for 2017, therefore no surplus has been segregated as of December 31, 2016.

(10) Changes in Unassigned Funds

The portion of unassigned funds represented by cumulative unrealized gains and losses was (\$229,302) at December 31, 2016.

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(11) Surplus Notes

The Company has surplus note principal outstanding at December 31, 2016 and 2015 in the amount of \$20,559,808 and \$20,559,808, respectively. A summary is as follows:

<u>Date Issued</u>	<u>Interest Rate</u>	<u>Par Value</u>	<u>Carrying Value of Note</u>	<u>Interest Paid Current Year</u>	<u>Total Interest Paid</u>	<u>Unapproved Interest Expense</u>	<u>Accrued Interest</u>	<u>Date of Maturity</u>
5/4/2010	8.0%	\$ 7,559,808	\$ 7,559,808	\$	\$	\$ 4,033,002	\$	
9/2/2010	8.0%	\$ 4,967,102	\$ 4,967,102			\$ 2,518,117		
9/17/2010	8.0%	\$ 2,032,898	\$ 2,032,898			\$ 1,023,912		
12/20/2012	8.0%	\$ 2,500,000	\$ 2,500,000			\$ 807,123		
12/31/2012	8.0%	\$ 2,500,000	\$ 2,500,000			\$ 801,096		
12/31/2013	8.0%	\$ 1,000,000	\$ 1,000,000			\$ 240,438		
Total		20,559,808				9,423,688		

As of December 31, 2016, the Company entered into promissory surplus notes to related parties totaling \$20,559,808. The notes bear interest at the rate of 8% per annum, however, in accordance with statutory accounting principles set forth in SSAP No. 41 interest shall not be recorded as a liability or an expense until such interest has been approved by the Florida OIR for payment.

Any payment of interest and repayment of surplus note principal may be paid only out of the Company’s earnings, subject to approval by the Florida OIR. Interest expense on surplus notes not yet approved by the Florida OIR and thus not recorded was \$9,423,688 and \$7,774,398 at both December 31, 2016 and 2015..

(12) Restatement due to Prior Quasi-reorganization

The Company has no restatements due to prior quasi-reorganizations.

(13) Quasi-reorganization over Prior 10 years

The Company has not been involved in a quasi-reorganization during the past 10 years.

14. Liabilities, Contingencies and Assessments

A. Contingent Commitments

The Company has no contingent commitments at December 31, 2016.

B. Assessments

1. The Company is subject to guaranty fund and other assessments by the state in which it writes business. Guaranty fund assessments are accrued at the time of insolvencies. Other assessments are accrued either at the time of the assessment or at the time the losses are incurred.

The State of Florida has not issued a guaranty fund assessment, and the Company has not recorded a liability for an assessment as of December 31, 2016 or 2015.

2. Not applicable.

C. Gain Contingencies

The Company has no gain contingencies at December 31, 2016.

D. Claims-Related Extra Contractual Obligations and Bad Faith Losses Stemming from Lawsuits

Not applicable.

E. Joint and Several Liabilities

Not applicable.

F. All Other Contingencies

In February 2015, Anthem reported that it was the target of a sophisticated external cyber-attack. The attackers gained unauthorized access to certain of Anthem’s information technology systems and

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obtained personal information related to many individuals and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that Anthem will not identify additional information that was accessed or obtained.

Upon discovery of the cyber-attack, Anthem took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate its systems and identify solutions based on the evolving landscape. Anthem is providing credit monitoring and identity protection services to those who have been affected by this cyber-attack. Anthem has continued to implement security enhancements since this incident. Anthem has incurred expenses subsequent to the cyber-attack to investigate and remediate this matter and expects to continue to incur expenses of this nature in the foreseeable future. Anthem will recognize these expenses in the periods in which they are incurred.

Actions have been filed in various federal and state courts and other claims have been or may be asserted against Anthem on behalf of current or former members, current or former employees, other individuals, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber-attack. Federal and state agencies, including state insurance regulators, state attorneys general, the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigation, are investigating events related to the cyber-attack, including how it occurred, its consequences and Anthem's responses. The NAIC's multistate targeted market conduct and financial exam was concluded in December 2016. As part of the resolution, the NAIC asked and Anthem has agreed to provide a customized credit protection program functionally equivalent to a credit freeze for minors who were under the age of 18 on January 27, 2015. No fines or penalties were issued. Although Anthem is cooperating in these investigations, Anthem may be subject to fines or other obligations, which may have an adverse effect on how Anthem operates its business and on its results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation in February 2015 and was subsequently heard by the Panel in May 2015. In June 2015, the Panel entered its order transferring the consolidated matter to the U.S. District Court for the Northern District of California. The U.S. District Court entered its case management order in September 2015. Anthem filed a motion to dismiss ten of the counts that are before the U.S. District Court. In February 2016, the court issued an order granting in part and denying in part our motion, dismissing three counts with prejudice, four counts without prejudice and allowing three counts to proceed. Plaintiffs filed a second amended complaint in March 2016, and Anthem subsequently filed a second motion to dismiss. In May 2016, the court issued an order granting in part and denying in part our motion, dismissing one count with prejudice, dismissing certain counts asserted by specific named plaintiffs with or without prejudice depending on their individualized facts, and allowing the remaining counts to proceed. In July 2016, plaintiffs filed a third amended complaint, which Anthem answered in August 2016. Fact discovery was completed in December 2016. There remain two state court cases that are presently proceeding outside of the Multidistrict Litigation.

Anthem has contingency plans and insurance coverage for certain expenses and potential liabilities of this nature. While a loss from these matters is reasonably possible, Anthem cannot reasonably estimate a range of possible losses because the investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

The Company is involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits and reviews and administrative proceedings include routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and Federal Agencies. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on The Company's business operations. The Company believes that any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on the Company's financial position or results of operations.

At December 31, 2016 and 2015, the Company reported admitted assets of \$19,748,387 and \$17,834,690, respectively, in premium receivables due from policyholders and agents and receivables due from uninsured plans. Based upon Company experience, any uncollectible receivables are not expected to exceed \$0 that was nonadmitted at December 31, 2016; therefore, no additional provision for uncollectible amounts has been recorded. The potential for any additional loss is not believed to be material to the Company's financial condition.

15. Leases

A. Lessee Operating Lease

- (1) The Company leases office space, office equipment, EDP equipment, software under various noncancelable operating leases. Related lease expense for 2016 and 2015 was \$805,581 and \$2,123,271 respectively.

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(2) At January 1, 2017, the minimum aggregate rental commitments are as follows:

Year Ending December 31	Operating Leases
2017	\$ 487,497
2018	2,844
2019	2,844
2020	2,844
2021	2,844
Total	\$ 498,873

(3) The Company has not entered into any material sale-leaseback transactions.

B. Lessor Leases

- (1) The Company has not entered into any operating leases.
- (2) The Company has not entered into any leveraged leases.

16. Information about Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk

The Company has no significant financial instruments with off-balance sheet risk.

Financial instruments that potentially subject the Company to concentrations of credit risk consist primarily of investment securities. All investment securities are managed by professional investment managers within policies authorized by the board of directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. As of December 31, 2016, there were no significant concentrations.

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. Transfers of Receivables Reported as Sales

Not applicable at December 31, 2016 and 2015.

B. Transfer and Servicing of Financial Assets

Not applicable at December 31, 2016 and 2015.

C. Wash Sales

1. In the course of the Company’s asset management, securities may be sold and reacquired within 30 days of the sale date to enhance the yield on the investments.
2. At December 31, 2016 and 2015, there were no wash sales involving securities with an NAIC designation of 3 or below or unrated.

18. Gain or Loss to the Reporting Entity from Uninsured Plans and Uninsured Portion of Partially Insured Plans

A. Administrative Services Only (“ASO”) Plans

The gain from operations from ASO uninsured plans and the uninsured portion of partially insured plans during 2016 was:

	ASO Uninsured Plans	Uninsured Portion of Partially Insured Plans	Total ASO
a. Net reimbursement for administrative expenses (including administrative fees) in excess of actual expenses	\$ (109,906)	\$ -	\$ (109,906)
b. Total net other income or expenses (including interest paid to or received from plans)	-	-	-
c. Net gain or (loss) from operations	\$ (109,906)		\$ (109,906)
d. Total claim payment volume	\$ 3,381,714		\$ 3,381,714

B. Administrative Services Contract (“ASC”) Plans

Not applicable in December 31, 2016 and 2015.

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C. Medicare or Other Similarly Structured Cost-Based Reimbursement Contract

- (1) The Company does not record revenue explicitly attributable to the cost share and reinsurance components of administered Medicare products.
- (2) As of December 31, 2016 and 2015, the Company recorded a receivable from CMS of \$502,605 and \$432,708, respectively, related to the cost share and reinsurance components of administered Medicare products.
- (3) As no revenue is recorded in connection with the cost share and reinsurance components of the Company’s reinsurance contracts, the Company has recorded no allowances and reserves for the adjustment of recorded revenues and receivables.
- (4) The Company has made no adjustment to revenue resulting from audit of receivables related to revenues recorded in the prior period.

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

No premiums were written by managing general agents or third party administrators during the years ended December 31, 2016 and 2015.

20. Fair Value

A. Fair Value Measurements

- (1) Fair Value Measurements at Reporting Date

Description for each class of asset or liability	(Level 1)	(Level 2)	(Level 3)	Total
a. Assets at fair value				
Bonds				
Industrial and Misc	\$ -	\$ 250,812	\$ -	250,812
Total bonds	\$ -	\$ 250,812	\$ -	\$ 250,812
Total assets at fair value	\$ -	\$ 250,812	\$ -	\$ 250,812

- (2) There are no investments in Level 3 as of December 31, 2016 and 2015.
- (3) The Company’s policy is to recognize transfers between Levels, if any, as of the beginning of the reporting period.
- (4) Fair values of fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level 1 or Level 2 inputs, for the determination of fair value to facilitate fair value measurements and disclosures. United States government securities represent Level 1 securities, while Level 2 securities primarily include corporate securities, securities from states, municipalities and political subdivisions and residential mortgage-backed securities. For Securities not actively traded, the third party pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds.

Fair values of equity securities are generally designated as Level 1 and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level 2. The Company has certain equity securities, including private equity securities, for which the fair value is estimated based on each security's current condition and the future cash flow projections. Such securities are designated Level 3. The fair values of these private equity securities are generally based on either broker quotes or discounted cash flow projections using assumptions for inputs such as the weighted-average cost of capital, long-term revenue growth rates and earnings before interest, taxes, depreciation and amortization, or revenue multiples that are not observable in the markets.

Certain financial assets are measured at fair value using Level 3 inputs, such as certain non-investment grade bonds and loan-backed securities or investments that are impaired during the year and recorded at fair value.

There have been no significant changes in the valuation techniques during the current period.

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B. Fair Value Measurements Under Other Accounting Pronouncements

Not applicable at December 31, 2016 and 2015.

C. Financial Instruments

Type of Financial Instrument	Aggregated Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practicable (Carrying Value)
Bonds	\$ 65,649,494	\$ 65,592,751	\$ -	\$ 65,649,494	\$ -	\$ -
Short Term Inv & MMFs	613,791	613,756	193,757	420,034	-	-
	<u>\$ 66,263,285</u>	<u>\$ 66,206,508</u>	<u>\$ 193,757</u>	<u>\$ 66,069,528</u>	<u>\$ -</u>	<u>\$ -</u>

D. Not Practicable to Estimate Fair Value

There are no financial instruments that were not practicable to estimate fair value.

21. Other Items

A. Unusual or Infrequent Items

The State of Florida, Agency of for Health Care Administration (“AHCA”), informed the Company on June 7, 2016 of a pricing error related to the State Fiscal Year 2015-2016 contract. AHCA indicated it underpaid the Company due to a mismatch of rates. Related to this, the Company received and recognized cash and premiums of \$6,039,743 from AHCA during 2016 related to 2015. Not applicable at December 31, 2015.

B. Troubled Debt Restructuring: Debtors

Not applicable at December 31, 2016 and 2015.

C. Other Disclosures

Not applicable at December 31, 2016 and 2015.

D. Business Interruption Insurance Recoveries

The Company has reported no recoveries for business interruption for the years ended December 31, 2016 and 2015.

E. State Transferable and Non-Transferable Tax Credits

The Company did not have state transferable tax credits at December 31, 2016 and 2015.

F. Subprime Mortgage-Related Risk Exposure

- (1) The Company’s investment strategy of providing safety and preservation of capital, sufficient liquidity to meet cash flow requirements and the attainment of a competitive after-tax investment return is supported by a well diversified portfolio consisting of many different types of investments. The portion of the Company’s investment portfolio with subprime mortgage-related risk exposure is relatively small in comparison to the overall investment portfolio, and consists mainly of investment grade securities with no exposure to collateralized debt obligations. All mortgage related investments are monitored closely as part of the quarterly investment review performed by the Anthem Investment Impairment Review Committee.
- (2) The Company did not carry investments in subprime mortgage loans in its portfolio at December 31, 2016 or 2015.
- (3) The Company did not have subprime mortgage-related risk exposure at December 31, 2016 or 2015.
- (4) The Company did not underwrite Mortgage Guaranty or Financial Guaranty insurance coverage at December 31, 2016 or 2015.

G. Retained Assets

The Company did not have any retained assets at December 31, 2016 and 2015.

H. Insurance-Linked Securities Contracts

Not applicable.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

22. Events Subsequent

The Company is subject to an annual fee under section 9010 of the ACA. A health insurance company’s portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. The annual fee under section 9010 of the ACA has been suspended for 2017 and will resume for 2018 and beyond.

	Current Year	Prior Year
A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the Federal Affordable Care Act (YES/NO)?	YES	
B. ACA fee assessment payable for the upcoming year	\$ -	\$ 20,013,754
C. ACA fee assessment paid	\$ 20,112,463	\$ -
D. Premium written subject to ACA 9010 assessment	\$ 1,214,753,168	\$ 986,471,542
E. Total Adjusted Capital before surplus adjustment (Five-Year Historical Line 14)	\$ 113,394,744	
F. Total Adjusted Capital after surplus adjustment (Five-Year Historical Line 14 minus Line 22B above)	\$ 113,394,744	
G. Authorized Control Level (Five-Year Historical Line 15)	\$ 35,332,507	
H. Would reporting the ACA assessment as of December 31,2015 have triggered an RBC action level (YES/NO)?	NO	

Subsequent events have been considered through March 31, 2017 for the statutory statement issued on March 31, 2017. There were no other events occurring subsequent to December 31, 2016 requiring recognition or disclosure.

23. Reinsurance

A. Ceded Reinsurance Report

Section 1 – General Interrogatories

(1) Are any of the reinsurers that are listed in Schedule S as non-affiliated owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?

Yes () No(X)

If yes, give full details.

(2) Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled, directly or indirectly, by an insured, a beneficiary, a creditor or an insured or any other person not primarily engaged in the insurance business?

Yes () No(X)

If yes, give full details.

Section 2 – Ceded Reinsurance Report – Part A

(1) Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credits?

Yes () No(X)

If yes, give full details.

(2) Does the reporting entity have any reinsurance agreements in effect such that the amount of losses paid or accrued though the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same insurer, exceed the total direct premium collected under reinsured policies?

Yes () No(X)

If yes, give full details.

Section 3 – Ceded Reinsurance Report – Part B

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

- (1) What is the estimated amount of the aggregate reduction in surplus, (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2) above of termination of ALL reinsurance agreements, by either party, as of the date of this statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

Not Applicable.

- (2) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement include policies or contract that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes () No(X)

If yes, give full details.

B. Uncollectible Reinsurance

The Company has no uncollectible reinsurance at December 31, 2016 and 2015.

C. Commutation of Ceded Reinsurance

The Company has not commuted ceded reinsurance during 2016 and 2015.

D. Certified Reinsurer Rating Downgraded or Status Subject Revocation

The Company has no downgraded certified reinsurer ratings or status subject revocations during 2016 and 2015.

24. Retrospectively Rated Contracts and Contracts Subject to Redetermination

- A. The Company's contract with CMS includes provisions for which the premiums vary based on loss experience. The Company estimates retrospective premium adjustments through the review of each retrospectively rated account, comparing the claim development with that anticipated in the policy contracts.
- B. The Company records accrued retrospective premium as an adjustment to earned premium.
- C. 100% of the Company's net premiums written is subject to retrospective rating features at December 31, 2016 and 2015.
- D. In accordance with the NAIC Accounting Practices and Procedures Manual, medical loss ratio rebates in accordance with the Federal 2010 Patient Protection and Affordable Care Act and Public Health Service Act, are to be reported in accordance with SSAP No. 66 - *Retrospectively Rated Contracts* ("SSAP No. 66"). A retrospectively rated contract is one that has the final policy premium calculated based on the loss experience of the insured during the term of the policy (including loss development after the term of the policy) and the stipulated formula set forth in the policy, or in the case of medical loss ratio rebates, a formula required by law. The Company based the incurred and unpaid liability amounts reported below based on its underwriting experience; actuarial, tax, and accounting estimates and assumptions at the financial statement date; as well as regulations and guidance available that is not final and subject to change prior to settlement. Accordingly, the Company's use of estimates and assumptions in the preparation of the statutory based financial statements and related footnote disclosures may differ from actual results. Hence, the amounts reported herein are for financial reporting purposes solely and not intended to be used for settlement purposes.

Medical loss ratio rebates accrued pursuant to the Public Health Service Act are as follows:

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

	Individual	Small Group Employer	Large Group Employer	Other Categories with Rebates	Total
Prior Reporting Year					
(1) Medical loss ratio rebates incurred	\$ -	\$ -	\$ -	\$ -	\$ -
(2) Medical loss ratio rebates paid	-	-	-	-	-
(3) Medical loss ratio rebates unpaid	-	-	-	-	-
(4) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(5) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(6) Rebate unpaid net of reinsurance	XXX	XXX	XXX	XXX	\$ -
Current Reporting Year-to-Date					
(7) Medical loss ratio rebates incurred	\$ -	\$ -	\$ -	\$ -	\$ -
(8) Medical loss ratio rebates paid	-	-	-	-	-
(9) Medical loss ratio rebates unpaid	-	-	-	-	-
(10) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(11) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(12) Rebate unpaid net of reinsurance	XXX	XXX	XXX	XXX	\$ -

E. Risk-Sharing Provisions of the Affordable Care Act ("ACA")

- (1) Did the reporting entity write accident and health insurance premium which is subject to the Affordable Care Act risk sharing provisions (YES/NO)? No
- (2) Impact of Risk-Sharing Provisions of the Affordable Care Act on Admitted Assets, Liabilities and Revenue for the Current Year

Not applicable.
- (3) Roll-forward of prior year ACA risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balance.

Not applicable.
- (4) Roll-Forward of Risk Corridors Asset and Liability Balances by Program Benefit Year.

Not applicable.
- (5) ACA Risk Corridors Receivable as of Reporting Date.

Not applicable.

25. Change in Incurred Claims and Claim Adjustment Expenses

The estimated cost of claims and claim adjustment expense attributable to insured events of prior years decreased by \$10,359,050 during 2016. This is approximately 10.0% of unpaid claims and claim adjustment expenses of \$103,332,573 as of December 31, 2015. The redundancy reflects the decreases in estimated claims and claims adjustment expenses as a result of claims payment during the year, and as additional information is received regarding claims incurred prior to 2016. Recent claim development trends are also taken into account in evaluating the overall adequacy of unpaid claims and unpaid claim adjustment expense.

26. Intercompany Pooling Arrangements

Not applicable at December 31, 2016 and 2015.

27. Structured Settlements

Not applicable at December 31, 2016 and 2015.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

28. Health Care Receivables

A. Pharmaceutical Rebate Receivables

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More Than 180 Days After Billing
12/31/2016	1,678,498	1,678,498	—	—	—
9/30/2016	1,920,659	1,585,347	—	—	—
6/30/2016	1,706,433	1,581,644	—	1,581,644	—
3/31/2016	1,469,800	1,444,667	—	1,444,667	—
12/31/2015	1,265,695	1,644,766	—	—	1,644,766
9/30/2015	991,277	1,862,979	—	—	1,862,979
6/30/2015	955,886	1,909,429	—	—	1,909,429
3/31/2015	992,693	1,552,554	—	—	1,552,554
12/31/2014	1,455,611	1,643,805	—	—	1,643,805
9/30/2014	1,264,332	1,610,684	—	—	1,610,684
6/30/2014	1,455,624	1,478,133	—	—	1,478,133
3/31/2014	1,235,399	1,208,472	—	—	1,208,472

B. Risk Sharing Receivables

Not applicable at December 31, 2016 and 2015.

29. Participating Policies

Not applicable at December 31, 2016 and 2015.

30. Premium Deficiency Reserves

The Company had no liabilities related to premium deficiency reserves as of December 31, 2016 and 2015.

31. Anticipated Salvage and Subrogation

Not applicable at December 31, 2016 and 2015.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

GENERAL INTERROGATORIES

PART 1 - COMMON INTERROGATORIES

GENERAL

1.1

Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer?
If yes, complete Schedule Y, Parts 1, 1A and 2

Yes [☒] No [☐]

1.2

If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent, or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations?

Yes [☒] No [☐] N/A [☐]

1.3

State Regulating?

Florida

2.1

Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity?

Yes [☐] No [☒]

2.2

If yes, date of change:

3.1

State as of what date the latest financial examination of the reporting entity was made or is being made.

12/31/2015

3.2

State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released.

12/31/2014

3.3

State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date).

06/17/2016

3.4

By what department or departments?
Florida Office of Insurance Regulation

3.5

Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments?

Yes [☒] No [☐] N/A [☐]

3.6

Have all of the recommendations within the latest financial examination report been complied with?

Yes [☒] No [☐] N/A [☐]

4.1

During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity), receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.11 sales of new business?
4.12 renewals?

Yes [☐] No [☒]
Yes [☐] No [☒]

4.2

During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.21 sales of new business?
4.22 renewals?

Yes [☐] No [☒]
Yes [☐] No [☒]

5.1

Has the reporting entity been a party to a merger or consolidation during the period covered by this statement?

Yes [☐] No [☒]

5.2

If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1	2	3
Name of Entity	NAIC Company Code	State of Domicile

6.1

Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period?

Yes [☐] No [☒]

6.2

If yes, give full information:
.....

7.1

Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity?

Yes [☐] No [☒]

7.2

If yes,
7.21 State the percentage of foreign control; %
7.22 State the nationality(s) of the foreign person(s) or entity(s) or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact; and identify the type of entity(s) (e.g., individual, corporation or government, manager or attorney in fact).

1	2
Nationality	Type of Entity

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

GENERAL INTERROGATORIES

8.1

Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board?

Yes [] No [X]

8.2

If response to 8.1 is yes, please identify the name of the bank holding company.
.....

8.3

Is the company affiliated with one or more banks, thrifts or securities firms?

Yes [] No [X]

8.4

If response to 8.3 is yes, please provide below the names and location (city and state of the main office) of any affiliates regulated by a federal regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1	2	3	4	5	6
Affiliate Name	Location (City, State)	FRB	OCC	FDIC	SEC

9.

What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?
Ernst & Young LLP, 111 Monument Circle, Suite 2600, Indianapolis, IN 46204

10.1

Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation?

Yes [] No [X]

10.2

If the response to 10.1 is yes, provide information related to this exemption:
.....

10.3

Has the insurer been granted any exemptions related to the other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 18A of the Model Regulation, or substantially similar state law or regulation?

Yes [] No [X]

10.4

If the response to 10.3 is yes, provide information related to this exemption:
.....

10.5

Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws?

Yes [X] No [] N/A []

10.6

If the response to 10.5 is no or n/a, please explain
.....

11.

What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?
Mark Blessinger, FSA, MAAA, Actuarial Director (employee); 4425 Corporation Lane, Virginia Beach, VA 23462

12.1

Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly?

Yes [] No [X]

12.11

Name of real estate holding company

12.12

Number of parcels involved

12.13

Total book/adjusted carrying value\$

12.2

If, yes provide explanation:
.....

13.

FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:

13.1

What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?
.....

13.2

Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located?

Yes [X] No []

13.3

Have there been any changes made to any of the trust indentures during the year?

Yes [] No [X]

13.4

If answer to (13.3) is yes, has the domiciliary or entry state approved the changes?

Yes [] No [] N/A []

14.1

Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards?

Yes [X] No []

14.1

(a) Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
(b) Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
(c) Compliance with applicable governmental laws, rules and regulations;
(d) The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
(e) Accountability for adherence to the code.

14.11

If the response to 14.1 is No, please explain:
.....

14.2

Has the code of ethics for senior managers been amended?

Yes [X] No []

14.21

If the response to 14.2 is yes, provide information related to amendment(s).
The Anthem Standards of Ethical Business Conduct applies to all associates, management, officers and directors of Anthem. In June 2016 the code of conduct was revised for the following: a) updated Gift policy (offering) to address new Finance policy prohibiting offering gift cards, unless an approved wellness program; b) added a new section on Telephone Consumer Protection Act: c) added a new section on Non-discrimination under the Affordable Care Act (ACA) since we had a section on non-discrimination for government business. In July 2016 the code of conduct was revised for minor administrative changes regarding definitions of confidential information pertaining to associates' information as wells as the certification at the end of the code.

14.3

Have any provisions of the code of ethics been waived for any of the specified officers?

Yes [] No [X]

14.31

If the response to 14.3 is yes, provide the nature of any waiver(s).
.....

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

GENERAL INTERROGATORIES

- 15.1 Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List? Yes [] No [X]
- 15.2 If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.

1 American Bankers Association (ABA) Routing Number	2 Issuing or Confirming Bank Name	3 Circumstances That Can Trigger the Letter of Credit	4 Amount

BOARD OF DIRECTORS

16. Is the purchase or sale of all investments of the reporting entity passed upon either by the board of directors or a subordinate committee thereof? Yes [X] No []
17. Does the reporting entity keep a complete permanent record of the proceedings of its board of directors and all subordinate committees thereof? Yes [X] No []
18. Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict with the official duties of such person? Yes [X] No []

FINANCIAL

19. Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)? Yes [] No [X]
- 20.1 Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):

20.11 To directors or other officers.\$

20.12 To stockholders not officers.\$

20.13 Trustees, supreme or grand (Fraternal Only) \$
- 20.2 Total amount of loans outstanding at the end of year (inclusive of Separate Accounts, exclusive of policy loans):

20.21 To directors or other officers.\$

20.22 To stockholders not officers.\$

20.23 Trustees, supreme or grand (Fraternal Only) \$
- 21.1 Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reported in the statement? Yes [] No [X]
- 21.2 If yes, state the amount thereof at December 31 of the current year:

21.21 Rented from others.\$

21.22 Borrowed from others.\$

21.23 Leased from others \$

21.24 Other \$
- 22.1 Does this statement include payments for assessments as described in the Annual Statement Instructions other than guaranty fund or guaranty association assessments? Yes [] No [X]
- 22.2 If answer is yes:

22.21 Amount paid as losses or risk adjustment \$

22.22 Amount paid as expenses \$

22.23 Other amounts paid \$
- 23.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? Yes [X] No []
- 23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: \$.0

INVESTMENT

- 24.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date? (other than securities lending programs addressed in 24.03) Yes [X] No []
- 24.02 If no, give full and complete information relating thereto
- 24.03 For security lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet. (an alternative is to reference Note 17 where this information is also provided)
- 24.04 Does the Company's security lending program meet the requirements for a conforming program as outlined in the Risk-Based Capital Instructions? Yes [] No [] N/A [X]
- 24.05 If answer to 24.04 is yes, report amount of collateral for conforming programs. \$
- 24.06 If answer to 24.04 is no, report amount of collateral for other programs. \$
- 24.07 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract? Yes [] No [] N/A [X]
- 24.08 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%? Yes [] No [] N/A [X]
- 24.09 Does the reporting entity or the reporting entity 's securities lending agent utilize the Master Securities lending Agreement (MSLA) to conduct securities lending? Yes [] No [] N/A [X]

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

GENERAL INTERROGATORIES

24.10 For the reporting entity's security lending program state the amount of the following as December 31 of the current year:

24.101 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2.\$0

24.102 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2\$0

24.103 Total payable for securities lending reported on the liability page.\$0

25.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity, or has the reporting entity sold or transferred any assets subject to a put option contract that is currently in force? (Exclude securities subject to Interrogatory 21.1 and 24.03). Yes [X] No []

25.2 If yes, state the amount thereof at December 31 of the current year:

25.21 Subject to repurchase agreements\$

25.22 Subject to reverse repurchase agreements\$

25.23 Subject to dollar repurchase agreements\$

25.24 Subject to reverse dollar repurchase agreements\$

25.25 Placed under option agreements\$

25.26 Letter stock or securities restricted as to sale -
 excluding FHLB Capital Stock\$

25.27 FHLB Capital Stock\$310,000

25.28 On deposit with states\$15,562,916

25.29 On deposit with other regulatory bodies\$

25.30 Pledged as collateral - excluding collateral pledged to
 an FHLB\$

25.31 Pledged as collateral to FHLB - including assets
 backing funding agreements\$

25.32 Other\$

25.3 For category (25.26) provide the following:

1 Nature of Restriction	2 Description	3 Amount

26.1 Does the reporting entity have any hedging transactions reported on Schedule DB? Yes [] No [X]

26.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes [] No [] N/A [X]
 If no, attach a description with this statement.

27.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity? Yes [] No [X]

27.2 If yes, state the amount thereof at December 31 of the current year.\$

28. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook?..... Yes [X] No []

28.01 For agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian's Address
Bank of New York Mellon Corporation	BNY Mellon Center, Pittsburgh, PA 15258

28.02 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

28.03 Have there been any changes, including name changes, in the custodian(s) identified in 28.01 during the current year?..... Yes [] No [X]

28.04 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

GENERAL INTERROGATORIES

28.05 Investment management – Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. ["...that have access to the investment accounts"; "...handle securities"]

1 Name of Firm or Individual	2 Affiliation
Wells Capital Management	U.....

28.0597 For those firms/individuals listed in the table for Question 28.05, do any firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") manage more than 10% of the reporting entity's assets?..... Yes [X] No []

28.0598 For firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") listed in the table for Question 28.05, does the total assets under management aggregate to more than 50% of the reporting entity's assets?..... Yes [] No [X]

28.06 For those firms or individuals listed in the table for 28.05 with an affiliation code of "A" (affiliated) or "U" (unaffiliated), provide the information for the table below.

1 Central Registration Depository Number	2 Name of Firm or Individual	3 Legal Entity Identifier (LEI)	4 Registered With	5 Investment Management Agreement (IMA) Filed
104973	Wells Capital Management .....	.....	Securities Exchange Commission	NO.....

29.1 Does the reporting entity have any diversified mutual funds reported in Schedule D, Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5(b)(1)])? Yes [] No [X]

29.2 If yes, complete the following schedule:

1 CUSIP #	2 Name of Mutual Fund	3 Book/Adjusted Carrying Value
29.2999 - Total		0

29.3 For each mutual fund listed in the table above, complete the following schedule:

1 Name of Mutual Fund (from above table)	2 Name of Significant Holding of the Mutual Fund	3 Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	4 Date of Valuation
.....

30. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

	1 Statement (Admitted) Value	2 Fair Value	3 Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
30.1 Bonds	66,206,507	66,263,291	56,784
30.2 Preferred stocks	0		0
30.3 Totals	66,206,507	66,263,291	56,784

30.4 Describe the sources or methods utilized in determining the fair values:
Fair values were obtained from third-party pricing sources. If a security was not priced by a third-party pricing source, internal analytical systems or broker quotes were utilized.

31.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D? Yes [] No [X]

31.2 If the answer to 31.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source? Yes [] No []

31.3 If the answer to 31.2 is no, describe the reporting entity's process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D:
N/A

32.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed? Yes [X] No []

32.2 If no, list exceptions:
N/A

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

GENERAL INTERROGATORIES

OTHER

33.1

Amount of payments to trade associations, service organizations and statistical or rating bureaus, if any?

\$

0

33.2

List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations and statistical or rating bureaus during the period covered by this statement.

1 Name	2 Amount Paid

34.1

Amount of payments for legal expenses, if any?

\$

72,686

34.2

List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.

1 Name	2 Amount Paid
LITTLER MENDELSON	47,340

35.1

Amount of payments for expenditures in connection with matters before legislative bodies, officers or departments of government, if any?

\$

44,873

35.2

List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid
Larry J. Overton & Associates	19,944
Corcoran & Johnston	24,929

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

GENERAL INTERROGATORIES

PART 2 - HEALTH INTERROGATORIES

1.1

Does the reporting entity have any direct Medicare Supplement Insurance in force?

Yes [] No [X]

1.2

If yes, indicate premium earned on U.S. business only.

\$

1.3

What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit?

\$

1.31

Reason for excluding

1.4

Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above

\$

1.5

Indicate total incurred claims on all Medicare Supplement Insurance.

\$

0

1.6

Individual policies:

Most current three years:

1.61

Total premium earned

\$

0

1.62

Total incurred claims

\$

0

1.63

Number of covered lives

0

All years prior to most current three years:

1.64

Total premium earned

\$

0

1.65

Total incurred claims

\$

0

1.66

Number of covered lives

0

1.7

Group policies:

Most current three years:

1.71

Total premium earned

\$

0

1.72

Total incurred claims

\$

0

1.73

Number of covered lives

0

All years prior to most current three years:

1.74

Total premium earned

\$

0

1.75

Total incurred claims

\$

0

1.76

Number of covered lives

0

2.

Health Test:

1

Current Year

2

Prior Year

2.1

Premium Numerator

1,229,640,802

985,291,150

2.2

Premium Denominator

1,229,640,802

985,291,150

2.3

Premium Ratio (2.1/2.2)

1.000

1.000

2.4

Reserve Numerator

149,861,419

103,566,501

2.5

Reserve Denominator

149,861,419

103,566,501

2.6

Reserve Ratio (2.4/2.5)

1.000

1.000

3.1

Has the reporting entity received any endowment or gift from contracting hospitals, physicians, dentists, or others that is agreed will be returned when, as and if the earnings of the reporting entity permits?

Yes [] No [X]

3.2

If yes, give particulars:

4.1

Have copies of all agreements stating the period and nature of hospitals', physicians', and dentists' care offered to subscribers and dependents been filed with the appropriate regulatory agency?

Yes [X] No []

4.2

If not previously filed, furnish herewith a copy(ies) of such agreement(s). Do these agreements include additional benefits offered?

Yes [X] No []

5.1

Does the reporting entity have stop-loss reinsurance?

Yes [] No [X]

5.2

If no, explain:
The Company became self-insured effective 08/01/2016.

5.3

Maximum retained risk (see instructions)

5.31

Comprehensive Medical

\$

5.32

Medical Only

\$

5.33

Medicare Supplement

\$

5.34

Dental & Vision

\$

5.35

Other Limited Benefit Plan

\$

5.36

Other

\$

6.

Describe arrangement which the reporting entity may have to protect subscribers and their dependents against the risk of insolvency including hold harmless provisions, conversion privileges with other carriers, agreements with providers to continue rendering services, and any other agreements:
Physician and hospital contracts contain provisions, including hold harmless agreements, to protect members and depedents against insolvency.

7.1

Does the reporting entity set up its claim liability for provider services on a service date basis?

Yes [X] No []

7.2

If no, give details

8.

Provide the following information regarding participating providers:

8.1

Number of providers at start of reporting year

19,102

8.2

Number of providers at end of reporting year

20,907

9.1

Does the reporting entity have business subject to premium rate guarantees?

Yes [] No [X]

9.2

If yes, direct premium earned:

9.21

Business with rate guarantees between 15-36 months

\$

0

9.22

Business with rate guarantees over 36 months

\$

0

28

AHCA ITN 001-17/18

Attachment 2016 Simply Healthcare Plans, Inc.
Annual Health Statement — Page 55

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

GENERAL INTERROGATORIES

10.1 Does the reporting entity have Incentive Pool, Withhold or Bonus Arrangements in its provider contracts? Yes [X] No []

10.2	If yes:	10.21 Maximum amount payable bonuses.....	\$	23,257,284
		10.22 Amount actually paid for year bonuses.....	\$	76,471,551
		10.23 Maximum amount payable withholds.....	\$	
		10.24 Amount actually paid for year withholds.....	\$	

11.1 Is the reporting entity organized as:	11.12 A Medical Group/Staff Model,	Yes []	No [X]
	11.13 An Individual Practice Association (IPA), or, .	Yes []	No [X]
	11.14 A Mixed Model (combination of above)?	Yes []	No [X]

11.2	Is the reporting entity subject to Statutory Minimum Capital and Surplus Requirements?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
11.3	If yes, show the name of the state requiring such minimum capital and surplus.	Florida
11.4	If yes, show the amount required.	\$ <u>24,592,816</u>
11.5	Is this amount included as part of a contingency reserve in stockholder's equity?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

11.6 If the amount is calculated, show the calculation
The State of Florida requires Surplus to exceed a) 2% of annualized revenues (\$1,229,640,802 x .02 = \$24,592,816), b) 10% of liabilities (\$180,576,650 x .10 = \$18,057,665), or c) \$1,500,000 whichever is greater

12. List service areas in which reporting entity is licensed to operate:

1
Name of Service Area
Alachua
Baker
Bay
Bradford
Brevard
Broward
Calhoun
Charlotte
Citrus
Clay
Collier
Columbia
Miami-Dade
De Soto
Dixie
Escambia
Flagler
Franklin
Gadsden
Gilchrist
Glades
Gulf
Hamilton
Hardee
Hendry
Hernando
Highlands
Hillsborough
Holmes
Indian River
Jackson
Jefferson
Lafayette
Lake
Lee
Leon
Levy
Liberty
Madison
Manatee
Marion
Martin
Monroe
Okaloosa
Okeechobee
Orange
Osceola
Palm Beach
Pasco
Pinellas
Polk
Putnam
Santa Rosa
Sarasota
Seminole
St. Lucie
Sumter
Suwannee
Taylor
Union

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

1
Name of Service Area
Wakulla
Walton
Washington
.....

- 13.1 Do you act as a custodian for health savings accounts? Yes [] No [X]
- 13.2 If yes, please provide the amount of custodial funds held as of the reporting date.\$
- 13.3 Do you act as an administrator for health savings accounts? Yes [] No [X]
- 13.4 If yes, please provide the balance of funds administered as of the reporting date.\$
- 14.1 Are any of the captive affiliates reported on Schedule S, Part 3, authorized reinsurers? Yes [] No [X] N/A []
- 14.2 If the answer to 14.1 is yes, please provide the following:

1 Company Name	2 NAIC Company Code	3 Domiciliary Jurisdiction	4 Reserve Credit	Assets Supporting Reserve Credit		
				5 Letters of Credit	6 Trust Agreements	7 Other
.....

15. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded):
- 15.1 Direct Premium Written\$
- 15.2 Total Incurred Claims\$
- 15.3 Number of Covered Lives

*Ordinary Life Insurance Includes
Term(whether full underwriting, limited underwriting, jet issue, "short form app")
Whole Life (whether full underwriting, limited underwriting, jet issue, "short form app")
Variable Life (with or without secondary gurantee)
Universal Life (with or without secondary gurantee)
Variable Universal Life (with or without secondary gurantee)

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

FIVE-YEAR HISTORICAL DATA

	1 2016	2 2015	3 2014	4 2013	5 2012
Balance Sheet (Pages 2 and 3)					
1. Total admitted assets (Page 2, Line 28)	293,971,394	183,316,055	199,847,663	77,612,488	43,491,061
2. Total liabilities (Page 3, Line 24)	180,576,650	137,198,837	172,528,370	64,312,121	32,529,724
3. Statutory minimum capital and surplus requirement	24,592,816	19,724,093	17,252,837	8,467,663	3,252,972
4. Total capital and surplus (Page 3, Line 33)	113,394,744	46,117,218	27,319,293	13,300,367	10,961,337
Income Statement (Page 4)					
5. Total revenues (Line 8)	1,213,859,571	986,204,659	834,607,654	423,383,150	149,958,347
6. Total medical and hospital expenses (Line 18)	990,261,853	833,041,758	739,324,144	365,609,057	116,526,276
7. Claims adjustment expenses (Line 20)	54,124,675	25,588,128	7,031,268	3,816,454	622,384
8. Total administrative expenses (Line 21)	74,514,230	85,788,144	65,803,921	41,421,479	30,496,823
9. Net underwriting gain (loss) (Line 24)	94,958,813	41,786,629	22,448,321	12,536,160	2,312,864
10. Net investment gain (loss) (Line 27)	1,545,515	748,561	287,004	165,635	81,785
11. Total other income (Lines 28 plus 29)	(42,336)	(422,334)	(99,140)	(85,524)	(83,257)
12. Net income or (loss) (Line 32)	55,584,861	21,810,919	11,856,730	8,135,542	2,051,006
Cash Flow (Page 6)					
13. Net cash from operations (Line 11)	96,802,893	(2,167,043)	90,771,219	34,865,839	23,747,224
Risk-Based Capital Analysis					
14. Total adjusted capital	113,394,744	46,117,218	27,319,293	13,300,367	10,961,337
15. Authorized control level risk-based capital	35,332,507	35,244,437	31,723,226	15,635,727	5,436,960
Enrollment (Exhibit 1)					
16. Total members at end of period (Column 5, Line 7)	133,053	116,224	116,166	66,244	37,306
17. Total members months (Column 6, Line 7)	1,538,368	1,366,614	1,103,246	667,160	380,645
Operating Percentage (Page 4) (Item divided by Page 4, sum of Lines 2, 3 and 5) x 100.0					
18. Premiums earned plus risk revenue (Line 2 plus Lines 3 and 5)	100.0	100.0	100.0	100.0	100.0
19. Total hospital and medical plus other non-health (Lines 18 plus Line 19)	81.6	84.5	88.6	86.4	77.7
20. Cost containment expenses	2.7	0.0	0.0	0.0	0.0
21. Other claims adjustment expenses	1.7	0.0	0.0	0.0	0.0
22. Total underwriting deductions (Line 23)	92.2	95.8	97.3	97.0	98.5
23. Total underwriting gain (loss) (Line 24)	7.8	4.2	2.7	3.0	1.5
Unpaid Claims Analysis (U&I Exhibit, Part 2B)					
24. Total claims incurred for prior years (Line 13, Col. 5)	86,214,672	92,941,231	56,603,830	15,977,491	7,165,528
25. Estimated liability of unpaid claims-[prior year (Line 13, Col. 6)]	100,555,494	98,785,406	52,349,879	17,898,835	8,143,563
Investments In Parent, Subsidiaries and Affiliates					
26. Affiliated bonds (Sch. D Summary, Line 12, Col. 1)		0	0	0	0
27. Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1)		0	0	0	0
28. Affiliated common stocks (Sch. D Summary, Line 24, Col. 1)		0	0	0	0
29. Affiliated short-term investments (subtotal included in Schedule DA Verification, Col. 5, Line 10)	0	0	0	0	0
30. Affiliated mortgage loans on real estate					
31. All other affiliated					
32. Total of above Lines 26 to 31	0	0	0	0	0
33. Total investment in parent included in Lines 26 to 31 above.					

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3, Accounting Changes and Correction of Errors?

If no, please explain:

Yes [] No []



ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.
EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION Simply Healthcare Plans, Inc. 2. Miami, FL

NAIC Group Code 0000		BUSINESS IN THE STATE OF Florida		DURING THE YEAR 2016							(LOCATION)
		1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10
		Total	2	3	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
			Individual	Group							
Total Members at end of:											
1.	Prior Year	116,224	0	0	0	0	0	0	24,914	91,310	0
2.	First Quarter	126,060							32,148	93,912	
3.	Second Quarter	125,831							33,600	92,231	
4.	Third Quarter	129,161							35,469	93,692	
5.	Current Year	133,053							37,160	95,893	
6.	Current Year Member Months	1,538,368							406,319	1,132,049	
Total Member Ambulatory Encounters for Year:											
7.	Physician	1,565,764							486,692	1,079,072	
8.	Non-Physician	124,208							27,202	97,006	
9.	Total	1,689,972	0	0	0	0	0	0	513,894	1,176,078	0
10.	Hospital Patient Days Incurred	88,266							47,162	41,104	
11.	Number of Inpatient Admissions	16,887							9,093	7,794	
12.	Health Premiums Written (b)	1,230,056,168							555,069,677	674,986,491	
13.	Life Premiums Direct	0									
14.	Property/Casualty Premiums Written	0									
15.	Health Premiums Earned	1,214,274,936							552,230,526	662,044,410	
16.	Property/Casualty Premiums Earned	0									
17.	Amount Paid for Provision of Health Care Services	965,480,253							424,111,888	541,368,365	
18.	Amount Incurred for Provision of Health Care Services	992,565,659							442,410,899	550,154,760	

(a) For health business: number of persons insured under PPO managed care products and number of persons insured under indemnity only products
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$555,069,677



ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.
EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION Simply Healthcare Plans, Inc. 2. Miami, FL

NAIC Group Code 0000		BUSINESS IN THE STATE OF		Grand Total		DURING THE YEAR		2016		(LOCATION)		NAIC Company Code 13726	
		1	Comprehensive (Hospital & Medical)		4	5	6	7	8	9	10		
		Total	2	3	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other		
Total Members at end of:			Individual	Group									
1. Prior Year		116,224	0	0	0	0	0	0	24,914	91,310	0		
2. First Quarter		126,060	0	0	0	0	0	0	32,148	93,912	0		
3. Second Quarter		125,831	0	0	0	0	0	0	33,600	92,231	0		
4. Third Quarter		129,161	0	0	0	0	0	0	35,469	93,692	0		
5. Current Year		133,053	0	0	0	0	0	0	37,160	95,893	0		
6. Current Year Member Months		1,538,368	0	0	0	0	0	0	406,319	1,132,049	0		
Total Member Ambulatory Encounters for Year:													
7. Physician		1,565,764	0	0	0	0	0	0	486,692	1,079,072	0		
8. Non-Physician		124,208	0	0	0	0	0	0	27,202	97,006	0		
9. Total		1,689,972	0	0	0	0	0	0	513,894	1,176,078	0		
10. Hospital Patient Days Incurred		88,266	0	0	0	0	0	0	47,162	41,104	0		
11. Number of Inpatient Admissions		16,887	0	0	0	0	0	0	9,093	7,794	0		
12. Health Premiums Written (b)		1,230,056,168	0	0	0	0	0	0	555,069,677	674,986,491	0		
13. Life Premiums Direct		0	0	0	0	0	0	0	0	0	0		
14. Property/Casualty Premiums Written		0	0	0	0	0	0	0	0	0	0		
15. Health Premiums Earned		1,214,274,936	0	0	0	0	0	0	552,230,526	662,044,410	0		
16. Property/Casualty Premiums Earned		0	0	0	0	0	0	0	0	0	0		
17. Amount Paid for Provision of Health Care Services		965,480,253	0	0	0	0	0	0	424,111,888	541,368,365	0		
18. Amount Incurred for Provision of Health Care Services		992,565,659	0	0	0	0	0	0	442,410,899	550,154,760	0		

(a) For health business: number of persons insured under PPO managed care products0 and number of persons insured under indemnity only products0 .
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$555,069,677

SCHEDULE S - PART 1 - SECTION 2

[illegible]

SCHEDULE S - PART 2

[illegible]

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE S - PART 3 - SECTION 2

Reinsurance Ceded Accident and Health Insurance Listed by Reinsuring Company as of December 31, Current Year

1 NAIC Company Code	2 ID Number	3 Effective Date	4 Name of Company	5 Domi- ciliary Juris- diction	6 Type of Reinsurance Ceded	7 Type of Business Ceded	8 Premiums	9 Unearned Premiums (Estimated)	10 Reserve Credit Taken Other than for Unearned Premiums	Outstanding Surplus Relief		13 Modified Coinsurance Reserve	14 Funds Withheld Under Coinsurance
										11 Current Year	12 Prior Year		
0399999. Total General Account - Authorized U.S. Affiliates							0	0	0	0	0	0	0
0699999. Total General Account - Authorized Non-U.S. Affiliates							0	0	0	0	0	0	0
0799999. Total General Account - Authorized Affiliates							0	0	0	0	0	0	0
.....11835.....	..04-1590940..	08/01/2015	Partner Re America Insurance Company	DE	SSL/A/I	MC	415,366						
0899999. General Account - Authorized U.S. Non-Affiliates							415,366	0	0	0	0	0	0
1099999. Total General Account - Authorized Non-Affiliates							415,366	0	0	0	0	0	0
1199999. Total General Account Authorized							415,366	0	0	0	0	0	0
1499999. Total General Account - Unauthorized U.S. Affiliates							0	0	0	0	0	0	0
1799999. Total General Account - Unauthorized Non-U.S. Affiliates							0	0	0	0	0	0	0
1899999. Total General Account - Unauthorized Affiliates							0	0	0	0	0	0	0
2199999. Total General Account - Unauthorized Non-Affiliates							0	0	0	0	0	0	0
2299999. Total General Account Unauthorized							0	0	0	0	0	0	0
2599999. Total General Account - Certified U.S. Affiliates							0	0	0	0	0	0	0
2899999. Total General Account - Certified Non-U.S. Affiliates							0	0	0	0	0	0	0
2999999. Total General Account - Certified Affiliates							0	0	0	0	0	0	0
3299999. Total General Account - Certified Non-Affiliates							0	0	0	0	0	0	0
3399999. Total General Account Certified							0	0	0	0	0	0	0
3499999. Total General Account Authorized, Unauthorized and Certified							415,366	0	0	0	0	0	0
3799999. Total Separate Accounts - Authorized U.S. Affiliates							0	0	0	0	0	0	0
4099999. Total Separate Accounts - Authorized Non-U.S. Affiliates							0	0	0	0	0	0	0
4199999. Total Separate Accounts - Authorized Affiliates							0	0	0	0	0	0	0
4499999. Total Separate Accounts - Authorized Non-Affiliates							0	0	0	0	0	0	0
4599999. Total Separate Accounts Authorized							0	0	0	0	0	0	0
4899999. Total Separate Accounts - Unauthorized U.S. Affiliates							0	0	0	0	0	0	0
5199999. Total Separate Accounts - Unauthorized Non-U.S. Affiliates							0	0	0	0	0	0	0
5299999. Total Separate Accounts - Unauthorized Affiliates							0	0	0	0	0	0	0
5599999. Total Separate Accounts - Unauthorized Non-Affiliates							0	0	0	0	0	0	0
5699999. Total Separate Accounts Unauthorized							0	0	0	0	0	0	0
5999999. Total Separate Accounts - Certified U.S. Affiliates							0	0	0	0	0	0	0
6299999. Total Separate Accounts - Certified Non-U.S. Affiliates							0	0	0	0	0	0	0
6399999. Total Separate Accounts - Certified Affiliates							0	0	0	0	0	0	0
6699999. Total Separate Accounts - Certified Non-Affiliates							0	0	0	0	0	0	0
6799999. Total Separate Accounts Certified							0	0	0	0	0	0	0
6899999. Total Separate Accounts Authorized, Unauthorized and Certified							0	0	0	0	0	0	0
6999999. Total U.S. (Sum of 0399999, 0899999, 1499999, 1999999, 2599999, 3099999, 3799999, 4299999, 4899999, 5399999, 5999999 and 6499999)							415,366	0	0	0	0	0	0
7099999. Total Non-U.S. (Sum of 0699999, 0999999, 1799999, 2099999, 2899999, 3199999, 4099999, 4399999, 5199999, 5499999, 6299999 and 6599999)							0	0	0	0	0	0	0
9999999 - Totals							415,366	0	0	0	0	0	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

Schedule S - Part 4

NONE

Schedule S - Part 4 - Bank Footnote

NONE

Schedule S - Part 5

NONE

Schedule S - Part 5 - Bank Footnote

NONE

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE S - PART 6

Five Year Exhibit of Reinsurance Ceded Business (000 Omitted)

	1 2016	2 2015	3 2014	4 2013	5 2012
A. OPERATIONS ITEMS					
1. Premiums .....	.0	.0	.0	.0	.15
2. Title XVIII - Medicare .....	.0	.494	.780	.637	.231
3. Title XIX - Medicaid .....	.415	.686	.507	.290	.259
4. Commissions and reinsurance expense allowance					
5. Total hospital and medical expenses					
B. BALANCE SHEET ITEMS					
6. Premiums receivable					
7. Claims payable .....	.0	.0	.0	.0	.0
8. Reinsurance recoverable on paid losses .....	.1,554	.253	.17	.0	.0
9. Experience rating refunds due or unpaid					
10. Commissions and reinsurance expense allowances due					
11. Unauthorized reinsurance offset					
12. Offset for reinsurance with Certified Reinsurers					
C. UNAUTHORIZED REINSURANCE (DEPOSITS BY AND FUNDS WITHHELD FROM)					
13. Funds deposited by and withheld from (F) .....	.0	.0	.0	.0	.0
14. Letters of credit (L) .....	.0	.0	.0	.0	.0
15. Trust agreements (T) .....	.0	.0	.0	.0	.0
16. Other (O) .....	.0	.0	.0	.0	.0
D. REINSURANCE WITH CERTIFIED REINSURERS (DEPOSITS BY AND FUNDS WITHHELD FROM)					
17. Multiple Beneficiary Trust .....		.0	.0	.0	.0
18. Funds deposited by and withheld from (F) .....		.0	.0	.0	.0
19. Letters of credit (L) .....		.0	.0	.0	.0
20. Trust agreements (T) .....		.0	.0	.0	.0
21. Other (O) .....		.0	.0	.0	.0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE S - PART 7

Restatement of Balance Sheet to Identify Net Credit For Ceded Reinsurance

	1 As Reported (net of ceded)	2 Restatement Adjustments	3 Restated (gross of ceded)
ASSETS (Page 2, Col. 3)			
1. Cash and invested assets (Line 12)	263,965,019		263,965,019
2. Accident and health premiums due and unpaid (Line 15)	19,245,782		19,245,782
3. Amounts recoverable from reinsurers (Line 16.1)	1,553,954		1,553,954
4. Net credit for ceded reinsurance	XXX	0	0
5. All other admitted assets (Balance)	9,206,639		9,206,639
6. Total assets (Line 28)	293,971,394	0	293,971,394
LIABILITIES, CAPITAL AND SURPLUS (Page 3)			
7. Claims unpaid (Line 1)	104,094,964		104,094,964
8. Accrued medical incentive pool and bonus payments (Line 2)	23,257,284		23,257,284
9. Premiums received in advance (Line 8)			0
10. Funds held under reinsurance treaties with authorized and unauthorized reinsurers (Line 19 first inset amount plus second inset amount)	0		0
11. Reinsurance in unauthorized companies (Line 20 minus inset amount)	0		0
12. Reinsurance with Certified Reinsurers (Line 20 inset amount)			0
13. Funds held under reinsurance treaties with Certified Reinsurers (Line 19 third inset amount)	0		0
14. All other liabilities (Balance)	53,224,402		53,224,402
15. Total liabilities (Line 24)	180,576,650	0	180,576,650
16. Total capital and surplus (Line 33)	113,394,744	XXX	113,394,744
17. Total liabilities, capital and surplus (Line 34)	293,971,394	0	293,971,394
NET CREDIT FOR CEDED REINSURANCE			
18. Claims unpaid	0		
19. Accrued medical incentive pool	0		
20. Premiums received in advance	0		
21. Reinsurance recoverable on paid losses	0		
22. Other ceded reinsurance recoverables	0		
23. Total ceded reinsurance recoverables	0		
24. Premiums receivable	0		
25. Funds held under reinsurance treaties with authorized and unauthorized reinsurers	0		
26. Unauthorized reinsurance	0		
27. Reinsurance with Certified Reinsurers	0		
28. Funds held under reinsurance treaties with Certified Reinsurers	0		
29. Other ceded reinsurance payables/offsets	0		
30. Total ceded reinsurance payables/offsets	0		
31. Total net credit for ceded reinsurance	0		

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE T PREMIUMS AND OTHER CONSIDERATIONS

Allocated by States and Territories									
States, etc.	1	Direct Business Only							
		2	3	4	5	6	7	8	9
	Active Status	Accident & Health Premiums	Medicare Title XVIII	Medicaid Title XIX	Federal Employees Health Benefits Plan Premiums	Life & Annuity Premiums & Other Considerations	Property/Casualty Premiums	Total Columns 2 Through 7	Deposit-Type Contracts
1. Alabama	AL	N						.0	
2. Alaska	AK	N						.0	
3. Arizona	AZ	N						.0	
4. Arkansas	AR	N						.0	
5. California	CA	N						.0	
6. Colorado	CO	N						.0	
7. Connecticut	CT	N						.0	
8. Delaware	DE	N						.0	
9. District of Columbia	DC	N						.0	
10. Florida	FL		555,069,677	674,986,491				1,230,056,168	
11. Georgia	GA	N						.0	
12. Hawaii	HI	N						.0	
13. Idaho	ID	N						.0	
14. Illinois	IL	N						.0	
15. Indiana	IN	N						.0	
16. Iowa	IA	N						.0	
17. Kansas	KS	N						.0	
18. Kentucky	KY	N						.0	
19. Louisiana	LA	N						.0	
20. Maine	ME	N						.0	
21. Maryland	MD	N						.0	
22. Massachusetts	MA	N						.0	
23. Michigan	MI	N						.0	
24. Minnesota	MN	N						.0	
25. Mississippi	MS	N						.0	
26. Missouri	MO	N						.0	
27. Montana	MT	N						.0	
28. Nebraska	NE	N						.0	
29. Nevada	NV	N						.0	
30. New Hampshire	NH	N						.0	
31. New Jersey	NJ	N						.0	
32. New Mexico	NM	N						.0	
33. New York	NY	N						.0	
34. North Carolina	NC	N						.0	
35. North Dakota	ND	N						.0	
36. Ohio	OH	N						.0	
37. Oklahoma	OK	N						.0	
38. Oregon	OR	N						.0	
39. Pennsylvania	PA	N						.0	
40. Rhode Island	RI	N						.0	
41. South Carolina	SC	N						.0	
42. South Dakota	SD	N						.0	
43. Tennessee	TN	N						.0	
44. Texas	TX	N						.0	
45. Utah	UT	N						.0	
46. Vermont	VT	N						.0	
47. Virginia	VA	N						.0	
48. Washington	WA	N						.0	
49. West Virginia	WV	N						.0	
50. Wisconsin	WI	N						.0	
51. Wyoming	WY	N						.0	
52. American Samoa	AS	N						.0	
53. Guam	GU	N						.0	
54. Puerto Rico	PR	N						.0	
55. U.S. Virgin Islands	VI	N						.0	
56. Northern Mariana Islands	MP	N						.0	
57. Canada	CAN	N						.0	
58. Aggregate other alien	OT	XXX	.0	.0	.0	.0	.0	.0	.0
59. Subtotal	XXX	.0	555,069,677	674,986,491	.0	.0	.0	1,230,056,168	.0
60. Reporting entity contributions for Employee Benefit Plans	XXX							.0	
61. Total (Direct Business)	(a) 1	0	555,069,677	674,986,491	0	0	0	1,230,056,168	0
DETAILS OF WRITE-INS									
58001.	XXX								
58002.	XXX								
58003.	XXX								
58998. Summary of remaining write-ins for Line 58 from overflow page	XXX	.0	.0	.0	.0	.0	.0	.0	.0
58999. Totals (Lines 58001 through 58003 plus 58998)(Line 58 above)	XXX	0	0	0	0	0	0	0	0

(L) Licensed or Chartered - Licensed Insurance Carrier or Domiciled RRG; (R) Registered - Non-domiciled RRGs; (Q) Qualified - Qualified or Accredited Reinsurer; (E) Eligible - Reporting Entities eligible or approved to write Surplus Lines in the state; (N) None of the above - Not allowed to write business in the state.
Explanation of basis of allocation by states, premiums by state, etc.

by states, premiums by state, etc.
(a) Insert the number of L responses except for Canada and Other Alien.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE T - PART 2
INTERSTATE COMPACT - EXHIBIT OF PREMIUMS WRITTEN
Allocated by States and Territories

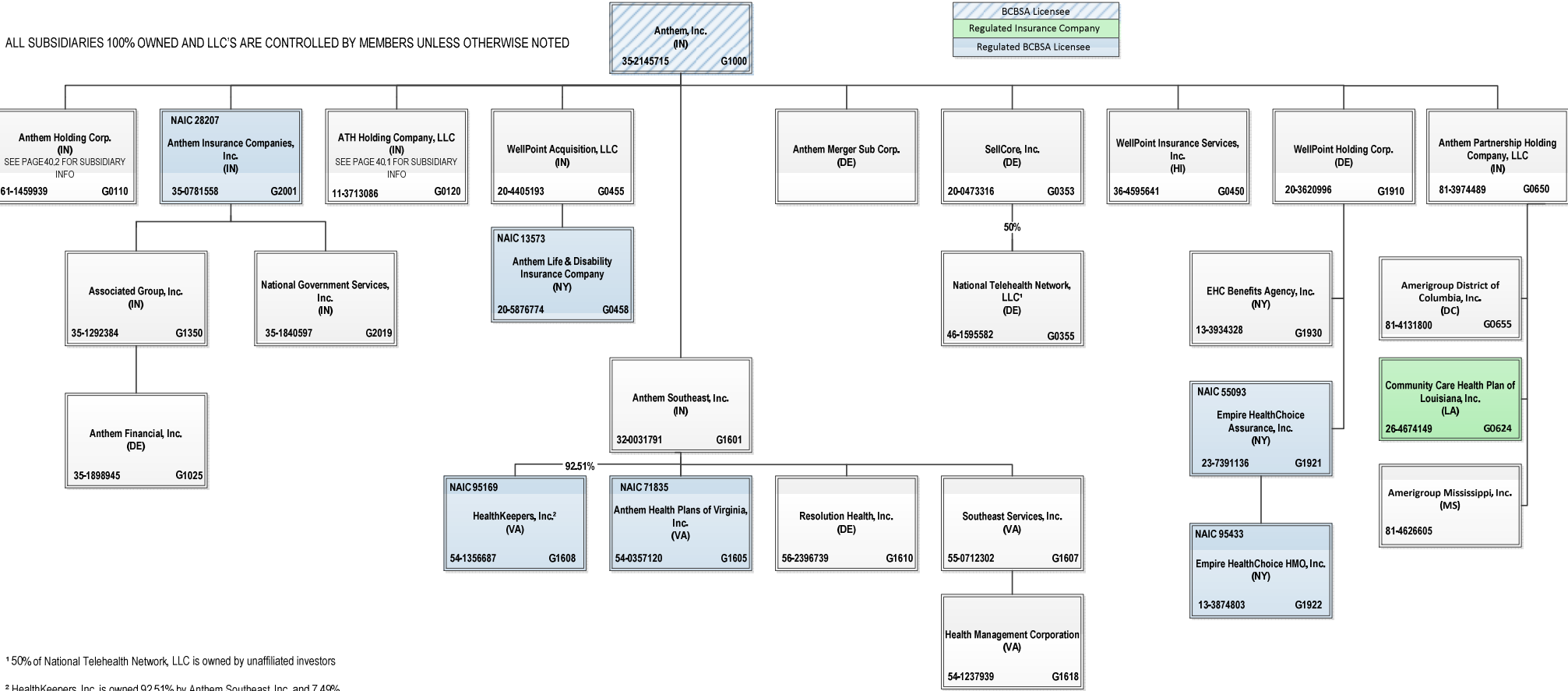
States, Etc.		Direct Business Only					6
		1	2	3	4	5	
		Life (Group and Individual)	Annuities (Group and Individual)	Disability Income (Group and Individual)	Long-Term Care (Group and Individual)	Deposit-Type Contracts	Totals
1.	Alabama.....AL						
2.	Alaska.....AK						
3.	Arizona.....AZ						
4.	Arkansas.....AR						
5.	California.....CA						
6.	Colorado.....CO						
7.	Connecticut.....CT						
8.	Delaware.....DE						
9.	District of Columbia.....DC						
10.	Florida.....FL						
11.	Georgia.....GA						
12.	Hawaii.....HI						
13.	Idaho.....ID						
14.	Illinois.....IL						
15.	Indiana.....IN						
16.	Iowa.....IA						
17.	Kansas.....KS						
18.	Kentucky.....KY						
19.	Louisiana.....LA						
20.	Maine.....ME						
21.	Maryland.....MD						
22.	Massachusetts.....MA						
23.	Michigan.....MI						
24.	Minnesota.....MN						
25.	Mississippi.....MS						
26.	Missouri.....MO						
27.	Montana.....MT						
28.	Nebraska.....NE						
29.	Nevada.....NV						
30.	New Hampshire.....NH						
31.	New Jersey.....NJ						
32.	New Mexico.....NM						
33.	New York.....NY						
34.	North Carolina.....NC						
35.	North Dakota.....ND						
36.	Ohio.....OH						
37.	Oklahoma.....OK						
38.	Oregon.....OR						
39.	Pennsylvania.....PA						
40.	Rhode Island.....RI						
41.	South Carolina.....SC						
42.	South Dakota.....SD						
43.	Tennessee.....TN						
44.	Texas.....TX						
45.	Utah.....UT						
46.	Vermont.....VT						
47.	Virginia.....VA						
48.	Washington.....WA						
49.	West Virginia.....WV						
50.	Wisconsin.....WI						
51.	Wyoming.....WY						
52.	American Samoa.....AS						
53.	Guam.....GU						
54.	Puerto Rico.....PR						
55.	U.S. Virgin Islands.....VI						
56.	Northern Mariana Islands.....MP						
57.	Canada.....CAN						
58.	Aggregate Other Alien.....OT						
59.	Total						

NONE

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 – ORGANIZATIONAL CHART



¹ 50% of National Telehealth Network, LLC is owned by unaffiliated investors

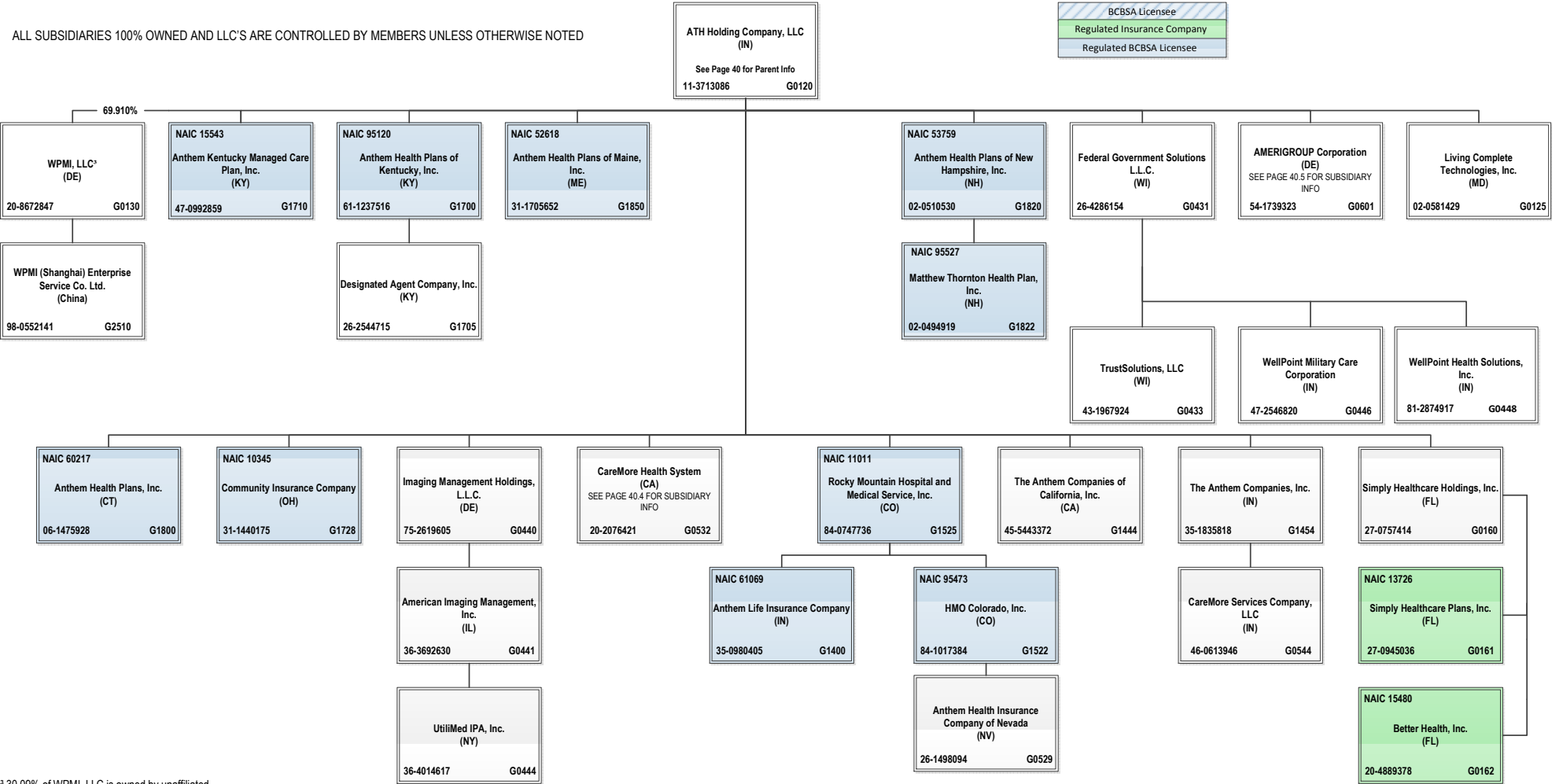
² HealthKeepers, Inc. is owned 92.51% by Anthem Southeast, Inc. and 7.49% by UNICARE National Services, Inc.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



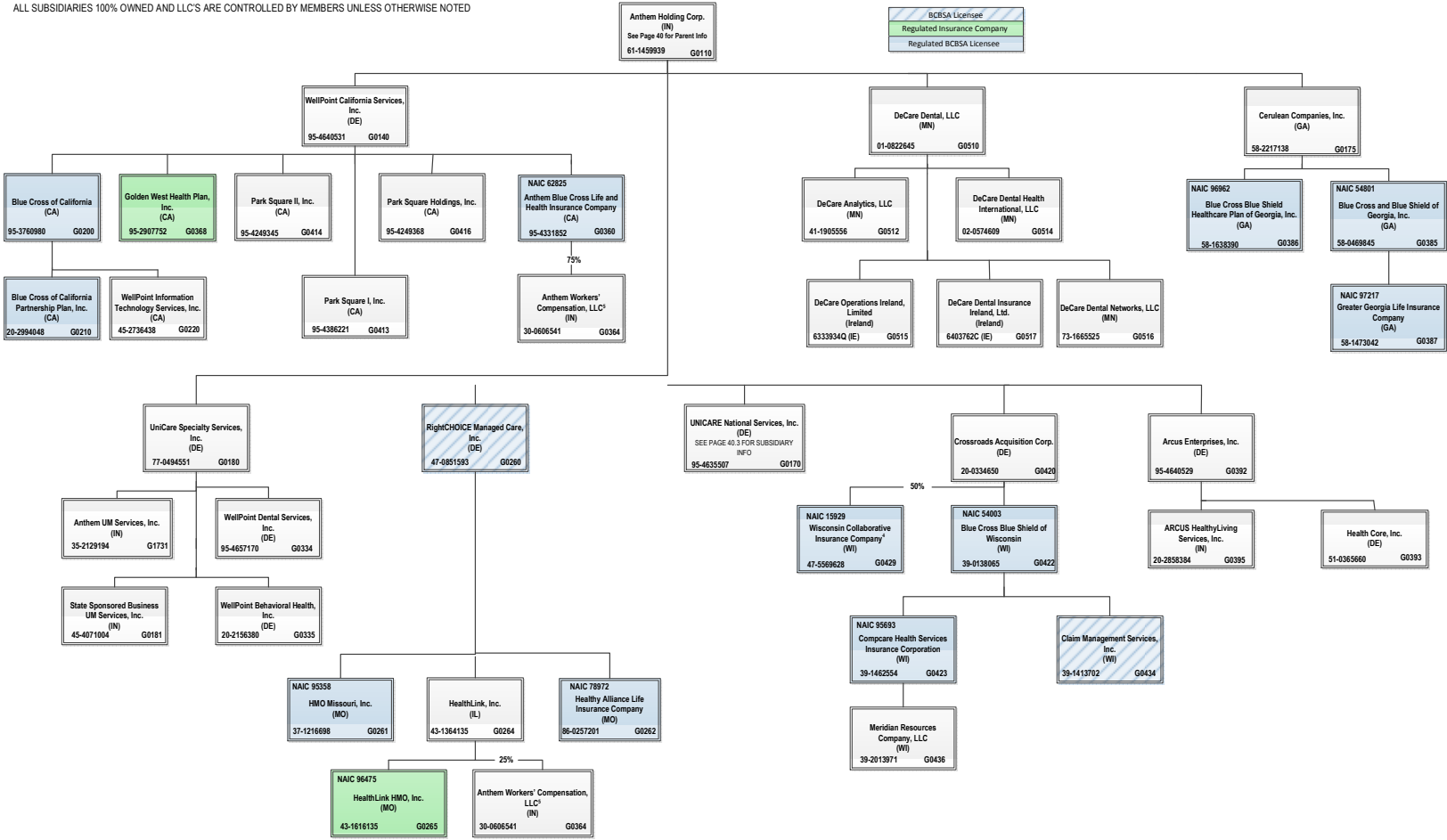
³ 30.09% of WPMI, LLC is owned by unaffiliated investors

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



⁴ 50% of WCIC is owned by an unaffiliated investor.

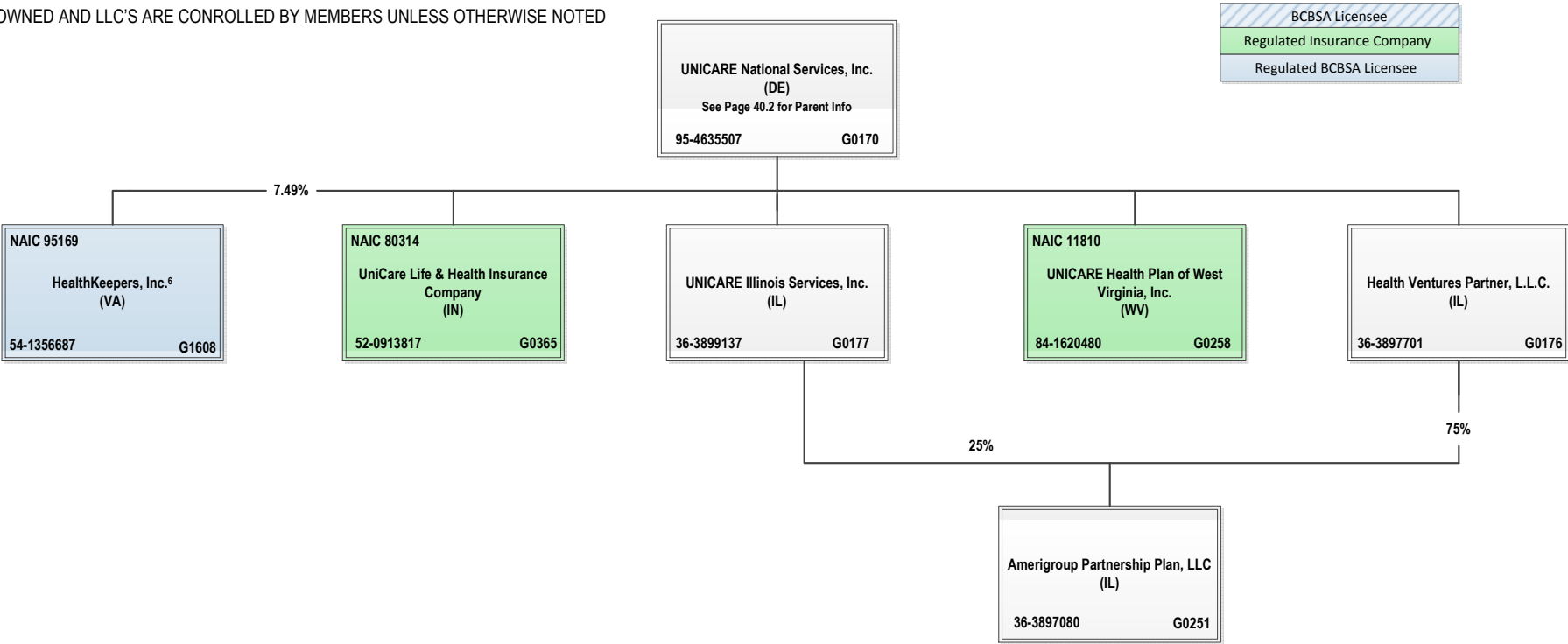
¹ Anthem Workers' Compensation LLC is owned 75% by Anthem Blue Cross Life and Health Insurance Company and 25% by HealthLink, Inc.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



⁶ HealthKeepers, Inc. is owned 92.51% by Anthem Southeast, Inc. and 7.49% by UNICARE National Services, Inc.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

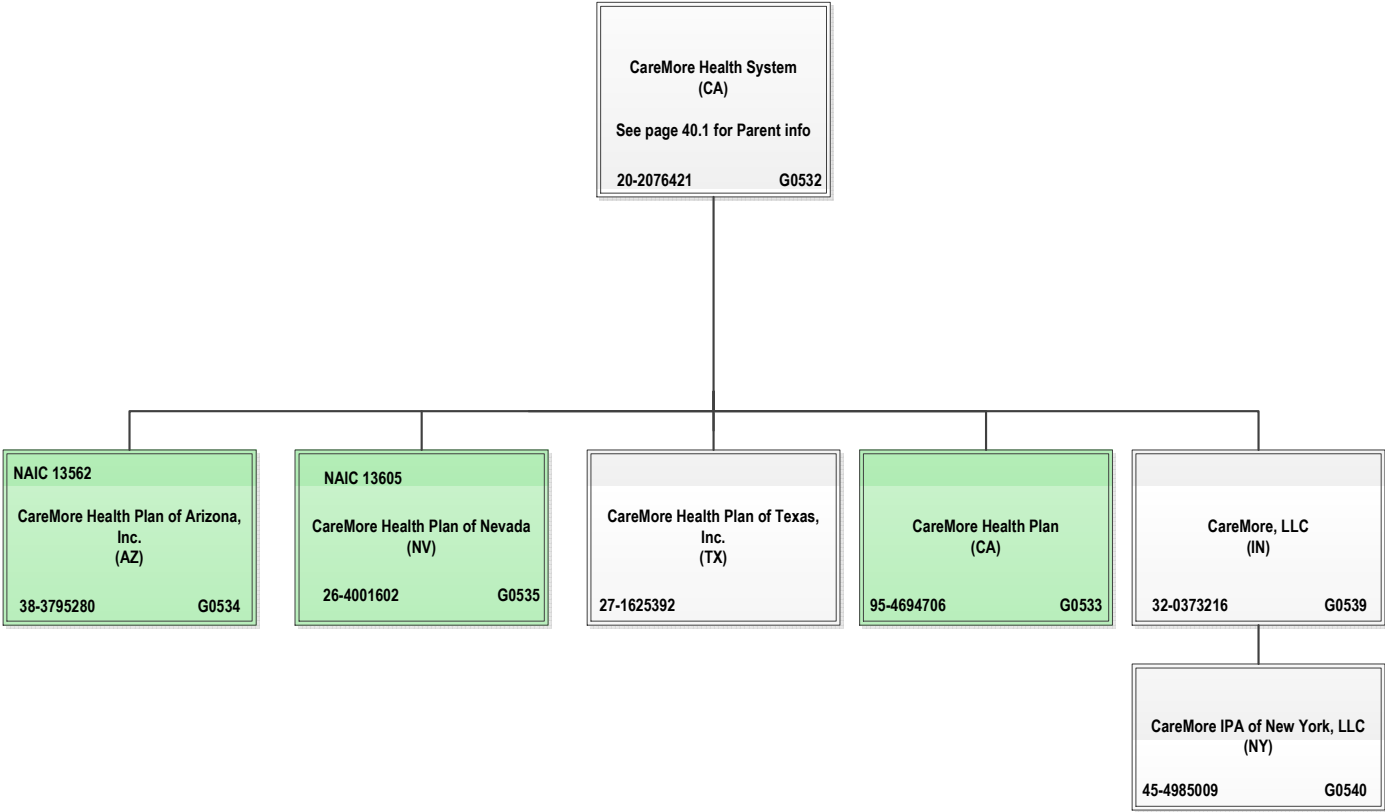
SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC’S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED

BCBSA Licensee
Regulated Insurance Company
Regulated BCBSA Licensee

40.4



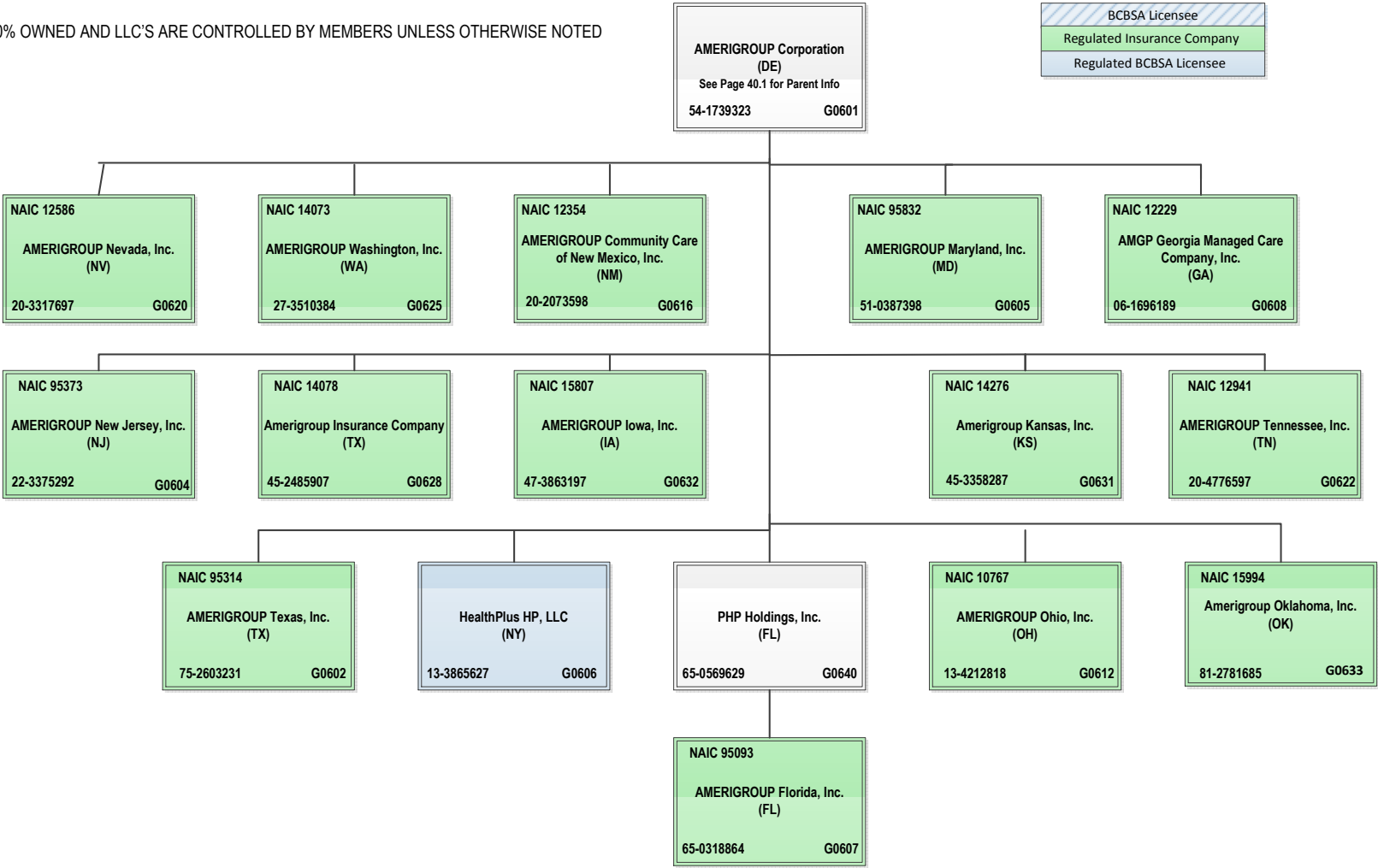
ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED

40.5



ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE Y
PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Required? (Y/N)	*
.0671	Anthem, Inc.		36-3692630				American Imaging Management, Inc. AMERIGROUP Community Care of New Mexico, Inc.	IL	NIA	Imaging Management Holdings, L.L.C.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	12354	20-2073598				AMERIGROUP Corporation	MI	IA	AMERIGROUP Corporation	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		54-1739323				Amegrup District of Columbia, Inc.	DE	NIA	ATH Holding Company, LLC	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		81-4131800				AMERIGROUP Florida, Inc.	DC	NIA	Anthem Partnership Holding Company, LLC	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	95093	65-0318864				AMERIGROUP Insurance Company	FL	IA	PHP Holdings, Inc.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	14078	45-2485907				AMERIGROUP Iowa, Inc.	TX	IA	AMERIGROUP Corporation	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	15807	47-3863197				Amegrup Kansas, Inc.	IA	IA	AMERIGROUP Corporation	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	14276	45-3358287				AMERIGROUP Maryland, Inc.	KS	IA	AMERIGROUP Corporation	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	95832	51-0387398				Amegrup Mississippi, Inc.	MD	IA	AMERIGROUP Corporation	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		81-4626605				AMERIGROUP Nevada, Inc.	MS	NIA	Anthem Partnership Holding Company, LLC	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	12586	20-3317697				AMERIGROUP New Jersey, Inc.	NV	IA	AMERIGROUP Corporation	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	95373	22-3375292				AMERIGROUP Ohio, Inc.	NJ	IA	AMERIGROUP Corporation	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	10767	13-4212818				AMERIGROUP Oklahoma, Inc.	OH	IA	AMERIGROUP Corporation	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	15994	81-2781685				Amegrup Partnership Plan, LLC	OK	IA	AMERIGROUP Corporation	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		36-3897080				AMERIGROUP Tennessee, Inc.	IL	NIA	Health Ventures Partner, L.L.C.	Ownership.....	75.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		36-3897080				AMERIGROUP Texas, Inc.	IL	NIA	UNICARE Illinois Services, Inc.	Ownership.....	25.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	12941	20-4776597				AMERIGROUP Washington, Inc.	TN	IA	AMERIGROUP Corporation	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	95314	75-2603231				AMGP Georgia Managed Care Company, Inc.	TX	IA	AMERIGROUP Corporation	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	14073	27-3510384				Anthem Blue Cross Life and Health Insurance Company	WA	IA	AMERIGROUP Corporation	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	12229	06-1696189				Anthem Financial, Inc.	GA	IA	AMERIGROUP Corporation	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	62825	95-4331852				Anthem Health Insurance Company of Nevada	CA	IA	WellPoint California Services, Inc.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		35-1898945				Anthem Health Plans of Kentucky, Inc.	DE	NIA	Associated Group, Inc.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		26-1498094				Anthem Health Plans of Maine, Inc.	NV	NIA	HMO Colorado, Inc.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	95120	61-1237516				Anthem Health Plans of New Hampshire, Inc.	KY	IA	ATH Holding Company, LLC	Ownership.....	100.000	Anthem, Inc.	Y	0108
.0671	Anthem, Inc.	52618	31-1705652				Anthem Health Plans of Virginia, Inc.	ME	IA	ATH Holding Company, LLC	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	53759	02-0510530				Anthem Holding Corp.	NH	IA	ATH Holding Company, LLC	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	71835	54-0357120	40003317		New York Stock Exchange (NYSE)	Anthem Insurance Companies, Inc.	VA	IA	Anthem Southeast, Inc.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	60217	06-1475928				Anthem Kentucky Managed Care Plan, Inc.	CT	IA	ATH Holding Company, LLC	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		61-1459939				Anthem Life & Disability Insurance Company	IN	NIA	Anthem, Inc.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		35-2145715		6324		Anthem Life Insurance Company	IN	UIP		Ownership.....			N	
.0671	Anthem, Inc.	28207	35-0781558				Anthem Merger Sub Corp.	IN	IA	Anthem, Inc.	Ownership.....	100.000	Anthem, Inc.	Y	
.0671	Anthem, Inc.	15543	47-0992859				Anthem Partnership Holding Company, LLC	KY	IA	ATH Holding Company, LLC	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	13573	20-5876774				Anthem Southeast, Inc.	NY	IA	WellPoint Acquisition, LLC	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	61069	35-0980405				Anthem UH Services, Inc.			Rocky Mountain Hospital and Medical Service, Inc.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		81-3974489				Anthem Workers' Compensation, LLC	IN	IA	Anthem, Inc.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		32-0031791				Arcus Enterprises, Inc.	DE	NIA	Anthem, Inc.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		35-2129194				ARCUS HealthLiving Services, Inc.	DE	NIA	Anthem, Inc.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		30-0606541				Associated Group, Inc.	IN	NIA	Anthem Insurance Companies, Inc.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		30-0606541				ATH Holding Company, LLC	IN	NIA	Anthem, Inc.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		95-4640529				Better Health, Inc.	IN	UIP	Anthem, Inc.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		20-2858384				Blue Cross and Blue Shield of Georgia, Inc.	IN	IA	Simply Healthcare Holdings, Inc.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		35-1292384				Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	FL	IA	Cerulean Companies, Inc.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		11-3713086				Georgia, Inc.	GA	IA	Cerulean Companies, Inc.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	15480	20-4899378				Blue Cross Blue Shield of Wisconsin	GA	IA	Cerulean Companies, Inc.	Ownership.....	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	54801	58-0469845					WI	IA	Crossroads Acquisition Corp.	Ownership.....	100.000	Anthem, Inc.	Y	0108
.0671	Anthem, Inc.	96962	58-1638390												
.0671	Anthem, Inc.	54003	39-0138065												

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE Y
PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domi-ciliary Location	Relation-ship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Owner-ship Provide Percen-tage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Re-quired? (Y/N)	*
..0671	Anthem, Inc. ....	.....	95-3760980	.....	.....	.....	Blue Cross of California	..CA	..IA	WellPoint California Services, Inc.	Ownership.....	100.000	Anthem, Inc. ....	..N	..0101
..0671	Anthem, Inc. ....	.....	20-2994048	.....	.....	.....	Blue Cross of California Partnership Plan, Inc. ....	..CA	..IA	Blue Cross of California	Ownership.....	100.000	Anthem, Inc. ....	..N	..0102
..0671	Anthem, Inc. ....	.....	95-4694706	.....	.....	.....	CareMore Health Plan	..CA	..IA	CareMore Health System	Ownership.....	100.000	Anthem, Inc. ....	..N	..0103
..0671	Anthem, Inc.	13582	38-3795280	.....	.....	.....	CareMore Health Plan of Arizona, Inc. ....	..AZ	..IA	CareMore Health System	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc.	13605	26-4001602	.....	.....	.....	CareMore Health Plan of Nevada	..NV	..IA	CareMore Health System	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	27-1625392	.....	.....	.....	CareMore Health Plan of Texas, Inc. ....	..TX	..NIA	CareMore Health System	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	45-4965009	.....	.....	.....	CareMore IPA of New York, LLC	..NY	..NIA	CareMore, LLC	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	32-0373216	.....	.....	.....	CareMore, LLC	..IN	..NIA	CareMore Health System	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	20-2076421	.....	.....	.....	CareMore Health System	..CA	..NIA	ATH Holding Company, LLC	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	46-0613946	.....	.....	.....	CareMore Services Company, LLC	..IN	..NIA	The Anthem Companies, Inc.	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	58-2217138	.....	.....	.....	Cerulean Companies, Inc.	..GA	..NIA	Anthem Holding Corp.	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	39-1413702	.....	.....	.....	Claim Management Services, Inc.	..WI	..NIA	Blue Cross Blue Shield of Wisconsin	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc.	14064	26-4674149	.....	.....	.....	Community Care Health Plan of Louisiana, Inc. ....	..LA	..IA	Anthem Partnership Holding Company, LLC	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc.	10345	31-1440175	.....	.....	.....	Community Insurance Company	..OH	..IA	ATH Holding Company, LLC	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc.	95693	39-1462554	.....	.....	.....	Compcare Health Services Insurance Corporation	..WI	..IA	Blue Cross Blue Shield of Wisconsin	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	20-0334650	.....	.....	.....	Crossroads Acquisition Corp.	..DE	..NIA	Anthem Holding Corp.	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	41-1905556	.....	.....	.....	DeCare Analytics, LLC	..MN	..NIA	DeCare Dental, LLC	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	02-0574609	.....	.....	.....	DeCare Dental Health International, LLC	..MN	..NIA	DeCare Dental, LLC	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	73-1665525	.....	.....	.....	DeCare Dental Insurance Ireland, Ltd.	..JRL	..NIA	DeCare Dental, LLC	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	01-0822645	.....	.....	.....	DeCare Dental Networks, LLC	..MN	..NIA	DeCare Dental, LLC	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	DeCare Dental, LLC	.....	.....	.....	DeCare Dental, LLC	..MN	..NIA	Anthem Holding Corp.	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	DeCare Operations Ireland, Limited	.....	.....	.....	DeCare Operations Ireland, Limited	..JRL	..NIA	DeCare Dental, LLC	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	26-2544715	.....	.....	.....	Designated Agent Company, Inc.	..KY	..NIA	Anthem Health Plans of Kentucky, Inc.	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	13-3934328	.....	.....	.....	EHC Benefits Agency, Inc.	..NY	..NIA	WellPoint Holding Corp	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc.	55093	23-7391136	.....	.....	.....	Empire HealthChoice Assurance, Inc.	..NY	..IA	WellPoint Holding Corp	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc.	95433	13-3874803	.....	.....	.....	Empire HealthChoice HMO, Inc.	..NY	..IA	Empire HealthChoice Assurance, Inc.	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	26-4286154	.....	.....	.....	Federal Government Solutions, LLC	..WI	..NIA	ATH Holding Company, LLC	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	95-2907752	.....	.....	.....	Golden West Health Plan, Inc.	..CA	..IA	WellPoint California Services, Inc.	Ownership.....	100.000	Anthem, Inc. ....	..N	..0104
..0671	Anthem, Inc.	97217	58-1473042	.....	.....	.....	Greater Georgia Life Insurance Company	..GA	..IA	Blue Cross and Blue Shield of Georgia, Inc.	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	51-0365660	.....	.....	.....	Health Core, Inc.	..DE	..NIA	Arcus Enterprises, Inc.	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	54-1237939	.....	.....	.....	Health Management Corporation	..VA	..NIA	Southeast Services, Inc.	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	36-3897701	.....	.....	.....	Health Ventures Partner, L.L.C.	..IL	..NIA	UNICARE National Services, Inc.	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc.	95169	54-1356687	.....	.....	.....	HealthKeepers, Inc.	..VA	..IA	Anthem Southeast, Inc.	Ownership.....	92.510	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc.	95169	54-1356687	.....	.....	.....	HealthKeepers, Inc.	..VA	..IA	UNICARE National Services, Inc.	Ownership.....	7.490	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc.	96475	43-1616135	.....	.....	.....	HealthLink HMO, Inc.	..MD	..IA	HealthLink, Inc.	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	43-1364135	.....	.....	.....	HealthLink, Inc.	..IL	..NIA	RightCHOICE Managed Care, Inc.	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	13-3865627	.....	.....	.....	HealthPlus HP, LLC	..NY	..IA	AMERIGROUP Corporation	Ownership.....	100.000	Anthem, Inc. ....	..N	..0100
..0671	Anthem, Inc.	78972	86-0257201	.....	.....	.....	Healthy Alliance Life Insurance Company	..MO	..NIA	RightCHOICE Managed Care, Inc.	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc.	95473	84-1017384	.....	.....	.....	HMO Colorado, Inc.	..CO	..IA	Rocky Mountain Hospital and Medical Service, Inc.	Ownership.....	100.000	Anthem, Inc. ....	..Y	..0108
..0671	Anthem, Inc.	95358	37-1216698	.....	.....	.....	HMO Missouri, Inc.	..MO	..IA	RightCHOICE Managed Care, Inc.	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	75-2619605	.....	.....	.....	Imaging Management Holdings, L.L.C.	..DE	..NIA	ATH Holding Company, LLC	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	02-0581429	.....	.....	.....	Living Complete Technologies, Inc.	..MD	..NIA	ATH Holding Company, LLC	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc.	95527	02-0494919	.....	.....	.....	Matthew Thornton Health Plan, Inc.	..NH	..IA	Anthem Health Plans of New Hampshire, Inc.	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	39-2013971	.....	.....	.....	Meridian Resource Company, LLC	..WI	..NIA	Compcare Health Services Insurance Corporation	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	35-1840597	.....	.....	.....	National Government Services, Inc.	..IN	..NIA	Anthem Insurance Companies, Inc.	Ownership.....	100.000	Anthem, Inc. ....	..N	.....
..0671	Anthem, Inc. ....	.....	46-1595582	.....	.....	.....	National Telehealth Network, LLC	..DE	..NIA	Sellcore, Inc.	Ownership.....	50.000	Anthem, Inc. ....	..N	..0105
..0671	Anthem, Inc.	95-4249368	Park Square Holdings, Inc.	..CA	..NIA	WellPoint California Services, Inc.	Ownership.....	100.000	Anthem, Inc.N

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE Y
PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Required? (Y/N)	*
.0671	Anthem, Inc.		95-4386221				Park Square I, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		95-4249345				Park Square II, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		65-0569629				PHP Holdings, Inc.	FL	NIA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		56-2396739				Resolution Health, Inc.	DE	NIA	Anthem Southeast, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		47-0851593				RightCHOICE Managed Care, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	11011	84-0747736				Rocky Mountain Hospital and Medical Service, Inc.	CO	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		20-0473316				SellCore, Inc.	DE	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		27-0757414				Simply Healthcare Holdings, Inc.	FL	UDP	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	13726	27-0945036				Simply Healthcare Plans, Inc.	FL	RE	Simply Healthcare Holdings, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		55-0712302				Southeast Services, Inc.	VA	NIA	Anthem Southeast, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		45-4071004				State Sponsored Business UM Services, Inc.	IN	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		35-1835818				The Anthem Companies, Inc.	IN	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		45-5443372				The Anthem Companies of California, Inc.	CA	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		43-1967924				TrustSolutions, LLC	WI	NIA	Government Health Services, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	11810	84-1620480				UNICARE Health Plan of West Virginia, Inc.	WV	IA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		36-3899137				UNICARE Illinois Services, Inc.	IL	NIA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	80314	52-0913817				UNICARE Life & Health Insurance Company	IN	IA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		95-4635507				UNICARE National Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		77-0494551				UNICARE Specialty Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		36-4014617				Utilimed IPA, Inc.	NY	NIA	American Imaging Management, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		20-4405193				WellPoint Acquisition, LLC	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		20-2156380				WellPoint Behavioral Health, Inc.	DE	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		95-4640531				WellPoint California Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		95-4657170				WellPoint Dental Services, Inc.	DE	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		81-2874917				WellPoint Health Solutions, Inc.	DE	NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		20-3620996				WellPoint Holding Corp	DE	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.						WellPoint Information Technology Services, Inc.	CA	NIA						
.0671	Anthem, Inc.		45-2736438				Inc.	CA	NIA	Blue Cross of California	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		36-4595641				WellPoint Insurance Services, Inc.	HI	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		47-2546820				WellPoint Military Care Corporation	IN	NIA	Government Health Services, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	15929	47-5569628				Wisconsin Collaborative Insurance Company	WI	IA	Crossroads Acquisition Corp.	Ownership	50.000	Anthem, Inc.	N	0107
.0671	Anthem, Inc.		98-0552141				WPMI (Shanghai) Enterprise Service Co. Ltd.	CHN	NIA	WPMI, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		20-8672847				WPMI, LLC	DE	NIA	ATH Holding Company, LLC	Ownership	69.910	Anthem, Inc.	N	0106

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Asterisk	Explanation
0100	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the New York State Department of Health.
0101	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0102	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0103	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0104	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0105	50% owned by unaffiliated investors
0106	30.09% owned by unaffiliated investors
0107	50% owned by an unaffiliated investor
0108	Received exemption from domestic regulator

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE Y
PART 2 - SUMMARY OF INSURER’S TRANSACTIONS WITH ANY AFFILIATES

1	2	3	4	5	6	7	8	9	10	11	12	13
NAIC Company Code	ID Number	Names of Insurers and Parent, Subsidiaries or Affiliates	Shareholder Dividends	Capital Contributions	Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	Management Agreements and Service Contracts	Income/ (Disbursements) Incurred Under Reinsurance Agreements	*	Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	Totals	Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
	36-3692630	American Imaging Management, Inc.					(45,143,273)				(45,143,273)	
12354	20-2073598	AMERIGROUP Community Care of New Mexico, Inc.										
	54-1739323	AMERIGROUP Corporation					(2,376,606)				(2,376,606)	
95093	65-0318864	AMERIGROUP Florida, Inc.			10,000,000		(23,463,877)				(23,463,877)	
14078	45-2485907	AMERIGROUP Insurance Company					(138,420,433)				(128,420,433)	
15807	47-3863197	AMERIGROUP Iowa, Inc.			250,000,000		(46,993,561)				(46,993,561)	
14276	45-3358287	AMERIGROUP Kansas, Inc.					(78,378,221)				171,621,779	
95832	51-0387398	AMERIGROUP Maryland, Inc.					(74,340,938)				(74,340,938)	
12586	20-3317697	AMERIGROUP Nevada, Inc.			(20,000,000)		(121,837,959)				(141,837,959)	
95373	22-3375292	AMERIGROUP New Jersey, Inc.			(50,000,000)		(61,302,699)				(61,302,699)	
10767	13-4212818	AMERIGROUP Ohio Inc					(145,692,060)				(195,692,060)	
	36-3897080	AMERIGROUP Partnership Plan, LLC					(469,933)				(469,933)	
12941	20-4776597	AMERIGROUP Tennessee, Inc.					(26,852,245)				(26,852,245)	
95314	75-2603231	AMERIGROUP Texas, Inc.			(30,000,000)		(190,076,813)				(190,076,813)	
14073	27-3510384	AMERIGROUP Washington, Inc.			(12,000,000)		(404,082,715)				(434,082,715)	
12229	06-1696189	AMGP Georgia Managed Care Company, Inc.			(15,000,000)		(68,215,341)				(80,215,341)	
62825	95-4331852	Anthem Blue Cross Life and Health Insurance Company, Inc.					(142,727,809)				(157,727,809)	
95120	61-1237516	Anthem Health Plans of Kentucky, Inc.			(235,600,000)		(941,956,611)	(983,470)			(1,178,540,081)	
52618	31-1705652	Anthem Health Plans of Maine, Inc.			(95,000,000)		(391,288,399)			3,138,000	(483,150,399)	
53759	02-0510530	Anthem Health Plans of New Hampshire, Inc.			(22,100,000)		(111,362,268)				(133,462,268)	
71835	54-0357120	Anthem Health Plans of Virginia, Inc.			(10,000,000)		(50,981,912)				(60,981,912)	
60217	06-1475928	Anthem Health Plans, Inc.			(216,100,000)		(614,651,485)	10,369,959		(3,540,000)	(823,921,526)	
28207	35-0781558	Anthem Insurance Companies, Inc.			(91,800,000)		(304,498,539)				(396,298,539)	
15543	47-0992859	Anthem Kentucky Managed Care Plan, Inc.			(325,000,000)		(1,254,634,382)	11,067,248			(1,568,567,134)	
13573	20-5876774	Anthem Life and Disability Insurance Company					(64,835,810)				(64,835,810)	
61069	35-0980405	Anthem Life Insurance Company			(18,900,000)		(1,071,963)				(1,071,963)	
	35-2145715	Anthem, Inc.			2,611,100,000	(300,000,000)	(35,571,292)	17,800,662			(36,670,630)	
	11-3713086	ATH Holding Company, LLC					6,354,566,658			402,000	8,666,068,658	
15480	20-4889378	Better Health, Inc.					(41,675,909)				(41,675,909)	
54801	58-0469845	Blue Cross and Blue Shield of Georgia, Inc.					(40,459,168)				(40,459,168)	
96962	58-1638390	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.			(73,600,000)		(352,736,642)				(426,336,642)	
54003	39-0138065	Blue Cross Blue Shield of Wisconsin			(25,700,000)		(401,841,849)				(427,541,849)	
	95-3760980	Blue Cross of California			(60,000,000)		(137,431,914)				(197,431,914)	
	20-2994048	Blue Cross of California Partnership Plan, Inc.			(425,000,000)		(1,318,129,334)				(1,743,129,334)	
	95-4694706	Caremore Health Plan			(50,000,000)		(332,338,749)				(332,338,749)	
13562	38-3975280	Caremore Health Plan of Arizona, Inc.					(187,480,869)				(237,480,869)	
13605	26-4001602	Caremore Health Plan of Nevada					(36,300,363)				(36,300,363)	
							(21,134,855)				(21,134,855)	

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE Y
PART 2 - SUMMARY OF INSURER’S TRANSACTIONS WITH ANY AFFILIATES

1	2	3	4	5	6	7	8	9	10	11	12	13
NAIC Company Code	ID Number	Names of Insurers and Parent, Subsidiaries or Affiliates	Shareholder Dividends	Capital Contributions	Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	Management Agreements and Service Contracts	Income/ (Disbursements) Incurred Under Reinsurance Agreements	*	Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	Totals	Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
	32-0373216	Caremore, LLC					(11,857,052)				(11,857,052)	
14064	26-4674149	Community Care Health Plan of Louisiana, Inc.			20,000,000		(69,006,060)				(49,006,060)	
10345	31-1440175	Community Insurance Company		(266,200,000)			(911,412,383)				(1,177,612,383)	
95693	39-1462554	Compcare Health Services Insurance Corporation		(10,000,000)			(92,054,648)				(102,054,648)	
	01-0822645	DeCare Dental, LLC					(45,567,014)				(45,567,014)	
55093	23-7391136	Empire HealthChoice Assurance, Inc.		(250,000,000)			(528,256,823)				(778,256,823)	
95433	13-3874803	Empire HealthChoice HMO, Inc.					(122,558,319)				(122,558,319)	
	95-2907752	Golden West Health Plan, Inc.					(790,279)				(790,279)	
97217	58-1473042	Greater Georgia Life Insurance Company					(7,681,353)				(7,681,353)	
	51-0365660	Health Core, Inc.					(21,346,159)				(21,346,159)	1,511,335
95169	54-1356687	HealthKeepers, Inc.		(35,000,000)	15,000,000		(388,403,745)	(10,369,959)			(418,773,704)	
96475	43-1616135	HealthLink HMO, Inc.		(10,000,000)			5,219,475				(4,780,525)	
	43-1364135	HealthLink, Inc.					(60,489,216)				(60,489,216)	
	13-3865627	HealthPlus LLC					(300,587,736)				(300,587,736)	(4,585,268)
78972	86-0257201	Healthy Alliance Life Insurance Company		(105,200,000)			(294,007,288)				(399,207,288)	
95473	84-1017384	HMO Colorado, Inc.			15,000,000		(40,662,843)				(25,662,843)	(1,644,166)
95358	37-1216698	HMO Missouri, Inc.		(800,000)			(18,848,458)				(19,648,458)	
	98-0408753	HTH Re, LTD						983,470			983,470	
95527	02-0494919	Matthew Thornton Health Plan, Inc.		(30,000,000)			(75,499,873)				(105,499,873)	(23,079,605)
	35-1840597	National Government Services, Inc.					(20,169,845)				(20,169,845)	
	47-0851593	RightCHOICE Managed Care, Inc.					(22,510,682)				(22,510,682)	
11011	84-0747736	Rocky Mountain Hospital and Medical Service, Inc.		(78,100,000)	(15,000,000)		(257,720,740)				(350,820,740)	
13726	27-0945036	Simply Healthcare Plans, Inc.					(140,514,747)				(140,514,747)	
	45-5443372	The Anthem Companies of California, Inc.					146,341,009				146,341,009	
	35-1835818	The Anthem Companies, Inc.					4,887,345,537				4,887,345,537	
11810	84-1620480	UNICARE Health Plan of West Virginia, Inc.					(43,128,585)				(43,128,585)	
80314	52-0913817	UNICARE Life & Health Insurance Company		(50,000,000)			(48,109,062)	(28,867,910)			(126,976,972)	
	45-2736438	WellPoint Information Technology Services										
	47-2546820	WellPoint Military Care Corporation					349,756,226				349,756,226	
15929	47-5569628	Wisconsin Collaborative Insurance Company					(7,365,246)				(7,365,246)	
					5,000,000		(3,923,953)				1,076,047	
9999999 Control Totals			0	0	0	0	0	0	XXX	0	0	(27,797,704)

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES








The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

		Responses
MARCH FILING		
1.	Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?	SEE EXPLANATION
2.	Will an actuarial opinion be filed by March 1?	YES
3.	Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?.....	YES
4.	Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1?.....	YES
APRIL FILING		
5.	Will Management’s Discussion and Analysis be filed by April 1?	YES
6.	Will the Supplemental Investment Risks Interrogatories be filed by April 1?	YES
7.	Will the Accident and Health Policy Experience Exhibit be filed by April 1?	YES
JUNE FILING		
8.	Will an audited financial report be filed by June 1?	YES
9.	Will Accountant's Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?	YES
AUGUST FILING		
10.	Will the regulator-only (non-public) Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile and electronically with the NAIC (as a regulator-only non-public document) by August 1?	YES






The following supplemental reports are required to be filed as part of your annual statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a “NONE” report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

MARCH FILING		
11.	Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?	NO
12.	Will the Supplemental Life data due March 1 be filed with the state of domicile and the NAIC?	NO
13.	Will the Supplemental Property/Casualty data due March 1 be filed with the state of domicile and the NAIC?.....	NO
14.	Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1?.....	NO
15.	Will the actuarial opinion on participating and non-participating policies as required in Interrogatories 1 and 2 on Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?.....	NO
16.	Will the actuarial opinion on non-guaranteed elements as required in Interrogatory 3 to Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?.....	NO
17.	Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?.....	NO
18.	Will an approval from the reporting entity’s state of domicile for relief related to the five-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1?	NO
19.	Will an approval from the reporting entity’s state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1?	NO
20.	Will an approval from the reporting entity’s state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?.....	NO
APRIL FILING		
21.	Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?	NO
22.	Will the Supplemental Life data due April 1 be filed with the state of domicile and the NAIC?	NO
23.	Will the Supplemental Property/Casualty Insurance Expense Exhibit due April 1 be filed with any state that requires it, and, if so, the NAIC?	NO
24.	Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?	YES
25.	Will the regulator only (non-public) Supplemental Health Care Exhibit’s Expense Allocation Report be filed with the state of domicile and the NAIC by April 1?	YES
AUGUST FILING		
26.	Will Management’s Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?	YES
Explanations:		
1.	The annual filing for Florida isn't due until April 1, 2017.	
11.		
12.		
13.		
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21.		
22.		
23.		

Bar Codes:

11.	Medicare Supplement Insurance Experience Exhibit [Document Identifier 360]	
12.	Life Supplement [Document Identifier 205]	
13.	Property/Casualty Supplement [Document Identifier 207]	
14.	SIS Stockholder Information Supplement [Document Identifier 420]	
15.	Participating Opinion for Exhibit 5 [Document Identifier 371]	
16.	Non-Guaranteed Opinion for Exhibit 5 [Document Identifier 370]	
17.	Medicare Part D Coverage Supplement [Document Identifier 365]	
18.	Relief from the five-year rotation requirement for lead audit partner [Document Identifier 224]	

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.
SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

19.	Relief from the one-year cooling off period for independent CPA [Document Identifier 225]	 1 3 7 2 6 2 0 1 6 2 2 5 0 0 0 0 0
20.	Relief from the Requirements for Audit Committees [Document Identifier 226]	 1 3 7 2 6 2 0 1 6 2 2 6 0 0 0 0 0
21.	Long-Term Care Experience Reporting Forms [Document Identifier 306]	 1 3 7 2 6 2 0 1 6 3 0 6 0 0 0 0 0
22.	Life Supplement [Document Identifier 211]	 1 3 7 2 6 2 0 1 6 2 1 1 0 0 0 0 0
23.	Property/Casualty Supplement Insurance Expense Exhibit [Document Identifier 213]	 1 3 7 2 6 2 0 1 6 2 1 3 0 0 0 0 0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

OVERFLOW PAGE FOR WRITE-INS

Additional Write-ins for Assets Line 25				
	Current Year			Prior Year
	1	2	3	4
	Assets	Nonadmitted Assets	Net Admitted Assets (Cols. 1 - 2)	Net Admitted Assets
2504. Other Receivables	53,988	53,988	0	0
2505. State Income Receivables	629,827	0	629,827	
2597. Summary of remaining write-ins for Line 25 from overflow page	683,815	53,988	629,827	0

Additional Write-ins for Liabilities Line 23				
	Current Year			Prior Year
	1	2	3	4
	Covered	Uncovered	Total	Total
2304.			0	0
2305.			0	0
2397. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0

Additional Write-ins for Exhibit of Nonadmitted Assets Line 25			
	1	2	3
	Current Year Total Nonadmitted Assets	Prior Year Total Nonadmitted Assets	Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
2504. Other Receivables	53,988	0	(53,988)
2505. State Income Receivables			0
2597. Summary of remaining write-ins for Line 25 from overflow page	53,988	0	(53,988)

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

OVERFLOW PAGE FOR WRITE-INS

Additional Write-ins for Analysis of Operations Line 5

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
0504.	0									XXX
0597. Summary of remaining write-ins for Line 5 from overflow page	0	0	0	0	0	0	0	0	0	XXX

Additional Write-ins for Analysis of Operations Line 6

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
0604.	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0697. Summary of remaining write-ins for Line 6 from overflow page	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0

Additional Write-ins for Analysis of Operations Line 13

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1304.	0									XXX
1397. Summary of remaining write-ins for Line 13 from overflow page	0	0	0	0	0	0	0	0	0	XXX

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SUMMARY INVESTMENT SCHEDULE

Investment Categories	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
	1	2	3	4	5	6
	Amount	Percentage	Amount	Securities Lending Reinvested Collateral Amount	Total (Col. 3 + 4) Amount	Percentage
1. Bonds:						
1.1 U.S. treasury securities		0.000			0	0.000
1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
1.21 Issued by U.S. government agencies		0.000			0	0.000
1.22 Issued by U.S. government sponsored agencies		0.000			0	0.000
1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)		0.000			0	0.000
1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S. :						
1.41 States, territories and possessions general obligations	2,009,718	0.761	2,009,718	0	2,009,718	0.761
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	11,785,267	4.465	11,785,267	0	11,785,267	4.465
1.43 Revenue and assessment obligations	51,797,766	19.623	51,797,766	0	51,797,766	19.623
1.44 Industrial development and similar obligations		0.000			0	0.000
1.5 Mortgage-backed securities (includes residential and commercial MBS):						
1.51 Pass-through securities:						
1.511 Issued or guaranteed by GNMA		0.000			0	0.000
1.512 Issued or guaranteed by FNMA and FHLMC		0.000			0	0.000
1.513 All other		0.000			0	0.000
1.52 CMOs and REMICs:						
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA		0.000			0	0.000
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521		0.000			0	0.000
1.523 All other		0.000			0	0.000
2. Other debt and other fixed income securities (excluding short-term):						
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)		0.000			0	0.000
2.2 Unaffiliated non-U.S. securities (including Canada)		0.000			0	0.000
2.3 Affiliated securities		0.000			0	0.000
3. Equity interests:						
3.1 Investments in mutual funds		0.000			0	0.000
3.2 Preferred stocks:						
3.21 Affiliated		0.000			0	0.000
3.22 Unaffiliated		0.000			0	0.000
3.3 Publicly traded equity securities (excluding preferred stocks):						
3.31 Affiliated		0.000			0	0.000
3.32 Unaffiliated		0.000			0	0.000
3.4 Other equity securities:						
3.41 Affiliated		0.000			0	0.000
3.42 Unaffiliated		0.000			0	0.000
3.5 Other equity interests including tangible personal property under lease:						
3.51 Affiliated		0.000			0	0.000
3.52 Unaffiliated		0.000			0	0.000
4. Mortgage loans:						
4.1 Construction and land development		0.000			0	0.000
4.2 Agricultural		0.000			0	0.000
4.3 Single family residential properties		0.000			0	0.000
4.4 Multifamily residential properties		0.000			0	0.000
4.5 Commercial loans		0.000			0	0.000
4.6 Mezzanine real estate loans		0.000			0	0.000
5. Real estate investments:						
5.1 Property occupied by company		0.000	0		0	0.000
5.2 Property held for production of income (including \$0 of property acquired in satisfaction of debt)		0.000	0		0	0.000
5.3 Property held for sale (including \$0 property acquired in satisfaction of debt)		0.000	0		0	0.000
6. Contract loans		0.000	0		0	0.000
7. Derivatives		0.000	0		0	0.000
8. Receivables for securities		0.000	0		0	0.000
9. Securities Lending (Line 10, Asset Page reinvested collateral)		0.000	0	XXX	XXX	XXX
10. Cash, cash equivalents and short-term investments	198,372,267	75.151	198,372,267	0	198,372,267	75.151
11. Other invested assets		0.000			0	0.000
12. Total invested assets	263,965,019	100.000	263,965,019	0	263,965,019	100.000

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

Schedule A - Verification - Real Estate

N O N E

Schedule B - Verification - Mortgage Loans

N O N E

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE BA - VERIFICATION BETWEEN YEARS

Other Long-Term Invested Assets

1.	Book/adjusted carrying value, December 31 of prior year	
2.	Cost of acquired:	
	2.1 Actual cost at time of acquisition (Part 2, Column 8)	
	2.2 Additional investment made after acquisition (Part 2, Column 9)	
3.	Capitalized deferred interest and other:	
	3.1 Totals, Part 1, Column 16	
	3.2 Totals, Part 3, Column 12	
4.	Accrual of discount	
5.	Unrealized valuation increase (decrease):	
	5.1 Totals, Part 1, Column 13	
	5.2 Totals, Part 3, Column 9	
6.	Total gain (loss) on disposals, Part 3, Column 19	
7.	Deduct amounts received on disposals, Part 3, Column 1	
8.	Deduct amortization of premium and depreciation	
9.	Total foreign exchange change in book/adjusted carrying value:	
	9.1 Totals, Part 1, Column 17	
	9.2 Totals, Part 3, Column 14	
10.	Deduct current year's other than temporary impairment recognized:	
	10.1 Totals, Part 1, Column 15	
	10.2 Totals, Part 3, Column 11	
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	
12.	Deduct total nonadmitted amounts	
13.	Statement value at end of current period (Line 11 minus Line 12)	

SCHEDULE D - VERIFICATION BETWEEN YEARS

Bonds and Stocks

1.	Book/adjusted carrying value, December 31 of prior year	64,559,755
2.	Cost of bonds and stocks acquired, Part 3, Column 7	5,551,297
3.	Accrual of discount	11,083
4.	Unrealized valuation increase (decrease):	
	4.1. Part 1, Column 12	(352,772)
	4.2. Part 2, Section 1, Column 15	
	4.3. Part 2, Section 2, Column 13	
	4.4. Part 4, Column 11	0 (352,772)
5.	Total gain (loss) on disposals, Part 4, Column 19	1,809
6.	Deduction consideration for bonds and stocks disposed of, Part 4, Column 7	3,288,239
7.	Deduct amortization of premium	890,181
8.	Total foreign exchange change in book/adjusted carrying value:	
	8.1. Part 1, Column 15	0
	8.2. Part 2, Section 1, Column 19	
	8.3. Part 2, Section 2, Column 16	
	8.4. Part 4, Column 15	0 0
9.	Deduct current year's other than temporary impairment recognized:	
	9.1. Part 1, Column 14	0
	9.2. Part 2, Section 1, Column 17	
	9.3. Part 2, Section 2, Column 14	
	9.4. Part 4, Column 13	0 0
10.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	65,592,752
11.	Deduct total nonadmitted amounts	0
12.	Statement value at end of current period (Line 10 minus Line 11)	65,592,752

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE D - SUMMARY BY COUNTRY

Long-Term Bonds and Stocks OWNED December 31 of Current Year

Description		1 Book/Adjusted Carrying Value	2 Fair Value	3 Actual Cost	4 Par Value of Bonds
BONDS					
Governments (Including all obligations guaranteed by governments)	1. United States				
	2. Canada				
	3. Other Countries				
	4. Totals	0	0	0	0
U.S. States, Territories and Possessions (Direct and guaranteed)	5. Totals	2,009,719	1,998,220	2,009,250	2,000,000
U.S. Political Subdivisions of States, Territories and Possessions (Direct and guaranteed)	6. Totals	11,785,267	11,886,169	12,021,220	10,755,000
U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions	7. Totals	51,797,766	51,765,111	53,075,213	47,965,000
Industrial and Miscellaneous, SVO Identified Funds and Hybrid Securities (unaffiliated)	8. United States				
	9. Canada				
	10. Other Countries				
	11. Totals	0	0	0	0
Parent, Subsidiaries and Affiliates	12. Totals				
	13. Total Bonds	65,592,752	65,649,500	67,105,683	60,720,000
PREFERRED STOCKS					
Industrial and Miscellaneous (unaffiliated)	14. United States				
	15. Canada				
	16. Other Countries				
	17. Totals	0	0	0	
Parent, Subsidiaries and Affiliates	18. Totals				
	19. Total Preferred Stocks	0	0	0	
COMMON STOCKS					
Industrial and Miscellaneous (unaffiliated)	20. United States				
	21. Canada				
	22. Other Countries				
	23. Totals	0	0	0	
Parent, Subsidiaries and Affiliates	24. Totals				
	25. Total Common Stocks	0	0	0	
	26. Total Stocks	0	0	0	
	27. Total Bonds and Stocks	65,592,752	65,649,500	67,105,683	

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE D - PART 1A - SECTION 1

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 10.7	9 Total from Col. 6 Prior Year	10 % From Col. 7 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
1. U.S. Governments												
1.1 NAIC 1	193,757	0	0	0	0	XXX	193,757	0.3	0	0.0	193,757	0
1.2 NAIC 2						XXX	0	0.0	0	0.0		0
1.3 NAIC 3						XXX	0	0.0	0	0.0		0
1.4 NAIC 4						XXX	0	0.0	0	0.0		0
1.5 NAIC 5						XXX	0	0.0	0	0.0		0
1.6 NAIC 6						XXX	0	0.0	0	0.0		0
1.7 Totals	193,757	0	0	0	0	XXX	193,757	0.3	0	0.0	193,757	0
2. All Other Governments												
2.1 NAIC 1						XXX	0	0.0	0	0.0		0
2.2 NAIC 2						XXX	0	0.0	0	0.0		0
2.3 NAIC 3						XXX	0	0.0	0	0.0		0
2.4 NAIC 4						XXX	0	0.0	0	0.0		0
2.5 NAIC 5						XXX	0	0.0	0	0.0		0
2.6 NAIC 6						XXX	0	0.0	0	0.0		0
2.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3. U.S. States, Territories and Possessions etc., Guaranteed												
3.1 NAIC 1	0	995,190	0	0	0	XXX	995,190	1.5	992,466	1.5	995,190	0
3.2 NAIC 2	0	0	1,014,529	0	0	XXX	1,014,529	1.5	1,016,962	1.6	1,014,529	0
3.3 NAIC 3						XXX	0	0.0	0	0.0		0
3.4 NAIC 4						XXX	0	0.0	0	0.0		0
3.5 NAIC 5						XXX	0	0.0	0	0.0		0
3.6 NAIC 6						XXX	0	0.0	0	0.0		0
3.7 Totals	0	995,190	1,014,529	0	0	XXX	2,009,719	3.0	2,009,428	3.1	2,009,719	0
4. U.S. Political Subdivisions of States, Territories and Possessions , Guaranteed												
4.1 NAIC 1	667,306	3,367,865	7,657,674	0	0	XXX	11,692,845	17.7	11,946,543	18.4	11,692,845	0
4.2 NAIC 2	0	512,422	0	0	0	XXX	512,422	0.8	955,912	1.5	512,422	0
4.3 NAIC 3						XXX	0	0.0	0	0.0		0
4.4 NAIC 4						XXX	0	0.0	0	0.0		0
4.5 NAIC 5						XXX	0	0.0	0	0.0		0
4.6 NAIC 6						XXX	0	0.0	0	0.0		0
4.7 Totals	667,306	3,880,287	7,657,674	0	0	XXX	12,205,267	18.4	12,902,455	19.9	12,205,267	0
5. U.S. Special Revenue & Special Assessment Obligations, etc., Non-Guaranteed												
5.1 NAIC 1	5,771,485	8,972,360	25,670,995	1,803,468	1,998,496	XXX	44,216,804	66.8	40,957,769	63.0	44,216,804	0
5.2 NAIC 2	1,530,343	3,232,462	1,666,545	900,800	0	XXX	7,330,150	11.1	8,921,921	13.7	7,330,150	0
5.3 NAIC 3						XXX	0	0.0	0	0.0		0
5.4 NAIC 4	0	0	0	250,812	0	XXX	250,812	0.4	0	0.0	250,812	0
5.5 NAIC 5						XXX	0	0.0	0	0.0		0
5.6 NAIC 6						XXX	0	0.0	0	0.0		0
5.7 Totals	7,301,828	12,204,822	27,337,540	2,955,080	1,998,496	XXX	51,797,766	78.2	49,879,690	76.8	51,797,766	0

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 10.7	9 Total from Col. 6 Prior Year	10 % From Col. 7 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
6. Industrial & Miscellaneous (Unaffiliated)												
6.1 NAIC 1						.XXX	0	0.0	193,952	0.3		0
6.2 NAIC 2						.XXX	0	0.0	0	0.0		0
6.3 NAIC 3						.XXX	0	0.0	0	0.0		0
6.4 NAIC 4						.XXX	0	0.0	0	0.0		0
6.5 NAIC 5						.XXX	0	0.0	0	0.0		0
6.6 NAIC 6						.XXX	0	0.0	0	0.0		0
6.7 Totals	0	0	0	0	0	.XXX	0	0.0	193,952	0.3	0	0
7. Hybrid Securities												
7.1 NAIC 1						.XXX	0	0.0	0	0.0		0
7.2 NAIC 2						.XXX	0	0.0	0	0.0		0
7.3 NAIC 3						.XXX	0	0.0	0	0.0		0
7.4 NAIC 4						.XXX	0	0.0	0	0.0		0
7.5 NAIC 5						.XXX	0	0.0	0	0.0		0
7.6 NAIC 6						.XXX	0	0.0	0	0.0		0
7.7 Totals	0	0	0	0	0	.XXX	0	0.0	0	0.0	0	0
8. Parent, Subsidiaries and Affiliates												
8.1 NAIC 1						.XXX	0	0.0	0	0.0		0
8.2 NAIC 2						.XXX	0	0.0	0	0.0		0
8.3 NAIC 3						.XXX	0	0.0	0	0.0		0
8.4 NAIC 4						.XXX	0	0.0	0	0.0		0
8.5 NAIC 5						.XXX	0	0.0	0	0.0		0
8.6 NAIC 6						.XXX	0	0.0	0	0.0		0
8.7 Totals	0	0	0	0	0	.XXX	0	0.0	0	0.0	0	0
9. SVO Identified Funds												
9.1 NAIC 1	.XXX	.XXX	.XXX	.XXX	.XXX		0	0.0	.XXX	.XXX		0
9.2 NAIC 2	.XXX	.XXX	.XXX	.XXX	.XXX		0	0.0	.XXX	.XXX		0
9.3 NAIC 3	.XXX	.XXX	.XXX	.XXX	.XXX		0	0.0	.XXX	.XXX		0
9.4 NAIC 4	.XXX	.XXX	.XXX	.XXX	.XXX		0	0.0	.XXX	.XXX		0
9.5 NAIC 5	.XXX	.XXX	.XXX	.XXX	.XXX		0	0.0	.XXX	.XXX		0
9.6 NAIC 6	.XXX	.XXX	.XXX	.XXX	.XXX		0	0.0	.XXX	.XXX		0
9.7 Totals	.XXX	.XXX	.XXX	.XXX	.XXX	0	0	0.0	.XXX	.XXX	0	0

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 10.7	9 Total from Col. 6 Prior Year	10 % From Col. 7 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
10. Total Bonds Current Year												
10.1 NAIC 1	(d) 6,632,548	13,335,415	33,328,669	1,803,468	1,998,496	0	57,098,596	86.2	XXX	XXX	57,098,596	0
10.2 NAIC 2	(d) 1,530,343	3,744,884	2,681,074	900,800	0	0	8,857,101	13.4	XXX	XXX	8,857,101	0
10.3 NAIC 3	(d) 0	0	0	0	0	0	0	0.0	XXX	XXX	0	0
10.4 NAIC 4	(d) 0	0	0	250,812	0	0	250,812	0.4	XXX	XXX	250,812	0
10.5 NAIC 5	(d) 0	0	0	0	0	0	0	0.0	XXX	XXX	0	0
10.6 NAIC 6	(d) 0	0	0	0	0	0	0	0.0	XXX	XXX	0	0
10.7 Totals	8,162,891	17,080,299	36,009,743	2,955,080	1,998,496	0	(b) 66,206,509	100.0	XXX	XXX	66,206,509	0
10.8 Line 10.7 as a % of Col. 7	12.3	25.8	54.4	4.5	3.0	0.0	100.0	XXX	XXX	XXX	100.0	0.0
11. Total Bonds Prior Year												
11.1 NAIC 1	1,693,869	14,916,909	32,670,109	2,188,157	2,621,686	XXX	XXX	XXX	54,090,730	83.2	54,090,730	0
11.2 NAIC 2	749,608	6,009,329	2,626,763	1,509,095	0	XXX	XXX	XXX	10,894,795	16.8	10,894,795	0
11.3 NAIC 3	0	0	0	0	0	XXX	XXX	XXX	0	0.0	0	0
11.4 NAIC 4	0	0	0	0	0	XXX	XXX	XXX	0	0.0	0	0
11.5 NAIC 5	0	0	0	0	0	XXX	XXX	XXX	(c) 0	0.0	0	0
11.6 NAIC 6	0	0	0	0	0	XXX	XXX	XXX	(c) 0	0.0	0	0
11.7 Totals	2,443,477	20,926,238	35,296,872	3,697,252	2,621,686	XXX	XXX	XXX	(b) 64,985,525	100.0	64,985,525	0
11.8 Line 11.7 as a % of Col. 9	3.8	32.2	54.3	5.7	4.0	XXX	XXX	XXX	100.0	XXX	100.0	0.0
12. Total Publicly Traded Bonds												
12.1 NAIC 1	6,632,548	13,335,415	33,328,669	1,803,468	1,998,496	0	57,098,596	86.2	54,090,730	83.2	57,098,596	XXX
12.2 NAIC 2	1,530,343	3,744,884	2,681,074	900,800	0	0	8,857,101	13.4	10,894,795	16.8	8,857,101	XXX
12.3 NAIC 3	0	0	0	0	0	0	0	0.0	0	0.0	0	XXX
12.4 NAIC 4	0	0	0	250,812	0	0	250,812	0.4	0	0.0	250,812	XXX
12.5 NAIC 5	0	0	0	0	0	0	0	0.0	0	0.0	0	XXX
12.6 NAIC 6	0	0	0	0	0	0	0	0.0	0	0.0	0	XXX
12.7 Totals	8,162,891	17,080,299	36,009,743	2,955,080	1,998,496	0	66,206,509	100.0	64,985,525	100.0	66,206,509	XXX
12.8 Line 12.7 as a % of Col. 7	12.3	25.8	54.4	4.5	3.0	0.0	100.0	XXX	XXX	XXX	100.0	XXX
12.9 Line 12.7 as a % of Line 10.7, Col. 7, Section 10	12.3	25.8	54.4	4.5	3.0	0.0	100.0	XXX	XXX	XXX	100.0	XXX
13. Total Privately Placed Bonds												
13.1 NAIC 1	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
13.2 NAIC 2	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
13.3 NAIC 3	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
13.4 NAIC 4	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
13.5 NAIC 5	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
13.6 NAIC 6	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
13.7 Totals	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
13.8 Line 13.7 as a % of Col. 7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	XXX	XXX	XXX	XXX	0.0
13.9 Line 13.7 as a % of Line 10.7, Col. 7, Section 10	0.0	0.0	0.0	0.0	0.0	0.0	0.0	XXX	XXX	XXX	XXX	0.0

(a) Includes \$ _____ freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A.

(b) Includes \$ _____ current year, \$ _____ prior year of bonds with Z designations and \$ _____, current year \$ _____ prior year of bonds with Z* designations. The letter "Z" means the NAIC designation was not assigned by the Securities Valuation Office (SVO) at the date of the statement. "Z*" means the SVO could not evaluate the obligation because valuation procedures for the security class are under regulatory review.

(c) Includes \$ _____ current year, \$ _____ prior year of bonds with 5* designations and \$ _____, current year \$ _____ prior year of bonds with 6* designations. "5*" means the NAIC designation was assigned by the (SVO) in reliance on the insurer's certification that the issuer is current in all principal and interest payments. "6*" means the NAIC designation was assigned by the SVO due to inadequate certification of principal and interest payments.

(d) Includes the following amount of short-term and cash equivalent bonds by NAIC designation: NAIC 1 \$ 613,757 ; NAIC 2 \$ 0 ; NAIC 3 \$ 0 ; NAIC 4 \$ 0 ; NAIC 5 \$ 0 ; NAIC 6 \$ 0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE D - PART 1A - SECTION 2

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 10.6	9 Total from Col. 6 Prior Year	10 % From Col. 7 Prior Year	11 Total Publicly Traded	12 Total Privately Placed
1. U.S. Governments												
1.1 Issuer Obligations	193,757	0	0	0	0	XXX	193,757	0.3	0	0.0	193,757	0
1.2 Residential Mortgage-Backed Securities						XXX	0	0.0	0	0.0		0
1.3 Commercial Mortgage-Backed Securities						XXX	0	0.0	0	0.0		0
1.4 Other Loan-Backed and Structured Securities						XXX	0	0.0	0	0.0		0
1.5 Totals	193,757	0	0	0	0	XXX	193,757	0.3	0	0.0	193,757	0
2. All Other Governments												
2.1 Issuer Obligations						XXX	0	0.0	0	0.0		0
2.2 Residential Mortgage-Backed Securities						XXX	0	0.0	0	0.0		0
2.3 Commercial Mortgage-Backed Securities						XXX	0	0.0	0	0.0		0
2.4 Other Loan-Backed and Structured Securities						XXX	0	0.0	0	0.0		0
2.5 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3. U.S. States, Territories and Possessions, Guaranteed												
3.1 Issuer Obligations	0	995,190	1,014,529	0	0	XXX	2,009,719	3.0	2,009,427	3.1	2,009,719	0
3.2 Residential Mortgage-Backed Securities						XXX	0	0.0	0	0.0		0
3.3 Commercial Mortgage-Backed Securities						XXX	0	0.0	0	0.0		0
3.4 Other Loan-Backed and Structured Securities						XXX	0	0.0	0	0.0		0
3.5 Totals	0	995,190	1,014,529	0	0	XXX	2,009,719	3.0	2,009,427	3.1	2,009,719	0
4. U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed												
4.1 Issuer Obligations	667,306	3,880,287	7,657,674	0	0	XXX	12,205,267	18.4	12,902,455	19.9	12,205,267	0
4.2 Residential Mortgage-Backed Securities						XXX	0	0.0	0	0.0		0
4.3 Commercial Mortgage-Backed Securities						XXX	0	0.0	0	0.0		0
4.4 Other Loan-Backed and Structured Securities						XXX	0	0.0	0	0.0		0
4.5 Totals	667,306	3,880,287	7,657,674	0	0	XXX	12,205,267	18.4	12,902,455	19.9	12,205,267	0
5. U.S. Special Revenue & Special Assessment Obligations etc., Non-Guaranteed												
5.1 Issuer Obligations	7,301,828	12,204,822	27,337,540	2,955,080	1,998,496	XXX	51,797,766	78.2	49,879,691	76.8	51,797,766	0
5.2 Residential Mortgage-Backed Securities						XXX	0	0.0	0	0.0		0
5.3 Commercial Mortgage-Backed Securities						XXX	0	0.0	0	0.0		0
5.4 Other Loan-Backed and Structured Securities						XXX	0	0.0	0	0.0		0
5.5 Totals	7,301,828	12,204,822	27,337,540	2,955,080	1,998,496	XXX	51,797,766	78.2	49,879,691	76.8	51,797,766	0
6. Industrial and Miscellaneous												
6.1 Issuer Obligations						XXX	0	0.0	193,952	0.3		0
6.2 Residential Mortgage-Backed Securities						XXX	0	0.0	0	0.0		0
6.3 Commercial Mortgage-Backed Securities						XXX	0	0.0	0	0.0		0
6.4 Other Loan-Backed and Structured Securities						XXX	0	0.0	0	0.0		0
6.5 Totals	0	0	0	0	0	XXX	0	0.0	193,952	0.3	0	0
7. Hybrid Securities												
7.1 Issuer Obligations						XXX	0	0.0	0	0.0		0
7.2 Residential Mortgage-Backed Securities						XXX	0	0.0	0	0.0		0
7.3 Commercial Mortgage-Backed Securities						XXX	0	0.0	0	0.0		0
7.4 Other Loan-Backed and Structured Securities						XXX	0	0.0	0	0.0		0
7.5 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8. Parent, Subsidiaries and Affiliates												
8.1 Issuer Obligations						XXX	0	0.0	0	0.0		0
8.2 Residential Mortgage-Backed Securities						XXX	0	0.0	0	0.0		0
8.3 Commercial Mortgage-Backed Securities						XXX	0	0.0	0	0.0		0
8.4 Other Loan-Backed and Structured Securities						XXX	0	0.0	0	0.0		0
8.5 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE D - PART 1A - SECTION 2 (Continued)

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

	1	2	3	4	5	6	7	8	9	10	11	12
Distribution by Type	1 Year or Less	Over 1 Year Through 5 Years	Over 5 Years Through 10 Years	Over 10 Years Through 20 Years	Over 20 Years	No Maturity Date	Total Current Year	Col. 7 as a % of Line 10.6	Total from Col. 6 Prior Year	% From Col. 7 Prior Year	Total Publicly Traded	Total Privately Placed
9. SVO Identified Funds												
9.1 Exchange Traded Funds Identified by the SVO	XXX	XXX	XXX	XXX	XXX		0	0.0	XXX	XXX		0
9.2 Bond Mutual Funds Identified by the SVO	XXX	XXX	XXX	XXX	XXX		0	0.0	XXX	XXX		0
9.3 Totals	XXX	XXX	XXX	XXX	XXX	0	0	0.0	XXX	XXX	0	0
10. Total Bonds Current Year												
10.1 Issuer Obligations	8,162,891	17,080,299	36,009,743	2,955,080	1,998,496	XXX	66,206,509	100.0	XXX	XXX	66,206,509	0
10.2 Residential Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
10.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
10.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	XXX	0	0.0	XXX	XXX	0	0
10.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX	0	0	0.0	XXX	XXX	0	0
10.6 Totals	8,162,891	17,080,299	36,009,743	2,955,080	1,998,496	0	66,206,509	100.0	XXX	XXX	66,206,509	0
10.7 Line 10.6 as a % of Col. 7	12.3	25.8	54.4	4.5	3.0	0.0	100.0	XXX	XXX	XXX	100.0	0.0
11. Total Bonds Prior Year												
11.1 Issuer Obligations	2,443,477	20,926,238	35,296,872	3,697,252	2,621,686	XXX	XXX	XXX	64,985,525	100.0	64,985,525	0
11.2 Residential Mortgage-Backed Securities	0	0	0	0	0	XXX	XXX	XXX	0	0.0	0	0
11.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	XXX	XXX	XXX	0	0.0	0	0
11.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	XXX	XXX	XXX	0	0.0	0	0
11.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
11.6 Totals	2,443,477	20,926,238	35,296,872	3,697,252	2,621,686	XXX	XXX	XXX	64,985,525	100.0	64,985,525	0
11.7 Line 11.6 as a % of Col. 9	3.8	32.2	54.3	5.7	4.0	XXX	XXX	XXX	100.0	XXX	100.0	0.0
12. Total Publicly Traded Bonds												
12.1 Issuer Obligations	8,162,891	17,080,299	36,009,743	2,955,080	1,998,496	XXX	66,206,509	100.0	64,985,525	100.0	66,206,509	XXX
12.2 Residential Mortgage-Backed Securities						XXX	0	0.0	0	0.0	0	XXX
12.3 Commercial Mortgage-Backed Securities						XXX	0	0.0	0	0.0	0	XXX
12.4 Other Loan-Backed and Structured Securities						XXX	0	0.0	0	0.0	0	XXX
12.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX		0	0.0	XXX	XXX	0	XXX
12.6 Totals	8,162,891	17,080,299	36,009,743	2,955,080	1,998,496	0	66,206,509	100.0	64,985,525	100.0	66,206,509	XXX
12.7 Line 12.6 as a % of Col. 7	12.3	25.8	54.4	4.5	3.0	0.0	100.0	XXX	XXX	XXX	100.0	XXX
12.8 Line 12.6 as a % of Line 10.6, Col. 7, Section 10	12.3	25.8	54.4	4.5	3.0	0.0	100.0	XXX	XXX	XXX	100.0	XXX
13. Total Privately Placed Bonds												
13.1 Issuer Obligations	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
13.2 Residential Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
13.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
13.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
13.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX	0	0	0.0	XXX	XXX	XXX	0
13.6 Totals	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
13.7 Line 13.6 as a % of Col. 7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	XXX	XXX	XXX	XXX	0.0
13.8 Line 13.6 as a % of Line 10.6, Col. 7, Section 10	0.0	0.0	0.0	0.0	0.0	0.0	0.0	XXX	XXX	XXX	XXX	0.0

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE DA - VERIFICATION BETWEEN YEARS

Short-Term Investments

	1	2	3	4	5
	Total	Bonds	Mortgage Loans	Other Short-term Investment Assets (a)	Investments in Parent, Subsidiaries and Affiliates
1. Book/adjusted carrying value, December 31 of prior year	425,768	231,815	0	193,953	0
2. Cost of short-term investments acquired	6,881,099	4,540,300	0	2,340,799	0
3. Accrual of discount	0				
4. Unrealized valuation increase (decrease)	0				
5. Total gain (loss) on disposals	0				
6. Deduct consideration received on disposals	6,691,292	4,156,540	0	2,534,752	0
7. Deduct amortization of premium	1,818	1,818	0	0	0
8. Total foreign exchange change in book/adjusted carrying value	0				
9. Deduct current year's other than temporary impairment recognized	0				
10. Book adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	613,757	613,757	0	0	0
11. Deduct total nonadmitted amounts	0				
12. Statement value at end of current period (Line 10 minus Line 11)	613,757	613,757	0	0	0

(a) Indicate the category of such assets, for example, joint ventures, transportation equipment:

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

Schedule DB - Part A - Verification - Options, Caps, Floors, Collars, Swaps and Forwards

NONE

Schedule DB - Part B - Verification - Futures Contracts

NONE

Schedule DB - Part C - Section 1 - Replication (Synthetic Asset) Transactions (RSATs) Open

NONE

Schedule DB-Part C-Section 2-Reconciliation of Replication (Synthetic Asset) Transactions Open

NONE

Schedule DB - Verification - Book/Adjusted Carrying Value, Fair Value and Potential Exposure of
Derivatives

NONE

Schedule E - Verification - Cash Equivalents

NONE

Schedule A - Part 1 - Real Estate Owned

NONE

Schedule A - Part 2 - Real Estate Acquired and Additions Made

NONE

Schedule A - Part 3 - Real Estate Disposed

NONE

Schedule B - Part 1 - Mortgage Loans Owned

NONE

Schedule B - Part 2 - Mortgage Loans Acquired and Additions Made

NONE

Schedule B - Part 3 - Mortgage Loans Disposed, Transferred or Repaid

NONE

Schedule BA - Part 1 - Other Long-Term Invested Assets Owned

NONE

Schedule BA - Part 2 - Other Long-Term Invested Assets Acquired and Additions Made

NONE

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

Schedule BA - Part 3 - Other Long-Term Invested Assets Disposed, Transferred or Repaid

N O N E

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book/Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	C o d e	F o r e i g n	Bond Char	NAIC Des.	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor- tization) Accretion	Current Year's Other- Than- Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
0599999	Total - U.S. Government Bonds					0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
1099999	Total - All Other Government Bonds					0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
20772J-HK-1	CONNECTICUT STATE SERIES D				1FE	991,250	100.1450	1,001,450	1,000,000	995,190	0	2,725	0	0	1.340	1.093	MON	1,022	8,530	07/22/2015	09/15/2018
452152-LN-9	ILLINOIS STATE			2	2FE	1,018,000	99.6770	1,000,000	1,000,000	1,014,529	0	(2,433)	0	0	5.000	4.680	MS	16,667	50,000	07/09/2015	03/01/2032
1199999	Subtotal - U.S. States, Territories and Possessions - Issuer Obligations					2,009,250	XXX	1,998,220	2,000,000	2,009,719	0	292	0	0	XXX	XXX	XXX	17,689	58,530	XXX	XXX
1799999	Total - U.S. States, Territories and Possessions Bonds					2,009,250	XXX	1,998,220	2,000,000	2,009,719	0	292	0	0	XXX	XXX	XXX	17,689	58,530	XXX	XXX
167496-ID-7	CHICAGO ILL SERIES A				2FE	517,895	99.8400	499,200	500,000	512,422	0	(3,815)	0	0	5.000	4.111	JJ	12,500	23,611	07/17/2015	01/01/2020
167505-FH-4	CHICAGO ILL BRD ED			2	1FE	567,000	104.4310	584,814	560,000	564,121	0	(2,005)	0	0	5.250	4.843	JD	2,450	29,400	07/08/2015	12/01/2023
180848-NA-7	CLARK CNTY NV			2	1FE	1,180,950	117.6740	1,176,740	1,000,000	1,156,808	0	(17,704)	0	0	5.000	2.760	WN	8,333	50,000	08/12/2015	11/01/2027
224437-BL-6	CRANE CNTY TX WTR DIST			2	1FE	1,226,095	105.0350	1,192,147	1,135,000	1,200,858	0	(20,227)	0	0	4.400	2.071	FA	17,151	39,599	09/04/2015	02/15/2020
248775-Z5-0	COUNTY OF DENTON TX			2	1FE	1,599,437	116.6370	1,395,037	1,395,000	1,571,896	0	(20,535)	0	0	5.000	3.101	JJ	32,163	63,938	07/23/2015	07/15/2031
283590-FR-3	EL PASO CNTY TX HOSP DIST			2	1FE	1,089,590	109.1230	1,091,230	1,000,000	1,075,726	0	(9,922)	0	0	5.000	3.700	FA	18,889	50,000	07/30/2015	08/15/2028
416415-HN-0	HARTFORD CT SERIES A			2	1FE	1,140,970	110.4810	1,104,810	1,000,000	1,113,931	0	(19,969)	0	0	5.000	2.660	AO	12,500	50,000	08/18/2015	04/01/2022
569280-D6-2	MARION CNTY OR SCH DIST 103 W			2	1FE	1,156,610	115.3260	1,153,260	1,000,000	1,137,113	0	(13,955)	0	0	5.000	3.141	JD	2,222	50,000	07/24/2015	06/15/2032
778017-NR-0	ROSEVILLE COMMUNITY SCHOOLS			2	1FE	1,628,113	113.9380	1,612,223	1,415,000	1,602,201	0	(19,336)	0	0	5.000	3.180	WN	11,792	70,750	08/20/2015	05/01/2030
92839N-CC-5	VISTANCIA AZ CNTY FACS DIST			2	1FE	1,122,370	107.5740	1,075,740	1,000,000	1,081,627	0	(31,205)	0	0	5.000	1.701	JJ	23,056	42,361	08/19/2015	07/15/2019
970294-BY-9	WILLIAMSTON MI CNTY SCHS SCH SERIES A				1FE	255,920	100.9240	247,304	245,000	247,304	0	(6,868)	0	0	4.400	1.160	WN	1,633	10,671	09/10/2015	05/01/2017
970294-BZ-6	WILLIAMSTON MI CNTY SCHS SCH SERIES A				1FE	536,270	103.2980	521,655	505,000	521,260	0	(11,972)	0	0	4.400	1.550	WN	3,367	21,996	09/10/2015	05/01/2018
1899999	Subtotal - Bonds - U.S. Political Subdivisions - Issuer Obligations					12,021,220	XXX	11,886,169	10,755,000	11,785,267	0	(177,513)	0	0	XXX	XXX	XXX	146,056	502,326	XXX	XXX
2499999	Total - U.S. Political Subdivisions Bonds					12,021,220	XXX	11,886,169	10,755,000	11,785,267	0	(177,513)	0	0	XXX	XXX	XXX	146,056	502,326	XXX	XXX
010267-AH-2	ALABAMA FEDERAL AID HIGHWAY F1			2	1FE	1,210,556	112.3290	1,179,455	1,050,000	1,181,966	0	(21,351)	0	0	5.000	2.600	MS	17,500	52,500	08/24/2015	09/01/2025
011842-SS-1	ALASKA ST INTL ARPTS REVS SERIES B			2	1FE	661,182	110.9810	665,886	600,000	661,117	0	(65)	0	0	5.000	3.630	AO	7,500	0	12/21/2016	10/01/2034
011908-DL-1	ALASKA IND DEV & EXPT AUTH PIR				2FE	1,104,580	107.1890	1,071,890	1,000,000	1,073,280	0	(23,260)	0	0	5.000	2.451	JJ	25,000	42,500	08/13/2015	01/01/2020
051177-BY-8	AUGUSTA GA ARPT REVENUE SERIES B				2FE	470,492	107.6470	457,500	425,000	460,121	0	(8,186)	0	0	5.000	2.802	JJ	10,625	16,351	09/02/2015	01/01/2021
051177-BZ-5	AUGUSTA GA ARPT REVENUE SERIES B				2FE	491,747	108.4530	482,987	445,000	482,987	0	(6,192)	0	0	5.000	3.142	JJ	11,125	17,120	09/02/2015	01/01/2022
074876-HM-8	BEAVER CNTY PA INDL DEVEL AUTH SERIES B				4FE	603,750	41.8020	250,812	600,000	250,812	(352,772)	(132)	0	0	3.500	3.457	JD	1,750	21,000	07/29/2015	12/01/2035
090888-GD-4	BIRMINGHAM ALABAMA ARPT AUTH			2	1FE	1,180,790	113.5400	1,135,400	1,000,000	1,131,304	0	(35,793)	0	0	6.000	2.090	JJ	30,000	60,000	08/06/2015	07/01/2022
116083-PK-6	BROWNSBURG IN 1999 SCH BLDG CO SERIES B				1FE	1,184,688	113.1210	1,148,178	1,015,000	1,149,311	0	(24,933)	0	0	5.000	2.210	JJ	23,401	48,917	07/09/2015	01/15/2022
116083-PP-5	BROWNSBURG IN 1999 SCH BLDG CO SERIES B				1FE	593,975	116.2940	581,470	500,000	579,508	0	(10,202)	0	0	5.000	2.520	JJ	11,528	24,097	07/09/2015	01/15/2024
116083-PQ-3	BROWNSBURG IN 1999 SCH BLDG CO SERIES B				1FE	595,395	116.8620	584,310	500,000	581,660	0	(9,687)	0	0	5.000	2.600	JJ	11,528	24,097	07/09/2015	07/15/2024
116475-BZ-0	BROWNSVILLE TX UTILITY SYS REV				1FE	1,107,110	105.8540	1,058,540	1,000,000	1,059,086	0	(34,800)	0	0	5.000	1.400	MS	16,667	52,500	07/16/2015	09/01/2028
167664-ZP-9	CHICAGO ILL PUB BLDG COMM BLDG				1FE	706,160	109.6240	712,556	650,000	701,306	0	(3,503)	0	0	5.250	4.350	MS	11,375	34,125	07/31/2015	03/01/2028
167727-TJ-5	CHICAGO ILL WASTEWATER TRANSM				1FE	622,854	104.9790	629,874	600,000	617,206	0	(3,968)	0	0	4.400	3.230	JJ	12,000	24,000	07/21/2015	01/01/2021
167727-TY-2	CHICAGO ILL WASTEWATER TRANSM				1FE	206,211	103.0850	201,016	195,000	199,687	0	(4,570)	0	0	5.000	2.550	JJ	4,875	9,750	07/21/2015	01/01/2018
178860-BL-5	CIVICENTURES AK				1FE	1,580,151	113.5120	1,549,439	1,365,000	1,547,336	0	(24,561)	0	0	5.000	2.790	MS	22,750	68,819	08/14/2015	09/01/2023
186352-PQ-7	CLEVELAND OHIO ARPT SYS SERIES A				1FE	455,624	110.4300	441,720	400,000	442,335	0	(10,012)	0	0	5.000	2.220	JJ	10,000	20,000	08/27/2015	01/01/2021
245980-AH-2	DELAWARE CNTY OK EDUCNL FACS				1FE	1,217,081	111.7520	1,184,571	1,060,000	1,187,311	0	(20,499)	0	0	5.000	2.700	MS	17,667	59,772	07/07/2015	09/01/2022
246389-RG-9	DELAWARE ST HLTH FACS AUTH REV SERIES A				2FE	421,908	102.7840	411,136	400,000	411,446	0	(7,895)	0	0	4.400	1.942	JD	1,333	16,000	08/26/2015	06/01/2018
31350A-BR-8	FEDERAL HOME LOAN MTGE CORP VA SERIES M034				1FE	1,014,891	102.0230	1,004,927	985,000	1,011,475	0	(2,671)	0	0	4.150	3.802	MON	1,817	40,878	09/14/2015	04/15/2025
395785-AH-3	GRAND JUNCTION CO REGl ARPT AU SERIES A			2	1FE	1,149,440	114.4230	1,104,182	965,000	1,147,697	0	(1,744)	0	0	5.000	2.800	JD	5,227	0	11/04/2016	12/01/2027
40065N-BN-6	GUAM GOVT BUSINESS PRIVILEGE TA SERIES D				1FE	311,886	101.0690	303,207	300,000	304,750	0	(5,381)	0	0	3.000	1.169	WN	1,150	10,800	08/26/2015	11/15/2017
40065N-BP-1	GUAM GOVT BUSINESS PRIVILEGE TA SERIES D				1FE	296,307	103.6610	285,068	275,000	287,595	0	(6,572)	0	0	4.400	1.509	WN	1,406	18,200	08/26/2015	11/15/2018
432937-ET-6	HILLSBOROUGH CNTY FLA SCH DIST				1FE	1,170,530	116.3190	1,144,311	1,000,000	1,144,311	0	(19,283)	0	0	5.000	2.651	AO	12,500	50,000	07/31/2015	10/01/2023
452034-BZ-7	ILLINOIS FIN AUTH SERIES A			2	1FE	1,119,750	113.0000	1,130,000	1,000,000	1,103,173	0	(11,421)	0	0	5.000	3.470	AO	12,500	50,000	07/09/2015	10/01/2033
45506D-GZ-2	INDIANA ST FIN			2	2FE	907,593	100.1260	925,166	925,000	925,000	0	(2,478)	0	0	5.000	1.451	JJ	23,125	46,250	07/30/2015	01/01/2019
471641-AL-4	JASPER IN HOSP AUTH REVENUE				1FE	802,678	113.5300	885,396	790,000	885,396	0	(12,389)	0	0	5.000	3.030	WN	6,583	39,500	07/31/2015	11/01/2023
49126P-EU-0	KENTUCKY ST ECON DEV FIN AUTH SERIES A			2	2FE	906,818	110.3700	921,590	835,000	900,800	0	(4,577)	0	0	5.000	4.134	JAUD	10,438	44,997	08/31/2015	07/01/2028
491501-DI-9	KENTUCKY ST MUNI PIR AGY PIR S SERIES A				1FE	1,184,380	114.6150	1,146,150	1,000,000	1,166,564	0	(16,726)	0	0	5.000	2.820	MS	16,667	50,000	12/02/2015	09/01/2025
546398-Z3-5	LOUISIANA PUB FACS AUTH REV				1FE	771,953	106.8290	747,803	700,000	746,870	0	(18,703)	0	0	5.000	2.142	JD	2,917	35,000	08/06/2015	06/01/2019
54651R-BV-0	LOUISIANA ST UNCLAIMED PROPERTY				1FE	722,156	111.5710	702,897	630,000	702,778	0	(14,583)	0	0	5.000	2.370	MS	10,500	31,500	08/19/2015	09/01/2021
54651R-BI-8	LOUISIANA ST UNCLAIMED PROPERTY				1FE	229,848	113.2480	226,496	200,000	224,576	0	(3,969)	0	0	5.000	2.650	MS	3,333	10,000	08/19/2015	09/01/2022
57419R-VT-9	MARYLAND ST CNTY DEV ADMIN SERIES E				1FE	1,000,000	99.9510	999,510	1,000,000	1,000,000	0	0	0	0	1.100	1.100	MS	3,667	10,725	09/03/2015	03/01/2017
57563P-LN-7	MASSACHUSETTS ST EDUCNL FING				1FE	273,438	105.3960	263,490	250,000	264,374</											

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book/Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	C o d e	F o r e i g n	Bond Char	NAIC Des.	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor- tization) Accretion	Current Year's Other- Than- Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
592250-AJ-3	MET PIER & EXPOSITION AUTH IL SERIES B			2	2FE	654,324	106.8700	635,220	800,000	644,339	0	(7,256)	0	0	5.000	3.500	JD	1,333	30,000	08/06/2015	12/15/2026
59259V-66-9	METROPOLITAN TRANSN AUTH NY SERIES C 2			2	1FE	1,108,610	107.5400	1,075,400	1,000,000	1,102,162	0	(4,685)	0	0	4.000	3.194	MN	5,111	40,000	07/24/2015	11/15/2033
59334A-AS-3	MIAMI-DADE CNTY FL HSG FIN AUT				1FE	1,000,000	99.9490	999,490	1,000,000	1,000,000	0	0	0	0	0.850	0.850	AO	2,125	9,279	08/25/2015	04/01/2017
60534T-4U-6	MISSISSIPPI ST DEV BANK SPL OB				1FE	909,634	107.6520	866,599	905,000	900,760	0	(8,874)	0	0	4.000	2.100	AO	8,050	13,685	04/07/2016	10/01/2023
60534W-CC-0	MISSISSIPPI ST DEV BANK SPL OB SERIES C				1FE	1,028,808	116.7820	963,452	825,000	1,020,036	0	(8,722)	0	0	5.000	1.990	FA	17,417	0	07/22/2016	08/01/2025
605360-CC-3	MISSISSIPPI ST HOSP EQUIPMENT F			2	2FE	792,098	102.1390	766,043	750,000	782,027	0	(9,533)	0	0	5.000	3.544	FA	14,167	37,500	12/07/2015	08/15/2020
623455-AB-8	MOUNT VERNON IN ENVRMNTL IMPT				1FE	1,000,000	100.5800	1,005,800	1,000,000	1,000,000	0	0	0	0	2.375	2.375	MS	7,917	23,222	08/26/2015	09/01/2055
645918-S2-0	NEW JERSEY ST ECON DEV AUTH RE SERIES H				1FE	987,500	100.0000	1,000,000	1,000,000	999,312	0	8,032	0	0	1.374	1.708	MON	1,167	12,594	07/07/2015	02/01/2017
646136-E8-0	NEW JERSEY ST TRANSN TR FD SERIES B			2	1FE	530,880	106.2770	531,385	500,000	524,234	0	(4,870)	0	0	5.250	4.050	JD	1,167	26,250	08/11/2015	06/15/2024
646139-2A-2	NEW JERSEY ST TURNPIKE AUTH			2	1FE	1,132,980	113.3190	1,133,190	1,000,000	1,110,811	0	(16,637)	0	0	5.000	2.970	JJ	25,000	50,000	08/25/2015	01/01/2028
649451-DJ-7	NEW YORK ST CONVENTION CENTERD			2	1FE	1,146,370	114.5560	1,145,560	1,000,000	1,129,888	0	(12,284)	0	0	5.000	3.299	MN	6,389	60,833	08/21/2015	11/15/2031
650035-N9-5	NEW YORK ST URBAN DEV CORP REV SERIES A			2	1FE	1,136,580	112.8740	1,128,740	1,000,000	1,117,040	0	(14,249)	0	0	5.000	3.170	MS	14,722	50,000	08/11/2015	03/15/2035
67884F-XU-5	OKLAHOMA DEV FIN AUTH LEASE RE SERIES A			2	1FE	1,800,036	114.3810	1,795,782	1,570,000	1,770,766	0	(20,433)	0	0	5.000	3.251	JD	6,542	78,500	07/09/2015	06/01/2030
696550-AB-5	PALM BEACH CNTY FLA SCH BRD SERIES C			2	1FE	1,129,210	113.4180	1,134,180	1,000,000	1,115,772	0	(11,441)	0	0	5.000	3.431	FA	20,833	37,917	09/23/2015	08/01/2032
717817-RY-8	PHILADELPHIA PA ARPT REV SERIES A				1FE	1,122,740	107.6370	1,076,370	1,000,000	1,080,504	0	(31,872)	0	0	5.000	1.641	JD	2,222	50,000	08/26/2015	06/15/2019
721342-AC-7	PIKEVILLE KY EDUCNTL FACS REVE			2	2FE	508,800	100.1020	500,510	500,000	500,475	0	(5,659)	0	0	3.000	1.850	FA	6,250	15,917	07/02/2015	08/01/2017
73358W-HD-9	PORT AUTH OF NEW YORK & NEW JE			2	1FE	1,102,690	108.7860	1,087,860	1,000,000	1,083,318	0	(14,331)	0	0	5.000	3.260	AO	12,500	50,000	08/18/2015	10/01/2034
76221R-VK-6	RHODE ISLAND ST HSG & MTGE FIN SERIES 66-B			2	1FE	998,430	99.9560	999,560	1,000,000	998,495	0	47	0	0	1.600	0.786	AO	4,009	10,304	07/23/2015	10/01/2045
85732M-B5-5	STATE PUBLIC SCHOOL BUILDING A SERIES A				1FE	996,959	111.1950	967,397	870,000	974,087	0	(17,522)	0	0	5.000	2.631	JD	1,933	43,500	08/06/2015	06/15/2022
88256C-EX-3	TEXAS MUN GAS ACQUISITION & SU			4	2FE	706,182	117.4410	704,646	800,000	704,640	0	(1,542)	0	0	6.250	3.579	JD	1,667	18,750	11/14/2016	12/15/2026
888809-AP-5	TOBACCO SETTLEMENT FING CORP SERIES A				1FE	1,526,546	101.1830	1,467,154	1,450,000	1,467,424	0	(41,512)	0	0	4.000	1.100	JD	4,833	58,000	07/22/2015	06/01/2017
89952P-DH-2	TULSA CNTY OK INDL AUTH EDUCTN				1FE	1,154,210	112.3080	1,123,080	1,000,000	1,122,095	0	(24,566)	0	0	5.000	2.230	MS	16,667	48,889	08/28/2015	09/01/2021
91402J-CL-3	UNIV OF ALABAMA AL HOSP REVENU SERIES A			2	1FE	1,125,220	107.4550	1,074,550	1,000,000	1,095,570	0	(20,745)	0	0	5.750	3.308	MS	19,167	57,500	07/20/2015	09/01/2022
91754T-MW-2	UTAH ST CHRT SCH FIN AUTH CHRT				1FE	465,586	106.9850	461,433	450,000	460,783	0	(3,721)	0	0	4.000	2.950	AO	3,800	19,500	08/21/2015	04/15/2025
95382T-CF-3	W JORDAN UT MUNI BLDG AUTH LEA			2	1FE	1,096,051	114.5220	1,099,411	960,000	1,095,054	0	(992)	0	0	5.000	3.301	AO	4,000	0	11/18/2016	10/01/2030
976890-BU-4	WISCONSIN ST HSG & ECON DEV AU SERIES A				1FE	1,000,000	99.8440	998,440	1,000,000	1,000,000	0	0	0	0	1.150	1.150	MS	3,833	11,053	09/04/2015	09/01/2017
25999999	Subtotal - Bonds - U.S. Special Revenues - Issuer Obligations					53,075,213	XXX	51,765,111	47,965,000	51,797,766	(352,772)	(687,907)	0	0	XXX	XXX	XXX	581,114	1,907,091	XXX	XXX
31999999	Total - U.S. Special Revenues Bonds					53,075,213	XXX	51,765,111	47,965,000	51,797,766	(352,772)	(687,907)	0	0	XXX	XXX	XXX	581,114	1,907,091	XXX	XXX
38999999	Total - Industrial and Miscellaneous (Unaffiliated) Bonds					0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
48999999	Total - Hybrid Securities					0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
55999999	Total - Parent, Subsidiaries and Affiliates Bonds					0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
60999999	Subtotal - SVO Identified Funds					0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
77999999	Total - Issuer Obligations					67,105,683	XXX	65,649,500	60,720,000	65,592,752	(352,772)	(865,128)	0	0	XXX	XXX	XXX	744,859	2,467,947	XXX	XXX
78999999	Total - Residential Mortgage-Backed Securities					0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
79999999	Total - Commercial Mortgage-Backed Securities					0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
80999999	Total - Other Loan-Backed and Structured Securities					0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
81999999	Total - SVO Identified Funds					0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
83999999	Total Bonds					67,105,683	XXX	65,649,500	60,720,000	65,592,752	(352,772)	(865,128)	0	0	XXX	XXX	XXX	744,859	2,467,947	XXX	XXX

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

Schedule D - Part 2 - Section 1 - Preferred Stocks Owned

N O N E

Schedule D - Part 2 - Section 2 - Common Stocks Owned

N O N E

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE D - PART 3

Showing All Long-Term Bonds and Stocks ACQUIRED During Current Year

1	2	3	4	5	6	7	8	9
CUSIP Identification	Description	Foreign	Date Acquired	Name of Vendor	Number of Shares of Stock	Actual Cost	Par Value	Paid for Accrued Interest and Dividends
011842-SS-1	ALASKA ST INTL APPTS REVIS SERIES B 5.000% 10/01/34		12/21/2016	Citigroup Global Markets		.661,182	.600,000	7,167
385785-AH-3	GRAND JUNCTION CO REGL APPT AU SERIES A 5.000% 12/01/27		11/04/2016	RBC Dominion		1,149,440	.965,000	.0
60534T-AU-6	MISSISSIPPI ST DEV BANK SPL OB 4.000% 10/01/23		04/07/2016	CREWS & ASSOCIATES		.909,634	.805,000	.0
60534H-CC-0	MISSISSIPPI ST DEV BANK SPL OB SERIES C 5.000% 08/01/25		07/22/2016	Morgan Stanley		1,028,808	.825,000	.0
88256C-EX-3	TEXAS MUN GAS ACQUISITION & SU 6.250% 12/15/26		11/14/2016	Morgan Stanley		.706,182	.600,000	15,625
953527-CF-3	W JORDAN UT MUNI BLDG AUTH LEA 5.000% 10/01/30		11/18/2016	Piper Jaffray & Hopwood Inc		1,096,051	.960,000	.0
31999999. Subtotal - Bonds - U.S. Special Revenues						5,551,297	4,755,000	22,792
83999997. Total - Bonds - Part 3						5,551,297	4,755,000	22,792
83999998. Total - Bonds - Part 5						0	0	0
83999999. Total - Bonds						5,551,297	4,755,000	22,792
89999997. Total - Preferred Stocks - Part 3						0	XXX	0
89999998. Total - Preferred Stocks - Part 5						0	XXX	0
89999999. Total - Preferred Stocks						0	XXX	0
97999997. Total - Common Stocks - Part 3						0	XXX	0
97999998. Total - Common Stocks - Part 5						0	XXX	0
97999999. Total - Common Stocks						0	XXX	0
98999999. Total - Preferred and Common Stocks						0	XXX	0
99999999 - Totals						5,551,297	XXX	22,792

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE D - PART 4

Showing All Long-Term Bonds and Stocks SOLD, REDEEMED or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21	
CUSIP Identi- fication	Description	For- eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Con- sideration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	11	12	13	14	15	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Con- tractual Maturity Date	
										Unrealized Valuation Increase/ Decrease	Current Year's (Amor- tization)/ Accretion	Current Year's Other- Than- Temporary Impairment Recognized	Total Change in Book/ Adjusted Carrying Value (11+12-13)	Total Foreign Exchange Change in Book/ Adjusted Carrying Value							
167486-HU-6	CHICAGO ILL SERIES A 5.250% 01/01/17		01/22/2016	Tax Free Exchange		500,000	500,000	501,625	500,000	0	0	0	0	0	500,000	0	0	0	14,656	01/01/2017	
167505-BS-4	CHICAGO ILL BRD ED SERIES D 5.000% 12/01/16		12/01/2016	Maturity		430,000	430,000	444,629	439,676	0	(9,676)	0	(9,676)	0	430,000	0	0	0	21,500	12/01/2016	
2499999. Subtotal - Bonds - U.S. Political Subdivisions of States, Territories and Possessions						930,000	930,000	946,254	939,676	0	(9,676)	0	(9,676)	0	930,000	0	0	0	36,156	XXX	
167664-ZP-9	CHICAGO ILL PUB BLDG COMM BLDG 5.250% 03/01/28		09/19/2016	Southwest Securities		5,975	5,000	5,432	5,422	0	(19)	0	(19)	0	5,402	0	573	573	278	03/01/2028	
31350A-BR-8	FEDERAL HOME LOAN MTGE CORP VA SERIES M034 4.150% 04/15/25		07/15/2016	Call 100.0000		15,000	15,000	15,455	15,444	0	(12)	0	(12)	0	15,432	0	(432)	(432)	207	04/15/2025	
57584X-CD-1	MASSACHUSETTS ST DEV FIN AGYRE 4.000% 04/15/20		04/15/2016	Call 100.0000		75,000	75,000	80,444	79,717	0	(547)	0	(547)	0	79,170	0	(4,170)	(4,170)	1,500	04/15/2020	
677525-TF-4	OHIO ST AIR QUALITY DEV AUTH 5.625% 06/01/18		08/10/2016	Chase		262,264	250,000	268,550	265,907	0	(3,994)	0	(3,994)	0	261,912	0	350	350	9,922	06/01/2018	
79642B-E6-6	SAN ANTONIO TEX WATER REVENUE 0.890% 05/01/44		10/31/2016	Raymond James & Associates		1,000,000	1,000,000	994,300	994,318	0	194	0	194	0	994,512	0	5,488	5,488	6,857	05/01/2044	
968254-AY-8	WILKES-BARRE PA FIN AUTH REVEN SERIES B 1.221% 11/01/16		11/01/2016	Maturity		1,000,000	1,000,000	999,890	999,916	0	84	0	84	0	1,000,000	0	0	0	12,210	11/01/2016	
3199999. Subtotal - Bonds - U.S. Special Revenues						2,358,239	2,345,000	2,364,071	2,360,724	0	(4,294)	0	(4,294)	0	2,356,428	0	1,809	1,809	30,974	XXX	
8399997. Total - Bonds - Part 4						3,288,239	3,275,000	3,310,325	3,300,400	0	(13,970)	0	(13,970)	0	3,286,428	0	1,809	1,809	67,130	XXX	
8399998. Total - Bonds - Part 5						0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	XXX
8399999. Total - Bonds						3,288,239	3,275,000	3,310,325	3,300,400	0	(13,970)	0	(13,970)	0	3,286,428	0	1,809	1,809	67,130	XXX	
8999997. Total - Preferred Stocks - Part 4						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	0	XXX
8999998. Total - Preferred Stocks - Part 5						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	0	XXX
8999999. Total - Preferred Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	0	XXX
9799997. Total - Common Stocks - Part 4						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	0	XXX
9799998. Total - Common Stocks - Part 5						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	0	XXX
9799999. Total - Common Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	0	XXX
9899999. Total - Preferred and Common Stocks						0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	0	XXX
9999999 - Totals						3,288,239	XXX	3,310,325	3,300,400	0	(13,970)	0	(13,970)	0	3,286,428	0	1,809	1,809	67,130	XXX	

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SCHEDULE D - PART 5

[illegible]

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

Schedule D-Part 6-Section 1-Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

N O N E

Schedule D - Part 6 - Section 2

N O N E

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE DA - PART 1

Showing All SHORT-TERM INVESTMENTS Owned December 31 of Current Year

1	2	Codes		5	6	7	8	Change in Book/Adjusted Carrying Value				13	14	Interest						21
		3	4					9	10	11	12			15	16	17	18	19	20	
CUSIP Identi- fication	Description	Code	For- eign	Date Acquired	Name of Vendor	Maturity Date	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor- tization)/ Accretion	Current Year's Other- Than- Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Par Value	Actual Cost	Amount Due and Accrued Dec. 31 of Current Year on Bonds not in Default	Non- Admitted Due and Accrued	Rate of	Effective Rate of	When Paid	Amount Received During Year	Paid for Accrued Interest
0599999. Total - U.S. Government Bonds							0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
1099999. Total - All Other Government Bonds							0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
1799999. Total - U.S. States, Territories and Possessions Bonds							0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
.....CHICAGO ILL SERIES A .....				..12/22/2016 ..	Tax Free Exchange .....	..01/01/2017 ..	420,000	0	0	0	0	420,000	420,000	11,025	0	5.250	5.250	JJ	11,025	1,286
1899999. Subtotal - Bonds - U.S. Political Subdivisions - Issuer Obligations							420,000	0	0	0	0	420,000	420,000	11,025	0	XXX	XXX	XXX	11,025	1,286
2499999. Total - U.S. Political Subdivisions Bonds							420,000	0	0	0	0	420,000	420,000	11,025	0	XXX	XXX	XXX	11,025	1,286
3199999. Total - U.S. Special Revenues Bonds							0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
3899999. Total - Industrial and Miscellaneous (Unaffiliated) Bonds							0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
4899999. Total - Hybrid Securities							0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
5599999. Total - Parent, Subsidiaries and Affiliates Bonds							0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
6099999. Subtotal - SVO Identified Funds							0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
7799999. Total - Issuer Obligations							420,000	0	0	0	0	420,000	420,000	11,025	0	XXX	XXX	XXX	11,025	1,286
7899999. Total - Residential Mortgage-Backed Securities							0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
7999999. Total - Commercial Mortgage-Backed Securities							0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
8099999. Total - Other Loan-Backed and Structured Securities							0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
8199999. Total - SVO Identified Funds							0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
8399999. Total Bonds							420,000	0	0	0	0	420,000	420,000	11,025	0	XXX	XXX	XXX	11,025	1,286
8699999. Total - Parent, Subsidiaries and Affiliates							0	0	0	0	0	XXX	0	0	0	XXX	XXX	XXX	0	0
09248U-70-0	BLACKROCK FEDERAL FUND 30 .....			..12/20/2016 ..	Direct	XXX	193,757	0	0	0	0	193,757	193,757	0	0	0.000	0.000		0	0
8899999. Subtotal - Exempt Money Market Mutual Funds - as Identified by the SVO							193,757	0	0	0	0	XXX	193,757	0	0	XXX	XXX	XXX	0	0
.....DREYFUS INSTL CASH ADVANTAGE .....				..12/31/2016 ..	No Broker	12/31/2017	0	0	0	0	0	0	0	0	0	0.000	0.000		115	0
9099999. Subtotal - Other Short-Term Invested Assets							0	0	0	0	0	XXX	0	0	0	XXX	XXX	XXX	115	0
9199999 - Totals							613,757	0	0	0	0	XXX	613,757	11,025	0	XXX	XXX	XXX	11,140	1,286

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

Schedule DB - Part A - Section 1 - Options, Caps, Floors, Collars, Swaps and Forwards Open

NONE

Schedule DB - Part A - Section 2 - Options, Caps, Floors, Collars, Swaps and Forwards Terminated

NONE

Schedule DB - Part B - Section 1 - Futures Contracts Open

NONE

Schedule DB - Part B - Section 1B - Brokers with whom cash deposits have been made

NONE

Schedule DB - Part B - Section 2 - Futures Contracts Terminated

NONE

Schedule DB - Part D - Section 1 - Counterparty Exposure for Derivative Instruments Open

NONE

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged By

NONE

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged To

NONE

Schedule DL - Part 1 - Reinvested Collateral Assets Owned

NONE

Schedule DL - Part 2 - Reinvested Collateral Assets Owned

NONE

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE E - PART 1 - CASH

1	2	3	4	5	6	7
Depository	Code	Rate of Interest	Amount of Interest Received During Year	Amount of Interest Accrued December 31 of Current Year	Balance	*
Florida Department of Financial Services					300,000	XXX
Bank of America					184,078,587	XXX
Fifth Third Bank					13,379,923	XXX
0199998 Deposits in ... depositories which do not exceed the allowable limit in any one depository (See instructions) - open depositories	XXX	XXX				XXX
0199999. Totals - Open Depositories	XXX	XXX	0	0	197,758,510	XXX
0299998 Deposits in ... depositories which do not exceed the allowable limit in any one depository (See instructions) - suspended depositories	XXX	XXX				XXX
0299999. Totals - Suspended Depositories	XXX	XXX	0	0	0	XXX
0399999. Total Cash on Deposit	XXX	XXX	0	0	197,758,510	XXX
0499999. Cash in Company's Office	XXX	XXX	XXX	XXX		XXX
.....						
.....						
.....						
.....						
.....						
.....						
.....						
.....						
0599999 Total - Cash	XXX	XXX	0	0	197,758,510	XXX

TOTALS OF DEPOSITORY BALANCES ON THE LAST DAY OF EACH MONTH DURING THE CURRENT YEAR

1. January.....	146,748,014	4. April.....	172,188,318	7. July.....	129,708,805	10. October.....	156,329,298
2. February.....	122,908,738	5. May.....	119,170,824	8. August.....	172,746,654	11. November.....	162,017,464
3. March.....	133,785,085	6. June.....	124,420,605	9. September.....	206,290,143	12. December.....	197,758,510

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE E - PART 2 - CASH EQUIVALENTS

Show Investments Owned December 31 of Current Year

1	2	3	4	5	6	7	8
Description	Code	Date Acquired	Rate of Interest	Maturity Date	Book/Adjusted Carrying Value	Amount of Interest Due and Accrued	Amount Received During Year
NONE							
8699999 - Total Cash Equivalents							

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

SCHEDULE E - PART 3 - SPECIAL DEPOSITS

States, Etc.	1 Type of Deposit	2 Purpose of Deposit	Deposits For the Benefit of All Policyholders		All Other Special Deposits	
			3 Book/Adjusted Carrying Value	4 Fair Value	5 Book/Adjusted Carrying Value	6 Fair Value
1. Alabama	AL					
2. Alaska	AK					
3. Arizona	AZ					
4. Arkansas	AR					
5. California	CA					
6. Colorado	CO					
7. Connecticut	CT					
8. Delaware	DE					
9. District of Columbia	DC					
10. Florida	FL	ST... Rehabilitative Administrative Expense Fund deposit (01R required)/Insolvency	15,872,916	15,872,916		
11. Georgia	GA					
12. Hawaii	HI					
13. Idaho	ID					
14. Illinois	IL					
15. Indiana	IN					
16. Iowa	IA					
17. Kansas	KS					
18. Kentucky	KY					
19. Louisiana	LA					
20. Maine	ME					
21. Maryland	MD					
22. Massachusetts	MA					
23. Michigan	MI					
24. Minnesota	MN					
25. Mississippi	MS					
26. Missouri	MO					
27. Montana	MT					
28. Nebraska	NE					
29. Nevada	NV					
30. New Hampshire	NH					
31. New Jersey	NJ					
32. New Mexico	NM					
33. New York	NY					
34. North Carolina	NC					
35. North Dakota	ND					
36. Ohio	OH					
37. Oklahoma	OK					
38. Oregon	OR					
39. Pennsylvania	PA					
40. Rhode Island	RI					
41. South Carolina	SC					
42. South Dakota	SD					
43. Tennessee	TN					
44. Texas	TX					
45. Utah	UT					
46. Vermont	VT					
47. Virginia	VA					
48. Washington	WA					
49. West Virginia	WV					
50. Wisconsin	WI					
51. Wyoming	WY					
52. American Samoa	AS					
53. Guam	GU					
54. Puerto Rico	PR					
55. U.S. Virgin Islands	VI					
56. Northern Mariana Islands	MP					
57. Canada	CAN					
58. Aggregate Alien and Other	OT	XXX	0	0	0	0
59. Subtotal	XXX	XXX	15,872,916	15,872,916	0	0
DETAILS OF WRITE-INS						
5801.						
5802.						
5803.						
5898. Summary of remaining write-ins for Line 58 from overflow page	XXX	XXX	0	0	0	0
5899. Totals (Lines 5801 thru 5803 plus 5898)(Line 58 above)	XXX	XXX	0	0	0	0



Relief from the five-year rotation requirement for lead audit partner



Relief from the one-year cooling off period for independent CPA



Relief from the Requirements for Audit Committees



SUPPLEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.
MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT
For The Year Ended December 31, 2016
(To Be Filed by March 1)

FOR THE STATE OF
NAIC Group Code 0000 NAIC Company Code 13726
ADDRESS (City, State and Zip Code) Miami , FL 33174
Person Completing This Exhibit
Title Telephone Number

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2013				Policies Issued in 2014; 2015; 2016			
										11	Incurred Claims		14	15	Incurred Claims		18
											12	13			16	17	
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details
2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss(c)(3)(E) for this state.
2.1 Address: ,
2.2 Contact Person and Phone Number:
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).
3.1 Address: ,
3.2 Contact Person and Phone Number:
4. Explain any policies identified above as policy type "O".



SUPPLEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.
MEDICARE PART D COVERAGE SUPPLEMENT
(Net of Reinsurance)

NAIC Group Code 0000		(To Be Filed by March 1)		NAIC Company Code 13726	
	Individual Coverage		Group Coverage		5
	1 Insured	2 Uninsured	3 Insured	4 Uninsured	Total Cash
1. Premiums Collected					
1.1 Standard Coverage					
1.11 With Reinsurance Coverage		XXX		XXX	0
1.12 Without Reinsurance Coverage		XXX		XXX	0
1.13 Risk-Corridor Payment Adjustments		XXX		XXX	0
1.2 Supplemental Benefits		XXX		XXX	0
2. Premiums Due and Uncollected-change					
2.1 Standard Coverage					
2.11 With Reinsurance Coverage		XXX		XXX	XXX
2.12 Without Reinsurance Coverage		XXX		XXX	XXX
2.2 Supplemental Benefits		XXX		XXX	XXX
3. Unearned Premium and Advance Premium-change					
3.1 Standard Coverage					
3.11 With Reinsurance Coverage		XXX		XXX	XXX
3.12 Without Reinsurance Coverage		XXX		XXX	XXX
3.2 Supplemental Benefits		XXX		XXX	XXX
4. Risk-Corridor Payment Adjustments-change					
4.1 Receivable		XXX		XXX	XXX
4.2 Payable		XXX		XXX	XXX
5. Earned Premiums					
5.1 Standard Coverage					
5.11 With Reinsurance Coverage	0	XXX	0	XXX	XXX
5.12 Without Reinsurance Coverage	0	XXX	0	XXX	XXX
5.13 Risk-Corridor Payment Adjustments	0	XXX	0	XXX	XXX
5.2 Supplemental Benefits	0	XXX	0	XXX	XXX
6. Total Premiums	0	XXX	0	XXX	0
7. Claims Paid					
7.1 Standard Coverage					
7.11 With Reinsurance Coverage		XXX		XXX	0
7.12 Without Reinsurance Coverage		XXX		XXX	0
7.2 Supplemental Benefits		XXX		XXX	0
8. Claim Reserves and Liabilities-change					
8.1 Standard Coverage					
8.11 With Reinsurance Coverage		XXX		XXX	XXX
8.12 Without Reinsurance Coverage		XXX		XXX	XXX
8.2 Supplemental Benefits		XXX		XXX	XXX
9. Health Care Receivables-change					
9.1 Standard Coverage					
9.11 With Reinsurance Coverage		XXX		XXX	XXX
9.12 Without Reinsurance Coverage		XXX		XXX	XXX
9.2 Supplemental Benefits		XXX		XXX	XXX
10. Claims Incurred					
10.1 Standard Coverage					
10.11 With Reinsurance Coverage	0	XXX	0	XXX	XXX
10.12 Without Reinsurance Coverage	0	XXX	0	XXX	XXX
10.2 Supplemental Benefits	0	XXX	0	XXX	XXX
11. Total Claims	0	XXX	0	XXX	0
12. Reinsurance Coverage and Low Income Cost Sharing					
12.1 Claims Paid - Net of Reimbursements Applied	XXX		XXX		0
12.2 Reimbursements Received but Not Applied-change	XXX		XXX		0
12.3 Reimbursements Receivable-change	XXX		XXX		XXX
12.4 Health Care Receivables-change	XXX		XXX		XXX
13. Aggregate Policy Reserves-change					XXX
14. Expenses Paid		XXX		XXX	0
15. Expenses Incurred		XXX		XXX	XXX
16. Underwriting Gain/Loss	0	XXX	0	XXX	XXX
17. Cash Flow Results	XXX	XXX	XXX	XXX	0



Non-Guaranteed Opinion for Exhibit 5



Participating Opinion for Exhibit 5

SUPPLEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

Schedule SIS
NONE

Schedule SIS II
NONE

Schedule SIS III
NONE

Schedule SIS IV
NONE

SUPPLEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

Life Supplement Cover
N O N E

Life Suppement - Exhibit 5 - Aggregate Reserve for Life Contracts
N O N E

Life Supplement - Exhibit 5 - Interrogatories
N O N E

Life Supplement - Exhibit 7 - Deposit-Type Contracts
N O N E

Life Supplement - Schedule S - Part 1 - Section 1
N O N E

Life Supplement - Schedule S - Part 3 - Section 1
N O N E

LS01, LS02, LS03, LS04, LS05, LS06



SUPPLEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

DIRECT BUSINESS IN THE STATE OF

DURING THE YEAR 2016

NAIC Group Code 0000

LIFE INSURANCE

NAIC Company Code 13726

DIRECT PREMIUMS AND ANNUITY CONSIDERATIONS	1	2	3	4	5
	Ordinary	Credit Life (Group and Individual)	Group	Industrial	Total
1. Life insurance					
2. Annuity considerations					
3. Deposit-type contract funds		XXX		XXX	
4. Other considerations					
5. Totals (Sum of Lines 1 to 4)					
DIRECT DIVIDENDS TO POLICYHOLDERS					
Life insurance:					
6.1 Paid in cash or left on deposit					
6.2 Applied to pay renewal premiums					
6.3 Applied to provide paid-up additions or shorten the endowment or premium-paying period					
6.4 Other					
6.5 Totals (sum of Line 6.1 to 6.4)					
Annuities:					
7.1 Paid in cash or left on deposit					
7.2 Applied to provide paid-up annuities					
7.3 Other					
7.4 Totals (sum of Lines 7.1 to 7.3)					
8. Grand Totals (Lines 6.5 plus 7.4)					
DIRECT CLAIMS AND BENEFITS PAID					
9. Death benefits					
10. Matured endowments					
11. Annuity benefits					
12. Surrender values and withdrawals for life contracts					
13. Aggregate write-ins for miscellaneous direct claims and benefits paid					
14. All other benefits, except accident and health					
15. Totals					
DETAILS OF WRITE-INS					
1301.					
1302.					
1303.					
1398. Summary of Line 13 from overflow page					
1399. Totals (Lines 1301 thru 1303 plus 1398) (Line 13 above)					

NONE

DIRECT DEATH BENEFITS AND MATURED ENDOWMENTS INCURRED	Ordinary		Credit Life (Group and Individual)		Group		Industrial		Total	
	1	2	3	4	5	6	7	8	9	10
	No.	Amount	No. of Ind.Pols. & Gr. Certifs.	Amount	No. of Certifs.	Amount	No.	Amount	No.	Amount
16. Unpaid December 31, prior year										
17. Incurred during current year										
Settled during current year:										
18.1 By payment in full										
18.2 By payment on compromised claims										
18.3 Totals paid										
18.4 Reduction by compromise										
18.5 Amount rejected										
18.6 Total settlements										
19. Unpaid Dec. 31, current year (16+17-18.6)										
POLICY EXHIBIT					No. of Policies					
20. In force December 31, prior year			(a)							
21. Issued during year										
22. Other changes to in force (Net)										
23. In force December 31 of current year			(a)							

(a) Includes Individual Credit Life Insurance prior year \$, current year \$
Includes Group Credit Life Insurance Loans less than or equal to 60 months at issue, prior year \$, current year \$
Loans greater than 60 months at issue BUT NOT GREATER THAN 120 MONTHS, prior year \$, current year \$

ACCIDENT AND HEALTH INSURANCE

	1	2	3	4	5
	Direct Premiums	Direct Premiums Earned	Dividends Paid Or Credited On Direct Business	Direct Losses Paid	Direct Losses Incurred
24. Group Policies (b)					
24.1 Federal Employees Health Benefits Plan premium (b)					
24.2 Credit (Group and Individual)					
24.3 Collectively renewable policies (b)					
24.4 Medicare Title XVIII exempt from state taxes or fees Other Individual Policies:					
25.1 Non-cancelable (b)					
25.2 Guaranteed renewable (b)					
25.3 Non-renewable for stated reasons only (b)					
25.4 Other accident only					
25.5 All other (b)					
25.6 Totals (sum of Lines 25.1 to 25.5)					
26. Totals (Lines 24 + 24.1 + 24.2 + 24.3 + 24.4 + 25.6)					

(b) For health business on indicated lines report: Number of persons insured under PPO managed care products .0 and number of persons
insured under indemnity only products .0

SUPPLEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

P&C Supplement Cover	NONE
P&C Supplement - Schedule F - Part 1	NONE
P&C Supplement - Schedule F - Part 3	NONE
P&C Supplement - Schedule P - Part 1 - Summary	NONE
P&C Supplement - Schedule P - Part 1A - Homeowners/Farmowners	NONE
P&C Supplement - Schedule P - Part 1B - Private Passenger Auto Liability/Medical	NONE
P&C Supplement - Schedule P - Part 1C - Commercial Auto/Truck Liability/Medical	NONE
P&C Supplement - Schedule P - Part 1D - Workers' Compensation (Excluding Excess Workers' Compensation)	NONE
P&C Supplement - Schedule P - Part 1E - Commercial Multiple Peril	NONE
P&C Supplement - Schedule P - Part 1F - Section 1 - Medical Professional Liability - Occurrence	NONE
P&C Supplement - Schedule P - Part 1F - Section 2 - Medical Professional Liability - Claims-Made	NONE
P&C Supplement - Schedule P - Part 1G - Special Liability (Ocean Marine, Aircraft (all perils), Boiler and Machinery)	NONE
P&C Supplement - Schedule P - Part 1H - Section 1 - Other Liability - Occurrence	NONE
P&C Supplement - Schedule P - Part 1H - Section 2 - Other Liability - Claims-Made	NONE

PS01, PS02, PS03, PS04, PS05, PS06, PS07, PS08, PS09, PS10, PS11, PS12, PS13, PS14

SUPPLEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

P&C Supplement - Schedule P - Part 1I - Special Property (Fire, Allied Lines...)

NONE

P&C Supplement - Schedule P - Part 1J - Auto Physical Damage

NONE

P&C Supplement - Schedule P - Part 1K - Fidelity/Surety

NONE

P&C Supplement - Schedule P - Part 1L - Other (Including Credit, Accident and Health)

NONE

P&C Supplement - Schedule P - Part 1M - International

NONE

P&C Supplement - Schedule P - Part 1N - Reinsurance - Nonproportional Assumed Property

NONE

P&C Supplement - Schedule P - Part 1O - Reinsurance - Nonproportional Assumed Liability

NONE

P&C Supplement - Schedule P - Part 1P - Reinsurance - Nonproportional Assumed Financial Lines

NONE

P&C Supplement - Schedule P - Part 1R - Section 1 - Products Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 1R - Section 2 - Products Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 1S - Financial Guaranty/Mortgage Guaranty

NONE

P&C Supplement - Schedule P - Part 1T - Warranty

NONE

P&C Supplement - Schedule P - Part 2 - Summary

NONE

P&C Supplement - Schedule P - Part 2A - Homeowners/Farmowners

NONE

PS15, PS16, PS17, PS18, PS19, PS20, PS21, PS22, PS23, PS24, PS25, PS26, PS27, PS28

SUPPLEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

P&C Supplement - Schedule P - Part 2B - Private Passenger Auto Liability/Medical	NONE
P&C Supplement - Schedule P - Part 2C - Commercial Auto/Truck Liability/Medical	NONE
P&C Supplement - Schedule P - Part 2D - Workers' Compensation (Excluding Excess Workers' Compensation)	NONE
P&C Supplement - Schedule P - Part 2E - Commercial Multiple Peril	NONE
P&C Supplement - Schedule P - Part 2F - Section 1 - Medical Professional Liability - Occurrence	NONE
P&C Supplement - Schedule P - Part 2F - Section 2 - Medical Professional Liability - Claims-Made	NONE
P&C Supplement - Schedule P - Part 2G - Special Liability (Ocean Marine, Aircraft (all perils), Boiler and Machinery)	NONE
P&C Supplement - Schedule P - Part 2H - Section 1 - Other Liability - Occurrence	NONE
P&C Supplement - Schedule P - Part 2H - Section 2- Other Liability - Claims-Made	NONE
P&C Supplement - Schedule P - Part 2I - Special Property	NONE
P&C Supplement - Schedule P - Part 2J - Auto Physical Damage	NONE
P&C Supplement - Schedule P - Part 2K - Fidelity/Surety	NONE
P&C Supplement - Schedule P - Part 2L - Other (Including Credit, Accident and Health)	NONE
P&C Supplement - Schedule P - Part 2M - International	NONE

SUPPLEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

P&C Supplement - Schedule P - Part 2N - Reinsurance - Nonproportional Assumed Property

NONE

P&C Supplement - Schedule P - Part 2O - Reinsurance - Nonproportional Assumed Liability

NONE

P&C Supplement - Schedule P - Part 2P - Reinsurance - Nonproportional Assumed Financial Lines

NONE

P&C Supplement - Schedule P - Part 2R - Section 1 - Products Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 2R - Section 2 - Products Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 2S - Financial Guaranty/Mortgage Guaranty

NONE

P&C Supplement - Schedule P - Part 2T - Warranty

NONE



SUPPLEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

EXHIBIT OF PREMIUMS AND LOSSES (Statutory Page 14)

NAIC Group Code 0000		BUSINESS IN THE STATE OF		DURING THE YEAR 2016						NAIC Company Code 13726		
Line of Business	Gross Premiums, Including Policy and Membership Fees, Less Return Premiums and Premiums on Policies not Taken		3	4	5	6	7	8	9	10	11	12
	1	2										
	Direct Premiums Written	Direct Premiums Earned	Dividends Paid or Credited to Policyholders on Direct Business	Direct Unearned Premium Reserves	Direct Losses Paid (deducting salvage)	Direct Losses Incurred	Direct Losses Unpaid	Direct Defense and Cost Containment Expense Paid	Direct Defense and Cost Containment Expense Incurred	Direct Defense and Cost Containment Expense Unpaid	Commissions and Brokerage Expenses	Taxes, Licenses and Fees
1. Fire												
2.1 Allied lines												
2.2 Multiple peril crop												
2.3 Federal flood												
2.4 Private crop												
2.5 Private flood												
3. Farmowners multiple peril												
4. Homeowners multiple peril												
5.1 Commercial multiple peril (non-liability portion)												
5.2 Commercial multiple peril (liability portion)												
6. Mortgage guaranty												
8. Ocean marine												
9. Inland marine												
10. Financial guaranty												
11. Medical professional liability												
12. Earthquake												
13. Group accident and health (b)												
14. Credit accident and health (group and individual)												
15.1 Collectively renewable accident and health (b)												
15.2 Non-cancelable accident and health(b)												
15.3 Guaranteed renewable accident and health(b)												
15.4 Non-renewable for stated reasons only (b)												
15.5 Other accident only												
15.6 Medicare Title XVIII exempt from state taxes or fees												
15.7 All other accident and health (b)												
15.8 Federal employees health benefits plan premium (b)												
16. Workers' compensation												
17.1 Other Liability - occurrence												
17.2 Other Liability - claims made												
17.3 Excess workers' compensation												
18. Products liability												
19.1 Private passenger auto no-fault (personal injury protection)												
19.2 Other private passenger auto liability												
19.3 Commercial auto no-fault (personal injury protection)												
19.4 Other commercial auto liability												
21.1 Private passenger auto physical damage												
21.2 Commercial auto physical damage												
22. Aircraft (all perils)												
23. Fidelity												
24. Surety												
26. Burglary and theft												
27. Boiler and machinery												
28. Credit												
30. Warranty												
34. Aggregate write-ins for other lines of business												
35. TOTALS (a)												
DETAILS OF WRITE-INS												
3401.												
3402.												
3403.												
3498. Summary of remaining write-ins for Line 34 from overflow page												
3499. Totals (Lines 3401 thru 3403 plus 3498)(Line 34 above)												

(a) Finance and service charges not included in Lines 1 to 35 \$
(b) For health business on indicated lines report: Number of persons insured under PPO managed care products and number of persons insured under indemnity only products

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.

Prior Year Validation Data

1.	XXASU900029	PYPPage ASSETS L28C3 = ASSETS L28C4.....	183,316,055
2.	XXASN000272	PYPPage REVEX2 L49C1 = REVEX2 L33C1.....	46,117,218
3.	XXASU900102	PYPPage ASSETS L05 C1 = CASH L19.1C1.....	92,585,051
4.	XXASU900066	PYPPage SCAVER L09C2 = SCAVER L01C2.....	0
5.	XXASU900067	PYPPage SCBVER L11C2 = SCBVER L01C2.....	0
6.	XXASU900068	PYPPage SCBAVER L11C2 = SCBAVER L01C2.....	0
7.	XXASU090298	PYPPage SCDVER L10C2 = SCDVER L01C2.....	64,559,755
8.	XXASU095082	PYPPage SCDAPT1 L9199999C8 = SCDAYER L01C1.....	425,768
9.	XXASU099985	PYPPage SCDBPTCSN2 L07C9 = SCDBPTCSN2 L01C1.....	0
10.	XXASU099986	PYPPage SCDBPTCSN2 L07C10 = SCDBPTCSN2 L01C2.....	0
11.	XXASU900058	PYPPage SCEPT2 L8699999C6 = SCEVER L01C1.....	0
12.	XXASN000339	PYPPage REVEX1 L02C2 = GENINTPT2 L02.2C5.....	985,291,150
13.	XXASN000341	PYPPage LIAB L01C3 + L02C3 + L04C3 + L07C3 = GENINTPT2 L02.5C5.....	103,566,501
14.	XXAAU900307	PYPPage SHCEPT1 - GT L05.5C15 = SHCEPT1 - GT L05.4C15.....	
15.	PXASU900138	PYPPage SCDBPTAVER L09C2 = SCDBPTAVER L09C1.....	0
16.	PXASU900140	PYPPage SCDBPTBVER L06C4 = SCDBPTBVER L01C4.....	0
17.	PXASU900141	PYPPage SCDBPTBSN1 L1449999C15 = SCDBPTBVER L03.12C1.....	0
18.	PXASU900142	PYPPage SCDBPTBSN1 L1449999C18 = SCDBPTBVER L03.14C1.....	0
19.	PXASU900143	PYPPage SCDBPTBSN1 L1449999C17 = SCDBPTBVER L03.22C1.....	0
20.	PXASU900144	PYPPage SCDBPTBSN1 L1449999C19 = SCDBPTBVER L03.24C1.....	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Simply Healthcare Plans, Inc.
ANNUAL DISKETTE TRANSMITTAL FORM AND CERTIFICATION (HEALTH)

Name of Insurer	Simply Healthcare Plans, Inc.		
Date		FEIN	27-0945036
NAIC Group #	0671	NAIC Company #	13726

THIS FORM IS REQUIRED FOR ALL DISKETTE TRANSMITTALS. PLEASE PROVIDE ANY ADDITIONAL COMMENTS THAT MAY HELP TO IDENTIFY DISKETTE CONTENT.

A.		MARCH	APRIL	JUNE
	1. Is this the first time you've submitted this filing? (Y/N)			
	2. Is this being re-filed at the request of the NAIC or a state insurance department? (Y/N)			
	3. Is this being re-filed due to changes to the data originally filed? (Y/N) (IF "YES", ENCLOSE HARD COPY PAGES FOR THE CHANGES.)			
	4. Other? (Y/N) (If "yes", attach an explanation.)			

B. Additional comments if necessary for clarification:

C. Diskette Contact Person:

Holly J Prince

Phone: 305-921-2610

Address:: 9250 W Flagler Street, Suite 600 Miami FL 33174

D. Software Vendor: Eagle Technology Management

Version: 2016

E. Have material validation failures been addressed in the explanation file?

Yes No

The undersigned hereby certifies, according to the best of his/her knowledge and belief: that the diskettes submitted with this form were prepared in compliance with the NAIC specifications, that the diskettes have been tested against the validations included with these specifications, and that annual statement information required to be contained on diskette is identical to the information in the 2016 Annual Statement blank filed with the insurer's domiciliary state insurance department. In addition, the diskettes submitted have been scanned through a virus detection software package, and no viruses are present on the diskettes. The virus detection software used was (name)

(version number)

Signed

Type Name and Title:

Schedule Qtr - G[illegible]

AUTH - F.A.C. RULE 690-191.075(6)

Schedule Qtr - D

Individually list prepaid expenses with account balances greater than 10% of Total Prepaid Expenses

AUTH - F.A.C. RULE 69O-191.075(6)

ANNUAL STATEMENT

OF THE

Simply Healthcare Plans, Inc

of **Miami**
in the state of **Florida**

TO THE

Insurance Department

OF THE

State of Florida

FOR THE YEAR ENDED

December 31, 2015

HEALTH

2015



ANNUAL STATEMENT
For the Year Ended December 31, 2015
OF THE CONDITION AND AFFAIRS OF THE

Simply Healthcare Plans, Inc.

NAIC Group Code	0000	4805	NAIC Company Code	13726	Employer's ID Number	27-0945036
(Current Period)		(Prior Period)				
Organized under the Laws of	Florida		State of Domicile or Port of Entry	Florida		
Country of Domicile	United States of America					
Licensed as business type:	Life, Accident & Health <input type="checkbox"/> Property/Casualty <input type="checkbox"/> Hospital, Medical & Dental Service or Indemnity <input type="checkbox"/>					
	Dental Service Corporation <input type="checkbox"/> Vision Service Corporation <input type="checkbox"/> Health Maintenance Organization <input checked="" type="checkbox"/>					
	Other <input type="checkbox"/> Is HMO Federally Qualified? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Incorporated/Organized	September 10, 2009		Commenced Business	January 7, 2010		
Statutory Home Office	9250 W Flagler St, Suite 600		Miami, FL, US	33174		
		(Street and Number)	(City or Town, State, Country and Zip Code)			
Main Administrative Office	4425 Corporation Lane					
		(Street and Number)				
	Virginia Beach, VA, US 23462		757-490-6900			
		(City or Town, State, Country and Zip Code)	(Area Code) (Telephone Number)			
Main Address	4425 Corporation Lane		Virginia Beach, VA, US 23462			
		(Street and Number or P.O. Box)	(City or Town, State, Country and Zip Code)			
Primary Location of Books and Records	4425 Corporation Lane		757-490-6900			
		(Street and Number)	(City or Town, State, Country and Zip Code) (Area Code) (Telephone Number)			
Internet Web Site Address	www.simplyhealthcareplans.com					
Statutory Statement Contact	Bette Lou Gronsen		757-516-3638			
		(Name)	(Area Code) (Telephone Number) (Extension)			
	Bette.Gronsen@flumengroup.com		757-557-6742			
		(E-Mail Address)	(Fax Number)			

OFFICERS

Name	Title
1. Lourdes Toma-Rivas	Chief Executive Officer
2. Kathleen S. Kiefer	Secretary
3. R. David Kriechner	Treasurer
4. Holly J. Prince	Chief Financial Officer

Vice Presidents

Name	Title	Name	Title
Vincent Panton	Chief Medical Officer	Eric K. Noble	Assistant Treasurer

DIRECTORS OR TRUSTEES

Lourdes Toma-Rivas	Catherine I. Kelaghan	Carter A. Bold	

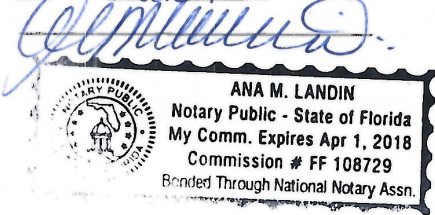
State of Florida

Country of Miami-Dade ss

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, amended or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of that attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

(Signature)	(Signature)	(Signature)
Lourdes Toma-Rivas	Holly Prince	Kathleen S. Kiefer
(Printed Name)	(Printed Name)	(Printed Name)
1	2	3
President & CEO	CFO	Secretary
(Title)	(Title)	(Title)

Subscribed and sworn to (or affirmed) before me this 29th day of March, 2016, by



a. Is this an original filing? [X] Yes [] No
b. If no:
1. State the amendment number
2. Date filed
3. Number of pages attached

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

ASSETS

	Current Year			Prior Year
	1	2	3	4
	Assets	Nonadmitted Assets	Net Admitted Assets (Cols. 1 - 2)	Net Admitted Assets
1. Bonds (Schedule D)	64,559,757	0	64,559,757	15,436,624
2. Stocks (Schedule D):				
2.1 Preferred stocks	0	0	0	0
2.2 Common stocks	0	0	0	0
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens	0	0	0	0
3.2 Other than first liens	0	0	0	0
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less \$ 0 encumbrances)	0	0	0	0
4.2 Properties held for the production of income (less \$ 0 encumbrances)	0	0	0	0
4.3 Properties held for sale (less \$ 0 encumbrances)	0	0	0	0
5. Cash (\$ 92,159,283, Schedule E - Part 1), cash equivalents (\$ 0, Schedule E - Part 2), and short-term investments (\$ 425,768, Schedule DA)	92,585,051	0	92,585,051	150,737,407
6. Contract loans (including \$ 0 premium notes)	0	0	0	0
7. Derivatives (Schedule DB)	0	0	0	0
8. Other invested assets (Schedule BA)	0	0	0	0
9. Receivables for securities	0	0	0	0
10. Securities lending reinvested collateral assets (Schedule DL)	0	0	0	0
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	157,144,808	0	157,144,808	166,174,031
13. Title plants less \$ 0 charged off (for Title insurers only)	0	0	0	0
14. Investment income due and accrued	699,805	2,054	697,751	151,723
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	10,759,189	0	10,759,189	6,723,193
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including \$ 0 earned but unbilled premiums)	0	0	0	0
15.3 Accrued retrospective premiums (\$ 5,344,320) and contracts subject to redetermination (\$ 0)	6,642,793	0	6,642,793	18,254,005
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers	252,686	0	252,686	16,752
16.2 Funds held by or deposited with reinsured companies	0	0	0	0
16.3 Other amounts receivable under reinsurance contracts	0	0	0	0
17. Amounts receivable relating to uninsured plans	432,708	0	432,708	0
18.1 Current federal and foreign income tax recoverable and interest thereon	0	0	0	0
18.2 Net deferred tax asset	7,375,932	3,852,709	3,523,223	1,408,149
19. Guaranty funds receivable or on deposit	0	0	0	0
20. Electronic data processing equipment and software	4,270,746	3,047,274	1,223,472	652,038
21. Furniture and equipment, including health care delivery assets (\$ 0)	9,325,353	9,325,353	0	0
22. Net adjustment in assets and liabilities due to foreign exchange rates	0	0	0	0
23. Receivables from parent, subsidiaries and affiliates	0	0	0	0
24. Health care (\$ 2,629,425) and other amounts receivable	7,004,093	4,374,668	2,629,425	6,457,772
25. Aggregate write-ins for other-than-invested assets	4,876,378	4,866,378	10,000	10,000
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	208,784,491	25,468,436	183,316,055	199,847,663
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0	0
28. Total (Lines 26 and 27)	208,784,491	25,468,436	183,316,055	199,847,663

DETAILS OF WRITE-IN LINES				
1101.	0	0	0	0
1102.	0	0	0	0
1103.	0	0	0	0
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)	0	0	0	0
2501. GOODWILL	3,128,663	3,128,663	0	0
2502. DEPOSITS	982,419	972,419	10,000	10,000
2503. PREPAID ASSETS	765,296	765,296	0	0
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	4,876,378	4,866,378	10,000	10,000

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

LIABILITIES, CAPITAL AND SURPLUS

	Current Year			Prior Year
	1 Covered	2 Uncovered	3 Total	4 Total
1. Claims unpaid (less \$ 0 reinsurance ceded)	83,129,310	0	83,129,310	88,751,134
2. Accrued medical incentive pool and bonus amounts	17,426,184	0	17,426,184	19,935,533
3. Unpaid claims adjustment expenses	2,777,079	0	2,777,079	902,056
4. Aggregate health policy reserves, including the liability of \$ 0 for medical loss ratio rebate per the Public Health Services Act	3,011,007	0	3,011,007	3,720,208
5. Aggregate life policy reserves	0	0	0	0
6. Property/casualty unearned premium reserves	0	0	0	0
7. Aggregate health claim reserves	0	0	0	0
8. Premiums received in advance	0	0	0	37,952,074
9. General expenses due or accrued	10,706,031	0	10,706,031	10,133,112
10.1. Current federal and foreign income tax payable and interest thereon (including \$ 0 on realized gains (losses))	4,558,726	0	4,558,726	5,256,165
10.2. Net deferred tax liability	0	0	0	0
11. Ceded reinsurance premiums payable	0	0	0	0
12. Amounts withheld or retained for the account of others	0	0	0	0
13. Remittances and items not allocated	0	0	0	0
14. Borrowed money (including \$ 0 current) and interest thereon \$ 0 (including \$ 0 current)	0	0	0	0
15. Amounts due to parent, subsidiaries and affiliates	2,974,679	0	2,974,679	64,241
16. Derivatives	0	0	0	0
17. Payable for securities	0	0	0	0
18. Payable for securities lending	0	0	0	0
19. Funds held under reinsurance treaties (with \$ 0 authorized reinsurers, \$ 0 unauthorized reinsurers and \$ 0 certified reinsurers)	0	0	0	0
20. Reinsurance in unauthorized and certified \$ (0) companies	0	0	0	0
21. Net adjustments in assets and liabilities due to foreign exchange rates	0	0	0	0
22. Liability for amounts held under uninsured plans	6,212,617	0	6,212,617	0
23. Aggregate write-ins for other liabilities (including \$ 0 current)	6,403,204	0	6,403,204	5,813,847
24. Total liabilities (Lines 1 to 23)	137,198,837	0	137,198,837	172,528,370
25. Aggregate write-ins for special surplus funds	X X X	X X X	20,013,754	9,169,007
26. Common capital stock	X X X	X X X	57	57
27. Preferred capital stock	X X X	X X X	0	0
28. Gross paid in and contributed surplus	X X X	X X X	5,714,050	5,714,050
29. Surplus notes	X X X	X X X	20,559,808	20,559,808
30. Aggregate write-ins for other than special surplus funds	X X X	X X X	0	0
31. Unassigned funds (surplus)	X X X	X X X	(170,451)	(8,123,629)
32. Less treasury stock, at cost:				
32.1 0 shares common (value included in Line 26 \$ 0)	X X X	X X X	0	0
32.2 0 shares preferred (value included in Line 27 \$ 0)	X X X	X X X	0	0
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	X X X	X X X	46,117,218	27,319,293
34. Total liabilities, capital and surplus (Lines 24 and 33)	X X X	X X X	183,316,055	199,847,663

DETAILS OF WRITE-IN LINES					
2301. 2014 Fee Year / 2013 Data Year ACA tax Liability	6,227,459	0	6,227,459	5,813,847	
2302. Unclaimed Funds	175,745	0	175,745	0	
2303.	0	0	0	0	
2398. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0	
2399. Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	6,403,204	0	6,403,204	5,813,847	
2501. 2015 Fee Year / 2014 Data Year ACA tax liability	X X X	X X X	20,013,754	9,169,007	
2502.	X X X	X X X	0	0	
2503.	X X X	X X X	0	0	
2598. Summary of remaining write-ins for Line 25 from overflow page	X X X	X X X	0	0	
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	X X X	X X X	20,013,754	9,169,007	
3001.	X X X	X X X	0	0	
3002.	X X X	X X X	0	0	
3003.	X X X	X X X	0	0	
3098. Summary of remaining write-ins for Line 30 from overflow page	X X X	X X X	0	0	
3099. Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	X X X	X X X	0	0	

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

STATEMENT OF REVENUE AND EXPENSES

	Current Year		Prior Year
	1 Uncovered	2 Total	3 Total
1. Member Months	X X X	1,366,614	1,103,246
2. Net premium income (including \$ 0 non-health premium income)	X X X	985,291,150	834,607,654
3. Change in unearned premium reserves and reserve for rate credits	X X X	913,509	0
4. Fee-for-service (net of \$ 0 medical expenses)	X X X	0	0
5. Risk revenue	X X X	0	0
6. Aggregate write-ins for other health care related revenues	X X X	0	0
7. Aggregate write-ins for other non-health revenues	X X X	0	0
8. Total revenues (Lines 2 to 7)	X X X	986,204,659	834,607,654
Hospital and Medical:			
9. Hospital/medical benefits	0	289,246,910	269,669,370
10. Other professional services	0	196,317,298	195,683,752
11. Outside referrals	0	0	0
12. Emergency room and out-of-area	0	0	0
13. Prescription drugs	0	294,950,327	231,191,519
14. Aggregate write-ins for other hospital and medical	0	0	0
15. Incentive pool, withhold adjustments and bonus amounts	0	52,849,209	43,440,525
16. Subtotal (Lines 9 to 15)	0	833,363,744	739,985,166
Less:			
17. Net reinsurance recoveries	0	321,986	661,022
18. Total hospital and medical (Lines 16 minus 17)	0	833,041,758	739,324,144
19. Non-health claims (net)	0	0	0
20. Claims adjustment expenses, including \$ 18,756,090 cost containment expenses	0	25,588,128	7,031,268
21. General administrative expenses	0	85,788,144	65,803,921
22. Increase in reserves for life and accident and health contracts (including \$ 0 increase in reserves for life only)	0	0	0
23. Total underwriting deductions (Lines 18 through 22)	0	944,418,030	812,159,333
24. Net underwriting gain or (loss) (Lines 8 minus 23)	X X X	41,786,629	22,448,321
25. Net investment income earned (Exhibit of Net Investment Income, Line 17)	0	742,319	275,839
26. Net realized capital gains (losses) less capital gains tax of \$ 0	0	6,242	11,165
27. Net investment gains (losses) (Lines 25 plus 26)	0	748,561	287,004
28. Net gain or (loss) from agents' or premium balances charged off [(amount recovered \$ 0) (amount charged off \$ 0)]	0	0	0
29. Aggregate write-ins for other income or expenses	0	(422,334)	(99,140)
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	X X X	42,112,856	22,636,185
31. Federal and foreign income taxes incurred	X X X	20,301,937	10,779,455
32. Net income (loss) (Lines 30 minus 31)	X X X	21,810,919	11,856,730

DETAILS OF WRITE-IN LINES			
0601.	X X X	0	0
0602.	X X X	0	0
0603.	X X X	0	0
0698. Summary of remaining write-ins for Line 06 from overflow page	X X X	0	0
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 06 above)	X X X	0	0
0701.	X X X	0	0
0702.	X X X	0	0
0703.	X X X	0	0
0798. Summary of remaining write-ins for Line 07 from overflow page	X X X	0	0
0799. Totals (Lines 0701 through 0703 plus 0798) (Line 07 above)	X X X	0	0
1401.	0	0	0
1402.	0	0	0
1403.	0	0	0
1498. Summary of remaining write-ins for Line 14 from overflow page	0	0	0
1499. Totals (Lines 1401 through 1403 plus 1498) (Line 14 above)	0	0	0
2901. FINES AND PENALTIES	0	(422,334)	(99,140)
2902.	0	0	0
2903.	0	0	0
2998. Summary of remaining write-ins for Line 29 from overflow page	0	0	0
2999. Totals (Lines 2901 through 2903 plus 2998) (Line 29 above)	0	(422,334)	(99,140)

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc.**

STATEMENT OF REVENUE AND EXPENSES (Continued)

	1	2
	Current Year	Prior Year
CAPITAL & SURPLUS ACCOUNT		
33. Capital and surplus prior reporting year	27,319,293	13,300,367
34. Net income or (loss) from Line 32	21,810,919	11,856,730
35. Change in valuation basis of aggregate policy and claim reserves	0	0
36. Change in net unrealized capital gains (losses) less capital gains tax of \$ 0	0	(679,063)
37. Change in net unrealized foreign exchange capital gain or (loss)	0	0
38. Change in net deferred income tax	5,967,785	1,433,369
39. Change in nonadmitted assets	(8,980,779)	1,407,890
40. Change in unauthorized and certified reinsurance	0	0
41. Change in treasury stock	0	0
42. Change in surplus notes	0	0
43. Cumulative effect of changes in accounting principles	0	0
44. Capital Changes:		
44.1 Paid in	0	0
44.2 Transferred from surplus (Stock Dividend)	0	0
44.3 Transferred to surplus	0	0
45. Surplus adjustments:		
45.1 Paid in	0	0
45.2 Transferred to capital (Stock Dividend)	0	0
45.3 Transferred from capital	0	0
46. Dividends to stockholders	0	0
47. Aggregate write-ins for gains or (losses) in surplus	0	0
48. Net change in capital and surplus (Lines 34 to 47)	18,797,925	14,018,926
49. Capital and surplus end of reporting year (Line 33 plus 48)	46,117,218	27,319,293

DETAILS OF WRITE-IN LINES		
4701.	0	0
4702.	0	0
4703.	0	0
4798. Summary of remaining write-ins for Line 47 from overflow page	0	0
4799. Totals (Lines 4701 through 4703 plus 4798) (Line 47 above)	0	0

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

CASH FLOW

	1	2
	Current Year	Prior Year
Cash from Operations		
1. Premiums collected net of reinsurance	950,213,598	855,519,593
2. Net investment income	616,112	197,568
3. Miscellaneous income	0	0
4. Total (Lines 1 through 3)	950,829,710	855,717,161
5. Benefit and loss related payments	838,487,707	692,868,431
6. Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0
7. Commissions, expenses paid and aggregate write-ins for deductions	95,888,944	66,225,363
8. Dividends paid to policyholders	0	0
9. Federal and foreign income taxes paid (recovered) net of \$ 0 tax on capital gains (losses)	18,620,102	5,855,121
10. Total (Lines 5 through 9)	952,996,753	764,948,915
11. Net cash from operations (Line 4 minus Line 10)	(2,167,043)	90,768,246
Cash from Investments		
12. Proceeds from investments sold, matured or repaid:		
12.1 Bonds	19,779,859	1,862,139
12.2 Stocks	0	0
12.3 Mortgage loans	0	0
12.4 Real estate	0	0
12.5 Other invested assets	0	1,175,000
12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	(1,746)	0
12.7 Miscellaneous proceeds	0	0
12.8 Total investment proceeds (Lines 12.1 to 12.7)	19,778,113	3,037,139
13. Cost of investments acquired (long-term only):		
13.1 Bonds	69,316,874	15,076,661
13.2 Stocks	0	0
13.3 Mortgage loans	0	0
13.4 Real estate	0	0
13.5 Other invested assets	0	0
13.6 Miscellaneous applications	0	0
13.7 Total investments acquired (Lines 13.1 to 13.6)	69,316,874	15,076,661
14. Net increase (decrease) in contract loans and premium notes	0	0
15. Net cash from investments (Line 12.8 minus Line 13.7 minus Line 14)	(49,538,761)	(12,039,522)
Cash from Financing and Miscellaneous Sources		
16. Cash provided (applied):		
16.1 Surplus notes, capital notes	0	0
16.2 Capital and paid in surplus, less treasury stock	0	0
16.3 Borrowed funds	0	0
16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	0
16.5 Dividends to stockholders	0	0
16.6 Other cash provided (applied)	(6,446,552)	8,907,968
17. Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6)	(6,446,552)	8,907,968
RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS		
18. Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	(58,152,356)	87,636,692
19. Cash, cash equivalents and short-term investments:		
19.1 Beginning of year	150,737,407	63,100,715
19.2 End of year (Line 18 plus Line 19.1)	92,585,051	150,737,407

Note: Supplemental disclosures of cash flow information for non-cash transactions:

20.0001	0	0
20.0002	0	0
20.0003	0	0

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Net premium income	985,291,150	0	0	0	0	0	378,269,064	607,022,086	0	0
2. Change in unearned premium reserves and reserve for rate credit	913,509	0	0	0	0	0	275,123	638,386	0	0
3. Fee-for-service (net of \$ 0 medical expenses)	0	0	0	0	0	0	0	0	0	X X X
4. Risk revenue	0	0	0	0	0	0	0	0	0	X X X
5. Aggregate write-ins for other health care related revenues	0	0	0	0	0	0	0	0	0	X X X
6. Aggregate write-ins for other non-health care related revenues	0	X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	0
7. Total revenues (Lines 1 to 6)	986,204,659	0	0	0	0	0	378,544,187	607,660,472	0	0
8. Hospital/medical benefits	289,246,911	0	0	0	0	0	126,181,712	163,065,199	0	X X X
9. Other professional services	196,317,298	0	0	0	0	0	104,621,936	91,688,817	6,545	X X X
10. Outside referrals	0	0	0	0	0	0	0	0	0	X X X
11. Emergency room and out-of-area	0	0	0	0	0	0	0	0	0	X X X
12. Prescription drugs	294,950,327	0	0	0	0	0	50,565,324	244,385,003	0	X X X
13. Aggregate write-ins for other hospital and medical	0	0	0	0	0	0	0	0	0	X X X
14. Incentive pool, withhold adjustments and bonus amounts	52,849,209	0	0	0	0	0	28,461,381	24,387,828	0	X X X
15. Subtotal (Lines 8 to 14)	833,363,745	0	0	0	0	0	309,830,353	523,526,847	6,545	X X X
16. Net reinsurance recoveries	321,986	0	0	0	0	0	27,575	294,411	0	X X X
17. Total hospital and medical (Lines 15 minus 16)	833,041,759	0	0	0	0	0	309,802,778	523,232,436	6,545	X X X
18. Non-health claims (net)	0	X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	0
19. Claims adjustment expenses including \$ 18,756,090 cost containment expenses	25,588,128	0	0	0	0	0	10,201,741	15,386,387	0	0
20. General administrative expenses	85,788,144	0	0	0	0	0	42,939,032	42,846,600	2,512	0
21. Increase in reserves for accident and health contracts	0	0	0	0	0	0	0	0	0	X X X
22. Increase in reserves for life contracts	0	X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	0
23. Total underwriting deductions (Lines 17 to 22)	944,418,031	0	0	0	0	0	362,943,551	581,465,423	9,057	0
24. Net underwriting gain or (loss) (Line 7 minus Line 23)	41,786,628	0	0	0	0	0	15,600,636	26,195,049	(9,057)	0

DETAILS OF WRITE-IN LINES										
0501.	0	0	0	0	0	0	0	0	0	X X X
0502.	0	0	0	0	0	0	0	0	0	X X X
0503.	0	0	0	0	0	0	0	0	0	X X X
0598. Summary of remaining write-ins for Line 05 from overflow page	0	0	0	0	0	0	0	0	0	X X X
0599. Totals (Lines 0501 through 0503 plus 0598) (Line 05 above)	0	0	0	0	0	0	0	0	0	X X X
0601.	0	X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	0
0602.	0	X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	0
0603.	0	X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	0
0698. Summary of remaining write-ins for Line 06 from overflow page	0	X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	0
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 06 above)	0	X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	0
1301.	0	0	0	0	0	0	0	0	0	X X X
1302.	0	0	0	0	0	0	0	0	0	X X X
1303.	0	0	0	0	0	0	0	0	0	X X X
1398. Summary of remaining write-ins for Line 13 from overflow page	0	0	0	0	0	0	0	0	0	X X X
1399. Totals (Lines 1301 through 1303 plus 1398) (Line 13 above)	0	0	0	0	0	0	0	0	0	X X X

Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc

UNDERWRITING AND INVESTMENT EXHIBIT
PART 1 – PREMIUMS

Line of Business	1 Direct Business	2 Reinsurance Assumed	3 Reinsurance Ceded	4 Net Premium Income (Cols. 1 + 2 - 3)
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Benefits Plan				
6. Title XVIII – Medicare	378,763,202		494,138	378,269,064
7. Title XIX – Medicaid	607,708,340		686,254	607,022,086
8. Other health				
9. Health subtotal (Lines 1 through 8)	986,471,542		1,180,392	985,291,150
10. Life				
11. Property/casualty				
12. Totals (Lines 9 to 11)	986,471,542		1,180,392	985,291,150

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2 – CLAIMS INCURRED DURING THE YEAR

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Payments during the year:										
1.1 Direct	783,215,200	0	0	0	0	0	279,502,524	503,700,761	11,915	0
1.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
1.3 Reinsurance ceded	96,443	0	0	0	0	0	48,885	47,558	0	0
1.4 Net	783,118,757	0	0	0	0	0	279,453,639	503,653,203	11,915	0
2. Paid medical incentive pools and bonuses	54,670,005	0	0	0	0	0	34,537,907	20,132,098	0	0
3. Claim liability December 31, current year from Part 2A:										
3.1 Direct	83,129,310	0	0	0	0	0	32,555,218	50,574,092	0	0
3.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
3.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
3.4 Net	83,129,310	0	0	0	0	0	32,555,218	50,574,092	0	0
4. Claim reserve December 31, current year from Part 2D:										
4.1 Direct	0	0	0	0	0	0	0	0	0	0
4.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
4.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
4.4 Net	0	0	0	0	0	0	0	0	0	0
5. Accrued medical incentive pools and bonuses, current year	17,426,184	0	0	0	0	0	6,615,754	10,810,430	0	0
6. Net healthcare receivables (a)	(2,921,159)	0	0	0	0	0	(1,783,943)	(1,137,216)	0	0
7. Amounts recoverable from reinsurers December 31, current year	252,687	0	0	0	0	0	5,834	246,853	0	0
8. Claim liability December 31, prior year from Part 2A:										
8.1 Direct	88,751,134	0	0	0	0	0	32,472,715	56,273,049	5,370	0
8.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
8.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
8.4 Net	88,751,134	0	0	0	0	0	32,472,715	56,273,049	5,370	0
9. Claim reserve December 31, prior year from Part 2D:										
9.1 Direct	0	0	0	0	0	0	0	0	0	0
9.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
9.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
9.4 Net	0	0	0	0	0	0	0	0	0	0
10. Accrued medical incentive pools and bonuses, prior year	19,246,980	0	0	0	0	0	12,692,279	6,554,701	0	0
11. Amounts recoverable from reinsurers December 31, prior year	27,144	0	0	0	0	0	27,144	0	0	0
12. Incurred benefits:										
12.1 Direct	780,514,535	0	0	0	0	0	281,368,970	499,139,020	6,545	0
12.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
12.3 Reinsurance ceded	321,986	0	0	0	0	0	27,575	294,411	0	0
12.4 Net	780,192,549	0	0	0	0	0	281,341,395	498,844,609	6,545	0
13. Incurred medical incentive pools and bonuses	52,849,209	0	0	0	0	0	28,461,382	24,387,827	0	0

(a) Excludes \$ 0 loans or advances to providers not yet expensed.

Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2A – CLAIMS LIABILITY END OF CURRENT YEAR

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Reported in Process of Adjustment:										
1.1 Direct	8,734,915						3,394,288	5,340,627		
1.2 Reinsurance assumed										
1.3 Reinsurance ceded										
1.4 Net	8,734,915						3,394,288	5,340,627		
2. Incurred but Unreported:										
2.1 Direct	74,394,395						29,160,930	45,233,465		
2.2 Reinsurance assumed										
2.3 Reinsurance ceded										
2.4 Net	74,394,395						29,160,930	45,233,465		
3. Amounts Withheld from Paid Claims and Capitations:										
3.1 Direct										
3.2 Reinsurance assumed										
3.3 Reinsurance ceded										
3.4 Net										
4. TOTALS:										
4.1 Direct	83,129,310						32,555,218	50,574,092		
4.2 Reinsurance assumed										
4.3 Reinsurance ceded										
4.4 Net	83,129,310						32,555,218	50,574,092		

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc.**

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2B – ANALYSIS OF CLAIMS UNPAID – PRIOR YEAR-NET OF REINSURANCE

Line of Business	Claims Paid During the Year		Claim Reserve and Claim Liability December 31 of Current Year		5	6
	1	2	3	4	Claims Incurred in Prior Years (Columns 1 + 3)	Estimated Claim Reserve and Claim Liability December 31 of Prior Year
	On Claims Incurred Prior to January 1 of Current Year	On Claims Incurred During the Year	On Claims Unpaid December 31 of Prior Year	On Claims Incurred During the Year		
1. Comprehensive (hospital and medical)	0	0	0	0	0	0
2. Medicare Supplement	0	0	0	0	0	0
3. Dental only	0	0	0	0	0	0
4. Vision only	0	0	0	0	0	0
5. Federal Employees Health Benefits Plan	0	0	0	0	0	0
6. Title XVIII – Medicare	30,977,886	256,303,819	319,038	32,236,180	31,296,924	32,472,715
7. Title XIX – Medicaid	50,042,440	454,430,963	1,356,872	49,217,220	51,399,312	56,273,049
8. Other health	11,915	0	0	0	11,915	5,370
9. Health subtotal (Lines 1 to 8)	81,032,241	710,734,782	1,675,910	81,453,400	82,708,151	88,751,134
10. Health care receivables (a)	6,088,811	2,848,220	0	7,216,037	6,088,811	9,901,262
11. Other non-health	0	0	0	0	0	0
12. Medical incentive pools and bonus amounts	16,321,891	39,335,824	0	17,426,184	16,321,891	19,935,534
13. Totals (Lines 9 - 10 + 11 + 12)	91,265,321	747,222,386	1,675,910	91,663,547	92,941,231	98,785,406

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(a) Excludes \$ 0 loans or advances to providers not yet expensed.

Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Hospital & Medical

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0		0	0	0
3. 2012	X X X		0	0	0
4. 2013	X X X	X X X	0	0	0
5. 2014	X X X	X X X	X X X	0	0
6. 2015	X X X	X X X	X X X	X X X	0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0		0	0	0
3. 2012	X X X		0	0	0
4. 2013	X X X	X X X	0	0	0
5. 2014	X X X	X X X	X X X	0	0
6. 2015	X X X	X X X	X X X	X X X	0

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2014	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2015	0	0	0	0.000	0	0.000	0	0	0	0.000

Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Medicare Supplement

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0		0	0	0
3. 2012	X X X		0	0	0
4. 2013	X X X	X X X	0	0	0
5. 2014	X X X	X X X	X X X	0	0
6. 2015	X X X	X X X	X X X	X X X	0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0		0	0	0
3. 2012	X X X		0	0	0
4. 2013	X X X	X X X	0	0	0
5. 2014	X X X	X X X	X X X	0	0
6. 2015	X X X	X X X	X X X	X X X	0

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2014	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2015	0	0	0	0.000	0	0.000	0	0	0	0.000

Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Dental Only

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0		0	0	0
3. 2012	X X X		0	0	0
4. 2013	X X X	X X X	0	0	0
5. 2014	X X X	X X X	X X X	0	0
6. 2015	X X X	X X X	X X X	X X X	0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0		0	0	0
3. 2012	X X X		0	0	0
4. 2013	X X X	X X X	0	0	0
5. 2014	X X X	X X X	X X X	0	0
6. 2015	X X X	X X X	X X X	X X X	0

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2014	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2015	0	0	0	0.000	0	0.000	0	0	0	0.000

Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Vision Only

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0		0	0	0
3. 2012	X X X		0	0	0
4. 2013	X X X	X X X	0	0	0
5. 2014	X X X	X X X	X X X	0	0
6. 2015	X X X	X X X	X X X	X X X	0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0		0	0	0
3. 2012	X X X		0	0	0
4. 2013	X X X	X X X	0	0	0
5. 2014	X X X	X X X	X X X	0	0
6. 2015	X X X	X X X	X X X	X X X	0

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2014	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2015	0	0	0	0.000	0	0.000	0	0	0	0.000

Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Fed Emp Health Benefits Plan

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0		0	0	0
3. 2012	X X X		0	0	0
4. 2013	X X X	X X X	0	0	0
5. 2014	X X X	X X X	X X X	0	0
6. 2015	X X X	X X X	X X X	X X X	0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0		0	0	0
3. 2012	X X X		0	0	0
4. 2013	X X X	X X X	0	0	0
5. 2014	X X X	X X X	X X X	0	0
6. 2015	X X X	X X X	X X X	X X X	0

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2014	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2015	0	0	0	0.000	0	0.000	0	0	0	0.000

Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Title XVIII - Medicare

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X	40,373	47,474	47,196	47,269
4. 2013	X X X	X X X	192,479		226,367
5. 2014	X X X	X X X	X X X	356,725	403,379
6. 2015	X X X	X X X	X X X	X X X	282,453

Section B – Incurred Health Claims

12XV

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X	47,891	47,474	47,196	47,269
4. 2013	X X X	X X X	226,262	226,202	226,591
5. 2014	X X X	X X X	X X X	396,723	403,626
6. 2015	X X X	X X X	X X X	X X X	321,377

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2012	61,183	47,269	0	0.000	47,269	77.258	0	0	47,269	77.258
3. 2013	254,014	226,367	244	0.108	226,611	89.212	0	0	226,611	89.212
4. 2014	448,681	403,379	2,709	0.672	406,088	90.507	319	0	406,407	90.578
5. 2015	378,269	282,453	9,095	3.220	291,548	77.074	38,852	1,107	331,507	87.638

Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Title XIX - Medicaid

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	21,325	21,778	21,720	21,710	21,710
2. 2011	26,350	32,606	32,786	32,591	32,635
3. 2012	X X X	57,956	66,651	66,314	66,274
4. 2013	X X X	X X X	122,702	145,927	146,622
5. 2014	X X X	X X X	X X X	279,658	339,214
6. 2015	X X X	X X X	X X X	X X X	467,494

Section B – Incurred Health Claims

12X1

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	21,413	21,866	21,720	21,710	21,710
2. 2011	33,610	40,210	32,786	32,591	32,635
3. 2012	X X X	67,878	66,651	66,313	66,274
4. 2013	X X X	X X X	141,269	146,410	146,622
5. 2014	X X X	X X X	X X X	337,752	339,521
6. 2015	X X X	X X X	X X X	X X X	527,560

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	41,104	32,635	0	0.000	32,635	79.396	0	0	32,635	79.396
2. 2012	87,228	66,274	210	0.317	66,484	76.219	0	0	66,484	76.219
3. 2013	169,427	146,622	1,426	0.973	148,048	87.382	0	0	148,048	87.382
4. 2014	385,937	339,214	2,706	0.798	341,920	88.595	308	0	342,228	88.675
5. 2015	607,022	467,494	13,717	2.934	481,211	79.274	61,077	1,670	543,958	89.611

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Other

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	863	850	851	851	851
2. 2011	1,594	1,719	1,727	1,723	1,723
3. 2012	X X X	1,621	1,671	1,668	1,680
4. 2013	X X X	X X X	0	0	0
5. 2014	X X X	X X X	X X X	0	0
6. 2015	X X X	X X X	X X X	X X X	0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	1,016	1,016	851	851	851
2. 2011	2,236	2,237	1,727	1,723	1,723
3. 2012	X X X	114	1,671	1,668	1,680
4. 2013	X X X	X X X	0	0	0
5. 2014	X X X	X X X	X X X	0	0
6. 2015	X X X	X X X	X X X	X X X	0

1207

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	2,375	1,723	0	0.000	1,723	72.547	0	0	1,723	72.547
2. 2012	1,449	1,680	7	0.417	1,687	116.425	0	0	1,687	116.425
3. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2014	(11)	0	0	0.000	0	0.000	0	0	0	0.000
5. 2015	0	0	0	0.000	0	0.000	0	0	0	0.000

Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Grand Total

Section A – Paid Health Claims

Year in Which Losses Were Incurred		Cumulative Net Amounts Paid				
		1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior		22,188	22,628	22,571	22,561	22,561
2. 2011		27,944	34,325	34,513	34,314	34,358
3. 2012	X X X		99,950	115,796	115,178	115,223
4. 2013	X X X		X X X	315,181	371,905	372,989
5. 2014	X X X		X X X	X X X	636,383	742,593
6. 2015	X X X		X X X	X X X	X X X	749,947

Section B – Incurred Health Claims

12GT

Year in Which Losses Were Incurred		Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
		1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior		22,429	22,882	22,571	22,561	22,561
2. 2011		35,846	42,447	34,513	34,314	34,358
3. 2012	X X X		115,883	115,796	115,177	115,223
4. 2013	X X X		X X X	367,531	372,612	373,213
5. 2014	X X X		X X X	X X X	734,475	743,147
6. 2015	X X X		X X X	X X X	X X X	848,937

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	43,479	34,358	0	0.000	34,358	79.022	0	0	34,358	79.022
2. 2012	149,860	115,223	217	0.188	115,440	77.032	0	0	115,440	77.032
3. 2013	423,441	372,989	1,670	0.448	374,659	88.480	0	0	374,659	88.480
4. 2014	834,607	742,593	5,415	0.729	748,008	89.624	627	0	748,635	89.699
5. 2015	985,291	749,947	22,812	3.042	772,759	78.430	99,929	2,777	875,465	88.853

Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2D – AGGREGATE RESERVE FOR ACCIDENT AND HEALTH CONTRACTS ONLY

	1	2	3	4	5	6	7	8	9
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
1. Unearned premium reserves	0	0	0	0	0	0	0	0	0
2. Additional policy reserves (a)	204,308	0	0	0	0	0	152,434	51,874	0
3. Reserve for future contingent benefits	0	0	0	0	0	0	0	0	0
4. Reserve for rate credits or experience rating refunds (including \$ 0 for investment income)	2,806,699	0	0	0	0	0	2,637,242	100,560	68,897
5. Aggregate write-ins for other policy reserves	0	0	0	0	0	0	0	0	0
6. Totals (gross)	3,011,007	0	0	0	0	0	2,789,676	152,434	68,897
7. Reinsurance ceded	0	0	0	0	0	0	0	0	0
8. Totals (Net) (Page 3, Line 4)	3,011,007	0	0	0	0	0	2,789,676	152,434	68,897
9. Present value of amounts not yet due on claims	0	0	0	0	0	0	0	0	0
10. Reserve for future contingent benefits	0	0	0	0	0	0	0	0	0
11. Aggregate write-ins for other claim reserves	0	0	0	0	0	0	0	0	0
12. Totals (gross)	0	0	0	0	0	0	0	0	0
13. Reinsurance ceded	0	0	0	0	0	0	0	0	0
14. Totals (Net) (Page 3, Line 7)	0	0	0	0	0	0	0	0	0

DETAILS OF WRITE-IN LINES									
0501.	0	0	0	0	0	0	0	0	0
0502.	0	0	0	0	0	0	0	0	0
0503.	0	0	0	0	0	0	0	0	0
0598. Summary of remaining write-ins for Line 05 from overflow page	0	0	0	0	0	0	0	0	0
0599. Totals (Lines 0501 through 0503 plus 0598) (Line 05 above)	0	0	0	0	0	0	0	0	0
1101.	0	0	0	0	0	0	0	0	0
1102.	0	0	0	0	0	0	0	0	0
1103.	0	0	0	0	0	0	0	0	0
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0	0	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)	0	0	0	0	0	0	0	0	0

(a) Includes \$ 0 premium deficiency reserve.

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc.**

UNDERWRITING AND INVESTMENT EXHIBIT

PART 3 – ANALYSIS OF EXPENSES

	Claim Adjustment Expenses		3	4	5
	1	2			
	Cost Containment Expenses	Other Claim Adjustment Expenses	General Administrative Expenses	Investment Expenses	Total
1. Rent (\$ 0 for occupancy of own building)			2,288,228		2,288,228
2. Salaries, wages and other benefits	14,253,317	2,432,182	50,291,193		66,976,692
3. Commissions (less \$ 0 ceded plus \$ 0 assumed)			5,432,387		5,432,387
4. Legal fees and expenses			153,468		153,468
5. Certifications and accreditation fees	1,214		154,153		155,367
6. Auditing, actuarial and other consulting services	155,645	12,707	8,268,228		8,436,580
7. Traveling expenses	103,186	13,985	187,517		304,688
8. Marketing and advertising	1,838	79	10,830,484		10,832,401
9. Postage, express and telephone	7,417	314,905	2,676,577		2,998,899
10. Printing and office supplies	782,019	257,046	1,664,917		2,703,982
11. Occupancy, depreciation and amortization	2,146,614	435,365	172,697		2,754,676
12. Equipment			433		433
13. Cost or depreciation of EDP equipment and software	23,818	2,961,328	3,808,127		6,793,273
14. Outsourced services including EDP, claims, and other services	11,100	176,669	116,615		304,384
15. Boards, bureaus and association fees					
16. Insurance, except on real estate			459,298		459,298
17. Collection and bank service charges			165,661		165,661
18. Group service and administration fees			(26,160,316)		(26,160,316)
19. Reimbursements by uninsured plans					
20. Reimbursements from fiscal intermediaries					
21. Real estate expenses					
22. Real estate taxes					
23. Taxes, licenses and fees:					
23.1 State and local insurance taxes			3,380,250		3,380,250
23.2 State premium taxes					
23.3 Regulatory authority licenses and fees					
23.4 Payroll taxes	1,269,922	227,775	2,753,534		4,251,231
23.5 Other (excluding federal income and real estate taxes)			18,786,951		18,786,951
24. Investment expenses not included elsewhere				37,967	37,967
25. Aggregate write-ins for expenses			357,741		357,741
26. Total expenses incurred (Lines 1 to 25)	18,756,090	6,832,041	85,788,143	37,967	(a) 111,414,241
27. Less expenses unpaid December 31, current year	2,035,598	741,481	10,706,031		13,483,110
28. Add expenses unpaid December 31, prior year		902,056	10,133,112		11,035,168
29. Amounts receivable relating to uninsured plans, prior year					
30. Amounts receivable relating to uninsured plans, current year					
31. Total expenses paid (Lines 26 minus 27 plus 28 minus 29 plus 30)	16,720,492	6,992,616	85,215,224	37,967	108,966,299

DETAILS OF WRITE-IN LINES					
2501. Interest Expense			185,727		185,727
2502. Miscellaneous Expenses			172,014		172,014
2503.					
2598. Summary of remaining write-ins for Line 25 from overflow page					
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)			357,741		357,741

(a) Includes management fees of \$ 26,160,316 to affiliates and \$ 0 to non-affiliates.

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

EXHIBIT OF NET INVESTMENT INCOME

	1 Collected During Year	2 Earned During Year
1. U.S. Government bonds	(a) 0	0
1.1 Bonds exempt from U.S. tax	(a) 0	0
1.2 Other bonds (unaffiliated)	(a) 61,208	759,546
1.3 Bonds of affiliates	(a) 0	0
2.1 Preferred stocks (unaffiliated)	(b) 0	0
2.11 Preferred stocks of affiliates	(b) 0	0
2.2 Common stocks (unaffiliated)	0	0
2.21 Common stocks of affiliates	0	0
3. Mortgage loans	(c) 0	0
4. Real estate	(d) 0	0
5. Contract loans	0	0
6. Cash, cash equivalents and short-term investments	(e) (19,192)	(18,617)
7. Derivative instruments	(f) 0	0
8. Other invested assets	0	0
9. Aggregate write-ins for investment income	39,357	39,357
10. Total gross investment income	81,373	780,286
11. Investment expenses		(g) 37,967
12. Investment taxes, licenses and fees, excluding federal income taxes		(g) 0
13. Interest expense		(h) 0
14. Depreciation on real estate and other invested assets		(i) 0
15. Aggregate write-ins for deductions from investment income		0
16. Total deductions (Lines 11 through 15)		37,967
17. Net investment income (Line 10 minus Line 16)		742,319

DETAILS OF WRITE-IN LINES			
0901. Miscellaneous Income		39,357	39,357
0902.		0	0
0903.		0	0
0998. Summary of remaining write-ins for Line 09 from overflow page		0	0
0999. Totals (Lines 0901 through 0903 plus 0998) (Line 09 above)		39,357	39,357
1501.			0
1502.			0
1503.			0
1598. Summary of remaining write-ins for Line 15 from overflow page			0
1599. Totals (Lines 1501 through 1503 plus 1598) (Line 15 above)			0

- (a) Includes \$ 5,056 accrual of discount less \$ 426,931 amortization of premium and less \$ (339,900) paid for accrued interest on purchases.
- (b) Includes \$ 0 accrual of discount less \$ 0 amortization of premium and less \$ 0 paid for accrued dividends on purchases.
- (c) Includes \$ 0 accrual of discount less \$ 0 amortization of premium and less \$ 0 paid for accrued interest on purchases.
- (d) Includes \$ 0 for company's occupancy of its own buildings; and excludes \$ 0 interest on encumbrances.
- (e) Includes \$ (48,393) accrual of discount less \$ 0 amortization of premium and less \$ 0 paid for accrued interest on purchases.
- (f) Includes \$ 0 accrual of discount less \$ 0 amortization of premium.
- (g) Includes \$ 0 investment expenses and \$ 0 investment taxes, licenses and fees, excluding federal income taxes, attributable to segregated and Separate Accounts.
- (h) Includes \$ 0 interest on surplus notes and \$ 0 interest on capital notes.
- (i) Includes \$ 0 depreciation on real estate and \$ 0 depreciation on other invested assets.

EXHIBIT OF CAPITAL GAINS (LOSSES)

	1 Realized Gain (Loss) on Sales or Maturity	2 Other Realized Adjustments	3 Total Realized Capital Gain (Loss) (Columns 1 + 2)	4 Change in Unrealized Capital Gain (Loss)	5 Change in Unrealized Foreign Exchange Capital Gain (Loss)
1. U.S. Government bonds	0	0	0	0	0
1.1 Bonds exempt from U.S. tax	0	0	0	0	0
1.2 Other bonds (unaffiliated)	7,988	0	7,988	0	0
1.3 Bonds of affiliates	0	0	0	0	0
2.1 Preferred stocks (unaffiliated)	0	0	0	0	0
2.11 Preferred stocks of affiliates	0	0	0	0	0
2.2 Common stocks (unaffiliated)	0	0	0	0	0
2.21 Common stocks of affiliates	0	0	0	0	0
3. Mortgage loans	0	0	0	0	0
4. Real estate	0	0	0	0	0
5. Contract loans	0	0	0	0	0
6. Cash, cash equivalents and short-term investments	(1,746)	0	(1,746)	0	0
7. Derivative instruments	0	0	0	0	0
8. Other invested assets	0	0	0	0	0
9. Aggregate write-ins for capital gains (losses)	0	0	0	0	0
10. Total capital gains (losses)	6,242	0	6,242	0	0

DETAILS OF WRITE-IN LINES					
0901.		0	0	0	0
0902.		0	0	0	0
0903.		0	0	0	0
0998. Summary of remaining write-ins for Line 09 from overflow page		0	0	0	0
0999. Totals (Lines 0901 through 0903 plus 0998) (Line 09 above)		0	0	0	0

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc.**

EXHIBIT OF NONADMITTED ASSETS

	1 Current Year Total Nonadmitted Assets	2 Prior Year Total Nonadmitted Assets	3 Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
1. Bonds (Schedule D)	0	0	0
2. Stocks (Schedule D):			
2.1 Preferred stocks	0	0	0
2.2 Common stocks	0	0	0
3. Mortgage loans on real estate (Schedule B):			
3.1 First liens	0	0	0
3.2 Other than first liens	0	0	0
4. Real estate (Schedule A):			
4.1 Properties occupied by the company	0	0	0
4.2 Properties held for the production of income	0	0	0
4.3 Properties held for sale	0	0	0
5. Cash (Schedule E - Part 1), cash equivalents (Schedule E - Part 2) and short-term investments (Schedule DA)	0	0	0
6. Contract loans	0	0	0
7. Derivatives (Schedule DB)	0	0	0
8. Other invested assets (Schedule BA)	0	0	0
9. Receivables for securities	0	0	0
10. Securities lending reinvested collateral assets (Schedule DL)	0	0	0
11. Aggregate write-ins for invested assets	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	0	0	0
13. Title plants (for Title insurers only)	0	0	0
14. Investment income due and accrued	2,054	0	(2,054)
15. Premiums and considerations:			
15.1 Uncollected premiums and agents' balances in the course of collection	0	0	0
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due	0	0	0
15.3 Accrued retrospective premiums and contracts subject to redetermination	0	0	0
16. Reinsurance:			
16.1 Amounts recoverable from reinsurers	0	0	0
16.2 Funds held by or deposited with reinsured companies	0	0	0
16.3 Other amounts receivable under reinsurance contracts	0	0	0
17. Amounts receivable relating to uninsured plans	0	0	0
18.1 Current federal and foreign income tax recoverable and interest thereon	0	0	0
18.2 Net deferred tax asset	3,852,709	0	(3,852,709)
19. Guaranty funds receivable or on deposit	0	0	0
20. Electronic data processing equipment and software	3,047,274	3,256,837	209,563
21. Furniture and equipment, including health care delivery assets	9,325,353	2,278,833	(7,046,520)
22. Net adjustment in assets and liabilities due to foreign exchange rates	0	0	0
23. Receivables from parent, subsidiaries and affiliates	0	539,430	539,430
24. Health care and other amounts receivable	4,374,668	5,760,925	1,386,257
25. Aggregate write-ins for other-than-invested assets	4,866,378	4,651,632	(214,746)
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	25,468,436	16,487,657	(8,980,779)
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0
28. Total (Lines 26 and 27)	25,468,436	16,487,657	(8,980,779)

DETAILS OF WRITE-IN LINES			
1101.	0	0	0
1102.	0	0	0
1103.	0	0	0
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)	0	0	0
2501. GOODWILL	3,128,663	3,128,663	0
2502. DEPOSITS	972,419	461,367	(511,052)
2503. Prepaid Assets	765,296	977,936	212,640
2598. Summary of remaining write-ins for Line 25 from overflow page	0	83,666	83,666
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	4,866,378	4,651,632	(214,746)

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc.**

EXHIBIT 1 – ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS ONLY

Source of Enrollment	Total Members at End of					6 Current Year Member Months
	1 Prior Year	2 First Quarter	3 Second Quarter	4 Third Quarter	5 Current Year	
1. Health Maintenance Organizations	116,166	114,546	116,643	112,477	116,224	1,366,614
2. Provider Service Organizations	0	0	0	0	0	0
3. Preferred Provider Organizations	0	0	0	0	0	0
4. Point of Service	0	0	0	0	0	0
5. Indemnity Only	0	0	0	0	0	0
6. Aggregate write-ins for other lines of business	0	0	0	0	0	0
7. Total	116,166	114,546	116,643	112,477	116,224	1,366,614

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DETAILS OF WRITE-IN LINES						
0601.	0	0	0	0	0	0
0602.	0	NONE	0	0	0	0
0603.	0		0	0	0	0
0698. Summary of remaining write-ins for Line 06 from overflow page	0		0	0	0	0
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 06 above)	0		0	0	0	0

NOTES TO FINANCIAL STATEMENTS

1. Significant Accounting Policies

A. Accounting Practices

The accompanying financial statements of have been prepared in conformity with the National Association of Insurance Commissioners’ (“NAIC”) Annual Statement Instructions and in accordance with accounting practices prescribed by the NAIC Accounting Practice and Procedures Manual (“NAIC SAP”), subject to any deviations prescribed or permitted by the Florida Office of Insurance Regulation (“OIR”).A reconciliation of the Company’s net income and capital and surplus between NAIC SAP and practices prescribed and permitted by the State of Florida is shown below:

		2015	2014
Net Income	State of Domicile		
1 Net Income state basis	FL	21,810,919	11,856,730
2 State Prescribed Practices (Income):		-	-
3 State Permitted Practices (Income):		-	-
4 Net Income, NAIC SAP		21,810,919	11,856,730
Surplus	State of Domicile		
5 Statutory Surplus state basis	FL	46,117,218	27,319,293
6 State Prescribed Practices (Surplus):	Intercompany non-admitted	-	(539,540)
7 State Permitted Practices (Surplus):		-	-
8 Statutory Surplus, NAIC SAP		46,117,218	27,858,723

B. Use of Estimates in the Preparation of the Financial Statements

Preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

C. Accounting Policy

Health premium revenues, based on membership records and premiums rates for each membership category within each county, are recognized as revenue during the period in which the Company is obligated to provide service to members. Premiums are reported net of excess loss reinsurance ceded and experience rating refunds. Premiums paid before the effective service month are recorded on the balance sheet as premiums received in advance and are subsequently credited to income as earned during the coverage period. Premium rates are subject to approval by Centers for Medicare, Medicaid Services (“CMS”) and the Florida Agency for Healthcare Administration (“AHCA”). Costs, such as premium taxes and other underwriting expenses are charged to operations as incurred.

In addition, the Company uses the following accounting policies:

1.

Short-term investments include investments with maturities of less than one year at the date of acquisition and are reported at amortized cost, which approximates fair value. Non-investment grade short-term investments are stated at the lower of amortized cost or fair value.
2.

Investment grade bonds not backed by other loans are stated at amortized cost, with amortization calculated based on the modified scientific method, using lower of yield to call or yield to maturity. Non-investment grade bonds are stated at the lower of amortized cost or fair value as determined by various third-party pricing sources.
3.

Common stocks of unaffiliated companies are stated at fair value based upon security ratings prescribed by various third-party pricing sources.
4.

The Company has no investments in preferred stocks.
5.

The Company has no mortgage loans - real estate.
6.

The Company has no investments in Loan-backed securities.
7.

The Company has no investments in subsidiaries, controlled and affiliated companies.
8.

The Company has no investments in joint ventures, partnerships or limited liability companies.
9.

The Company has no derivative instruments.
10.

The Company does not anticipate investment income as a factor in the premium deficiency calculations.
11.

Unpaid claims and claims adjustment expenses include management’s best estimate of amounts based on historical claim development patterns and certain individual case estimates. The established

NOTES TO FINANCIAL STATEMENTS

- liability considers health benefit provisions, business practices, economic conditions and other factors that may materially affect the cost, frequency and severity of claims. Liabilities for unpaid claims and claim adjustment expenses are based on assumptions and estimates, and while management believes such estimates are reasonable, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed and changes in estimates are incorporated into current period estimates.
12. The Company has not modified its capitalization policy from the prior period.
13. Pharmacy rebate receivables are recorded when earned based upon actual rebate receivables billed and an estimate of receivables based upon current utilization of specific pharmaceuticals and provider contract terms.

D. Going Concern

Not Applicable.

2. Accounting Changes and Corrections of Errors

There were no accounting changes or corrections of errors during the years ended December 31, 2015 and 2014.

3. Business Combinations and Goodwill

All Goodwill is non-admitted.

A. Statutory Purchase Method

Not applicable.

B. Statutory Merger

Not applicable.

C. Assumption Reinsurance

Not applicable.

D. Impairment Loss

Not applicable.

4. Discontinued Operations

The Company had no operations that were discontinued during 2015 or 2014.

5. Investment

A. Mortgage Loans, including Mezzanine Real Estate Loans

The Company did not have investments in mortgage loans at December 31, 2015 or 2014.

B. Debt Restructuring

The Company did not have invested assets that were restructured debt at December 31, 2015 or 2014.

C. Reverse Mortgages

The Company did not have investments in reverse mortgages at December 31, 2015 or 2014.

D. Loan-Backed Securities

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

NOTES TO FINANCIAL STATEMENTS

The Company did not have investments in loan-backed securities at December 31, 2015 or 2014.

E. Repurchase Agreements and/or Securities Lending Transactions

The Company did not enter into repurchase agreements or securities lending transactions at December 31, 2015 or 2014.

F. Real Estate

The Company did not have investments in real estate and did not engage in retail land sales operations during 2015 or 2014.

G. Low-income housing tax credits (LIHTC)

The Company did not invest in properties generating low-income housing tax credits during 2015 or 2014.

H. Restricted Assets

1. Restricted Assets (Including Pledged):

	1	2	3	4	5	6
Restricted Asset Category	Total Gross Restricted from Current Year	Total Gross Restricted from Prior Year	Increase / (Decrease) (1 minus 2)	Total Current Year Admitted Restricted	Percentag e Gross Restricted to Total Assets	Percentage Admitted Restrict. to Total Admitted Assets
a. Subject to contractual obligation for which liability is not shown						
b. Collateral held under security lending agreements						
c. Subject to repurchase agreements						
d. Subject to reverse repurchase agreements						
e. Subject to dollar repurchase agreements						
f. Subject to dollar reverse repurchase agreements						
g. Placed under option contracts						
h. Letter stock or securities restricted as to sale						
i. On deposit with states	300,000	300,000	0	300,000	0.138%	0.151%
j. On deposit with other regulatory bodies	5,544,056	5,887,905	(343,089)	5,544,056	2.649%	3.024%
k. Pledged as collateral not captured in other cat.						
l. Other restricted Assets						
m. Total Restricted Assets	5,844,056	6,187,905	(343,849)	5,844,056	2.792%	3.188%

2. Details of Assets Pledged as Collateral Not Captured in Other Categories

Not applicable.

3. Detail of Other Restricted Assets (Contracts that Share Similar Characteristics, Such as Reinsurance and Derivatives, Are Reported in the Aggregate)

Not applicable.

I. Working Capital Finance Investments

The Company did not have any working capital finance investments as December 31, 2015 and 2014.

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

NOTES TO FINANCIAL STATEMENTS

J. Offsetting and Netting of Assets and Liabilities

The Company did not have any offsetting and netting of assets and liabilities at December 31, 2015 and 2014.

K. Structured Notes

The Company did not have any structured notes at December 31, 2015 and 2014.

6. Joint Ventures, Partnerships and Limited Liability Companies

- A. The Company has no investments in joint ventures, partnerships, or limited liability companies that exceeded 10% of its admitted assets at December 31, 2015 or 2014.
- B. The Company did not recognize impairment write downs for its investments in joint ventures, partnerships or limited liability companies during 2015 or 2014.

7. Investment Income

- A. All investment income due and accrued with amounts that are over 90 days past due is non-admitted.
- B. There was \$2,054 and \$0 respectively at December 31, 2015 and 2014, of non-admitted accrued investment interest income.

8. Derivative Instruments

The Company has no derivative instruments.

9. Income Taxes

- A. The components of the net deferred tax asset/(liability) at December 31, 2015 are as follows:

01.		12/31/2015			12/31/2014		
		(1)	(2)	(3)	(4)	(5)	(6)
				(Col 1 + 2)			(Col 4 + 5)
		Ordinary	Capital	Total	Ordinary	Capital	Total
a.	Gross Deferred Tax Assets	\$ 7,877,713	-	7,877,713	2,869,023	-	2,869,023
b.	Statutory Valuation Allowance Adjustments	\$ -	-	-	-	-	-
c.	Adjusted Gross Deferred Tax Assets (1a - 1b)	\$ 7,877,713	-	7,877,713	2,869,023	-	2,869,023
d.	Deferred Tax Assets Nonadmitted	\$ 3,352,435	-	3,352,435	-	-	-
e.	Subtotal Net Admitted Deferred Tax Asset (1c - 1d)	\$ 4,025,278	-	4,025,278	2,869,023	-	2,869,023
f.	Deferred Tax Liabilities	\$ 499,970	2,084	502,054	1,460,874	-	1,460,874
g.	Net Admitted Deferred Tax Asset / (Net Deferred Tax Liability) (1e - 1f)	\$ 3,525,308	(2,084)	3,352,224	1,408,149	-	1,408,149

01.		Change		
		(7)	(8)	(9)
		(Col 1 - 4)	(Col 2-5)	(Col 7 + 8)
		Ordinary	Capital	Total
a.	Gross Deferred Tax Assets	\$ 5,008,690	-	5,008,690
b.	Statutory Valuation Allowance Adjustments	\$ -	-	-
c.	Adjusted Gross Deferred Tax Assets (1a - 1b)	\$ 5,008,690	-	5,008,690
d.	Deferred Tax Assets Nonadmitted	\$ 3,852,435	-	3,852,435
e.	Subtotal Net Admitted Deferred Tax Asset (1c - 1d)	\$ 1,156,255	-	1,156,255
f.	Deferred Tax Liabilities	\$ (960,904)	2,084	(958,820)

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

NOTES TO FINANCIAL STATEMENTS

g.	Net Admitted Deferred Tax Asset / (Net Deferred Tax Liability) (1e - 1f)	\$	2,117,159	(2,084)	2,115,075
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02.		12/31/2015			12/31/2014	
		(1)	(2)	(3) (Col 1 + 2)	(4)	(5) Capit al (6) (Col 4 + 5) Total
	Admission Calc. Components SSAP No. 101	Ordinary	Capital	Total	Ordinary	Total
a.	Federal Income Taxes Paid In Prior Years Recoverable Through Loss Carrybacks.	\$	3,233,312	-	3,233,312	2,869,023 - 2,869,023
b.	Adjusted Gross Deferred Tax Assets Expected To Be Realized (Excluding The Amount Of Deferred Tax Assets From 2(a) above) After Application of the Threshold Limitation. (The Lesser of 2(b)1 and 2(b)2 Below)	\$	289,912	-	289,912	- - -
1.	Adjusted Gross Deferred Tax Assets to be Realized Following the Balance Sheet Date.	\$	289,912	-	289,912	- - -
2.	Adjusted Gross Deferred Tax Assets					
	Allowed per Limitation Threshold	\$	X X X	X X X	-	X X X X -
c.	Adjusted Gross Deferred Tax Assets (Excluding the Amount Of Deferred Tax Assets From 2(a) and 2(b) above) Offset byGross Deferred Tax Liabilities.	\$	502,054	-	502,054	- - -
d.	Deferred Tax Assets Admitted as the result of application of SSAPNo. 101. Total (2(a) + 2(b) + 2(c))	\$	4,025,278	-	4,025,278	2,869,023 - 2,869,023

02.		Change		
		(7) (Col 1 - 4) Ordinary	(8) (Col 2- 5) Capital	(9) (Col 7 + 8) Total
a.	Admission Calc. Components SSAP No. 101 Federal Income Taxes Paid In Prior Years Recoverable Through Loss Carrybacks.	\$	364,289	- 364,289
b.	Adjusted Gross Deferred Tax Assets Expected To Be Realized (Excluding The Amount Of Deferred Tax Assets From 2(a) above) After Application of the Threshold Limitation. (The Lesser of 2(b)1 and 2(b)2 Below)	\$	289,912	- 289,912
1.	Adjusted Gross Deferred Tax Assets to be Realized Following the Balance Sheet Date.	\$	289,912	- 289,912
2.	Adjusted Gross Deferred Tax Assets			
	Allowed per Limitation Threshold	\$	X X X	X X X -
c.	Adjusted Gross Deferred Tax Assets (Excluding the Amount Of Deferred Tax Assets From 2(a) and 2(b) above) Offset byGross Deferred Tax Liabilities.	\$	502,054	- 502,054
d.	Deferred Tax Assets Admitted as the result of application of SSAPNo. 101. Total (2(a) + 2(b) + 2(c))	\$	1,156,255	- 1,156,255

03.		2015	2014
a.	Ratio Percentage Used to Determine Recover Period And Threshold Limitation Amount.	0.000	0.000
b.	Amount Of Adjusted Capital And Surplus Used To Determine Recovery Period And Threshold Limitation In 2(b)2 Above.	\$ 46,117,218	0.00

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

NOTES TO FINANCIAL STATEMENTS

4.						
	Impact of Tax Planning Strategies					
a	Determination of Adjusted Gross Deferred Tax Assets and Net Admitted Deferred Tax Assets, By Tax Character As A Percentage.				(Col 1 - 3)	(Col 2 - 4)
		Ordinary	Capital	Ordinary	Capital	Ordinary
1.	Adjusted Gross DTAs Amount From Note 9A1(c)	\$ 7,877,713	-	2,869,023	-	5,008,690
2.	Percentage of Adjusted Gross DTAs By Tax Character Attributable To The Impact of Tax Planning Strategies	\$ 0.000%	0.00%	0.000%	0.00%	0.000%
3.	Net Admitted Adjusted Gross DTAs Amount from Note 9A1(e)	\$ 4,025,278	-	2,869,023	-	1,156,255
4.	Percentage of Net Admitted Adjusted Gross DTAs by Tax Character Attributable To The Impact of Tax Planning Strategies	\$ 0.000%	0.00%	0.000%	0.00%	0.000%
b.	Does the Company's Tax-planning Strategies include the use of reinsurance?					NO

B. Regarding deferred tax liabilities that are not recognized

None

C. Current income tax incurred consist of the following major components:

		(1)	(2)	(3)
		12/31/2015	12/31/2014	(Col 1 - 2) Change
1.	Current Income Tax			
a.	Federal.....	\$ 20,301,938	10,779,455	9,522,483
b.	Foreign.....	\$ -	-	-
c.	Subtotal.....	\$ 20,301,938	10,779,455	9,522,483
d.	Federal Income Tax on net capital gains.....	\$ -	-	-
e.	Utilization of capital loss carry-forwards.....	\$ -	-	-
f.	Other.....	\$ -	-	-
g.	Federal and foreign income taxes incurred.....	\$ 20,301,938	10,779,455	9,522,483
2.	Deferred Tax Assets:			
a.	Ordinary			
	(1) Discounting of unpaid losses.....	\$ 300,037	251,805	48,232
	(2) Unearned premium reserve.....	\$ -	2,510,530	(2,510,530)
	(3) Policyholder reserves.....	\$ -	-	-
	(4) Investments.....	\$ -	-	-
	(5) Deferred acquisition costs.....	\$ -	-	-
	(6) Policyholder dividends accrual.....	\$ -	-	-
	(7) Fixed assets.....	\$ 3,009,524		3,009,524
	(8) Compensation and benefits accrual.....	\$ 54,534	106,688	(52,154)
	(9) Pension accrual.....	\$ -	-	-
	(10) Receivables - nonadmitted.....	\$ 1,871,480	-	1,871,480
	(11) Net operating loss carry-forward.....	\$ -	-	-
	(12) Tax credit carry-forward.....	\$ -	-	-
	(13) Other (including items <5% of total ordinary tax assets).....	\$ 2,642,137	-	2,642,137
	(99) Subtotal.....	\$ 7,877,712	2,869,023	5,088,689
b.	Statutory valuation allowance adjustment.....	\$ -	-	-
c.	Nonadmitted.....	\$ 3,852,435	-	3,852,435

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc.**

NOTES TO FINANCIAL STATEMENTS

d.	Admitted ordinary deferred tax assets (2a99 - 2b - 2c).....	\$	4,025,277	2,869,023	1,156,254
e.	Capital:				
(1)	Investments.....	\$	-	-	-
(2)	Net capital loss carry-forward.....	\$	-	-	-
(3)	Real estate.....	\$	-	-	-
(4)	Other (including items <5% of total capital tax assets).....	\$	-	-	-
(99)	Subtotal.....	\$	-	-	-
f.	Statutory valuation allowance adjustment.....	\$	-	-	-
g.	Nonadmitted.....	\$	-	-	-
h.	Admitted capital deferred tax assets (2e99 - 2f - 2g).....	\$	-	-	-
i.	Admitted deferred tax assets (2d + 2h).....	\$	4,025,277	2,869,023	1,156,254
3.	Deferred Tax Liabilities:				
a.	Ordinary				
(1)	Investments.....	\$	-	-	-
(2)	Fixed assets.....	\$	-	1,460,874	(1,460,874)
(3)	Deferred and uncollected premium.....	\$	-	-	-
(4)	Policyholder reserves.....	\$	-	-	-
(5)	Other (including items <5% of total ordinary tax liabilities).....	\$	499,970	-	499,970
(99)	Subtotal.....	\$	499,970	1,460,874	(960,909)
b.	Capital:				
(1)	Investments.....	\$	2,084	-	2,084
(2)	Real Estate.....	\$	-	-	-
(3)	Other (including items <5% of total capital tax liabilities).....	\$	-	-	-
(99)	Subtotal.....	\$	2,084	-	2,084
c.	Deferred tax liabilities (3a99 + 3b99).....	\$	502,054	1,460,874	(958,825)
4.	Net deferred tax assets/liabilities (2i - 3c).....	\$	502,054	1,408,144	2,115,079

D. The Company's income tax expense and change in deferred income taxes differs from the amount obtained by applying the federal statutory income tax rate of 35% for the year ended December 31 as follows:

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NOTES TO FINANCIAL STATEMENTS

		2015	2014
Tax expense computed using federal statutory rate		\$ 14,739,500	\$ 7,922,664
Change in nonadmitted assets		(7,565,504)	-
Tax exempt income and dividend received deduction net of proration		(186,655)	-
Prior year true-ups and adjustments		1,491,841	40,300
Interest (FIT and SIT)		-	-
Tax settlements and contingencies		-	-
Intercompany transfers and adjustments		-	-
IMR/AMR tax		-	-
Intercompany dividends		-	-
Valuation allowance		-	-
ACA health insurer fee		5,733,375	1,221,053
Write-in		-	-
Write-in		-	-
Write-in		-	-
Other		117,681	162,069
Total		\$ 14,330,238	\$ 9,346,086
Federal income taxes incurred		\$ 20,297,748	\$ 10,779,455
Change in net deferred income taxes		(5,967,510)	(1,433,369)
Total statutory income taxes		\$ 14,330,238	\$ 9,346,086

E. Operating loss carryforwards:

1. The Company has no operating loss carryforwards and no tax credit carryforwards as of December 31, 2015.
2. The following are income taxes incurred in the current and prior year(s) that will be available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2015	\$ 19,394,688	\$ 19,860	\$ 19,414,547
2014	11,930,844	-	11,930,844
2013	N/A	-	-

3. The Company has no protective tax deposits reported as admitted assets under Section 6603 of the Internal Revenue Code as of December 31, 2015 and 2014.

- F. The following companies will be included in the consolidated federal income tax return with their parent Anthem, Inc. as of December 31, 2015, and either are current members of the consolidated tax sharing agreement or are in the process of being added to the consolidated tax sharing agreement. Allocation of federal income taxes with affiliates subject to the tax sharing agreement is based upon separate income tax return calculations with credit for net losses that can be used on a consolidated basis. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

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American Imaging Management, Inc.	DeCare Dental Health International, LLC
AMERIGROUP Community Care of New Mexico, Inc.	DeCare Dental Networks, LLC
AMERIGROUP Corporation	DeCare Dental, LLC
AMERIGROUP Florida, Inc.	Designated Agent Company, Inc.
Amerigroup Insurance Company	EHC Benefits Agency, Inc.
AMERIGROUP Iowa, Inc.	Empire HealthChoice Assurance, Inc.
Amerigroup Kansas, Inc.	Empire HealthChoice HMO, Inc.
AMERIGROUP Louisiana, Inc.	Forty-Four Forty-Four Forest Park Redevelopment Corp
AMERIGROUP Maryland, Inc.	Golden West Health Plan, Inc.
AMERIGROUP Nevada, Inc.	Government Health Services, LLC
AMERIGROUP New Jersey, Inc.	Greater Georgia Life Insurance Company
AMERIGROUP Ohio, Inc.	Health Core, Inc.
AMERIGROUP Pennsylvania, Inc.	Health Management Corporation
Amerigroup Services, Inc.	HealthKeepers, Inc.
AMERIGROUP Tennessee, Inc.	HealthLink HMO, Inc.
AMERIGROUP Texas, Inc.	HealthLink, Inc.
AMERIGROUP Washington, Inc.	HealthPlus HP, LLC (fka AMERIGROUP New York, LLC)
AMGP Georgia Managed Care Company, Inc.	Healthy Alliance Life Insurance Company
Anthem Blue Cross Life and Health Insurance Company	HMO Colorado, Inc.
Anthem Financial, Inc.	HMO Missouri, Inc.
Anthem Health Insurance Company of Nevada	Imaging Management Holdings, LLC
Anthem Health Plans of Kentucky, Inc.	Imaging Providers of Texas
Anthem Health Plans of Maine, Inc.	Matthew Thornton Health Plan, Inc.
Anthem Health Plans of New Hampshire, Inc.	National Government Services, Inc.
Anthem Health Plans of Virginia, Inc.	OneNation Insurance Company
Anthem Health Plans, Inc.	Park Square Holdings, Inc.
Anthem Holding Corp.	Park Square I, Inc.
Anthem Insurance Companies, Inc.	Park Square II, Inc.
Anthem Kentucky Managed Care Plan, Inc.	PHP Holdings, Inc.
Anthem Life & Disability Insurance Company	R&P Realty, Inc.
Anthem Southeast, Inc.	Resolution Health, Inc.
Anthem UM Services, Inc.	RightCHOICE Managed Care, Inc.
Anthem, Inc.	Rocky Mountain Hospital and Medical Service, Inc.
Arcus Enterprises, Inc.	SellCore, Inc.
ARCUS HealthyLiving Services, Inc.	Simply Healthcare Holdings, Inc.
Associated Group, Inc.	Simply Healthcare Plans, Inc.
Better Health, Inc.	Southeast Services, Inc.
Blue Cross and Blue Shield of Georgia, Inc.	State Sponsored Business UM Services, Inc.
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	The Anthem Companies of California, Inc.
Blue Cross Blue Shield of Wisconsin	The Anthem Companies, Inc.
Blue Cross of California	Tidgewell Associates, Inc.
Blue Cross of California Partnership Plan, Inc.	TrustSolutions, LLC
CareMore Health Group, Inc.	UNICARE Health Plan of Kansas, Inc.
CareMore Health Plan	UNICARE Health Plan of West Virginia, Inc.
CareMore Health Plan of Arizona, Inc.	UNICARE Health Plans of Texas, Inc.
CareMore Health Plan of Colorado, Inc.	UNICARE Illinois Services, Inc.
CareMore Health Plan of Georgia, Inc.	UNICARE Life & Health Insurance Company
CareMore Health Plan of Nevada	UNICARE National Services, Inc.
CareMore Health Plan of Texas, Inc.	UNICARE Specialty Services, Inc.
CareMore Health System	UtiliMed IPA, Inc.
CareMore Holdings, Inc.	WellPoint Behavioral Health, Inc.
Cerulean Companies, Inc.	WellPoint California Services, Inc.
Claim Management Services, Inc.	WellPoint Dental Services, Inc.
Community Insurance Company	WellPoint Holding Corporation
Compcare Health Services Insurance Corporation	WellPoint Information Technology Services, Inc.
Crossroads Acquisition Corp	WellPoint Insurance Services, Inc.
DeCare Analytics, LLC	WellPoint Military Care Corporation

G. Not applicable.

10. Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

A. Nature of the Relationship

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The Company is a Florida domiciled stock insurance company and is a wholly-own subsidiary of ATH Holding Company, LLC (“ATH Holding”), which is an indirect wholly-owned subsidiary of Anthem, Inc. (“Anthem”), a publicly traded.

Simply Healthcare Plans, Inc. (“the Company”) is a for-profit health maintenance organization incorporated in the State of Florida and licensed under Chapter 641 of the Florida Statutes. The Company is a wholly owned subsidiary of Simply Healthcare Holdings, Inc., (“the Parent”), a Florida corporation.

In April 2010, the Company entered into an Asset Purchase Agreement, as amended, with Total Health Choice, Inc. (“Total”), whereby certain assets and liabilities of Total were acquired by the Company and the Company assumed the Medicaid and State Child Health Improvement Program contracts of Total in the State of Florida.

In August 2011, the Company entered into a contract with Centers for Medicaid and Medicare as a Medicare Advantage provider. The Company began enrolling Medicare member effective January 1, 2012.

In February 2012, the Company under its d/b/a Clear Health Alliance (“Clear”) entered into a contract with the State of Florida to provide Medicaid benefits to members with certain chronic conditions. The first members were effective with the Company on April 1, 2012.

On April 11, 2013, the Company entered into an agreement with their affiliate, Better Health, LLC (“Better Health”), whereby both companies agreed to purchase and sell Medicaid members in different regions in the state of Florida. The purchase agreement of the Medicaid members were transferred at their respective and fair values which resulted in a payable balance of approximately \$70,000 due to Better Health.

During 2012, the Agency for Health Care Administration, the chief health policy and planning entity for the state of Florida, released information for Health Maintenance Organizations and Provider Service Networks to competitively bid for the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program. In 2013, the Company was awarded a five year contract in ten regions for Clear and in one region for the Company commencing May and July 2014, respectively.

On December 19, 2014, Simply Healthcare Holdings, the parent company of Simply, entered into an Agreement and Plan of Merger (“Purchase Agreement”) with a subsidiary of Anthem, Inc. Based on receipt of all federal and state regulatory approvals, the acquisition was finalized and closed on February 17th, 2015.

On July 24, 2015, the Company’s ultimate parent company, Anthem Inc. (“Anthem”), and Cigna Corporation (“Cigna”) entered into an Agreement and Plan of Merger dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and a direct wholly-owned subsidiary of Anthem, pursuant to which Anthem will acquire all outstanding shares of Cigna.

The acquisition is expected to close in the second half of 2016 and is subject to certain state regulatory approvals, standard closing conditions, customary approvals required under the Hart-Scott-Rodino Antitrust Improvements Act and the approval of both the Anthem, Inc. shareholders and Cigna’s stockholders.

B. Significant Transactions for Each Period

The following significant transactions took place between the Company and its affiliates:

The Company received no capital contributions from its parent for the year ended December 31, 2015 and December 31, 2014.

The Company paid no dividends for the years ended December 31, 2015 and 2014.

C. Intercompany Management and Service Arrangements

In June 2010, the Company entered into a Management Service Agreement with Better Health, LLC (“Better Health”), a related party through common ownership, in which the Company provides services to administer a significant portion of Better Health’s benefits and business support services. In addition, the Company is entitled to receive reimbursements for reasonable expenses incurred in furtherance of operating Better Health in so much as these expenses exceed the amount of the management fee. For the year ended December 31, 2015 and year ended December 31, 2014, \$26,160,000 and \$36,493,000 respectively was received in relation to

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NOTES TO FINANCIAL STATEMENTS

this agreement and has been recorded as an offset to general administrative expenses on the Company's accompanying statutory statements of income.

For the year ended December 31, 2015 and year ended December 31, 2014, approximately \$532,000 and \$1,600,000, respectively, was paid to a related party for management fees and reimbursable expenses. There is no formal agreement between the parties and as a result, the reimbursement amounts are based on expenses paid by the related party, which are approved by the Company's executives.

D. Amounts Due to or from Related Parties

At December 31, 2015 and 2014, the Company reported \$2,974,679 and \$64,241 due to affiliates, respectively. The payable balances represent intercompany transactions that will be settled in accordance with the settlement terms of the intercompany agreement.

E. Guarantees or Contingencies for Related Parties

The Company did not enter into guarantees or undertakings for the benefit of an affiliate which would result in a material contingent exposure of the Company's or any affiliated insurer's assets or liabilities.

F. Management and Service Contracts and Cost Sharing Arrangements

Effective January 1, 2016 the Company entered into an administrative services agreement with its affiliated companies. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The costs and expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Costs include expenses such as salaries, employee benefits, communications, advertising, consulting services, billing, accounting, underwriting, and product development, which support the Company's operations. These costs are allocated based on various utilization statistics.

G. Nature of Control Relationships that Could Affect Operations or Financial Position

The Company's ultimate parent is Anthem, Inc.

H. Amount deducted for Investment in Upstream Company

The Company does not own shares of upstream intermediate entities or Anthem.

I. Detail of Investments in Affiliates Greater than 10% of Admitted Assets

The Company does not have investment in affiliates greater than 10% of admitted assets.

J. Write-down for Impairments of Investments in Subsidiaries, Controlled or Affiliated Companies

The Company did not write-down any investments in subsidiaries, controlled or affiliated companies as of December 31, 2015 and 2014.

K. Investment in a Foreign Insurance Subsidiary

The Company does not have investments in foreign insurance subsidiaries.

L. Investment in Downstream Non-insurance Holding Companies

The Company does not have investments in downstream non-insurance holding companies.

11. Debt

A. Capital Notes

The Company had no capital notes outstanding at December 31, 2015 and 2014.

NOTES TO FINANCIAL STATEMENTS

B. All Other Debt

The Company had no other debt outstanding at December 31, 2015 and 2014.

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

A. Defined Benefit Plan

Not applicable – See Note 12G.

B. Not applicable – See Note 12G.

C. Not applicable – See Note 12G.

D. Not applicable – See Note 12G.

E. Defined Contribution Plan

Not applicable – See Note 12G.

F. Multiemployer Plan

The Company does not participate in a multiemployer plan.

G. Consolidated/Holding Company Plans

The Company participates in a deferred compensation plan sponsored by Anthem which covers certain employees. The deferred amounts are payable according to the terms and subject to the conditions of said deferred compensation agreements. Anthem allocates a share of the total accumulated costs of this plan to the Company based on the number of allocated employees subject to the deferred compensation agreements. During 2015 and 2014, these costs totaled \$0 and \$0. The Company has no legal obligation for benefits under this plan.

The Company participates in the Anthem 401(k) Retirement Savings Plan, sponsored by ATH Holding and covering substantially all employees. Voluntary employee contributions are matched by ATH Holding subject to certain limitations. ATH Holding allocates a share of the total accumulated costs of this plan to the Company based on the number of allocated employees. During 2015 and 2014, these costs totaled \$0 and \$0, respectively. The Company has no legal obligation for benefits under these plans.

H. Post Employment Benefits and Compensated Absences

Liabilities for earned not yet taken vacation and severance benefits have been accrued as of December 31, 2015 and 2014.

I. Impact of Medicare Modernization Act on Postretirement Benefits (INT 04-17)

Not applicable.

13. Capital and Surplus, Shareholders’ Dividend Restrictions and Quasi-Reorganizations

1. Outstanding Shares

As of December 31, 2015 the Company has 10,000 shares authorized, 57 issued and outstanding. All shares are Class A shares.

2. Preferred Stock

The Company has no preferred stock outstanding.

3. Dividend Restrictions

Per the Florida Statute 641.365, there are certain limitations exist on the Company’s ability to pay dividends to its parent. The Company may pay funds only from accumulated surplus funds that were

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derived from realized net operating profits on its business and net realized capital gains. Prior written approval by the Florida DFS is required for payment of any dividend which would result in these accumulated surplus funds being less than zero. Florida DFS approval is not required if the dividend to be paid is less than the greater of 1) ten percent of the Company’s accumulated surplus or 2) the Company’s entire net operating profit, including realized capital gains, for the immediately preceding calendar year.

4. Dividends Paid

No ordinary dividends were paid by the Company as of December 31, 2015.

5. Maximum Ordinary Dividends During 2016

Within the limitations of (3) above, the Company may pay no dividends during 2015 without prior approval.

6. Unassigned Surplus Restrictions

Unassigned surplus funds are not restricted at December 31, 2015.

7. Mutual Surplus Advances

Not applicable.

8. Company Stock Held for Special Purpose

There are no shares of stock held for special purposes at December 31, 2015.

9. Changes in Special Surplus Funds

The changes in balances of special surplus funds from the prior year are due to amounts segregated for the estimated 2016 Affordable Care Act (“ACA”) health insurer fee.

10. Changes in Unassigned Funds

The portion of unassigned funds represented by cumulative unrealized gains and losses was \$0 at December 31, 2015.

11. Surplus Notes

The Company received the following surplus debentures or similar obligations:

Date Issued	Interest Rate	Par Value (Face Amount of Notes)	Carrying Value of Note	Interest And/Or Principal Paid Current Year	Total Interest And/Or Principal Paid	Unapproved Interest And/Or Principal	Date of Maturity
5/4/2010	8%	7,559,808	7,559,808	-	-	3,426,561	12/31/2016
9/2/2010	8%	4,967,102	4,967,102	-	-	2,119,660	12/31/2016
9/17/2010	8%	2,032,898	2,032,898	-	-	860,835	12/31/2016
12/20/2012	8%	2,500,000	2,500,000	-	-	606,575	12/31/2016
12/31/2012	8%	2,500,000	2,500,000	-	-	600,548	12/31/2016
12/31/2013	8%	1,000,000	1,000,000	-	-	160,219	12/31/2016
	Total	20,559,808	20,559,808			7,774,398	

As of December 31, 2015, the Company entered into promissory surplus notes to related parties totaling \$20,559,808. The notes bear interest at the rate of 8% per annum, however, in accordance with statutory accounting principles set forth in SSAP No. 41 interest shall not be recorded as a liability or an expense until such interest has been approved by the Office of Insurance Regulation for payment.

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As of December 2015 and December 2014, the Company did not seek nor did the Office of Insurance Regulation approve any interest payments. As of December 31, 2015 and December 31, 2014, the “unapproved” cumulative interest relating to the surplus notes is approximately \$7,774,000 and \$6,130,000, respectively.

Payment of principal and interest on the surplus notes are subordinated to claims of all policyholders, creditors, and other liabilities of the Company.

12. Restatement due to Prior Quasi-reorganization

The Company has no restatements due to prior quasi-reorganizations.

13. Quasi-reorganization over Prior 10 years

The Company has not been involved in a quasi-reorganization during the past 10 years.

14. Contingencies

A. Contingent Commitments

The Company has no contingent commitments at December 31, 2015.

B. Assessments

- 1. The Company is subject to guaranty fund and other assessments by the state(s) in which it writes business. Guaranty fund assessments are accrued at the time of insolvencies. Other assessments are accrued either at the time of the assessment or at the time the losses are incurred.

The State of Florida has not issued a guaranty fund assessment, and the Company has not recorded a liability for an assessment as of December 31, 2015.

- 2. .Not applicable.

C. Gain Contingencies

The Company has no gain contingencies at December 31, 2015.

D. Claims-Related Extra Contractual Obligations and Bad Faith Losses Stemming from Lawsuits

Not applicable.

E. Joint and Several Liabilities

Not applicable.

F. All Other Contingencies

In February 2015, Anthem reported that it was the target of a sophisticated external cyber-attack. The attackers gained unauthorized access to certain of Anthem’s information technology systems and obtained personal information related to many individuals and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that Anthem will not identify additional information that was accessed or obtained.

Anthem has continued to implement security enhancements since this incident and is supporting federal law enforcement efforts to identify the responsible parties. Upon discovery of the

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cyber-attack, Anthem took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate its systems and identify solutions based on the evolving landscape. Anthem is providing credit monitoring and identity protection services to those who have been affected by this cyber-attack. Anthem has incurred expenses subsequent to the cyber-attack to investigate and remediate this matter and expects to continue to incur expenses of this nature in the foreseeable future. Anthem will recognize these expenses in the periods in which they are incurred.

Actions have been filed in various federal and state courts, and other claims have been or may be asserted against Anthem on behalf of current or former members, current or former employees, other individuals, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber-attack. State and federal agencies, including state insurance regulators, state attorneys general, the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigation, are investigating events related to the cyber-attack, including how it occurred, its consequences and Anthem's responses. Although Anthem is cooperating in these investigations, Anthem may be subject to fines or other obligations, which may have an adverse effect on how Anthem operates its business and results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation in February 2015 and was subsequently heard by the Panel in May 2015. In June 2015, the Panel entered its order transferring the consolidated matter to the U.S. District Court for the Northern District of California. The U.S. District Court entered its Case Management Order in September 2015. Anthem has filed a Motion to Dismiss several of the counts that are before the U.S. District Court. There remain a few state court cases that are presently proceeding outside of the Multidistrict Litigation.

Anthem has contingency plans and insurance coverage for certain expenses and potential liabilities of this nature. The coverage has been sufficient to cover the majority of claims and liabilities incurred to date. While a loss from these matters is reasonably possible, Anthem cannot reasonably estimate a range of possible losses because the investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

The Company is involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental and administrative proceedings. These investigations, audits and reviews include routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and Federal Agencies. Such investigations could result in the imposition of civil or criminal fines, penalties and other sanctions. The Company believes that any liability that may result from any one of these actions is unlikely to have a material adverse effect on the Company's financial position or results of operations.

At December 31, 2015 and 2014, the Company reported admitted assets of \$17,834,690 and \$24,977,198 respectively in premium receivables due from policyholders and agents, and receivables due from uninsured plans. The receivables are not deemed to be uncollectible, therefore, no provision for uncollectible amounts have been recorded. The potential for any additional loss is not believed to be material to the Company's financial condition.

15. Leases

A. Lessee Operating Lease

1.
 - a. The Company leases office space in Tampa, Orlando, Sunrise and offices in South Florida. These leases expire at various dates through 2017. Rent expenses for the year ended December 31, 2015 and year ended December 31, 2014, totaled approximately \$2,248,000 and \$1,847,000, respectively. The Company entered into a software licensing agreement for a claims processing system, which expires in 2016. For the year ended December 31, 2015 and year ended December 31, 2014, software licensing expense totaled approximately \$3,884,000 and \$4,213,000.
 - b. The leases contain base rent escalations and, as a result, the Company records the rental expense on a straight-line basis over the life of the lease.

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- c.

As of December 31, 2015 and December 31, 2014, item (c) resulted in a liability for deferred rent obligation of approximately \$211,000 and \$212,000, respectively.
2.

As of December 31, 2015, total future minimum lease payments under operating leases for the years ended December 31 were as follows (Dollars in thousands) :

At January 1, 2016, the minimum aggregate rental commitments are as follows: (Dollars in thousands)

	Operating Leases
Year Ending December 31	
2016 (as seen in Notes text)	\$ 1,776,000
2017 (as seen in Notes text)	\$ 2,475,000
2018 (as seen in Notes text)	\$ 2,335,000
2019 (as seen in Notes text)	\$ 2,406,000
2020 (as seen in Notes text)	\$ 2,478,000
Total	\$ 11,470,000

3.

The Company is not involved in any material sales-leaseback transactions

B. Lessor Leases

1.

The Company has not entered into any operating leases.
2.

The Company has not entered into any leverage leases

16. Information about Financial Instruments with Off-Balance-Sheet Risk and Financial Instruments with Concentrations of Credit Risk

The Company has no significant financial instruments with off-balance sheet risk.

Financial instruments that potentially subject the Company to concentration of credit risk consist primarily of investment securities. All investment securities are managed by professional investment managers within policies authorized by the board of directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. As of December 31, 2015, there were no significant concentrations.

17. Sales, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. Transfers of Receivables Reported as Sales

Not applicable at December 31, 2015 and 2014.

B. Transfer and Servicing of Financial Assets

1– 7. Not applicable.

C. Wash Sales

1.

In the course of the Company’s asset management, securities may be sold and reacquired within 30 days of the sale date to enhance the yield on the investments.
2.

At December 31, 2015 and 2014, there were no wash sales involving securities with an NAIC designation of 3 or below or unrated.

18. Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

A. Administrative Services Only (“ASO”) Plans

Not applicable in December 31, 2015 and 2014.

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B. Administrative Services Contract (“ASC”) Plans

Not applicable in December 31, 2015 and 2014.

C. Medicare or Other Similarly Structured Cost-Based Reimbursement Contract

Not applicable at December 31, 2015 and 2014.

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

No premiums were written by managing general agents or third party administrators during the years ended December 31, 2015 and 2014.

20. Fair Value Measurement

A. Fair Value Measure

1. Fair Value Measurements at Reporting Date

(1)		(2)	(3)	(4)	(5)
Description		(Level 1)	(Level 2)	(Level 3)	Total
a.	Assets at fair Value				
	None	0	0	0	0
		0	0	0	0
	Total assets at fair value	0	0	0	0
b.	Liabilities at fair value				
	None	0	0	0	0
		0	0	0	0
	Total liabilities at fair value	0	0	0	0

2. The Company does not have assets or liabilities within Level 3 fair value hierarchy.
3. The Company's policy is to recognize transfers between Levels, if any, as of the beginning of the reporting period.
4. Fair values of fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level 1 or Level 2 inputs, for the determination of fair value to facilitate fair value measurements and disclosures. United States Government securities represent Level 1 securities, while Level 2 securities primarily include corporate securities, securities from states, municipalities and political subdivisions and residential mortgage-backed securities. For Securities not actively traded, the third party pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds.

Fair values of equity securities are generally designated as Level 1 and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level 2. The Company has certain equity securities, including private equity securities, for which the fair value is estimated based on each security's current condition and future cash flow projections. Such securities are designated Level 3. The fair values of these private equity securities are generally based on either broker quotes or discounted cash flow projections using assumptions for inputs such as the weighted-average cost of capital, long-term revenue growth rates and earnings before interest, taxes, depreciation and amortization, or revenue multiples that are not observable in the markets.

There have been no significant changes in the valuation techniques during the current period.

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B. Fair Value Measurements Under Other Accounting Pronouncements

Not applicable at December 31, 2015 and 2014.

C. Financial Instruments

Type of Financial Instrument		Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practicable (Carrying Value)
Bonds		65,671,236	64,559,754	0	66,671,236	0	0
Short Term	\$	427,197	425,770	193,952	233,245	0	0
Total	\$	66,098,433	68,163,355	193,952	65,904,481	0	0

D. Not Practicable to Estimate Fair Value

The Company does not have assets or liabilities that are not practicable to estimate fair value.

21. Other Items

A. Unusual or Infrequent Items

Not applicable at December 31, 2015 and 2014.

B. Troubled Debt Restructuring: Debtors

Not applicable at December 31, 2015 and 2014.

C. Other Disclosures

Not applicable at December 31, 2015 and 2014.

D. Business Interruption Insurance Recoveries

The Company has reported no recoveries for business interruption for the years ended December 31, 2015 and 2014.

E. State Transferable and Non-Transferable Tax Credits

The Company did not have state transferable tax credits at December 31, 2015 and 2014.

F. Subprime Mortgage-Related Risk Exposure

1. The Company’s investment strategy of providing safety and preservation of capital, sufficient liquidity to meet cash flow requirements and the attainment of a competitive after-tax investment return is supported by a well diversified portfolio consisting of many different types of investments. The portion of the Company’s investment portfolio with subprime mortgage-related risk exposure is relatively small in comparison to the overall investment portfolio, and consists of investment grade securities with no exposure to collateralized debt obligations. All mortgage related investments are monitored closely as part of the quarterly investment review performed by the Anthem Investment Impairment Review Committee.
2. The Company did not carry investments in subprime mortgage loans in its portfolio at December 31, 2015 or 2014.
3. The Company did not have subprime mortgage-related risk exposure at December 31, 2015 or 2014.

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

NOTES TO FINANCIAL STATEMENTS

4. The Company did not underwrite Mortgage Guaranty or Financial Guaranty insurance coverage at December 31, 2015.

G. Retained Assets

The Company did not have any retained assets at December 31, 2015 and 2014.

22. Events Subsequent

The Company is subject to an annual fee under section 9010 of the Affordable Care Act (“ACA”). A health insurance company’s portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. The Company has written health insurance subject to the ACA assessment and expects to conduct health insurance business in 2016. The Company reflected its estimated portion of the fee payable on September 30, 2016 in special surplus. The annual fee under section 9010 of the ACA has been suspended for 2017 and will resume for 2018 and beyond.

	Current Year	Prior Year
A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the Federal Affordable Care Act (YES/NO)?	YES	
B. ACA fee assessment payable for the upcoming year	\$ 20,013,754	9,169,007
C. ACA fee assessment paid	\$ 0	0
D. Premium written subject to ACA 9010 assessment	\$ 986,471,542	835,536,722
E. Total Adjusted Capital before surplus adjustment (Five-Year Historical Line 14)	\$ 46,117,218	
F. Total Adjusted Capital after surplus adjustment (Five-Year Historical Line 14 minus 22B above)	\$ 25,675,270	
G. Authorized Control Level (Five-Year Historical Line 15)	\$ 35,244,437	
H. Would reporting the ACA assessment as of Dec. 31, 2015 have triggered an RBC action level (YES/NO)?	NO	

Subsequent events have been considered through March 31, 2016 for the statutory statement issued on March 31, 2016. There were no other events occurring subsequent to December 31, 2015 requiring recognition or disclosure.

23. Reinsurance

A. Ceded Reinsurance Report

Section 1 – General Interrogatories

1.

Are any of the reinsurers that are listed in Schedule S as non-affiliated owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?

Yes () No (X)
2.

Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled, directly or indirectly, by an insured, a beneficiary, a creditor or an insured or any other person not primarily engaged in the insurance business?

Yes () No (X)

Section 2 – Ceded Reinsurance Report – Part A

1.

Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credits?

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

NOTES TO FINANCIAL STATEMENTS

Yes () No (X)

3. Does the reporting entity have any reinsurance agreements in effect such that the amount of losses paid or accrued though the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same insurer, exceed the total direct premium collected under reinsured policies?

Yes () No (X)

Section 3 – Ceded Reinsurance Report – Part B

1. What is the estimated amount of the aggregate reduction in surplus, (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2) above of termination of ALL reinsurance agreements, by either party, as of the date of this statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

Not Applicable.

2. Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement include policies or contract that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes () No (X)

B. Uncollectible Reinsurance

The Company has no uncollectible reinsurance at December 31, 2015 and 2014.

C. Commutation of Ceded Reinsurance

The Company has not commuted ceded reinsurance during 2015 and 2014.

D. Certified Reinsurer Rating Downgraded or Status Subject Revocation

The Company has no downgraded certified reinsurer ratings or status subject revocations during 2015 and 2014.

24. Retrospectively Rated Contracts & Contracts Subject to Redetermination

- A. The Company’s contracts with CMS and AHCA include provisions for which the premiums vary based on loss experience. The Company estimates retrospective premium adjustments through the review of each retrospectively rated account, comparing the claim development with that anticipated in the policy contracts.
- B. The Company records accrued retrospective premium as an adjustment to earned premium.
- C. The amount of net premiums written by the Company at December 31, 2015 and 2014 that were subject to retrospective rating features was \$986,471,542 and \$835,607,654 respectively, which represents 100% and 100% of the total net premiums written. No other net premiums written by the Company are subject to retrospective rating features.

D. Not Applicable

E. Risk-Sharing Provisions of the Affordable Care Act ("ACA")

1. Did the reporting entity write accident and health insurance premium which is subject to the Affordable Care Act risk sharing provisions (YES/NO)? No
2. Impact of Risk-Sharing Provisions of the Affordable Care Act on Admitted Assets, Liabilities and Revenue for the Current Year

Not applicable.

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

NOTES TO FINANCIAL STATEMENTS

3. Roll-forward of prior year ACA risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balance.

Not applicable.

25. Change in Incurred Claims and Claims Adjustment Expenses

The estimated cost of claims and claim adjustment expense attributable to insured events of prior years increased by \$1,514,245 during 2015. This is approximately 1.4% of unpaid claims and claim adjustment expense of \$109,588,723 as of December 31, 2014. The deficiency reflects the increases in estimated claims expenses as a result of claim payments during the year, and as additional information is received regarding claims incurred prior to 2015. Recent claim development trends are also taken into account in evaluating the overall adequacy of unpaid claims and claim adjustment expense.

26. Intercompany Pooling Arrangements

Not applicable at December 31, 2015 and 2014.

27. Structured Settlements

Not applicable at December 31, 2015 and 2014.

28. Health Care Receivables

A. Pharmaceutical Rebate Receivables

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More Than 180 Days After Billing
12/31/2015	1,265,695	1,265,695	0	0	0
09/30/2015	991,277	1,174,218	0	0	0
06/30/2015	955,886	1,318,276	0	0	1,318,276
03/31/2015	992,693	1,211,013	0	0	1,211,013
12/31/2014	1,455,611	1,655,913	0	0	1,655,913
09/30/2014	1,264,332	1,606,530	0	0	1,606,530
06/30/2014	1,455,624	1,469,017	0	0	1,469,017
03/31/2014	1,235,399	1,174,754	0	0	1,174,754
12/31/2013	564,962	866,809	0	0	866,809
09/30/2013	495,785	686,225	0	0	686,225
06/30/2013	401,508	501,265	0	0	501,265
03/31/2013	343,044	406,194	0	0	406,194

B. Risk Sharing Receivables

Risk Sharing receivables are accounted for as non-admitted assets at December 31, 2015.

29. Participating Policies

Not applicable at December 31, 2015 and 2014.

30. Premium Deficiency Reserve

1. Liability carried for premium deficiency reserve

\$-
2. Date of the most recent evaluation of this liability

12/31/2015
3. Was anticipated investment income utilized in the calculation

Yes

No

31. Anticipated Salvage and Subrogation

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

NOTES TO FINANCIAL STATEMENTS

Not applicable at December 31, 2015 and 2014.

Annual Statement for the year 2015 of the

Simply Healthcare Plans, Inc

GENERAL INTERROGATORIES

PART 1 – COMMON INTERROGATORIES

GENERAL

- 1.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer?

Yes ☒ No ☐

If yes, complete Schedule Y, Parts 1, 1A and 2.
- 1.2 If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations?

Yes ☒ No ☐ N/A ☐
- 1.3 State Regulating?

Florida
- 2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity?

Yes ☐ No ☒
- 2.2 If yes, date of change:
- 3.1 State as of what date the latest financial examination of the reporting entity was made or is being made.

12/31/2014
- 3.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released.

12/31/2014
- 3.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date).
- 3.4 By what department or departments?

Florida Office of Insurance Regulations
- 3.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with departments?

Yes ☐ No ☐ N/A ☒
- 3.6 Have all of the recommendations within the latest financial examination report been complied with?

Yes ☐ No ☐ N/A ☒
- 4.1 During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity) receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:

4.11 sales of new business?

Yes ☐ No ☒

4.12 renewals?

Yes ☐ No ☒
- 4.2 During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:

4.21 sales of new business?

Yes ☐ No ☒

4.22 renewals?

Yes ☐ No ☒
- 5.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement?

Yes ☒ No ☐
- 5.2 If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc.**

GENERAL INTERROGATORIES

6.1 Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period?

Yes ☐ No ☒

6.2 If yes, give full information:

7.1 Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity?

Yes ☐ No ☒

7.2 If yes,

7.21 State the percentage of foreign control.

7.22 State the nationality(s) of the foreign person(s) or entity(s); or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact and identify the type of entity(s) (e.g., individual, corporation, government, manager or attorney-in-fact).

0.00 %

1	2
Nationality	Type of Entity

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board?

Yes ☐ No ☒

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

8.3 Is the company affiliated with one or more banks, thrifts or securities firms?

Yes ☐ No ☒

8.4 If response to 8.3 is yes, please provide the names and locations (city and state of the main office) of any affiliates regulated by a federal financial regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1	2	3	4	5	6
Affiliate Name	Location (City, State)	FRB	OCC	FDIC	SEC

9. What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?

Ernst & Young LLP, 111 Monument Circle #4000, Indianapolis, IN 46204

10.1 Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation?

Yes ☐ No ☒

10.2 If response to 10.1 is yes, provide information related to this exemption:

10.3 Has the insurer been granted any exemptions related to the other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 18A of the Model Regulation, or substantially similar state law or regulation?

Yes ☐ No ☒

10.4 If response to 10.3 is yes, provide information related to this exemption:

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc.**

GENERAL INTERROGATORIES

10.5 Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws? Yes [X] No [] N/A []

10.6 If the response to 10.5 is no or n/a, please explain.

11. What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?
Brian Weible, Wakely Consulting Group, 19321 US Highway 19N, Suite 515, Clearwater, FL 33764

12.1 Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly? Yes [] No [X]

12.11 Name of real estate holding company	
12.12 Number of parcels involved	0
12.13 Total book/adjusted carrying value	\$ 0

12.2 If yes, provide explanation:

13. FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:

13.1 What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?

13.2 Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located? Yes [X] No []

13.3 Have there been any changes made to any of the trust indentures during the year? Yes [] No [X]

13.4 If answer to (13.3) is yes, has the domiciliary or entry state approved the changes? Yes [] No [] N/A [X]

14.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards?

a. Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;

b. Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;

c. Compliance with applicable governmental laws, rules, and regulations;

d. The prompt internal reporting of violations to an appropriate person or persons identified in the code; and

e. Accountability for adherence to the code.

Yes [X] No []

14.11 If the response to 14.1 is no, please explain:

14.2 Has the code of ethics for senior managers been amended? Yes [] No [X]

14.21 If the response to 14.2 is yes, provide information related to amendment(s).

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc.**

GENERAL INTERROGATORIES

14.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes [] No [X]

14.31 If the response to 14.3 is yes, provide the nature of any waiver(s).

15.1 Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List? Yes [] No [X]

15.2 If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.

1 American Bankers Association (ABA) Routing Number	2 Issuing or Confirming Bank Name	3 Circumstances That Can Trigger the Letter of Credit	4 Amount
0			0
0			0
0			0

BOARD OF DIRECTORS

16. Is the purchase or sale of all investments of the reporting entity passed upon either by the board of directors or a subordinate committee thereof? Yes [X] No []

17. Does the reporting entity keep a complete permanent record of the proceedings of its board of directors and all subordinate committees thereof? Yes [X] No []

18. Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict or is likely to conflict with the official duties of such person? Yes [X] No []

FINANCIAL

19. Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)? Yes [] No [X]

20.1 Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):

20.11 To directors or other officers

20.12 To stockholders not officers

20.13 Trustees, supreme or grand (Fraternal only)

\$

\$

\$

0

0

0

20.2 Total amount of loans outstanding at the end of year (inclusive of Separate Accounts, exclusive of policy loans):

20.21 To directors or other officers

20.22 To stockholders not officers

20.23 Trustees, supreme or grand (Fraternal only)

\$

\$

\$

0

0

0

21.1 Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reported in the statement? Yes [] No [X]

21.2 If yes, state the amount thereof at December 31 of the current year:

21.21 Rented from others

21.22 Borrowed from others

21.23 Leased from others

21.24 Other

\$

\$

\$

\$

0

0

0

0

22.1 Does this statement include payments for assessments as described in the Annual Statement Instructions other than guaranty fund or guaranty association assessments? Yes [] No [X]

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc.**

GENERAL INTERROGATORIES

22.2 If answer is yes:

22.21 Amount paid as losses or risk adjustment

22.22 Amount paid as expenses

22.23 Other amounts paid

\$

0

\$

0

\$

0

23.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement?

Yes ☐ No ☒

23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount:

\$ 0

INVESTMENT

24.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date? (other than securities lending programs addressed in 24.03)

Yes ☒ No ☐

24.02 If no, give full and complete information, relating thereto:

24.03 For security lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet. (an alternative is to reference Note 17 where this information is also provided)

24.04 Does the company's security lending program meet the requirements for a conforming program as outlined in the Risk-Based Capital Instructions?

Yes ☐ No ☐ N/A ☒

24.05 If answer to 24.04 is yes, report amount of collateral for conforming programs.

\$ 0

24.06 If answer to 24.04 is no, report amount of collateral for other programs.

\$ 0

24.07 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract?

Yes ☐ No ☐ N/A ☒

24.08 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%?

Yes ☐ No ☐ N/A ☒

24.09 Does the reporting entity or the reporting entity's securities lending agent utilize the Master Securities Lending Agreement (MSLA) to conduct securities lending?

Yes ☐ No ☐ N/A ☒

24.10 For the reporting entity's security lending program, state the amount of the following as of December 31 of the current year:

24.101 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2

24.102 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2

24.103 Total payable for securities lending reported on the liability page

\$ 0

\$ 0

\$ 0

25.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity or has the reporting entity sold or transferred any assets subject to a put option contract that is currently in force? (Exclude securities subject to Interrogatory 21.1 and 24.03).

Yes ☐ No ☒

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc.**

GENERAL INTERROGATORIES

25.2 If yes, state the amount thereof at December 31 of the current year:

25.21	Subject to repurchase agreements	\$	0
25.22	Subject to reverse repurchase agreements	\$	0
25.23	Subject to dollar repurchase agreements	\$	0
25.24	Subject to reverse dollar repurchase agreements	\$	0
25.25	Placed under option agreements	\$	0
25.26	Letter stock or securities restricted as to sale - excluding FHLB Capital Stock	\$	0
25.27	FHLB Capital Stock	\$	0
25.28	On deposit with states	\$	300,000
25.29	On deposit with other regulatory bodies	\$	5,544,056
25.30	Pledged as collateral - excluding collateral pledged to an FHLB	\$	0
25.31	Pledged as collateral to FHLB - including assets backing funding agreements	\$	0
25.32	Other	\$	0

25.3 For category (25.26) provide the following:

1 Nature of Restriction	2 Description	3 Amount
		0
		0
		0

26.1 Does the reporting entity have any hedging transactions reported on Schedule DB? Yes [] No [X]

26.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes [] No [] N/A [X]
If no, attach a description with this statement.

27.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity? Yes [] No [X]

27.2 If yes, state the amount thereof at December 31 of the current year. \$ 0

28. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? Yes [X] No []

28.01 For agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian's Address
The Bank of New York Mellon	BNY Mellon Center, Pittsburgh, PA 15258

28.02 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

28.03 Have there been any changes, including name changes, in the custodian(s) identified in 28.01 during the current year? Yes [] No [X]

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

GENERAL INTERROGATORIES

28.04 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

28.05 Identify all investment advisors, broker/dealers or individuals acting on behalf of broker/dealers that have access to the investment accounts, handle securities and have authority to make investments on behalf of the reporting entity:

1 Central Registration Depository Number(s)	2 Name	3 Address
104973	Wells Capital Management	San Francisco, CA

29.1 Does the reporting entity have any diversified mutual funds reported in Schedule D – Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5 (b) (1)])?

Yes [] No [X]

29.2 If yes, complete the following schedule:

1 CUSIP #	2 Name of Mutual Fund	3 Book/Adjusted Carrying Value
		0
		0
		0
29.2999 TOTAL		0

29.3 For each mutual fund listed in the table above, complete the following schedule:

1 Name of Mutual Fund (from above table)	2 Name of Significant Holding of the Mutual Fund	3 Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	4 Date of Valuation
		0	
		0	
		0	

30. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

	1 Statement (Admitted) Value	2 Fair Value	3 Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
30.1 Bonds	64,985,524	66,098,434	1,112,910
30.2 Preferred stocks	0	0	0
30.3 Totals	64,985,524	66,098,434	1,112,910

30.4 Describe the sources or methods utilized in determining the fair values:
Fair values of fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level 1 or Level 2 inputs, for the determination of fair value to facilitate fair value measurements and disclosures. United States Government securities represent Level 1 securities, while Level 2 securities primarily include corporate securities, securities from states, municipalities and political subdivisions and residential mortgage-backed securities. For Securities not actively traded, the third party pricing services may use quoted market prices of

31.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D?

Yes [] No [X]

31.2 If the answer to 31.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source?

Yes [] No []

Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc

GENERAL INTERROGATORIES

31.3 If the answer to 31.2 is no, describe the reporting entity’s process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D:

32.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed?

Yes [X] No []

32.2 If no, list exceptions:

OTHER

33.1 Amount of payments to trade associations, service organizations and statistical or Rating Bureaus, if any?

\$ 0

33.2 List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations and statistical or rating bureaus during the period covered by this statement.

1 Name	2 Amount Paid
	\$ 0
	\$ 0
	\$ 0

34.1 Amount of payments for legal expenses, if any?

\$ 153,468

34.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.

1 Name	2 Amount Paid
Greenberg & Traurig P.A.	\$ 94,291
Holland & Knight LLP	\$ 43,055
	\$ 0

35.1 Amount of payments for expenditures in connection with matters before legislative bodies, officers or departments of government, if any?

\$ 76,400

35.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid
Larry J. Overton and Associates, Inc.	\$ 20,400
Southern Strategy Group, Inc.	\$ 56,000
	\$ 0

Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc.

GENERAL INTERROGATORIES

PART 2 - HEALTH INTERROGATORIES

1.1 Does the reporting entity have any direct Medicare Supplement Insurance in force?

Yes [] No [X]

1.2 If yes, indicate premium earned on U.S. business only.

\$ 0

1.3 What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit?

\$ 0

1.31 Reason for excluding

1.4 Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above.

\$ 0

1.5 Indicate total incurred claims on all Medicare Supplement insurance.

\$ 0

1.6 Individual policies:

Most current three years:

1.61 Total premium earned

\$ 0

1.62 Total incurred claims

\$ 0

1.63 Number of covered lives

0

All years prior to most current three years:

1.64 Total premium earned

\$ 0

1.65 Total incurred claims

\$ 0

1.66 Number of covered lives

0

1.7 Group policies:

Most current three years:

1.71 Total premium earned

\$ 0

1.72 Total incurred claims

\$ 0

1.73 Number of covered lives

0

All years prior to most current three years:

1.74 Total premium earned

\$ 0

1.75 Total incurred claims

\$ 0

1.76 Number of covered lives

0

2. Health Test:

1

Current Year

2

Prior Year

2.1 Premium Numerator

\$ 985,291,150

\$ 834,582,443

2.2 Premium Denominator

\$ 985,291,150

\$ 834,582,443

2.3 Premium Ratio (2.1 / 2.2)

1.000

1.000

2.4 Reserve Numerator

\$ 103,566,501

\$ 112,406,875

2.5 Reserve Denominator

\$ 103,566,501

\$ 112,406,875

2.6 Reserve Ratio (2.4 / 2.5)

1.000

1.000

3.1 Has the reporting entity received any endowment or gift from contracting hospitals, physicians, dentists, or others that is agreed will be returned when, as and if the earnings of the reporting entity permits?

Yes [] No [X]

3.2 If yes, give particulars:

4.1 Have copies of all agreements stating the period and nature of hospitals', physicians', and dentists' care offered to subscribers and dependents been filed with the appropriate regulatory agency?

Yes [X] No []

4.2 If not previously filed, furnish herewith a copy(ies) of such agreement(s). Do these agreements include additional benefits offered?

Yes [X] No []

5.1 Does the reporting entity have stop-loss reinsurance?

Yes [X] No []

5.2 If no, explain:

5.3 Maximum retained risk (see instructions)

5.31 Comprehensive Medical

\$ 350,000

5.32 Medical Only

\$ 0

5.33 Medicare Supplement

\$ 0

5.34 Dental and vision

\$ 0

5.35 Other Limited Benefit Plan

\$ 0

5.36 Other

\$ 0

6. Describe arrangement which the reporting entity may have to protect subscribers and their dependents against the risk of insolvency including hold harmless provisions, conversion privileges with other carriers, agreements with providers to continue rendering services, and any other agreements:

All provider contracts provide for continuation of services regardless of status of payment from the Plan.

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc.**

GENERAL INTERROGATORIES
PART 2 - HEALTH INTERROGATORIES

7.1 Does the reporting entity set up its claim liability for provider services on a service date basis? Yes ☒ No ☐

7.2 If no, give details:
.....
.....
.....

8. Provide the following information regarding participating providers:

8.1 Number of providers at start of reporting year20,028

8.2 Number of providers at end of reporting year19,102

9.1 Does the reporting entity have business subject to premium rate guarantees? Yes ☐ No ☒

9.2 If yes, direct premium earned:

9.21 Business with rate guarantees between 15-36 months0

9.22 Business with rate guarantees over 36 months0

10.1 Does the reporting entity have Incentive Pool, Withhold or Bonus Arrangements in its provider contracts? Yes ☒ No ☐

10.2 If yes:

10.21 Maximum amount payable bonuses\$0

10.22 Amount actually paid for year bonuses\$0

10.23 Maximum amount payable withholds\$0

10.24 Amount actually paid for year withholds\$0

11.1 Is the reporting entity organized as:

11.12 A Medical Group/Staff Model, Yes ☐ No ☒

11.13 An Individual Practice Association (IPA), or, Yes ☐ No ☒

11.14 A Mixed Model (combination of above)? Yes ☐ No ☒

11.2 Is the reporting entity subject to Statutory Minimum Capital and Surplus Requirements? Yes ☒ No ☐

11.3 If yes, show the name of the state requiring such minimum capital and surplus:

Florida

11.4 If yes, show the amount required. \$19,724,093

11.5 Is this amount included as part of a contingency reserve in stockholder's equity? Yes ☐ No ☒

11.6 If the amount is calculated, show the calculation:

The State of Florida requires Surplus to exceed a) 2% of annualized revenues (\$986,204,659 x .02 = \$19,724,093), b) 10% of liabilities (\$137,655,076 x .1 = \$13,765,508), or c) \$1,500,000 whichever is greater

12. List service areas in which reporting entity is licensed to operate:

1		
Name of Service Area		
Florida		

13.1 Do you act as a custodian for health savings accounts? Yes ☐ No ☒

13.2 If yes, please provide the amount of custodial funds held as of the reporting date. \$0

13.3 Do you act as an administrator for health savings accounts? Yes ☐ No ☒

13.4 If yes, please provide the balance of the funds administered as of the reporting date. \$0

14.1 Are any of the captive affiliates reported on Schedule S, Part 3, authorized reinsurers? Yes ☐ No ☒ N/A ☐

14.2 If the answer to 14.1 is yes, please provide the following:

1 Company Name	2 NAIC Company Code	3 Domiciliary Jurisdiction	4 Reserve Credit	Assets Supporting Reserve Credit		
				5 Letters of Credit	6 Trust Agreements	7 Other
			0	0	0	0
			0	0	0	0
			0	0	0	0

15. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded).

15.1 Direct Premium Written\$0

15.2 Total Incurred Claims\$0

15.3 Number of Covered Lives0

*Ordinary Life Insurance Includes
Term (whether full underwriting, limited underwriting, jet issue, "short form app")
Whole Life (whether full underwriting, limited underwriting, jet issue, "short form app")
Variable Life (with or without secondary guarantee)
Universal Life (with or without secondary guarantee)
Variable Universal Life (with or without secondary guarantee)

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc**

FIVE – YEAR HISTORICAL DATA

	1	2	3	4	5
	2015	2014	2013	2012	2011
Balance Sheet (Pages 2 and 3)					
1. Total admitted assets (Page 2, Line 28)	183,316,055	199,847,663	77,612,488	43,491,061	15,867,686
2. Total liabilities (Page 3, Line 24)	137,198,837	172,528,370	64,312,121	32,529,724	11,944,711
3. Statutory minimum capital and surplus requirement	19,724,093	17,252,837	8,467,663	3,252,972	1,875,000
4. Total capital and surplus (Page 3, Line 33)	46,117,218	27,319,293	13,300,367	10,961,337	3,922,975
Income Statement (Page 4)					
5. Total revenues (Line 8)	986,204,659	834,607,654	423,383,150	149,958,347	43,478,597
6. Total medical and hospital expenses (Line 18)	833,041,758	739,324,144	365,609,057	116,526,276	34,415,174
7. Claims adjustment expenses (Line 20)	25,588,128	7,031,268	3,816,454	622,384	172,235
8. Total administrative expenses (Line 21)	85,788,144	65,803,921	41,421,479	30,496,823	8,439,507
9. Net underwriting gain (loss) (Line 24)	41,786,629	22,448,321	12,536,160	2,312,864	451,681
10. Net investment gain (loss) (Line 27)	748,561	287,004	165,635	81,785	20,810
11. Total other income (Lines 28 plus 29)	(422,334)	(99,140)	(85,524)	(83,257)	
12. Net income or (loss) (Line 32)	21,810,919	11,856,730	8,135,542	2,051,006	472,578
Cash Flow (Page 6)					
13. Net cash from operations (Line 11)	(2,167,043)	90,771,219	34,865,839	23,747,224	(374,116)
Risk-Based Capital Analysis					
14. Total adjusted capital	46,117,218	27,319,293	13,300,367	10,961,337	3,922,975
15. Authorized control level risk-based capital	35,244,437	31,723,226	15,635,727	5,436,960	2,155,825
Enrollment (Exhibit 1)					
16. Total members at end of period (Column 5, Line 7)	116,224	116,166	66,244	37,306	22,829
17. Total members months (Column 6, Line 7)	1,366,614	1,103,246	667,160	380,645	208,708
Operating Percentage (Page 4)					
(Item divided by Page 4, sum of Lines 2, 3, and 5) x 100.0					
18. Premiums earned plus risk revenue (Line 2 plus Lines 3 and 5)	100.0	100.0	100.0	100.0	100.0
19. Total hospital and medical plus other non-health (Line 18 plus Line 19)	84.5	88.6	86.4	77.7	79.2
20. Cost containment expenses					
21. Other claims adjustment expenses					
22. Total underwriting deductions (Line 23)	95.8	97.3	97.0	98.5	99.0
23. Total underwriting gain (loss) (Line 24)	4.2	2.7	3.0	1.5	1.0
Unpaid Claims Analysis					
(U&I Exhibit, Part 2B)					
24. Total claims incurred for prior years (Line 13, Col. 5)	92,941,231	56,603,830	15,977,491	7,165,528	4,010,651
25. Estimated liability of unpaid claims-[prior year (Line 13, Col. 6)]	98,785,406	52,349,879	17,898,835	8,143,563	5,441,311
Investments In Parent, Subsidiaries and Affiliates					
26. Affiliated bonds (Sch. D Summary, Line 12, Col. 1)					
27. Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1)					
28. Affiliated common stocks (Sch. D Summary, Line 24, Col. 1)					
29. Affiliated short-term investments (subtotal included in Sch. DA Verification, Col. 5, Line 10)					
30. Affiliated mortgage loans on real estate					
31. All other affiliated					
32. Total of above Lines 26 to 31					
33. Total investment in parent included in Lines 26 to 31 above.					

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3, Accounting Changes and Correction of Errors?

Yes [] No [X]

If no, please explain:

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc.**

SCHEDULE T - PREMIUMS AND OTHER CONSIDERATIONS
Allocated by States and Territories

		1	Direct Business Only							
			2	3	4	5	6	7	8	9
			Accident & Health Premiums	Medicare Title XVIII	Medicaid Title XIX	Federal Employees Health Benefits Plan Premiums	Life & Annuity Premiums & Other Considerations	Property/ Casualty Premiums	Total Columns 2 Through 7	Deposit-Type Contracts
States, Etc.		Active Status								
1. Alabama	AL	N	0	0	0	0	0	0	0	0
2. Alaska	AK	N	0	0	0	0	0	0	0	0
3. Arizona	AZ	N	0	0	0	0	0	0	0	0
4. Arkansas	AR	N	0	0	0	0	0	0	0	0
5. California	CA	N	0	0	0	0	0	0	0	0
6. Colorado	CO	N	0	0	0	0	0	0	0	0
7. Connecticut	CT	N	0	0	0	0	0	0	0	0
8. Delaware	DE	N	0	0	0	0	0	0	0	0
9. District of Columbia	DC	N	0	0	0	0	0	0	0	0
10. Florida	FL	L		378,763,202	607,708,340	0	0	0	986,471,542	0
11. Georgia	GA	N	0	0	0	0	0	0	0	0
12. Hawaii	HI	N	0	0	0	0	0	0	0	0
13. Idaho	ID	N	0	0	0	0	0	0	0	0
14. Illinois	IL	N	0	0	0	0	0	0	0	0
15. Indiana	IN	N	0	0	0	0	0	0	0	0
16. Iowa	IA	N	0	0	0	0	0	0	0	0
17. Kansas	KS	N	0	0	0	0	0	0	0	0
18. Kentucky	KY	N	0	0	0	0	0	0	0	0
19. Louisiana	LA	N	0	0	0	0	0	0	0	0
20. Maine	ME	N	0	0	0	0	0	0	0	0
21. Maryland	MD	N	0	0	0	0	0	0	0	0
22. Massachusetts	MA	N	0	0	0	0	0	0	0	0
23. Michigan	MI	N	0	0	0	0	0	0	0	0
24. Minnesota	MN	N	0	0	0	0	0	0	0	0
25. Mississippi	MS	N	0	0	0	0	0	0	0	0
26. Missouri	MO	N	0	0	0	0	0	0	0	0
27. Montana	MT	N	0	0	0	0	0	0	0	0
28. Nebraska	NE	N	0	0	0	0	0	0	0	0
29. Nevada	NV	N	0	0	0	0	0	0	0	0
30. New Hampshire	NH	N	0	0	0	0	0	0	0	0
31. New Jersey	NJ	N	0	0	0	0	0	0	0	0
32. New Mexico	NM	N	0	0	0	0	0	0	0	0
33. New York	NY	N	0	0	0	0	0	0	0	0
34. North Carolina	NC	N	0	0	0	0	0	0	0	0
35. North Dakota	ND	N	0	0	0	0	0	0	0	0
36. Ohio	OH	N	0	0	0	0	0	0	0	0
37. Oklahoma	OK	N	0	0	0	0	0	0	0	0
38. Oregon	OR	N	0	0	0	0	0	0	0	0
39. Pennsylvania	PA	N	0	0	0	0	0	0	0	0
40. Rhode Island	RI	N	0	0	0	0	0	0	0	0
41. South Carolina	SC	N	0	0	0	0	0	0	0	0
42. South Dakota	SD	N	0	0	0	0	0	0	0	0
43. Tennessee	TN	N	0	0	0	0	0	0	0	0
44. Texas	TX	N	0	0	0	0	0	0	0	0
45. Utah	UT	N	0	0	0	0	0	0	0	0
46. Vermont	VT	N	0	0	0	0	0	0	0	0
47. Virginia	VA	N	0	0	0	0	0	0	0	0
48. Washington	WA	N	0	0	0	0	0	0	0	0
49. West Virginia	WV	N	0	0	0	0	0	0	0	0
50. Wisconsin	WI	N	0	0	0	0	0	0	0	0
51. Wyoming	WY	N	0	0	0	0	0	0	0	0
52. American Samoa	AS	N	0	0	0	0	0	0	0	0
53. Guam	GU	N	0	0	0	0	0	0	0	0
54. Puerto Rico	PR	N	0	0	0	0	0	0	0	0
55. U.S. Virgin Islands	VI	N	0	0	0	0	0	0	0	0
56. Northern Mariana Islands	MP	N	0	0	0	0	0	0	0	0
57. Canada	CAN	N	0	0	0	0	0	0	0	0
58. Aggregate other alien	OT	X X X	0	0	0	0	0	0	0	0
59. Subtotal		X X X	0	378,763,202	607,708,340	0	0	0	986,471,542	0
60. Reporting entity contributions for Employee Benefit Plans		X X X	0	0	0	0	0	0	0	0
61. Totals (Direct Business)		(a) 1	0	378,763,202	607,708,340	0	0	0	986,471,542	0

DETAILS OF WRITE-INS									
58001.		X X X	0	0	0	0	0	0	0
58002.		X X X	0	0	0	0	0	0	0
58003.		X X X	0	0	0	0	0	0	0
58998.	Summary of remaining write-ins for Line 58 from overflow page	X X X	0	0	0	0	0	0	0
58999.	Totals (Lines 58001 through 58003 plus 58998) (Line 58 above)	X X X	0	0	0	0	0	0	0

(L) Licensed or Chartered - Licensed Insurance Carrier or Domiciled RRG; (R) Registered - Non-domiciled RRGs; (Q) Qualified - Qualified or Accredited Reinsurer; (E) Eligible - Reporting Entities eligible or approved to write Surplus Lines in the state; (E) Eligible - Reporting Entities eligible or approved to write Surplus Lines in the state; (N) None of the above - Not allowed to write business in the state.

Explanation of basis of allocation by states, premiums by state, etc.

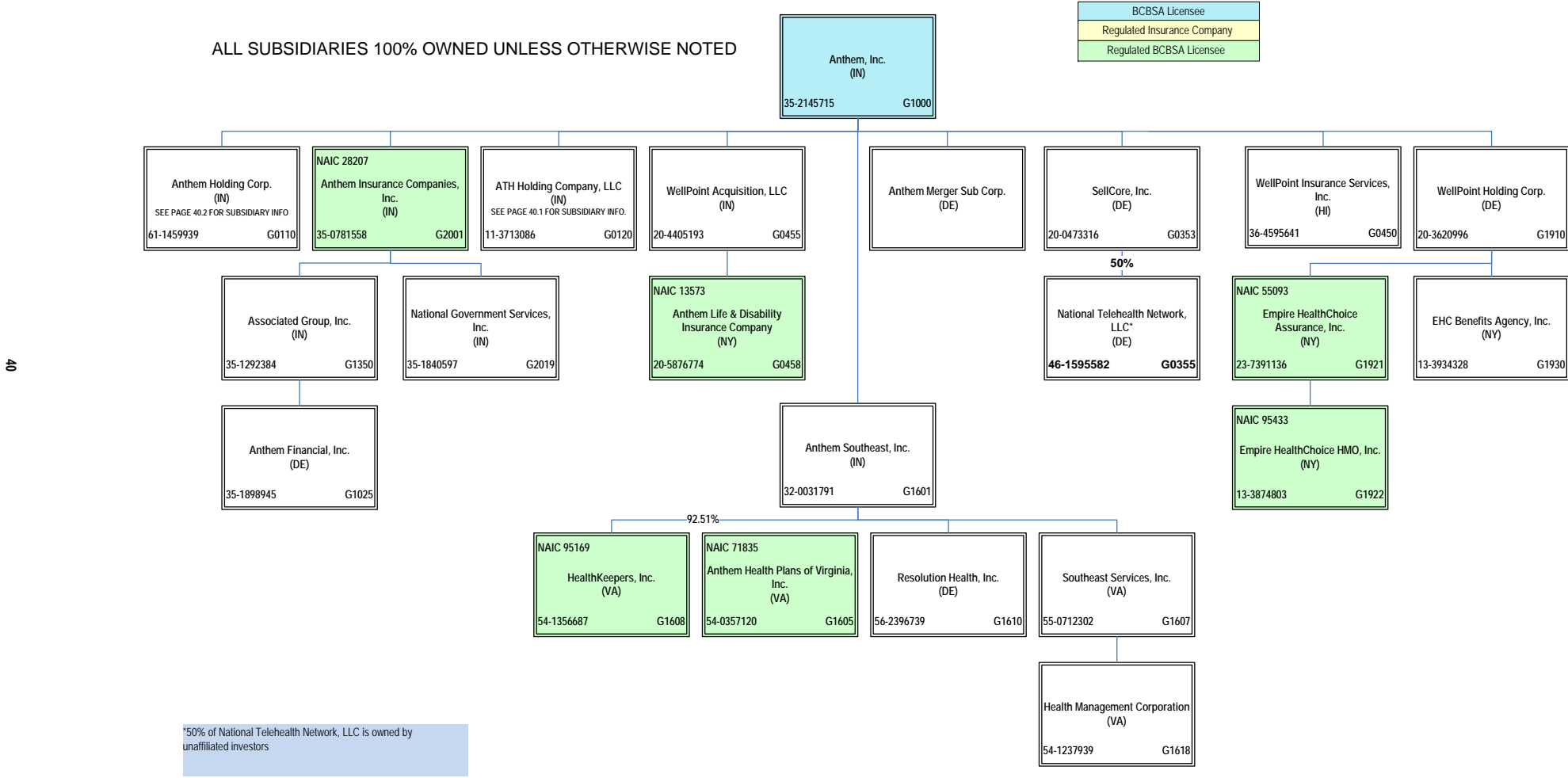
All Premiums are written in Florida.

(a) Insert the number of L responses except for Canada and Other Alien.

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc.**

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

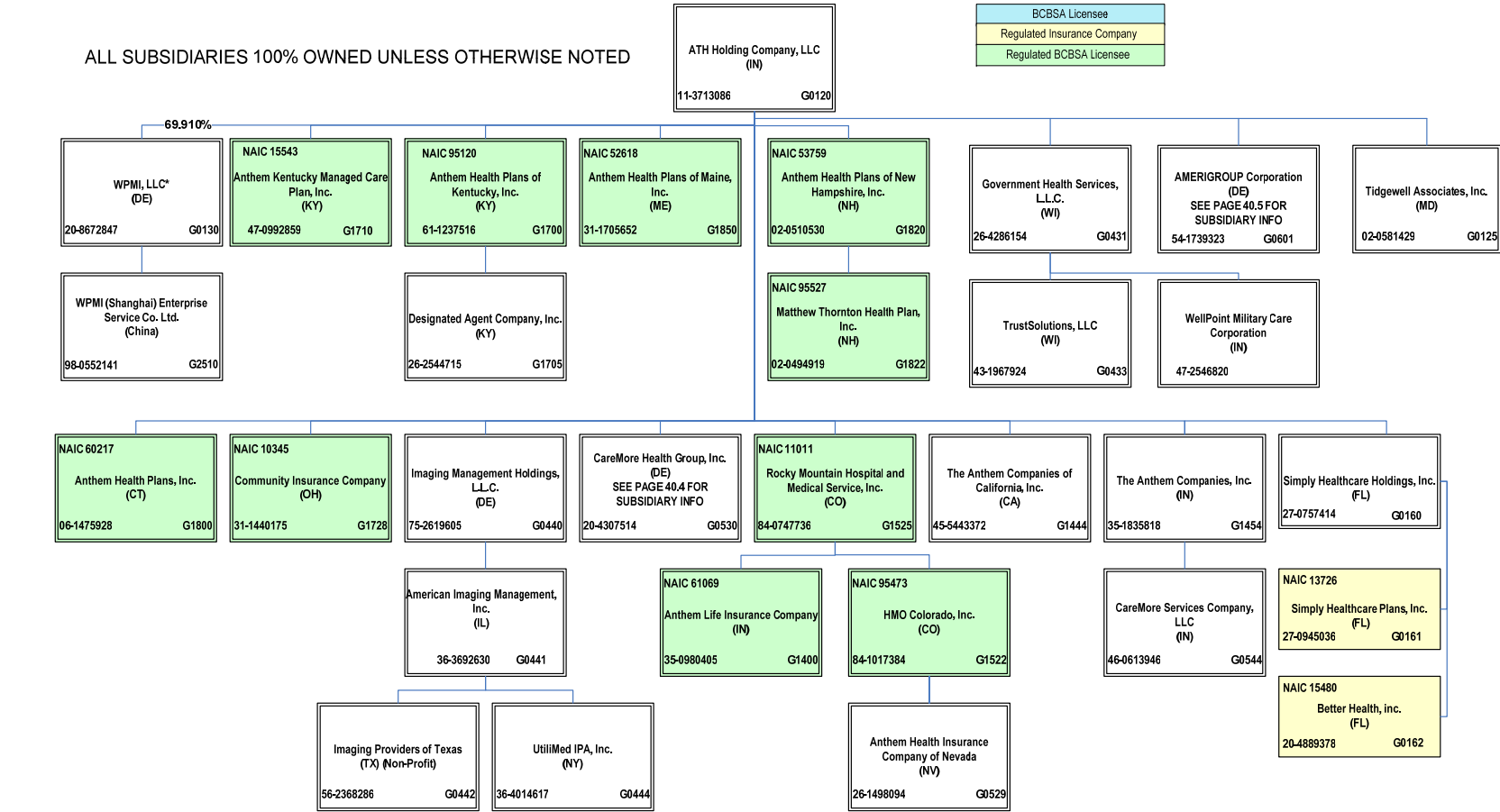
PART 1 - ORGANIZATIONAL CHART



Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc.

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART



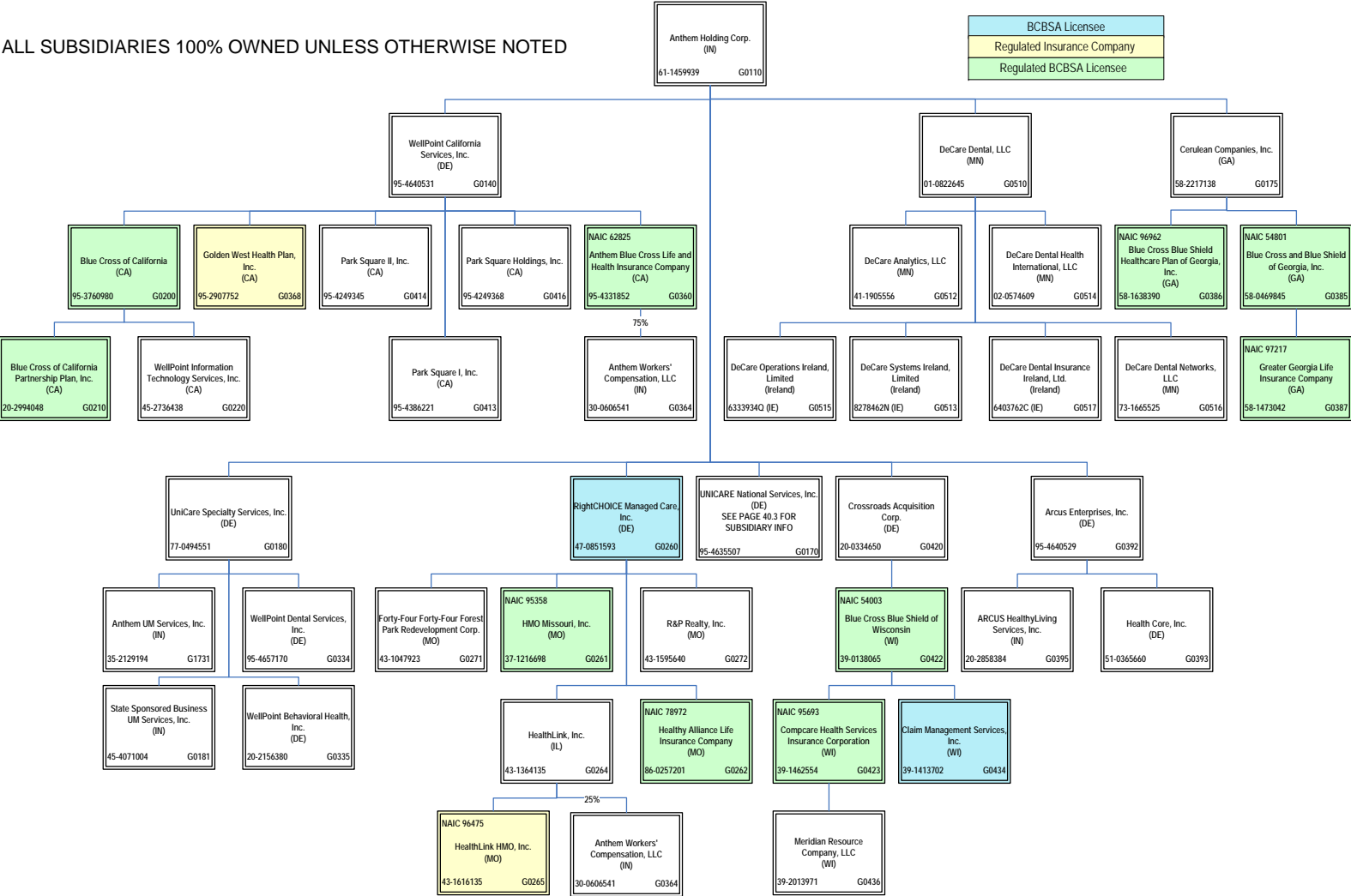
*30.09% of WPMI, LLC is owned by unaffiliated investors

Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc.

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED UNLESS OTHERWISE NOTED



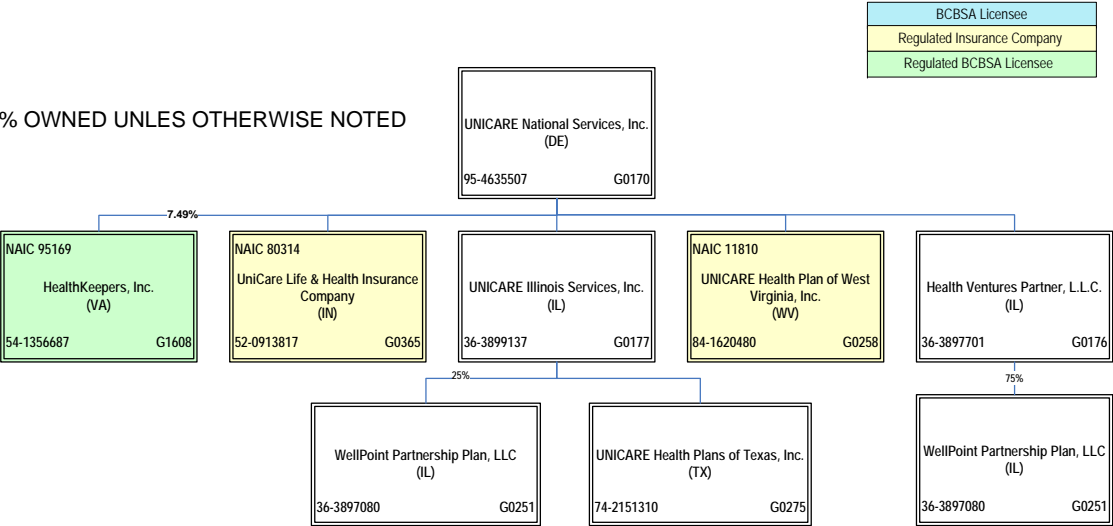
40.2

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc.**

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED UNLES OTHERWISE NOTED

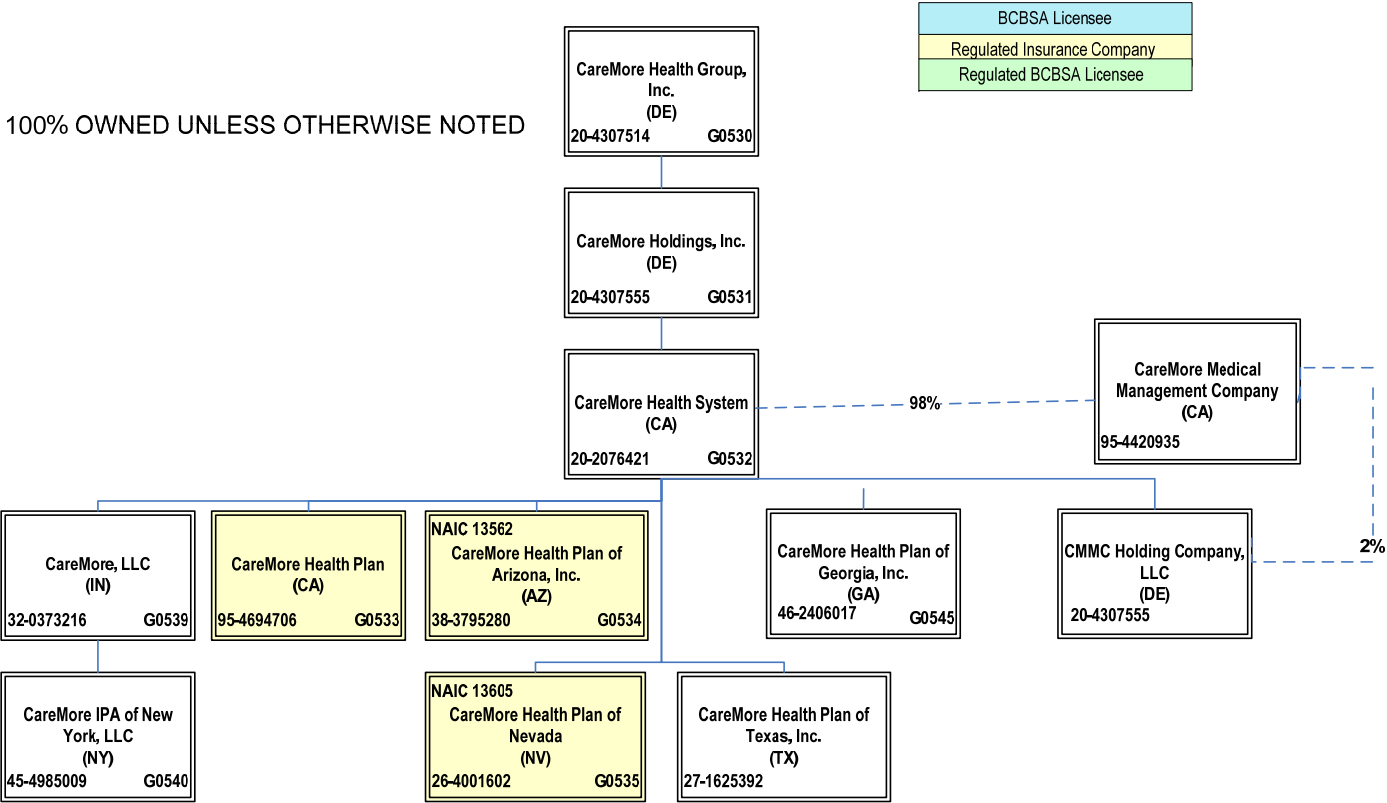


Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc.

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED UNLESS OTHERWISE NOTED



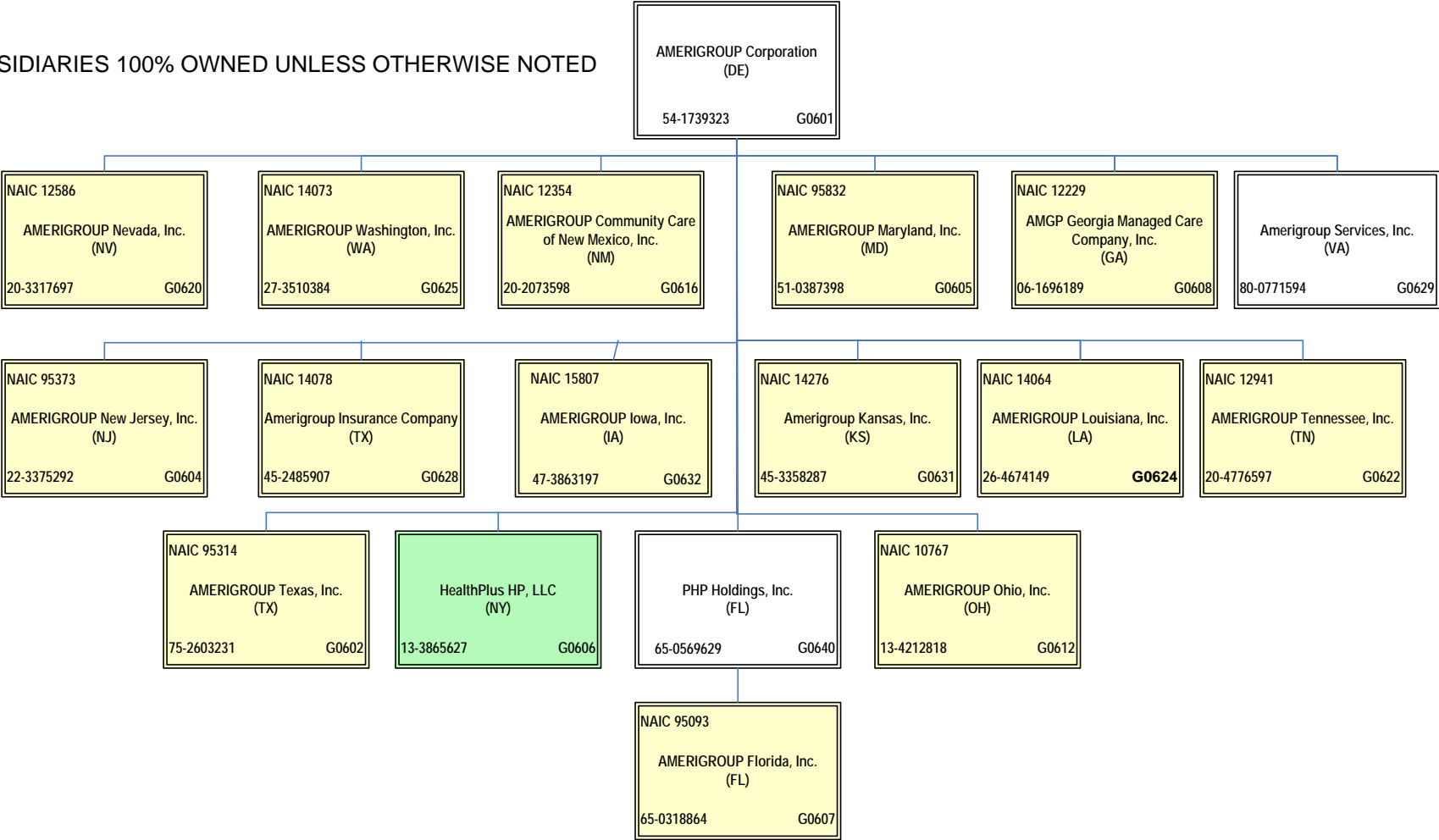
Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc.**

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED UNLESS OTHERWISE NOTED

40.5



Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc

OVERFLOW PAGE FOR WRITE-INS

Page 2 - Continuation

ASSETS

	Current Year			Prior Year
	1	2	3	4
REMAINING WRITE-INS AGGREGATED AT LINE 25 FOR OTHER THAN INVESTED ASSETS	Assets	Nonadmitted Assets	Net Admitted Assets (Cols. 1 - 2)	Net Admitted Assets
2504. INTANGIBLE ASSETS	0	0	0	0
2597. Totals (Lines 2504 through 2596) (Page 2, Line 2598)	0	0	0	0

Annual Statement for the year 2015 of the Simply Healthcare Plans, Inc

OVERFLOW PAGE FOR WRITE-INS

Page 16 - Continuation

EXHIBIT OF NONADMITTED ASSETS

	1	2	3
	Current Year	Prior Year	Change in Total
	Total	Total	Nonadmitted Assets
DETAILS OF WRITE-IN LINES FOR	Nonadmitted	Nonadmitted Assets	(Col. 2 - Col. 1)
OTHER THAN INVESTED ASSETS AT LINE 25	Assets		
2504. INTANGIBLE ASSETS	0	83,666	83,666
2597. Totals (Lines 2504 through 2596) (Page 16, Line 2598)	0	83,666	83,666

Annual Statement for the year 2015 of the **Simply Healthcare Plans, Inc.**

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ANNUAL STATEMENT

OF THE

Simply Healthcare Plans, Inc.

of **Miami**

in the state of **Florida**

TO THE

Insurance Department

OF THE

Florida

FOR THE YEAR ENDED

December 31, 2014

HEALTH

2014

Print Date: 04/02/2015 09:45:22 AM



ANNUAL STATEMENT
For the Year Ended December 31, 2014
OF THE CONDITION AND AFFAIRS OF THE

Simply Healthcare Plans, Inc

NAIC Group Code	0000	4806	NAIC Company Code	13726	Employer's ID Number	27-0945036
	(Current Period)	(Prior Period)				
Organized under the Laws of	Florida		State of Domicile or Port of Entry	Florida		
Country of Domicile	United States of America					
Licensed as business type:	Life, Accident & Health []	Property/Casualty []	Hospital, Medical & Dental Service or Indemnity []			
	Dental Services Corporation []	Vision Service Corporation []	Health Maintenance Organization [X]			
	Other []	Is HMO Federally Qualified? Yes [] No [X]				
Incorporated/Organized	September 10, 2009	Commenced Business	January 7, 2010			
Statutory Home Office	804 Douglas Road, 6th Floor		Coral Gables, FL, US 33134			
	(Street and Number)		(City or Town, State, Country and Zip Code)			
Main Administrative Office	1701 Ponce de Leon Blvd, Suite 300					
	(Street and Number)					
	Coral Gables, FL, US 33134		305-921-2654			
	(City or Town, State, Country and Zip Code)		(Area Code) (Telephone Number)			
Mail Address	1701 Ponce de Leon Blvd, Suite 300		Coral Gables, FL, US 33134			
	(Street and Number or P.O. Box)		(City or Town, State, Country and Zip Code)			
Primary Location of Books and Records	804 Douglas Road, 6th Floor		Coral Gables, FL, US 33134		305-921-2654	
	(Street and Number)		(City or Town, State, Country and Zip Code)		(Area Code) (Telephone Number)	
Internet Web Site Address	www.simplyhealthcareplans.com					
Statutory Statement Contact	Kevin C. Wirges		305-921-2654			
	(Name)		(Area Code) (Telephone Number) (Extension)			
	kwirges@simplyhealthcareplans.com		305-408-5845			
	(E-Mail Address)		(Fax Number)			

OFFICERS

Name	Title
1. Lourdes Tome-Rivas	Chief Executive Officer
2. Marcio C. Carbrera	Chief Financial Officer
3. Barbara R. Cowley	Medical Director

Vice Presidents

Name	Title	Name	Title
Jorge L. Rico	Vice President, Secretary	Marcio C. Carbrera	Vice President, Treasurer

DIRECTORS OR TRUSTEES

Jorge L. Rico	Marcio C. Carbrera		
---------------	--------------------	--	--

State of Florida
County of Miami-Dade ss

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefor for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

(Signature)	(Signature)	(Signature)
Lourdes Tome-Rivas	Kevin C. Wirges	Kathleen S. Kieler
(Printed Name)	(Printed Name)	(Printed Name)
1.	2.	3.
President & CEO	CFO	Secretary
(Title)	(Title)	(Title)

Subscribed and sworn to (or affirmed) before me this on this
20th day of March, 2015, by

Dana Gryniuk
JANA GRYNIUK



a. Is this an original filing? [X] Yes [] No
b. If no: 1. State the amendment number
2. Date filed
3. Number of pages attached

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc**

ASSETS

	Current Year			Prior Year
	1	2	3	4
	Assets	Nonadmitted Assets	Net Admitted Assets (Cols. 1 - 2)	Net Admitted Assets
1. Bonds (Schedule D)	15,436,624		15,436,624	2,250,000
2. Stocks (Schedule D):				
2.1 Preferred stocks				
2.2 Common stocks				
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens				
3.2 Other than first liens				
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less \$ 0 encumbrances)				
4.2 Properties held for the production of income (less \$ 0 encumbrances)				
4.3 Properties held for sale (less \$ 0 encumbrances)				
5. Cash (\$ 100,685,021, Schedule E - Part 1), cash equivalents (\$ 1,500,000, Schedule E - Part 2), and short-term investments (\$ 48,552,385, Schedule DA)	150,737,406		150,737,406	63,100,715
6. Contract loans (including \$ 0 premium notes)				
7. Derivatives (Schedule DB)				
8. Other invested assets (Schedule BA)				1,175,000
9. Receivables for securities				
10. Securities lending reinvested collateral assets (Schedule DL)				
11. Aggregate write-ins for invested assets				
12. Subtotals, cash and invested assets (Lines 1 to 11)	166,174,030		166,174,030	66,525,715
13. Title plants less \$ 0 charged off (for Title insurers only)				
14. Investment income due and accrued	151,723		151,723	34,389
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	6,723,193		6,723,193	3,968,749
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including \$ 0 earned but unbilled premiums)				
15.3 Accrued retrospective premiums	18,254,005		18,254,005	2,102,135
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers	16,752		16,752	
16.2 Funds held by or deposited with reinsured companies				
16.3 Other amounts receivable under reinsurance contracts				
17. Amounts receivable relating to uninsured plans				2,853,901
18.1 Current federal and foreign income tax recoverable and interest thereon				
18.2 Net deferred tax asset	1,408,149		1,408,149	
19. Guaranty funds receivable or on deposit				
20. Electronic data processing equipment and software	3,908,875	3,256,837	652,038	293,861
21. Furniture and equipment, including health care delivery assets (\$ 0)	2,278,833	2,278,833		
22. Net adjustment in assets and liabilities due to foreign exchange rates				
23. Receivables from parent, subsidiaries and affiliates	539,430	539,430		
24. Health care (\$ 3,956,019) and other amounts receivable	12,218,697	5,760,925	6,457,772	1,823,738
25. Aggregate write-ins for other-than-invested assets	4,661,632	4,651,632	10,000	10,000
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	216,335,319	16,487,657	199,847,662	77,612,488
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts				
28. Total (Lines 26 and 27)	216,335,319	16,487,657	199,847,662	77,612,488

DETAILS OF WRITE-IN LINES				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page				
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)				
2501. GOODWILL	3,128,663	3,128,663		
2502. PREPAID ASSETS	977,936	977,936		
2503. DEPOSITS	471,367	461,367	10,000	10,000
2598. Summary of remaining write-ins for Line 25 from overflow page	83,666	83,666		
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	4,661,632	4,651,632	10,000	10,000

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc**

LIABILITIES, CAPITAL AND SURPLUS

	Current Year			Prior Year
	1 Covered	2 Uncovered	3 Total	4 Total
1. Claims unpaid (less \$ 0 reinsurance ceded)	88,751,134		88,751,134	43,953,611
2. Accrued medical incentive pool and bonus amounts	19,935,533		19,935,533	9,461,943
3. Unpaid claims adjustment expenses	902,056		902,056	507,857
4. Aggregate health policy reserves, including the liability of \$ 0 for medical loss ratio rebate per the Public Health Services Act	3,720,208		3,720,208	1,207,224
5. Aggregate life policy reserves				
6. Property/casualty unearned premium reserves				
7. Aggregate health claim reserves				
8. Premiums received in advance	37,952,074		37,952,074	646,805
9. General expenses due or accrued	10,133,112		10,133,112	7,657,097
10.1. Current federal and foreign income tax payable and interest thereon (including \$ 0 on realized gains (losses))	5,256,165		5,256,165	331,831
10.2. Net deferred tax liability				25,220
11. Ceded reinsurance premiums payable				
12. Amounts withheld or retained for the account of others				
13. Remittances and items not allocated				
14. Borrowed money (including \$ 0 current) and interest thereon \$ 0 (including \$ 0 current)				
15. Amounts due to parent, subsidiaries and affiliates	64,241		64,241	95,306
16. Derivatives				
17. Payable for securities				
18. Payable for securities lending				
19. Funds held under reinsurance treaties (with \$ 0 authorized reinsurers, \$ 0 unauthorized reinsurers and \$ 0 certified reinsurers)				
20. Reinsurance in unauthorized and certified \$ (0) companies				
21. Net adjustments in assets and liabilities due to foreign exchange rates				
22. Liability for amounts held under uninsured plans				425,227
23. Aggregate write-ins for other liabilities (including \$ 0 current)	5,813,847		5,813,847	
24. Total liabilities (Lines 1 to 23)	172,528,370		172,528,370	64,312,121
25. Aggregate write-ins for special surplus funds	X X X	X X X	9,169,007	
26. Common capital stock	X X X	X X X	57	57
27. Preferred capital stock	X X X	X X X		
28. Gross paid in and contributed surplus	X X X	X X X	5,714,050	5,714,050
29. Surplus notes	X X X	X X X	20,559,808	20,559,808
30. Aggregate write-ins for other than special surplus funds	X X X	X X X		
31. Unassigned funds (surplus)	X X X	X X X	(8,123,629)	(12,973,548)
32. Less treasury stock, at cost:				
32.1 0 shares common (value included in Line 26 \$ 0)	X X X	X X X		
32.2 0 shares preferred (value included in Line 27 \$ 0)	X X X	X X X		
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	X X X	X X X	27,319,293	13,300,367
34. Total liabilities, capital and surplus (Lines 24 and 33)	X X X	X X X	199,847,663	77,612,488

DETAILS OF WRITE-IN LINES				
2301. 2014 Fee Year / 2013 Data Year ACA tax Liability	5,813,847		5,813,847	
2302.				
2303.				
2398. Summary of remaining write-ins for Line 23 from overflow page				
2399. Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	5,813,847		5,813,847	
2501. 2015 Fee Year / 2014 Data Year ACA tax liability	X X X	X X X	9,169,007	
2502.	X X X	X X X		
2503.	X X X	X X X		
2598. Summary of remaining write-ins for Line 25 from overflow page	X X X	X X X		
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	X X X	X X X	9,169,007	
3001.	X X X	X X X		
3002.	X X X	X X X		
3003.	X X X	X X X		
3098. Summary of remaining write-ins for Line 30 from overflow page	X X X	X X X		
3099. Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	X X X	X X X		

NONE

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

STATEMENT OF REVENUE AND EXPENSES

	Current Year		Prior Year
	1 Uncovered	2 Total	3 Total
1. Member Months	X X X	1,103,246	667,160
2. Net premium income (including \$ 0 non-health premium income)	X X X	834,607,654	423,383,150
3. Change in unearned premium reserves and reserve for rate credits	X X X		
4. Fee-for-service (net of \$ 0 medical expenses)	X X X		
5. Risk revenue	X X X		
6. Aggregate write-ins for other health care related revenues	X X X		
7. Aggregate write-ins for other non-health revenues	X X X		
8. Total revenues (Lines 2 to 7)	X X X	834,607,654	423,383,150
Hospital and Medical:			
9. Hospital/medical benefits		269,669,370	159,298,866
10. Other professional services		195,683,752	93,125,325
11. Outside referrals			
12. Emergency room and out-of-area			
13. Prescription drugs		231,191,519	85,564,148
14. Aggregate write-ins for other hospital and medical			
15. Incentive pool, withhold adjustments and bonus amounts		43,440,525	27,620,718
16. Subtotal (Lines 9 to 15)		739,985,166	365,609,057
Less:			
17. Net reinsurance recoveries		661,022	
18. Total hospital and medical (Lines 16 minus 17)		739,324,144	365,609,057
19. Non-health claims (net)			
20. Claims adjustment expenses, including \$ 0 cost containment expenses		7,031,268	3,816,454
21. General administrative expenses		65,803,921	41,421,479
22. Increase in reserves for life and accident and health contracts (including \$ 0 increase in reserves for life only)			
23. Total underwriting deductions (Lines 18 through 22)		812,159,333	410,846,990
24. Net underwriting gain or (loss) (Lines 8 minus 23)	X X X	22,448,321	12,536,160
25. Net investment income earned (Exhibit of Net Investment Income, Line 17)		275,839	165,635
26. Net realized capital gains (losses) less capital gains tax of \$ 0		11,165	
27. Net investment gains (losses) (Lines 25 plus 26)		287,004	165,635
28. Net gain or (loss) from agents' or premium balances charged off [(amount recovered \$ 0) (amount charged off \$ 0)]		(99,140)	
29. Aggregate write-ins for other income or expenses			(85,524)
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	X X X	22,636,185	12,616,271
31. Federal and foreign income taxes incurred	X X X	10,779,455	4,480,729
32. Net income (loss) (Lines 30 minus 31)	X X X	11,856,730	8,135,542

DETAILS OF WRITE-IN LINES			
0601.	NONE	X X X	
0602.	NONE	X X X	
0603.	NONE	X X X	
0698. Summary of remaining write-ins for Line 06 from overflow page	NONE	X X X	
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 06 above)	NONE	X X X	
0701.	NONE	X X X	
0702.	NONE	X X X	
0703.	NONE	X X X	
0798. Summary of remaining write-ins for Line 07 from overflow page	NONE	X X X	
0799. Totals (Lines 0701 through 0703 plus 0798) (Line 07 above)	NONE	X X X	
1401.	NONE		
1402.	NONE		
1403.	NONE		
1498. Summary of remaining write-ins for Line 14 from overflow page	NONE		
1499. Totals (Lines 1401 through 1403 plus 1498) (Line 14 above)	NONE		
2901. FINES AND PENALTIES			(85,524)
2902.			
2903.			
2998. Summary of remaining write-ins for Line 29 from overflow page			
2999. Totals (Lines 2901 through 2903 plus 2998) (Line 29 above)			(85,524)

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

STATEMENT OF REVENUE AND EXPENSES (Continued)

	1	2
	Current Year	Prior Year
CAPITAL & SURPLUS ACCOUNT		
33. Capital and surplus prior reporting year	13,300,367	10,961,337
34. Net income or (loss) from Line 32	11,856,730	8,135,542
35. Change in valuation basis of aggregate policy and claim reserves		
36. Change in net unrealized capital gains (losses) less capital gains tax of \$ 0	(679,063)	(394,040)
37. Change in net unrealized foreign exchange capital gain or (loss)		
38. Change in net deferred income tax	1,433,369	(256,723)
39. Change in nonadmitted assets	1,407,890	(6,075,624)
40. Change in unauthorized and certified reinsurance		
41. Change in treasury stock		
42. Change in surplus notes		1,000,000
43. Cumulative effect of changes in accounting principles		
44. Capital Changes:		
44.1 Paid in		
44.2 Transferred from surplus (Stock Dividend)		
44.3 Transferred to surplus		
45. Surplus adjustments:		
45.1 Paid in		(70,125)
45.2 Transferred to capital (Stock Dividend)		
45.3 Transferred from capital		
46. Dividends to stockholders		
47. Aggregate write-ins for gains or (losses) in surplus		
48. Net change in capital and surplus (Lines 34 to 47)	14,018,926	2,339,030
49. Capital and surplus end of reporting year (Line 33 plus 48)	27,319,293	13,300,367

DETAILS OF WRITE-IN LINES		
4701.		
4702.		
4703.		
4798. Summary of remaining write-ins for Line 47 from overflow page		
4799. Totals (Lines 4701 through 4703 plus 4798) (Line 47 above)		

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

CASH FLOW

	1	2
	Current Year	Prior Year
Cash from Operations		
1. Premiums collected net of reinsurance	855,519,593	415,409,607
2. Net investment income	197,568	148,734
3. Miscellaneous income		
4. Total (Lines 1 through 3)	855,717,161	415,558,341
5. Benefit and loss related payments	692,868,431	331,158,013
6. Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts		
7. Commissions, expenses paid and aggregate write-ins for deductions	66,225,363	45,227,931
8. Dividends paid to policyholders		
9. Federal and foreign income taxes paid (recovered) net of \$ 0 tax on capital gains (losses)	5,855,121	4,070,987
10. Total (Lines 5 through 9)	764,948,915	380,456,931
11. Net cash from operations (Line 4 minus Line 10)	90,768,246	35,101,410
Cash from Investments		
12. Proceeds from investments sold, matured or repaid:		
12.1 Bonds	1,862,139	
12.2 Stocks		
12.3 Mortgage loans		
12.4 Real estate		
12.5 Other invested assets	1,175,000	
12.6 Net gains or (losses) on cash, cash equivalents and short-term investments		
12.7 Miscellaneous proceeds		
12.8 Total investment proceeds (Lines 12.1 to 12.7)	3,037,139	
13. Cost of investments acquired (long-term only):		
13.1 Bonds	15,076,661	2,250,000
13.2 Stocks		
13.3 Mortgage loans		
13.4 Real estate		
13.5 Other invested assets		1,175,000
13.6 Miscellaneous applications		
13.7 Total investments acquired (Lines 13.1 to 13.6)	15,076,661	3,425,000
14. Net increase (decrease) in contract loans and premium notes		
15. Net cash from investments (Line 12.8 minus Line 13.7 minus Line 14)	(12,039,522)	(3,425,000)
Cash from Financing and Miscellaneous Sources		
16. Cash provided (applied):		
16.1 Surplus notes, capital notes		1,000,000
16.2 Capital and paid in surplus, less treasury stock		(70,125)
16.3 Borrowed funds		
16.4 Net deposits on deposit-type contracts and other insurance liabilities		
16.5 Dividends to stockholders		
16.6 Other cash provided (applied)	8,907,968	(8,718,687)
17. Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6)	8,907,968	(7,788,812)
RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS		
18. Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	87,636,692	23,887,598
19. Cash, cash equivalents and short-term investments:		
19.1 Beginning of year	63,100,715	39,213,117
19.2 End of year (Line 18 plus Line 19.1)	150,737,407	63,100,715
Note: Supplemental disclosures of cash flow information for non-cash transactions:		
20.0001		
20.0002		
20.0003		

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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Net premium income	834,607,654						448,681,426	385,936,973	(10,745)	
2. Change in unearned premium reserves and reserve for rate credit										
3. Fee-for-service (net of \$ 0 medical expenses)										X X X
4. Risk revenue										X X X
5. Aggregate write-ins for other health care related revenues										X X X
6. Aggregate write-ins for other non-health care related revenues		X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	
7. Total revenues (Lines 1 to 6)	834,607,654						448,681,426	385,936,973	(10,745)	
8. Hospital/medical benefits	269,669,370						158,126,328	111,551,300	(8,258)	X X X
9. Other professional services	195,683,752						121,410,948	74,271,807	997	X X X
10. Outside referrals										X X X
11. Emergency room and out-of-area										X X X
12. Prescription drugs	231,191,519						89,878,526	141,312,993		X X X
13. Aggregate write-ins for other hospital and medical										X X X
14. Incentive pool, withhold adjustments and bonus amounts	43,440,525						28,177,397	15,263,128		X X X
15. Subtotal (Lines 8 to 14)	739,985,166						397,593,199	342,399,228	(7,261)	X X X
16. Net reinsurance recoveries	661,022						612,269	48,753		X X X
17. Total hospital and medical (Lines 15 minus 16)	739,324,144						396,980,930	342,350,475	(7,261)	X X X
18. Non-health claims (net)		X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	
19. Claims adjustment expenses including \$ 0 cost containment expenses	7,031,268						3,926,876	3,104,392		
20. General administrative expenses	65,803,921						37,608,757	28,040,743	154,421	
21. Increase in reserves for accident and health contracts										X X X
22. Increase in reserves for life contracts		X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	
23. Total underwriting deductions (Lines 17 to 22)	812,159,333						438,516,563	373,495,610	147,160	
24. Net underwriting gain or (loss) (Line 7 minus Line 23)	22,448,321						10,164,863	12,441,363	(157,905)	

DETAILS OF WRITE-IN LINES										
0501.										X X X
0502.										X X X
0503.										X X X
0598. Summary of remaining write-ins for Line 05 from overflow page										X X X
0599. Totals (Lines 0501 through 0503 plus 0598) (Line 05 above)										X X X
0601.		X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	
0602.		X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	
0603.		X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	
0698. Summary of remaining write-ins for Line 06 from overflow page		X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 06 above)		X X X	X X X	X X X	X X X	X X X	X X X	X X X	X X X	
1301.										X X X
1302.										X X X
1303.										X X X
1398. Summary of remaining write-ins for Line 13 from overflow page										X X X
1399. Totals (Lines 1301 through 1303 plus 1398) (Line 13 above)										X X X

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

UNDERWRITING AND INVESTMENT EXHIBIT
PART 1 – PREMIUMS

Line of Business	1 Direct Business	2 Reinsurance Assumed	3 Reinsurance Ceded	4 Net Premium Income (Cols. 1 + 2 - 3)
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Benefits Plan				
6. Title XVIII – Medicare	449,461,130		779,703	448,681,427
7. Title XIX – Medicaid	386,444,161		507,189	385,936,972
8. Other health	(10,745)			(10,745)
9. Health subtotal (Lines 1 through 8)	835,894,546		1,286,892	834,607,654
10. Life				
11. Property/casualty				
12. Totals (Lines 9 to 11)	835,894,546		1,286,892	834,607,654

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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

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UNDERWRITING AND INVESTMENT EXHIBIT

PART 2 – CLAIMS INCURRED DURING THE YEAR

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Payments during the year:										
1.1 Direct	660,922,887						371,925,665	289,004,483	(7,261)	
1.2 Reinsurance assumed										
1.3 Reinsurance ceded	644,270						595,517	48,753		
1.4 Net	660,278,617						371,330,148	288,955,730	(7,261)	
2. Paid medical incentive pools and bonuses	32,589,814						19,212,044	13,377,770		
3. Claim liability December 31, current year from Part 2A:										
3.1 Direct	88,751,134						32,472,715	56,278,419		
3.2 Reinsurance assumed										
3.3 Reinsurance ceded										
3.4 Net	88,751,134						32,472,715	56,278,419		
4. Claim reserve December 31, current year from Part 2D:										
4.1 Direct										
4.2 Reinsurance assumed										
4.3 Reinsurance ceded										
4.4 Net										
5. Accrued medical incentive pools and bonuses, current year	19,246,979						12,692,279	6,554,700		
6. Net healthcare receivables (a)	9,175,769						4,926,891	4,248,878		
7. Amounts recoverable from reinsurers December 31, current year	16,752						16,752			
8. Claim liability December 31, prior year from Part 2A:										
8.1 Direct	43,953,611						30,055,687	13,897,924		
8.2 Reinsurance assumed										
8.3 Reinsurance ceded										
8.4 Net	43,953,611						30,055,687	13,897,924		
9. Claim reserve December 31, prior year from Part 2D:										
9.1 Direct										
9.2 Reinsurance assumed										
9.3 Reinsurance ceded										
9.4 Net										
10. Accrued medical incentive pools and bonuses, prior year	8,396,268						3,726,926	4,669,342		
11. Amounts recoverable from reinsurers December 31, prior year										
12. Incurred benefits:										
12.1 Direct	696,544,641						369,415,802	327,136,100	(7,261)	
12.2 Reinsurance assumed										
12.3 Reinsurance ceded	661,022						612,269	48,753		
12.4 Net	695,883,619						368,803,533	327,087,347	(7,261)	
13. Incurred medical incentive pools and bonuses	43,440,525						28,177,397	15,263,128		

(a) Excludes \$ 0 loans or advances to providers not yet expensed.

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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2B – ANALYSIS OF CLAIMS UNPAID – PRIOR YEAR-NET OF REINSURANCE

Line of Business	Claims Paid During the Year		Claim Reserve and Claim Liability December 31 of Current Year		5	6
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid December 31 of Prior Year	4 On Claims Incurred During the Year	Claims Incurred in Prior Years (Columns 1 + 3)	Estimated Claim Reserve and Claim Liability December 31 of Prior Year
1. Comprehensive (hospital and medical)						
2. Medicare Supplement						
3. Dental only						
4. Vision only						
5. Federal Employees Health Benefits Plan						
6. Title XVIII – Medicare	26,988,264	344,341,884	223,801	32,248,914	27,212,065	30,055,687
7. Title XIX – Medicaid	17,010,383	271,945,348	490,585	55,787,834	17,500,968	13,897,924
8. Other health	(7,261)				(7,261)	
9. Health subtotal (Lines 1 to 8)	43,991,386	616,287,232	714,386	88,036,748	44,705,772	43,953,611
10. Health care receivables (a)	710,829			9,881,076	710,829	1,065,675
11. Other non-health						
12. Medical incentive pools and bonus amounts	12,608,887	20,691,755		19,935,534	12,608,887	9,461,943
13. Totals (Lines 9 - 10 + 11 + 12)	55,889,444	636,978,987	714,386	98,091,206	56,603,830	52,349,879

(a) Excludes \$ 0 loans or advances to providers not yet expensed.

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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Hospital & Medical

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	0	0	0	0	0
2. 2010	0	0	0	0	0
3. 2011	X X X	X X X	X X X	X X X	0
4. 2012	X X X	X X X	0	0	0
5. 2013	X X X	X X X	X X X	0	0
6. 2014	X X X	X X X	X X X	X X X	0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	0	0	0	0	0
2. 2010	0	0	0	0	0
3. 2011	X X X	X X X	X X X	X X X	0
4. 2012	X X X	X X X	0	0	0
5. 2013	X X X	X X X	X X X	0	0
6. 2014	X X X	X X X	X X X	X X X	0

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2010	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2014	0	0	0	0.000	0	0.000	0	0	0	0.000

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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Medicare Supplement

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	0	0	0	0	0
2. 2010	0	0	0	0	0
3. 2011	X X X	X X X	X X X	X X X	0
4. 2012	X X X	X X X	0	0	0
5. 2013	X X X	X X X	X X X	0	0
6. 2014	X X X	X X X	X X X	X X X	0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	0	0	0	0	0
2. 2010	0	0	0	0	0
3. 2011	X X X	X X X	X X X	X X X	0
4. 2012	X X X	X X X	0	0	0
5. 2013	X X X	X X X	X X X	0	0
6. 2014	X X X	X X X	X X X	X X X	0

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2010	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2014	0	0	0	0.000	0	0.000	0	0	0	0.000

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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Dental Only

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	0	0	0	0	0
2. 2010	0	0	0	0	0
3. 2011	X X X	X X X	X X X	X X X	0
4. 2012	X X X	X X X	0	0	0
5. 2013	X X X	X X X	X X X	0	0
6. 2014	X X X	X X X	X X X	X X X	0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	0	0	0	0	0
2. 2010	0	0	0	0	0
3. 2011	X X X	X X X	X X X	X X X	0
4. 2012	X X X	X X X	0	0	0
5. 2013	X X X	X X X	X X X	0	0
6. 2014	X X X	X X X	X X X	X X X	0

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2010	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2014	0	0	0	0.000	0	0.000	0	0	0	0.000

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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Vision Only

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	0	0	0	0	0
2. 2010	0	0	0	0	0
3. 2011	X X X	X X X	X X X	X X X	0
4. 2012	X X X	X X X	0	0	0
5. 2013	X X X	X X X	X X X	0	0
6. 2014	X X X	X X X	X X X	X X X	0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	0	0	0	0	0
2. 2010	0	0	0	0	0
3. 2011	X X X	X X X	X X X	X X X	0
4. 2012	X X X	X X X	0	0	0
5. 2013	X X X	X X X	X X X	0	0
6. 2014	X X X	X X X	X X X	X X X	0

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2010	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2014	0	0	0	0.000	0	0.000	0	0	0	0.000

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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS

(000 Omitted)

Fed Emp Health Benefits Plan

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	0	0	0	0	0
2. 2010	0	0	0	0	0
3. 2011	X X X	X X X	X X X	X X X	0
4. 2012	X X X	X X X	0	0	0
5. 2013	X X X	X X X	X X X	0	0
6. 2014	X X X	X X X	X X X	X X X	0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	0	0	0	0	0
2. 2010	0	0	0	0	0
3. 2011	X X X	X X X	X X X	X X X	0
4. 2012	X X X	X X X	0	0	0
5. 2013	X X X	X X X	X X X	0	0
6. 2014	X X X	X X X	X X X	X X X	0

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2010	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2014	0	0	0	0.000	0	0.000	0	0	0	0.000

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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Title XVIII - Medicare

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	0	0	0	0	0
2. 2010	0	0	0	0	0
3. 2011	X X X	0	0	0	0
4. 2012	X X X	X X X	40,373	47,474	47,196
5. 2013	X X X	X X X	X X X	192,479	225,978
6. 2014	X X X	X X X	X X X	X X X	356,725

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	0	0	0	0	0
2. 2010	0	0	0	0	0
3. 2011	X X X	0	0	0	0
4. 2012	X X X	X X X	47,891	47,474	47,196
5. 2013	X X X	X X X	X X X	226,262	226,202
6. 2014	X X X	X X X	X X X	X X X	396,723

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2010	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2012	61,183	47,196	244	0.517	47,440	77.538	0	0	47,440	77.538
4. 2013	254,014	225,978	2,709	1.199	228,687	90.029	224	0	228,911	90.117
5. 2014	448,681	356,725	3,423	0.960	360,148	80.268	39,998	504	400,650	89.295

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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Title XIX - Medicaid

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	8,498	9,025	9,027	9,021	9,021
2. 2010	9,250	12,300	12,751	12,699	12,689
3. 2011	X X X	26,350	32,606	32,786	32,591
4. 2012	X X X	X X X	57,956	66,651	66,314
5. 2013	X X X	X X X	X X X	122,702	145,927
6. 2014	X X X	X X X	X X X	X X X	279,658

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	11,645	9,025	9,027	9,021	9,021
2. 2010	4,903	12,388	12,839	12,699	12,689
3. 2011	X X X	33,610	40,210	32,786	32,591
4. 2012	X X X	X X X	67,878	66,651	66,313
5. 2013	X X X	X X X	X X X	141,269	146,410
6. 2014	X X X	X X X	X X X	X X X	337,752

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2010	14,633	12,689	0	0.000	12,689	86.715	0	0	12,689	86.715
2. 2011	41,104	32,591	0	0.000	32,591	79.289	0	0	32,591	79.289
3. 2012	87,228	66,313	210	0.317	66,523	76.263	0	0	66,523	76.263
4. 2013	169,427	145,920	1,426	0.977	147,346	86.967	490	0	147,836	87.256
5. 2014	385,937	279,658	2,706	0.968	282,364	73.163	58,094	398	340,856	88.319

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UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Other

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	60	61	61	61	61
2. 2010	611	802	789	790	790
3. 2011	X X X	1,594	1,719	1,727	1,723
4. 2012	X X X	X X X	1,621	1,671	1,668
5. 2013	X X X	X X X	X X X	0	0
6. 2014	X X X	X X X	X X X	X X X	0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	202	61	61	61	61
2. 2010	511	955	955	790	790
3. 2011	X X X	2,236	2,237	1,727	1,723
4. 2012	X X X	X X X	114	1,671	1,668
5. 2013	X X X	X X X	X X X	0	0
6. 2014	X X X	X X X	X X X	X X X	0

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2010	1,236	790	0	0.000	790	63.916	0	0	790	63.916
2. 2011	2,375	1,723	0	0.000	1,723	72.547	0	0	1,723	72.547
3. 2012	1,449	1,668	7	0.420	1,675	115.597	0	0	1,675	115.597
4. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2014	(11)	0	0	0.000	0	0.000	0	0	0	0.000

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UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Grand Total

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	8,558	9,086	9,088	9,082	9,082
2. 2010	9,861	13,102	13,540	13,489	13,479
3. 2011	X X X	27,944	34,325	34,513	34,314
4. 2012	X X X	X X X	99,950	115,796	115,178
5. 2013	X X X	X X X	X X X	315,181	371,905
6. 2014	X X X	X X X	X X X	X X X	636,383

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	11,847	9,086	9,088	9,082	9,082
2. 2010	5,414	13,343	13,794	13,489	13,479
3. 2011	X X X	35,846	42,447	34,513	34,314
4. 2012	X X X	X X X	115,883	115,796	115,177
5. 2013	X X X	X X X	X X X	367,531	372,612
6. 2014	X X X	X X X	X X X	X X X	734,475

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2010	15,869	13,479	0	0.000	13,479	84.939	0	0	13,479	84.939
2. 2011	43,479	34,314	0	0.000	34,314	78.921	0	0	34,314	78.921
3. 2012	149,860	115,177	461	0.400	115,638	77.164	0	0	115,638	77.164
4. 2013	423,441	371,898	4,135	1.112	376,033	88.804	714	0	376,747	88.973
5. 2014	834,607	636,383	6,129	0.963	642,512	76.984	98,092	902	741,506	88.845

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UNDERWRITING AND INVESTMENT EXHIBIT
PART 2D – AGGREGATE RESERVE FOR ACCIDENT AND HEALTH CONTRACTS ONLY

	1	2	3	4	5	6	7	8	9
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
1. Unearned premium reserves									
2. Additional policy reserves (a)									
3. Reserve for future contingent benefits									
4. Reserve for rate credits or experience rating refunds (including \$ 0 for investment income)	3,720,208						3,012,925	638,386	68,897
5. Aggregate write-ins for other policy reserves									
6. Totals (gross)	3,720,208						3,012,925	638,386	68,897
7. Reinsurance ceded									
8. Totals (Net) (Page 3, Line 4)	3,720,208						3,012,925	638,386	68,897
9. Present value of amounts not yet due on claims									
10. Reserve for future contingent benefits									
11. Aggregate write-ins for other claim reserves									
12. Totals (gross)									
13. Reinsurance ceded									
14. Totals (Net) (Page 3, Line 7)									

DETAILS OF WRITE-IN LINES									
0501.									
0502.									
0503.									
0598. Summary of remaining write-ins for Line 05 from overflow page									
0599. Totals (Lines 0501 through 0503 plus 0598) (Line 05 above)									
1101.									
1102.									
1103.									
1198. Summary of remaining write-ins for Line 11 from overflow page									
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)									

(a) Includes \$ 0 premium deficiency reserve.

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

UNDERWRITING AND INVESTMENT EXHIBIT
PART 3 – ANALYSIS OF EXPENSES

	Claim Adjustment Expenses		3	4	5
	1	2			
	Cost Containment Expenses	Other Claim Adjustment Expenses	General Administrative Expenses	Investment Expenses	Total
1. Rent (\$ 0 for occupancy of own building)			2,067,019		2,067,019
2. Salaries, wages and other benefits		2,556,172	51,138,360		53,694,532
3. Commissions (less \$ 0 ceded plus \$ 0 assumed)			7,321,181		7,321,181
4. Legal fees and expenses			405,564		405,564
5. Certifications and accreditation fees			186,139		186,139
6. Auditing, actuarial and other consulting services		146,590	8,121,276		8,267,866
7. Traveling expenses		11,950	1,216,329		1,228,279
8. Marketing and advertising			8,638,207		8,638,207
9. Postage, express and telephone		299,801	3,070,065		3,369,866
10. Printing and office supplies		539,896	2,233,679		2,773,575
11. Occupancy, depreciation and amortization		138,503	2,529,159		2,667,662
12. Equipment			265		265
13. Cost or depreciation of EDP equipment and software		3,000,645	3,953,580		6,954,225
14. Outsourced services including EDP, claims, and other services		162,444	134,773		297,217
15. Boards, bureaus and association fees					
16. Insurance, except on real estate			1,199,489		1,199,489
17. Collection and bank service charges			358,850		358,850
18. Group service and administration fees			(36,493,224)		(36,493,224)
19. Reimbursements by uninsured plans					
20. Reimbursements from fiscal intermediaries					
21. Real estate expenses					
22. Real estate taxes					
23. Taxes, licenses and fees:					
23.1 State and local insurance taxes			1,851,720		1,851,720
23.2 State premium taxes					
23.3 Regulatory authority licenses and fees					
23.4 Payroll taxes		175,270	3,760,710		3,935,980
23.5 Other (excluding federal income and real estate taxes)			3,540,533		3,540,533
24. Investment expenses not included elsewhere					
25. Aggregate write-ins for expenses			570,244		570,244
26. Total expenses incurred (Lines 1 to 25)		7,031,271	65,803,918	(a)	72,835,189
27. Less expenses unpaid December 31, current year		902,056	10,133,112		11,035,168
28. Add expenses unpaid December 31, prior year		507,857	7,657,097		8,164,954
29. Amounts receivable relating to uninsured plans, prior year			(425,227)		(425,227)
30. Amounts receivable relating to uninsured plans, current year					
31. Total expenses paid (Lines 26 minus 27 plus 28 minus 29 plus 30)		6,637,072	63,753,130		70,390,202

DETAILS OF WRITE-IN LINES					
2501. Charitable Contributions			184,463		184,463
2502. Interest Expense			187,966		187,966
2503. Other Expenses			197,815		197,815
2598. Summary of remaining write-ins for Line 25 from overflow page					
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)			570,244		570,244

(a) Includes management fees of \$ 0 to affiliates and \$ 0 to non-affiliates.

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc**

EXHIBIT OF NET INVESTMENT INCOME

	1 Collected During Year	2 Earned During Year
1. U.S. Government bonds	(a)	
1.1 Bonds exempt from U.S. tax	(a)	
1.2 Other bonds (unaffiliated)	(a) (13,395)	49,930
1.3 Bonds of affiliates	(a)	
2.1 Preferred stocks (unaffiliated)	(b)	
2.11 Preferred stocks of affiliates	(b)	
2.2 Common stocks (unaffiliated)		
2.21 Common stocks of affiliates		
3. Mortgage loans	(c)	
4. Real estate	(d)	
5. Contract loans		
6. Cash, cash equivalents and short-term investments	(e) (14,526)	227,050
7. Derivative instruments	(f)	
8. Other invested assets		(1,141)
9. Aggregate write-ins for investment income		
10. Total gross investment income	(27,921)	275,839
11. Investment expenses		(g)
12. Investment taxes, licenses and fees, excluding federal income taxes		(g)
13. Interest expense		(h)
14. Depreciation on real estate and other invested assets		(i)
15. Aggregate write-ins for deductions from investment income		
16. Total deductions (Lines 11 through 15)		
17. Net investment income (Line 10 minus Line 16)		275,839

DETAILS OF WRITE-IN LINES			
0901.	NONE		
0902.			
0903.			
0998. Summary of remaining write-ins for Line 09 from overflow page			
0999. Totals (Lines 0901 through 0903 plus 0998) (Line 09 above)			
1501.	NONE		
1502.			
1503.			
1598. Summary of remaining write-ins for Line 15 from overflow page			
1599. Totals (Lines 1501 through 1503 plus 1598) (Line 15 above)			

- (a) Includes \$ 279 accrual of discount less \$ 39,352 amortization of premium and less \$ 83,163 paid for accrued interest on purchases.
- (b) Includes \$ 0 accrual of discount less \$ 0 amortization of premium and less \$ 0 paid for accrued dividends on purchases.
- (c) Includes \$ 0 accrual of discount less \$ 0 amortization of premium and less \$ 0 paid for accrued interest on purchases.
- (d) Includes \$ 0 for company's occupancy of its own buildings; and excludes \$ 0 interest on encumbrances.
- (e) Includes \$ 0 accrual of discount less \$ 65,171 amortization of premium and less \$ 63,520 paid for accrued interest on purchases.
- (f) Includes \$ 0 accrual of discount less \$ 0 amortization of premium.
- (g) Includes \$ 0 investment expenses and \$ 0 investment taxes, licenses and fees, excluding federal income taxes, attributable to segregated and Separate Accounts.
- (h) Includes \$ 0 interest on surplus notes and \$ 0 interest on capital notes.
- (i) Includes \$ 0 depreciation on real estate and \$ 0 depreciation on other invested assets.

EXHIBIT OF CAPITAL GAINS (LOSSES)

	1 Realized Gain (Loss) on Sales or Maturity	2 Other Realized Adjustments	3 Total Realized Capital Gain (Loss) (Columns 1 + 2)	4 Change in Unrealized Capital Gain (Loss)	5 Change in Unrealized Foreign Exchange Capital Gain (Loss)
1. U.S. Government bonds					
1.1 Bonds exempt from U.S. tax					
1.2 Other bonds (unaffiliated)	11,165		11,165		
1.3 Bonds of affiliates					
2.1 Preferred stocks (unaffiliated)					
2.11 Preferred stocks of affiliates					
2.2 Common stocks (unaffiliated)					
2.21 Common stocks of affiliates					
3. Mortgage loans					
4. Real estate					
5. Contract loans					
6. Cash, cash equivalents and short-term investments					
7. Derivative instruments					
8. Other invested assets					
9. Aggregate write-ins for capital gains (losses)					
10. Total capital gains (losses)	11,165		11,165		

DETAILS OF WRITE-IN LINES					
0901.	NONE				
0902.					
0903.					
0998. Summary of remaining write-ins for Line 09 from overflow page					
0999. Totals (Lines 0901 through 0903 plus 0998) (Line 09 above)					

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

EXHIBIT OF NONADMITTED ASSETS

	1	2	3
	Current Year Total Nonadmitted Assets	Prior Year Total Nonadmitted Assets	Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
1. Bonds (Schedule D)			
2. Stocks (Schedule D):			
2.1 Preferred stocks			
2.2 Common stocks			
3. Mortgage loans on real estate (Schedule B):			
3.1 First liens			
3.2 Other than first liens			
4. Real estate (Schedule A):			
4.1 Properties occupied by the company			
4.2 Properties held for the production of income			
4.3 Properties held for sale			
5. Cash (Schedule E - Part 1), cash equivalents (Schedule E - Part 2) and short-term investments (Schedule DA)			
6. Contract loans			
7. Derivatives (Schedule DB)			
8. Other invested assets (Schedule BA)			
9. Receivables for securities			
10. Securities lending reinvested collateral assets (Schedule DL)			
11. Aggregate write-ins for invested assets			
12. Subtotals, cash and invested assets (Lines 1 to 11)			
13. Title plants (for Title insurers only)			
14. Investment income due and accrued			
15. Premiums and considerations:			
15.1 Uncollected premiums and agents' balances in the course of collection			
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due			
15.3 Accrued retrospective premiums			
16. Reinsurance:			
16.1 Amounts recoverable from reinsurers			
16.2 Funds held by or deposited with reinsured companies			
16.3 Other amounts receivable under reinsurance contracts			
17. Amounts receivable relating to uninsured plans			
18.1 Current federal and foreign income tax recoverable and interest thereon			
18.2 Net deferred tax asset			
19. Guaranty funds receivable or on deposit			
20. Electronic data processing equipment and software	3,256,837	2,964,979	(291,858)
21. Furniture and equipment, including health care delivery assets	2,278,833	2,482,078	203,245
22. Net adjustment in assets and liabilities due to foreign exchange rates			
23. Receivables from parent, subsidiaries and affiliates	539,430	69,682	(469,748)
24. Health care and other amounts receivable	5,760,925	1,788,200	(3,972,725)
25. Aggregate write-ins for other-than-invested assets	4,651,632	10,590,610	5,938,978
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	16,487,657	17,895,549	1,407,892
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts			
28. Total (Lines 26 and 27)	16,487,657	17,895,549	1,407,892

DETAILS OF WRITE-IN LINES			
1101.	NONE		
1102.			
1103.			
1198. Summary of remaining write-ins for Line 11 from overflow page			
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)			
2501. GOODWILL	3,128,663	4,893,920	1,765,257
2502. Prepaid Assets	977,936	1,541,008	563,072
2503. DEPOSITS	461,367	3,821,015	3,359,648
2598. Summary of remaining write-ins for Line 25 from overflow page	83,666	334,667	251,001
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	4,651,632	10,590,610	5,938,978

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.

EXHIBIT 1 – ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS ONLY

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Source of Enrollment	Total Members at End of					6
	1	2	3	4	5	Current Year Member Months
	Prior Year	First Quarter	Second Quarter	Third Quarter	Current Year	
1. Health Maintenance Organizations	66,244	71,964	57,334	113,549	116,166	1,103,246
2. Provider Service Organizations						
3. Preferred Provider Organizations						
4. Point of Service						
5. Indemnity Only						
6. Aggregate write-ins for other lines of business						
7. Total	66,244	71,964	57,334	113,549	116,166	1,103,246

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DETAILS OF WRITE-IN LINES						
0601.		NONE				
0602.						
0603.						
0698. Summary of remaining write-ins for Line 06 from overflow page						
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 06 above)						

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EXHIBIT 3A – ANALYSIS OF HEALTH CARE RECEIVABLES COLLECTED AND ACCRUED

Type of Health Care Receivable	Health Care Receivables Collected During the Year		Health Care Receivables Accrued as of December 31 of Current Year		5 Health Care Receivables in Prior Years (Cols. 1 + 3)	6 Estimated Health Care Receivables Accrued as of December 31 of Prior Year
	1 On Amounts Accrued Prior to January 1 of Current Year	2 On Amounts Accrued During the Year	3 On Amounts Accrued December 31 of Prior Year	4 On Amounts Accrued During the Year		
1. Pharmaceutical rebate receivables	1,805,299			5,410,966	1,805,299	1,805,299
2. Claim overpayment receivables	2,043,684	1,146,153		3,764,803	2,043,684	584,912
3. Loans and advances to providers	16,078	149		9,064	16,078	25,291
4. Capitation arrangement receivables						
5. Risk sharing receivables	584,763			688,555	584,763	584,763
6. Other health care receivables				20,185		
7. Total (Lines 1 through 6)	4,449,824	1,146,302		9,893,573	4,449,824	3,000,265

Note that the accrued amounts in Columns 3, 4 and 6 are the total health care receivables, not just the admitted portion.

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Payment Method	1 Direct Medical Expense Payment	2 Column 1 as a % of Total Payments	3 Total Members Covered	4 Column 3 as a % of Total Members	5 Column 1 Expenses Paid to Affiliated Providers	6 Column 1 Expenses Paid to Non-Affiliated Providers
Capitation Payments:						
1. Medical groups	54,759,236	7.903	72,155	62.114		54,759,236
2. Intermediaries						
3. All other providers	17,087,509	2.466	44,011	37.886		17,087,509
4. Total capitation payments	71,846,745	10.369	116,166	100.000		71,846,745
Other Payments:						
5. Fee-for-service	588,431,871	84.927	X X X	X X X		588,431,871
6. Contractual fee payments			X X X	X X X		
7. Bonus/withhold arrangements – fee-for-service			X X X	X X X		
8. Bonus/withhold arrangements – contractual fee payments	32,589,814	4.704	X X X	X X X		32,589,814
9. Non-contingent salaries			X X X	X X X		
10. Aggregate cost arrangements			X X X	X X X		
11. All other payments			X X X	X X X		
12. Total other payments	621,021,685	89.631	X X X	X X X		621,021,685
13. Total (Line 4 plus Line 12)	692,868,430	100.000	X X X	X X X		692,868,430

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NONE

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EXHIBIT 8 – FURNITURE, EQUIPMENT AND SUPPLIES OWNED

	1	2	3	4	5	6
Description	Cost	Improvements	Accumulated Depreciation	Book Value Less Encumbrances	Assets Not Admitted	Net Admitted Assets
1. Administrative furniture and equipment	5,334,279	0	2,285,511	0	2,278,833	0
2. Medical furniture, equipment and fixtures	0	0	0	0	0	0
3. Pharmaceuticals and surgical supplies	0	0	0	0	0	0
4. Durable medical equipment	0	0	0	0	0	0
5. Other property and equipment	0	0	0	0	0	0
6. Total	5,334,279	0	2,285,511	0	2,278,833	0

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.

NOTES TO FINANCIAL STATEMENTS

Organization

Simply Healthcare Plans, Inc. (“the Company”) is a for-profit health maintenance organization incorporated in the State of Florida and licensed under Chapter 641 of the Florida Statutes. The Company is a wholly owned subsidiary of Simply Healthcare Holdings, Inc., (“the Parent”), a Florida corporation.

In April 2010, the Company entered into an Asset Purchase Agreement, as amended, with Total Health Choice, Inc. (“Total”), whereby certain assets and liabilities of Total were acquired by the Company and the Company assumed the Medicaid and State Child Health Improvement Program contracts of Total in the State of Florida.

In August 2011, the Company entered into a contract with Centers for Medicaid and Medicare as a Medicare Advantage provider. The Company began enrolling Medicare member effective January 1, 2012.

In February 2012, the Company under its d/b/a Clear Health Alliance (“Clear”) entered into a contract with the State of Florida to provide Medicaid benefits to members with certain chronic conditions. The first members were effective with the Company on April 1, 2012.

On April 11, 2013, the Company entered into an agreement with their affiliate, Better Health, LLC (“Better Health”), whereby both companies agreed to purchase and sell Medicaid members in different regions in the state of Florida. The purchase agreement of the Medicaid members were transferred at their respective and fair values which resulted in a payable balance of approximately \$70,000 due to Better Health.

During 2012, the Agency for Health Care Administration, the chief health policy and planning entity for the state of Florida, released information for Health Maintenance Organizations and Provider Service Networks to competitively bid for the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program. In 2013, the Company was awarded a five year contract in ten regions for Clear and in one region for the Company commencing May and July 2014, respectively.

On December 19, 2014, Simply Healthcare Holdings, the parent company of Simply, entered into an Agreement and Plan of Merger (“Purchase Agreement”) with a subsidiary of Anthem, Inc. Based on receipt of all federal and state regulatory approvals, the acquisition was finalized and closed on February 17, 2015.

1. Significant Accounting Policies

A. Accounting Practices

The accompanying statutory financial statements have been prepared in conformity with statutory accounting practices prescribed or permitted by the Florida Office of Insurance Regulation. The Florida Office of Insurance Regulation has adopted the National Association of Insurance Commissioners statutory accounting practices (NAIC SAP) as the basis of its statutory accounting practice. NAIC SAP is a comprehensive basis of accounting and differs from accounting principles generally accepted in the United States of America ("GAAP"). Prescribed statutory accounting practices include a variety of publication of the NAIC, as well as state laws, regulations and general administrative rules.

A reconciliation of the Company’s net income and capital and surplus between NAIC SAP and practices prescribed and permitted by the State of Florida is shown below:

		<u>2014</u>	<u>2013</u>
Net Income	State of Domicile		
1 Net Income state basis	FL	11,856,730	8,135,542
2 State Prescribed Practices (Income):		-	-
3 State Permitted Practices (Income):		-	-
4 Net Income, NAIC SAP		11,856,730	8,135,542
Surplus	State of Domicile		
5 Statutory Surplus state basis	FL	27,319,293	13,300,367
6 State Prescribed Practices (Surplus):		-	-
7 State Permitted Practices (Surplus):		-	-

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

NOTES TO FINANCIAL STATEMENTS

8	Statutory Surplus, NAIC SAP	27,319,293	13,300,367
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B. Use of Estimates in the Preparation of the Financial Statements

The preparation of statutory-basis financial statements requires management to make estimates and assumptions that affect the reported amounts of admitted assets and liabilities and disclosure of admitted assets and contingent liabilities at the date of the statutory-basis financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

C. Accounting Policy

The following is a summary of the significant accounting policies followed by the Company.

Under statutory accounting, certain assets designated as "non-admitted assets" (principally premiums over 90 days past due (excludes governmental premiums receivables), prepaid expenses, software in development, and office furniture and equipment) are charged directly to surplus. Under GAAP, the Company would be required to maintain a reserve for doubtful accounts based upon estimated collectability while office furniture and equipment would be carried on the balance sheet at cost and depreciated over its estimated useful life.

Under statutory accounting, the statement of cash flow does not provide for a reconciliation of indirect cash flows.

Under statutory accounting, a statement of comprehensive income is not provided.

Under statutory accounting, goodwill is being amortized over a 10 year period.

Under statutory accounting, unpaid claims and claims adjustment expenses are presented net of reinsurance on the statements of admitted assets, liabilities, and capital and surplus. Ceded reserves for losses and loss adjustment expenses have been reported as reductions of the related reserves rather than as assets on the balance sheets as required by GAAP.

Under statutory accounting, deferred income taxes are only recorded for federal income taxes. Such changes in the net deferred tax asset or net deferred tax liability are charged to capital and surplus. The net deferred tax asset is subject to specified limitations. Under GAAP, changes in deferred income taxes are accounted for as a component of net income.

Concentration of Credit Risk

A portion of the Company’s revenue is earned under the Company’s Medicaid contract with the Florida Agency for Healthcare Administration (“AHCA”) (representing approximately 46% and 40% of year to date revenues for the year ending December 31, 2014 and year ending December 31, 2013, respectively.) Additionally, in August 2011, the Company entered into a contract with the Centers for Medicaid and Medicare (“CMS”) as a Medicare Advantage provider. The Company began enrolling Medicare members effective January 1, 2012. The Company’s Medicare contract represents approximately 54% and 60% of revenues for the year ended December 31, 2014 and year ended December 31, 2013, respectively. The Medicaid and Medicare contracts expire on December 31, 2018 and December 31, 2014, respectively, but can be terminated at any time by AHCA or CMS with thirty days written notice. Changes in Medicare and Medicaid funding could adversely impact the Company.

Financial instruments which potentially subject the Company to concentrations of credit risk consist principally of cash deposits in excess of the FDIC insured limit of \$250,000. The Company generally limits exposure by placing deposits with several quality financial institutions. However, at times, such cash balances may be in excess of insured amounts.

Cash and Short-term Investments

Cash and short-term investments consist of liquid investments including certificates of deposit with maturity dates of three months or less at the date of acquisition. Cash and short-term investments are carried at cost, which approximates fair value.

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc.**

NOTES TO FINANCIAL STATEMENTS

Letter of Credit

At December 31, 2014, the Company has an outstanding letter of credit of \$100,000 maturing December 31, 2015 and is collateralized by certain assets of the Parent.

Investment Income Due and Accrued

Investment income due and accrued includes interest due on long-term investments.

Premises and Equipment

EDP equipment and software are stated at the lower of cost less accumulated depreciation or the amount allowable as admitted assets which is limited to 3% of the Company’s capital and surplus as shown on the statutory statements of admitted assets, liabilities, capital and surplus of the Company’s most recent filed statements with the Florida Department of Financial Services. Depreciation is computed using the straight-line method over the estimated useful lives of the related assets, which is generally three to five years. Gain or loss on disposition of assets, if any, is recognized currently.

Risk Adjustment Premium Receivable

Risk adjustment premium receivable is an estimate of additional revenues from CMS for retroactive changes to the member’s Medicare risk score. The additional risk payments are based on member diagnosis codes from the proceeding calendar year and are typically paid in August follow the contract year. As of December 31, 2014 and December 31, 2013, the actuary estimates the Company will receive approximately \$2,832,000 and \$2,854,000, respectively, in retroactive premiums.

Claims Adjustment Expenses

Claims adjustment expense is an estimate of costs expected to be incurred in connection with adjustment and recording of incurred but unpaid claims.

Unpaid Claims

Reserves for unpaid claims include incurred but not reported claims which are estimated using the Company's accumulated statistical data, adjusted for current experience. These estimates are continually reviewed and updated. Any resulting adjustments are reflected in current operating results.

Management believes the amounts accrued are adequate to cover claims incurred and unpaid as of December 31, 2014 and December 31, 2013, respectively.

However, as the liability for claims payable is based on estimates, the ultimate amounts paid to settle the liability may vary from recorded amounts.

Deferred Revenue

Deferred revenue represents premiums received in advance.

Premium Revenue Recognition and Premium Receivables

The Company earns premium income from contracts for regular premiums for which the Company bears the underwriting risk. Premiums are generally paid at the beginning of the coverage month and recognized as revenue at the commencement of the coverage month.

All non-government receivables outstanding are less than 90 days past due. Items greater than 90 days past due are considered non-admitted assets.

Net Investment Income Earned

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.

NOTES TO FINANCIAL STATEMENTS

Net investment income earned is comprised of net interest income.

Income Taxes

The Company's results of operations are included in the federal consolidated tax return of Simply Healthcare Holdings, Inc. Income taxes are accounted for under the asset and liability method. Deferred income taxes are recognized, subject to statutory limitations, for temporary differences between the financial reporting basis and the income tax basis of assets and liabilities based on enacted tax laws and statutory tax rates applicable to the periods in which the temporary difference are expected to reverse. Gross deferred tax assets are first reduced by a statutory valuation allowance adjustment if, based on the weight of available evidence, it is more likely than not that some portion of the gross deferred tax asset will not be realized.

Generally, adjusted deferred tax assets are limited to (1) the amount of federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year, plus (2) the lesser of the remaining gross deferred tax assets expected to be realized within one year of the balance sheet date or 10% of capital and surplus excluding any net deferred tax assets, EDP equipment and operating software, and any net positive goodwill, plus (3) the amount of remaining gross deferred tax asset that can be offset against existing gross deferred tax liabilities. The remaining deferred tax assets are non-admitted.

As the Company is not subject to risk-based capital requirements, the determination of the applicable percentage and number of years to apply with respect to the admissibility of deferred tax assets can vary depending on the ratio of adjusted gross deferred tax assets to the adjusted capital and surplus.

On January 1, 2012, the Company adopted the provisions of a new income tax accounting standard which outlines the treatment of uncertain tax positions as well as the admissibility of deferred tax assets. The adoption of this standard did not have any effect of the Company’s financial statements on the adoption date.

2. Accounting Changes and Corrections of Errors

None

3. Business Combinations and Goodwill

As mentioned above, in April 2010, the Company agreed to acquire certain assets and assume certain liabilities of Total. The purchase price was \$6,446,000, which was calculated using the excess of the liabilities assumed over the assets acquired since the Company did not pay any cash consideration in the transaction. Release of funds contractually held for a specific period of time occurred during 2013, reducing the sales price to \$5,866,000

At December 31, 2014 and December 31, 2013, the Company had goodwill of \$3,129,000 and \$3,821,000, respectively, net of accumulated amortization of \$2,738,000 and \$2,045,000. For the year ended December 31, 2014 and year ended December 31, 2013, the Company recorded amortization expense related to goodwill of \$692,000 and \$326,000, respectively, as a change in net unrealized capital losses directly to surplus.

A letter dated August 3, 2012 from the Florida Office of Insurance Regulation asked the Company to stop admitting goodwill from future financial statement filings beginning with the June 30, 2012 quarterly financial statement. The Company has complied with this request.

4. Discontinued Operations

None

5. Investment

A. Mortgage Loans, including Mezzanine Real Estate Loans

None

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

NOTES TO FINANCIAL STATEMENTS

B. Debt Restructuring

None

C. Reverse Mortgages

None

D. Loan-Backed Securities

None

E. Repurchase Agreements and/or Securities Lending Transactions

None

F. Real Estate

None

G. Low-income housing tax credits (LIHTC)

None

H. Restricted Assets

1. Restricted Assets (Including Pledged):

	1	2	3	4	5	6
Restricted Asset Category	Total Gross Restricted from Current Year	Total Gross Restricted from Prior Year	Increase / (Decrease) (1 minus 2)	Total Current Year Admitted Restricted	Percentag e Gross Restricted to Total Assets	Percentage Admitted Restrict. to Total Admitted Assets
a. Subject to contractual obligation for which liability is not shown						
b. Collateral held under security lending agreements						
c. Subject to repurchase agreements						
d. Subject to reverse repurchase agreements						
e. Subject to dollar repurchase agreements						
f. Subject to dollar reverse repurchase agreements						
g. Placed under option contracts						
h. Letter stock or securities restricted as to sale						
i. On deposit with states	300,000	300,000	0	300,000	0.139%	0.150%
j. On deposit with other regulatory bodies	5,887,905	5,882,041	5,864	5,887,905	2.722%	2.946%
k. Pledged as collateral not captured in other cat.						
l. Other restricted Assets						
m Total Restricted Assets	6,187,905	6,182,041	5,864	6,187,905	2.860%	3.096%

2. Details of Assets Pledged as Collateral Not Captured in Other Categories

None

3. Detail of Other Restricted Assets (Contracts that Share Similar Characteristics, Such as Reinsurance and Derivatives, Are Reported in the Aggregate)

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

NOTES TO FINANCIAL STATEMENTS

None

6. Joint Ventures, Partnerships and Limited Liability Companies

None

7. Investment Income

- A. Due and accrued income was excluded from surplus on the following basis:
All investment income due and accrued with amounts that are over 90 days past due.
- B. The total amount excluded was \$0

8. Derivative Instruments

None

9. Income Taxes

- A. The components of the net deferred tax asset/(liability) at December 31, 2014 are as follows:

01		12/31/2014			12/31/2013		
		(1)	(2)	(3)	(4)	(5)	(6)
				(Col 1 + 2)			(Col 4 + 5)
		Ordinary	Capital	Total	Ordinary	Capital	Total
a.	Gross Deferred Tax Assets	\$ 2,869,023	-	2,869,023	1,129,819	-	1,129,819
b.	Statutory Valuation Allowance Adjustments	\$ -	-	-	-	-	-
c.	Adjusted Gross Deferred Tax Assets (1a - 1b)	\$ 2,869,023	-	2,869,023	1,129,819	-	1,129,819
d.	Deferred Tax Assets Nonadmitted	\$ -	-	-	-	-	-
e.	Subtotal Net Admitted Deferred Tax Asset (1c - 1d)	\$ 2,869,023	-	2,869,023	1,129,819	-	1,129,819
f.	Deferred Tax Liabilities	\$ 1,460,874	-	1,460,874	1,155,039	-	1,155,039
g.	Net Admitted Deferred Tax Asset / (Net Deferred Tax Liability) (1e - 1f)	\$ 1,408,149	-	1,408,149	(25,220)	-	(25,220)

01		Change		
		(7)	(8)	(9)
		(Col 1 - 4)	(Col 2- 5)	(Col 7 + 8)
		Ordinary	Capital	Total
a.	Gross Deferred Tax Assets	\$ 1,739,204	-	1,739,204
b.	Statutory Valuation Allowance Adjustments	\$ -	-	-
c.	Adjusted Gross Deferred Tax Assets (1a - 1b)	\$ 1,739,204	-	1,739,204
d.	Deferred Tax Assets Nonadmitted	\$ -	-	-
e.	Subtotal Net Admitted Deferred Tax Asset (1c - 1d)	\$ 1,739,204	-	1,739,204
f.	Deferred Tax Liabilities	\$ 305,835	-	305,835
g.	Net Admitted Deferred Tax Asset / (Net Deferred Tax Liability) (1e - 1f)	\$ 1,433,369	-	1,433,369

02		12/31/2014			12/31/2013		
		(1)	(2)	(3)	(4)	(5)	(6)
				(Col 1 + 2)			(Col 4 + 5)
		Ordinary	Capital	Total	Ordinary	Capital	Total
Admission Calc. Components SSAP No. 101							
a.	Federal Income Taxes Paid In Prior Years						

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NOTES TO FINANCIAL STATEMENTS

	Recoverable Through Loss Carrybacks.	\$	2,869,023	-	2,869,023	1,616,947	-	1,616,947
b.	Adjusted Gross Deferred Tax Assets Expected To Be Realized (Excluding The Amount Of Deferred Tax Assets From 2(a) above) After Application of the Threshold Limitation. (The Lesser of 2(b)1 and 2(b)2 Below)	\$	-	-	-	-	-	-
1.	Adjusted Gross Deferred Tax Assets to be Realized Following the Balance Sheet Date.	\$	-	-	-	-	-	-
2.	Adjusted Gross Deferred Tax Assets Allowed per Limitation Threshold	\$	X X X	X X X	-	X X X	X X X	-
c.	Adjusted Gross Deferred Tax Assets (Excluding the Amount Of Deferred Tax Assets From 2(a) and 2(b) above) Offset byGross Deferred Tax Liabilities.	\$	-	-	-	-	-	-
d.	Deferred Tax Assets Admitted as the result of application of SSAPNo. 101. Total (2(a) + 2(b) + 2(c))	\$	2,869,023	-	2,869,023	1,616,947	-	1,616,947

02								
.								
	Admission Calc. Components SSAP No. 101							
a.	Federal Income Taxes Paid In Prior Years Recoverable Through Loss Carrybacks.	\$	1,252,076	-	1,252,076			
b.	Adjusted Gross Deferred Tax Assets Expected To Be Realized (Excluding The Amount Of Deferred Tax Assets From 2(a) above) After Application of the Threshold Limitation. (The Lesser of 2(b)1 and 2(b)2 Below)	\$	-	-	-			
1.	Adjusted Gross Deferred Tax Assets to be Realized Following the Balance Sheet Date.	\$	-	-	-			
2.	Adjusted Gross Deferred Tax Assets Allowed per Limitation Threshold	\$	X X X	X X X	-			
c.	Adjusted Gross Deferred Tax Assets (Excluding the Amount Of Deferred Tax Assets From 2(a) and 2(b) above) Offset byGross Deferred Tax Liabilities.	\$	-	-	-			
d.	Deferred Tax Assets Admitted as the result of application of SSAPNo. 101. Total (2(a) + 2(b) + 2(c))	\$	1,252,076	-	1,252,076			

03								
.								
a.	Ratio Percentage Used to Determine Recover Period And Threshold Limitation Amount.		2014	2013				
			0.00	0.00				
			0	0				
b.	Amount Of Adjusted Capital And Surplus Used To Determine Recovery Period And Threshold Limitation In 2(b)2 Above.	\$	0.00	0.00				

4.	Impact of Tax Planning Strategies		12/31/2014	12/31/2013	Change			
			(1)	(2)	(3)	(4)	(5)	(6)
a	Determination of Adjusted Gross Deferred Tax Assets and Net Admitted Deferred Tax Assets, By Tax Character As A Percentage.		Ordinary	Capital	Ordinary	Capital	(Col 1 - 3) Ordinary	(Col 2 - 4) Capital
1.	Adjusted Gross DTAs Amount From Note 9A1(c)	\$	2,869,023	-	1,129,819	-	1,739,204	

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NOTES TO FINANCIAL STATEMENTS

2.	Percentage of Adjusted Gross DTAs By Tax Character Attributable To The Impact of Tax Planning Strategies	\$	0.000%	0.00%	0.000%	0.00%	0.000%	0.00%
3.	Net Admitted Adjusted Gross DTAs Amount from Note 9A1(e)	\$	2,869,023	-	1,129,819	-	1,739,204	
4.	Percentage of Net Admitted Adjusted Gross DTAs by Tax Character Attributable To The Impact of Tax Planning Strategies	\$	0.000%	0.00%	0.000%	0.00%	0.000%	0.00%

b. Does the Company's Tax-planning Strategies include the use of reinsurance?

NO

B. Regarding deferred tax liabilities that are not recognized

None

C. Current income tax incurred consist of the following major components:

		(1)	(2)	(3)
		12/31/2014	12/31/2013	(Col 1 - 2) Change
1.	Current Income Tax			
a.	Federal.....	\$ 10,779,455	4,737,452	6,042,003
b.	Foreign.....	\$ -	-	-
c.	Subtotal.....	\$ 10,779,455	4,737,452	6,042,003
d.	Federal Income Tax on net capital gains.....	\$ -	-	-
e.	Utilization of capital loss carry-forwards.....	\$ -	-	-
f.	Other.....	\$ -	-	-
g.	Federal and foreign income taxes incurred.....	\$ 10,779,455	4,737,452	6,042,003
2.	Deferred Tax Assets:			
a.	Ordinary			
(1)	Discounting of unpaid losses.....	\$ 251,805	260,058	(8,253)
(2)	Unearned premium reserve.....	\$ 2,510,530	42,786	2,467,744
(3)	Policyholder reserves.....	\$ -	-	-
(4)	Investments.....	\$ -	-	-
(5)	Deferred acquisition costs.....	\$ -	-	-
(6)	Policyholder dividends accrual.....	\$ -	-	-
(7)	Fixed assets.....	\$ -	-	-
(8)	Compensation and benefits accrual.....	\$ 106,688	826,975	(720,287)
(9)	Pension accrual.....	\$ -	-	-
(10)	Receivables - nonadmitted.....	\$ -	-	-
(11)	Net operating loss carry-forward.....	\$ -	-	-
(12)	Tax credit carry-forward.....	\$ -	-	-
(13)	Other (including items <5% of total ordinary tax assets).....	\$ -	-	-
(99)	Subtotal.....	\$ 2,869,023	1,129,819	1,739,204
b.	Statutory valuation allowance adjustment.....	\$ -	-	-
c.	Nonadmitted.....	\$ -	-	-
d.	Admitted ordinary deferred tax assets (2a99 - 2b - 2c).....	\$ 2,869,023	1,129,819	1,739,204
e.	Capital:			
(1)	Investments.....	\$ -	-	-

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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc			
NOTES TO FINANCIAL STATEMENTS			
(2) Net capital loss carry-forward.....	\$	-	-
(3) Real estate.....	\$	-	-
(4) Other (including items <5% of total capital tax assets).....	\$	-	-
(99) Subtotal.....	\$	-	-
f. Statutory valuation allowance adjustment.....	\$	-	-
g. Nonadmitted.....	\$	-	-
h. Admitted capital deferred tax assets (2e99 - 2f - 2g).....	\$	-	-
i. Admitted deferred tax assets (2d + 2h).....	\$	2,869,023	1,129,819
			1,739,204
3. Deferred Tax Liabilities:			
a. Ordinary			
(1) Investments.....	\$	-	-
(2) Fixed assets.....	\$	1,460,874	1,155,039
(3) Deferred and uncollected premium.....	\$	-	-
(4) Policyholder reserves.....	\$	-	-
(5) Other (including items <5% of total ordinary tax liabilities).....	\$	-	-
(99) Subtotal.....	\$	1,460,874	1,155,039
			305,835
b. Capital:			
(1) Investments.....	\$	-	-
(2) Real Estate.....	\$	-	-
(3) Other (including items <5% of total capital tax liabilities).....	\$	-	-
(99) Subtotal.....	\$	-	-
c. Deferred tax liabilities (3a99 + 3b99).....	\$	1,460,874	1,155,039
			305,835
4. Net deferred tax assets/liabilities (2i - 3c).....	\$	1,408,149	(25,220)
			1,433,369
D. None			
E. None			
F. The method of tax allocation among the regulated company and Simply Healthcare Holdings, Inc. is subject to a written agreement, approved by the Board of Directors, whereby an allocation is made primarily on a separate-return basis with current credit for net operating losses or other items utilized in the consolidated tax return. Intercompany balances are settled periodically or when deemed necessary.			
As of December 31, 2014 and December 31, 2013, no provision for tax contingencies was required.			
G. None			

10. Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

In June 2010, the Company entered into a Management Service Agreement with Better Health, LLC (“Better Health”), a related party through common ownership, in which the Company provides services to administer a significant portion of Better Health’s benefits and business support services. In addition, the Company is entitled to receive reimbursements for reasonable expenses incurred in furtherance of operating Better Health in so much as these expenses exceed the amount of the management fee. For the year ended December 31, 2014 and year ended December 31, 2013, \$36,493,000 and \$35,303,000 respectively was received in relation to this agreement and has been recorded as an offset to general administrative expenses on the Company’s accompanying statutory statements of income.

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

NOTES TO FINANCIAL STATEMENTS

For the year ended December 31, 2014 and year ended December 31, 2013, approximately \$1,600,000 and \$2,033,000, respectively, was paid to a related party for management fees and reimbursable expenses. There is no formal agreement between the parties and as a result, the reimbursement amounts are based on expenses paid by the related party, which are approved by the Company’s executives.

11. Debt

None

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

During 2010, the Company created an employee 401(k) contribution plan (“the Plan”). All employees of the Company who have attained the age of 18 and have completed 90 days of service are eligible to participate in the Plan. Contributions by the Company are discretionary. As of December 31, 2014, there have been no Company contributions.

13. Capital and Surplus, Shareholders’ Dividend Restrictions and Quasi-Reorganizations

- (1) The Company has 10,000 shares authorized, 57 issued and outstanding. All shares are Class A shares.
- (2) The Company has no preferred stock outstanding.
- (3) Without prior approval of its domiciliary commissioner, dividends to shareholders are limited by the laws of the Company’s state of incorporation, Florida, to \$0, an amount that is based on restrictions relating to statutory surplus.
- (4) No ordinary dividends were paid by the Company as of December 2014.
- (5) Within the limitation of (3) above, there are no restrictions placed on the portion of Company profits that may be paid as ordinary dividends to stockholders.
- (6) There were no restrictions placed on the Company’s surplus, including for whom the surplus is being held.
- (7) There were no advances to surplus as of September 2014.
- (8) The amounts of stock held by the Company, including stock of affiliated companies, for special purposes are:

a. For conversion of preferred stock: 0 shares

b. For employee stock options: 0 shares

c. For stock purchase warrants: 0 shares
- (9) There were no changes in balances of special surplus funds from the prior year
- (10)The portion of unassigned funds (surplus) represented or reduced by cumulative unrealized gains and losses are \$(0).
- (11)The Company received the following surplus debentures or similar obligations:

Date Issued	Interest Rate	Par Value (Face Amount of Notes)	Carrying Value of Note	Interest And/Or Principal Paid Current Year	Total Interest And/Or Principal Paid	Unapproved Interest And/Or Principal	Date of Maturity
5/4/2010	8%	7,559,808	7,559,808	-	-	2,821,776	12/31/2014
9/2/2010	8%	4,967,102	4,967,102	-	-	1,722,292	12/31/2014
9/17/2010	8%	2,032,898	2,032,898	-	-	698,203	12/31/2014

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.							
NOTES TO FINANCIAL STATEMENTS							
12/20/2012	8%	2,500,000	2,500,000	-	-	406,575	12/31/2014
12/31/2012	8%	2,500,000	2,500,000	-	-	400,548	12/31/2014
12/31/2013	8%	1,000,000	1,000,000	-	-	80,219	12/31/2014
	Total	20,559,808	20,559,808			6,129,613	

As of December 31, 2013, the Company entered into promissory surplus notes to related parties totaling \$20,559,808. The notes bear interest at the rate of 8% per annum, however, in accordance with statutory accounting principles set forth in SSAP No. 41 interest shall not be recorded as a liability or an expense until such interest has been approved by the Office of Insurance Regulation for payment.

As of December 2014 and December 2013, the Company did not seek nor did the Office of Insurance Regulation approve any interest payments. As of December 31, 2014 and December 31, 2013, the “unapproved” cumulative interest relating to the surplus notes is approximately \$6,130,000 and \$4,485,000, respectively.

Payment of principal and interest on the surplus notes are subordinated to claims of all policyholders, creditors, and other liabilities of the Company.

(12)The Company has not gone through any type of reorganization.

(13)None

14. Contingencies

The Company is involved in various legal proceedings in the normal course of business none of which are anticipated to have a material adverse impact of the Company’s future financial results or current financial position.

Service Agreement

During March 2012, the Company entered into a service agreement with a related party through common ownership, whereby a celebrity will provide certain marketing and communications services with respect to the Company’s managed care services. As part of the agreement, the celebrity will be required to make public appearances on behalf of the Company. The agreement is for a term of five years, expiring in March 2017, and requires escalating monthly installments throughout the term. The Company is also required to reimburse the celebrity’s reasonable out of pocket expenses including travel and meal expenses. The Company is entitled to terminate the agreement, with a thirty day written notice, under certain conditions defined in the agreement.

As of December 31, 2014, future minimum payments under the service agreement for the years ending after December 31, 2014 are approximately as follows:

Years Ended December 31,	Amount
2015	\$ 3,500,000
2016	3,500,000
2017	802,000
Total	\$ 7,802,000

15. Leases

A. Lessee Operating Lease

(1)

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

NOTES TO FINANCIAL STATEMENTS

- a.

The Company leases office space in Tampa, Orlando, Sunrise and two offices in Coral Gables. These leases expire at various dates through 2017. Rent expenses for the year ended December 31, 2015 and year ended December 31, 2014, totaled approximately \$1,847,000 and \$1,209,000, respectively. The Company entered into a software licensing agreement for a claims processing system, which expires in 2016. For the year ended December 31, 2014 and year ended December 31, 2013, software licensing expense totaled approximately \$4,213,000 and \$3,207,000.
- c.

The leases contain base rent escalations and, as a result, the Company records the rental expense on a straight-line basis over the life of the lease.
- e.

As of December 31, 2014 and December 31, 2013, item (c) resulted in a liability for deferred rent obligation of approximately \$212,000 and \$294,000, respectively.
- (2)

As of December 31, 2013, total future minimum lease payments under operating leases for the years ended December 31 were as follows (Dollars in thousands) :

2015	\$	2,415
2016		440
2017		208
Total	\$	3,063

- (3)

The Company is not involved in any material sales-leaseback transactions

B. Lessor Leases

None

16. Information about Financial Instruments with Off-Balance-Sheet Risk and Financial Instruments with Concentrations of Credit Risk

None

17. Sales, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

None

18. Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

None

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

None

20. Fair Value Measurement

A. Fair Value Measure

(1) Fair Value Measurements at Reporting Date

	(1)	(2)	(3)	(4)	(5)
	Description	(Level 1)	(Level 2)	(Level 3)	Total
a.	Assets at fair Value				
	Bonds – CDs Corporate Industrial and Misc.	\$	5,425,000	-	5,425,000
	Bonds – Corporate Industrial and Misc.	\$	6,076,026	-	6,076,026
	Bonds – Municipal		3,935,599		3,935,598
	Total assets at fair value	\$	15,436,625	-	15,436,625

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NOTES TO FINANCIAL STATEMENTS

b.	Liabilities at fair value				
	NONE				
	Total liabilities at fair value	\$	-	-	-

- (2) The Company does not have assets or liabilities within Level 3 fair value hierarchy.
- (3) No transfers between hierarchy levels.
- (4) The Company does not have derivative assets or liabilities.

C.

Type of Financial Instrument		Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practicable (Carrying Value)
Bonds	\$	15,436,625	15,436,625		15,436,625	-	-
Total	\$	15,436,625	15,436,625		15,436,625	-	-

D. The Company does not have assets or liabilities that are not practicable to estimate fair value.

21. Other Items

None

22. Events Subsequent

Type I – Recognized Subsequent Events:

None

Type II – Nonrecognized Subsequent Events:

On January 1, 2014, the Company became subject to an annual fee under section 9010 of the Affordable Care Act (ACA). This annual fee will be allocated to individual health insurers based on the ratio of the amount of the entity's net premiums written during the preceding calendar year to the amount of the health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual becomes payable once the entity provides health insurance for an U.S. health risk for each calendar year beginning on or after January 1, 2014.

The Company adopted new accounting guidance relating to the recognition and income statement reporting of the mandated fee to be paid to the federal government by health insurers. This guidance applies to the new health insurer fee ("HIF") included in Health Care Reform. For the year ended December 31, 2014, the Company recorded approximately \$5.8 million dollars for the Company's portion of the entire estimated 2014 annual HIF. This amount is reflected under other liabilities in the statutory statements of admitted assets, liabilities and capital and surplus. Although the Company filed the appropriate documents with the IRS in April 2014, no assessment was issued. After following up with the IRS, it was determined the document was never received. The Company has confirmed no penalty is due for the late filing, but believes the IRS will impose a fee in 2015.

As of December 31, 2014, the Company has written insurance subject to the ACA assessment, expects to conduct health insurance business in 2015, and estimates their portion of the annual health insurance industry fee to be payable on September 30, 2015 to be \$9,169,000 on its portion of the Medicare business. This amount is reflected in special surplus. Reporting the ACA assessment as of December 31, 2014, would not have triggered an RBC action level. For the Medicaid business, the amount payable, \$7,872,000, is being funded as a pass through from Florida's Agency for Health Care Administration. Because the Company is not subject to Risk Based Capital under Florida Statues, it has not assessed the impact from ACA insurer fee.

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc.**

NOTES TO FINANCIAL STATEMENTS

23. Reinsurance

The Company purchases excess liability insurance for provider claims which exceed certain deductible amounts. Under the stop loss policy, the Company is responsible for the first \$350,000 of claims for each member and has a 10% coinsurance thereafter. For the year ended December, 31, 2014, the Company had approximately \$661,000 in reinsurance recoveries. For the year ended December, 31, 2014, reinsurance experience refunds of approximately \$122,000 were received in relation to minimum loss ratio requirements. These refunds were included in premium for 2013 as a reduction of the cost of the ceded reinsurance.

The Company estimated \$17,000 and \$27,000 recoverable from reinsurers respectively for the years ended December 31, 2014 and December 31, 2013 of which \$17,000 and \$27,000 have been admitted.

Reinsurance premium reduces net premiums earned in the statutory statement of income. Recoveries for reinsurance are reported as a reduction of medical expenses for any paid losses in the period that such payment is made. During the year ended December 31, 2014 and year ended December 31, 2013, reinsurance premiums of approximately \$1,287,000 and \$927,000, respectively, are included as a reduction in net premiums earned in the accompanying statutory statements of income.

A. Ceded Reinsurance Report

Section 1 – General Interrogatories

- (1) Are any of the reinsurers, listed in Schedule S as non-affiliated, owned in excess of 10% or controlled, either directly or indirectly, by the company or by any representative, officer, trustee, or director of the company?

Yes () No (x)

- (2) Have any policies issued by the company been reinsured with a company chartered in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled directly or indirectly by an insured, a beneficiary, a creditor or any other person not primarily engaged in the insurance business?

Yes () No (x)

Section 2 – Ceded Reinsurance Report – Part A

- (1) Does the company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayments of premium or other similar credit?

Yes () No (x)

- a. If yes, what is the estimated amount of the aggregate reduction in surplus of a unilateral cancellation by the reinsurer as of the date of this statement, for those agreements in which cancellation results in a net obligation of the reporting entity to the reinsurer, and for which such obligation is not presently accrued? Where necessary, the reporting entity may consider the current to anticipated experience of the business reinsured in making this estimate \$ NA.

- b. What is the total amount of reinsurance credits taken, whether as an asset or as a reduction of liability for these agreements in this statement? \$ NA.

- (2) Does the reporting entity have any reinsurance agreements in effect such that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc**

NOTES TO FINANCIAL STATEMENTS

Yes () No (x)

Section 3 – Ceded Reinsurance Report – Part B

(1) What is the estimated amount of the aggregate reduction in surplus, (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of ALL reinsurance agreements, by either party, as of the date of this statement? Where necessary, the company may consider the current or anticipated experience of the business reinsured in making the estimate. \$ NA .

(2) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had exiting reserves established by the company as of the effective date of the agreement?

Yes () No (x)

(3) If yes, what is the amount of the reinsurance credits, whether an asset or a reduction of liability, taken for such new agreements or amendments? \$ NA .

B. Uncollectible Reinsurance

None

C. Commutation of Ceded Reinsurance

None

D. Certified Reinsurer Rating Downgraded or Status Subject to Revocation

None

24. Retrospectively Rated Contracts & Contracts Subject to Redetermination

None

25. Change in Incurred Claims and Claims Adjustment Expenses

Activity in the liability for unpaid claims is summarized as follows:

	2014	2013
Unpaid claims at beginning of year	<u>\$ 53,415,554</u>	<u>\$ 18,882,630</u>
Incurred related to		
Current year	744,951,268	368,059,711
Prior year	<u>3,899,106</u>	<u>(2,450,655)</u>
	<u>748,850,374</u>	<u>365,609,057</u>
Paid related to		
Current year	636,978,986	314,644,158
Prior year	<u>56,600,274</u>	<u>16,431,975</u>
	<u>693,579,260</u>	<u>331,076,133</u>
Balance at end of year	<u>108,686,668</u>	<u>\$ 53,415,554</u>

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

NOTES TO FINANCIAL STATEMENTS

The foregoing reconciliation reflects an inadequacy of \$3,899,106 in the December 31, 2013 unpaid claim reserves and a redundancy of \$2,450,655 in the December 31, 2012 unpaid claims reserves. The inadequacy in 2013 is primarily attributable to unfavorable claims development driven by higher than expected utilization levels while the redundancy in 2012 is primarily attributable to favorable claims development primarily driven by lower than expected utilization levels. For the year ended December 31, 2014, the total amounts incurred per reconciliation above excludes \$688,555 of a risk provider component and \$9,175,769 of other healthcare receivables, that have been recorded within accounts receivable on the Company’s accompanying statutory statements of admitted assets, liabilities, and capital and surplus. These components reduce the expenses incurred.

26. Intercompany Pooling Arrangements

None

27. Structured Settlements

None

28. Health Care Receivables

A. Pharmaceutical Rebate Receivables									
	Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More Than 180 Days After Billing			
		\$							
	12/31/2014	1,455,611	1,455,611	\$ -	\$ -	\$ -			
	9/30/2014	1,264,332	1,264,332	-	-	-			
	6/30/2014	1,455,624	1,455,624	-	-	-			
	3/31/2014	1,235,399	1,235,399	-	-	-			
	12/31/2013	\$ -	847,061	\$ -	\$ -	\$ 847,061			
	9/30/2013	-	684,496	-	-	684,496			
	6/30/2013	-	497,116	-	-	497,116			
	3/31/2013	-	404,068	-	-	404,068			
	12/31/2012	\$ -	\$ 188,619	\$ -	\$ -	\$ 188,619			
	9/30/2012	-	163,916	-	63,360	100,556			
	6/30/2012	-	93,069	12,946	47,724	32,399			
	3/31/2012	-	-	-	-	-			
B. Risk Sharing Receivables									
		Risk Sharing Receivable	Risk Sharing Receivable	Risk Sharing Receivable	Actual Risk Sharing Amounts	Actual Risk Sharing Amounts	Actual Risk Sharing Amounts	Actual Risk Sharing Amounts	
	Evaluation Period Year	as Estimated in the Prior Year	as Estimated in the Current Year	Risk Sharing Receivable Billed	Risk Sharing Receivable Not yet Billed	Actual Risk Sharing Amounts Received in Year Billed	Actual Risk Sharing Amounts Received First Year Subs	Actual Risk Sharing Amounts Received Second Yr. Subs	Actual Risk Sharing Amounts Received All Other
Year	Ending								
2014	2014	0	688,555	688,555	0	0	0	0	0

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc									
NOTES TO FINANCIAL STATEMENTS									
2014	2013	1,065,675	0	1,065,675	0	0	1,065,675	0	0
2013	2013	0	1,065,675	1,065,675	0	0	0	0	0
2013	2012	983,797	0	983,797	0	0	454,484	0	0
2012	2012	0	983,797	983,797	0	0	0	0	0

29. Participating Policies

None

30. Premium Deficiency Reserve

1. Liability carried for premium deficiency reserve\$-
2. Date of the most recent evaluation of this liability3/27/2014

3. Was anticipated investment income utilized in the calculationYesNo

31. Anticipated Salvage and Subrogation

None.

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc.**

GENERAL INTERROGATORIES

PART 1 – COMMON INTERROGATORIES

GENERAL

1.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer?

Yes [X] No []

If yes, complete Schedule Y, Parts 1, 1A and 2.

1.2 If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations?

Yes [X] No [] N/A []

1.3 State Regulating?

Florida

2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity?

Yes [] No [X]

2.2 If yes, date of change:

3.1 State as of what date the latest financial examination of the reporting entity was made or is being made.

3.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released.

3.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date).

3.4 By what department or departments?

3.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with departments?

Yes [] No [] N/A [X]

3.6 Have all of the recommendations within the latest financial examination report been complied with?

Yes [] No [] N/A [X]

4.1 During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity) receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:

4.11 sales of new business?

Yes [] No [X]

4.12 renewals?

Yes [] No [X]

4.2 During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:

4.21 sales of new business?

Yes [] No [X]

4.22 renewals?

Yes [] No [X]

5.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement?

Yes [] No [X]

5.2 If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1	2	3
Name of Entity	NAIC Company Code	State of Domicile

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc.**

GENERAL INTERROGATORIES

- 6.1 Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period?

Yes [☐] No [☒]
- 6.2 If yes, give full information:
- 7.1 Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity?

Yes [☐] No [☒]
- 7.2 If yes,

7.21 State the percentage of foreign control.

7.22 State the nationality(s) of the foreign person(s) or entity(s); or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact and identify the type of entity(s) (e.g., individual, corporation, government, manager or attorney-in-fact).

1 Nationality	2 Type of Entity

- 8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board?

Yes [☐] No [☒]
- 8.2 If response to 8.1 is yes, please identify the name of the bank holding company.
- 8.3 Is the company affiliated with one or more banks, thrifts or securities firms?

Yes [☐] No [☒]
- 8.4 If response to 8.3 is yes, please provide the names and locations (city and state of the main office) of any affiliates regulated by a federal financial regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC

9. What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?

Morris, Brown, Argiz & Farra, LLC., 1450 Brickell Avenue, 18th Floor, Miami, FL 33131
- 10.1 Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation?

Yes [☐] No [☒]
- 10.2 If response to 10.1 is yes, provide information related to this exemption:
- 10.3 Has the insurer been granted any exemptions related to the other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 17A of the Model Regulation, or substantially similar state law or regulation?

Yes [☐] No [☒]
- 10.4 If response to 10.3 is yes, provide information related to this exemption:

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc.**

GENERAL INTERROGATORIES

10.5 Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws? Yes [X] No [] N/A []

10.6 If the response to 10.5 is no or n/a, please explain.

11. What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?
Brian Weible, Wakely Consulting Group, 19321 US Highway 19N, Suite 515, Clearwater, FL 33764

12.1 Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly? Yes [] No [X]

12.11 Name of real estate holding company

12.12 Number of parcels involved

12.13 Total book/adjusted carrying value

\$

12.2 If yes, provide explanation:

13. FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:

13.1 What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?

13.2 Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located? Yes [] No []

13.3 Have there been any changes made to any of the trust indentures during the year? Yes [] No []

13.4 If answer to (13.3) is yes, has the domiciliary or entry state approved the changes? Yes [] No [] N/A []

14.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards?

a. Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;

b. Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;

c. Compliance with applicable governmental laws, rules, and regulations;

d. The prompt internal reporting of violations to an appropriate person or persons identified in the code; and

e. Accountability for adherence to the code.

Yes [X] No []

14.11 If the response to 14.1 is no, please explain:

14.2 Has the code of ethics for senior managers been amended? Yes [] No [X]

14.21 If the response to 14.2 is yes, provide information related to amendment(s).

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc.**

GENERAL INTERROGATORIES

14.3 Have any provisions of the code of ethics been waived for any of the specified officers?

Yes [] No [X]

14.31 If the response to 14.3 is yes, provide the nature of any waiver(s).

15.1 Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List?

Yes [] No [X]

15.2 If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.

1 American Bankers Association (ABA) Routing Number	2 Issuing or Confirming Bank Name	3 Circumstances That Can Trigger the Letter of Credit	4 Amount

BOARD OF DIRECTORS

16. Is the purchase or sale of all investments of the reporting entity passed upon either by the board of directors or a subordinate committee thereof?

Yes [X] No []

17. Does the reporting entity keep a complete permanent record of the proceedings of its board of directors and all subordinate committees thereof?

Yes [X] No []

18. Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict or is likely to conflict with the official duties of such person?

Yes [X] No []

FINANCIAL

19. Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)?

Yes [] No [X]

20.1 Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):

20.11 To directors or other officers

20.12 To stockholders not officers

20.13 Trustees, supreme or grand (Fraternal only)

\$

\$

\$

20.2 Total amount of loans outstanding at the end of year (inclusive of Separate Accounts, exclusive of policy loans):

20.21 To directors or other officers

20.22 To stockholders not officers

20.23 Trustees, supreme or grand (Fraternal only)

\$

\$

\$

21.1 Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reported in the statement?

Yes [] No [X]

21.2 If yes, state the amount thereof at December 31 of the current year:

21.21 Rented from others

21.22 Borrowed from others

21.23 Leased from others

21.24 Other

\$

\$

\$

\$

22.1 Does this statement include payments for assessments as described in the Annual Statement Instructions other than guaranty fund or guaranty association assessments?

Yes [] No [X]

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc.**

GENERAL INTERROGATORIES

22.2 If answer is yes:

22.21 Amount paid as losses or risk adjustment

22.22 Amount paid as expenses

22.23 Other amounts paid

\$

\$

\$

23.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement?

Yes [X] No []

23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount:

\$159,388

INVESTMENT

24.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date? (other than securities lending programs addressed in 24.03)

Yes [X] No []

24.02 If no, give full and complete information, relating thereto:

24.03 For security lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet. (an alternative is to reference Note 17 where this information is also provided)

24.04 Does the company's security lending program meet the requirements for a conforming program as outlined in the Risk-Based Capital Instructions?

Yes [] No [] N/A [X]

24.05 If answer to 24.04 is yes, report amount of collateral for conforming programs.

\$

24.06 If answer to 24.04 is no, report amount of collateral for other programs.

\$

24.07 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract?

Yes [] No [] N/A [X]

24.08 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%?

Yes [] No [] N/A [X]

24.09 Does the reporting entity or the reporting entity's securities lending agent utilize the Master Securities Lending Agreement (MSLA) to conduct securities lending?

Yes [] No [] N/A [X]

24.10 For the reporting entity's security lending program, state the amount of the following as of December 31 of the current year:

24.101 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2

24.102 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2

24.103 Total payable for securities lending reported on the liability page

\$

\$

\$

25.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity or has the reporting entity sold or transferred any assets subject to a put option contract that is currently in force? (Exclude securities subject to Interrogatory 21.1 and 24.03).

Yes [] No [X]

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc.**

GENERAL INTERROGATORIES

25.2 If yes, state the amount thereof at December 31 of the current year:

25.21	Subject to repurchase agreements	\$ _____
25.22	Subject to reverse repurchase agreements	\$ _____
25.23	Subject to dollar repurchase agreements	\$ _____
25.24	Subject to reverse dollar repurchase agreements	\$ _____
25.25	Placed under option agreements	\$ _____
25.26	Letter stock or securities restricted as to sale - excluding FHLB Capital Stock	\$ _____
25.27	FHLB Capital Stock	\$ _____
25.28	On deposit with states	\$ _____
25.29	On deposit with other regulatory bodies	\$ _____
25.30	Pledged as collateral - excluding collateral pledged to an FHLB	\$ _____
25.31	Pledged as collateral to FHLB - including assets backing funding agreements	\$ _____
25.32	Other	\$ _____

25.3 For category (25.26) provide the following:

1	2	3
Nature of Restriction	Description	Amount
.....
.....

26.1 Does the reporting entity have any hedging transactions reported on Schedule DB?

Yes [☐] No [☒]

26.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state?

Yes [☐] No [☐] N/A [☒]

If no, attach a description with this statement.

27.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity?

Yes [☐] No [☒]

27.2 If yes, state the amount thereof at December 31 of the current year.

\$ _____

28. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook?

Yes [☒] No [☐]

28.01 For agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1	2
Name of Custodian(s)	Custodian's Address
Fifth Third Bank	999 Vanderbilt Beach Rd, MD-B9997A, Naples, FL 34108
JP Morgan	P.O. Box 6076, Newark, DE 19714
Gibraltar Private Bank & Trust	220 Alhambra Circle, 5th Floor, Coral Gables, FL 33134

28.02 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1	2	3
Name(s)	Location(s)	Complete Explanation(s)
.....
.....

28.03 Have there been any changes, including name changes, in the custodian(s) identified in 28.01 during the current year?

Yes [☐] No [☒]

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc**

GENERAL INTERROGATORIES

28.04 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

28.05 Identify all investment advisors, broker/dealers or individuals acting on behalf of broker/dealers that have access to the investment accounts, handle securities and have authority to make investments on behalf of the reporting entity:

1 Central Registration Depository Number(s)	2 Name	3 Address

29.1 Does the reporting entity have any diversified mutual funds reported in Schedule D – Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5 (b) (1)])? Yes [] No [X]

29.2 If yes, complete the following schedule:

1 CUSIP #	2 Name of Mutual Fund	3 Book/Adjusted Carrying Value
29.2999 TOTAL		

29.3 For each mutual fund listed in the table above, complete the following schedule:

1 Name of Mutual Fund (from above table)	2 Name of Significant Holding of the Mutual Fund	3 Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	4 Date of Valuation

30. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

	1 Statement (Admitted) Value	2 Fair Value	3 Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
30.1 Bonds	65,489,009	65,469,255	(19,754)
30.2 Preferred stocks			
30.3 Totals	65,489,009	65,469,255	(19,754)

30.4 Describe the sources or methods utilized in determining the fair values:
Prices are determined by Investment accounting vendor - Clearwater Analytics

31.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D? Yes [] No [X]

31.2 If the answer to 31.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source? Yes [] No [X]

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc.**

GENERAL INTERROGATORIES

31.3 If the answer to 31.2 is no, describe the reporting entity's process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D:

32.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Securities Valuation Office been followed? Yes [X] No []

32.2 If no, list exceptions:

OTHER

33.1 Amount of payments to trade associations, service organizations and statistical or Rating Bureaus, if any? \$ _____

33.2 List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations and statistical or rating bureaus during the period covered by this statement.

1 Name	2 Amount Paid
	\$
	\$
	\$

34.1 Amount of payments for legal expenses, if any? \$ _____ 405,564

34.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.

1 Name	2 Amount Paid
Akerman Senterfitt	\$ 133,139
Holland & Knight LLP	\$ 185,846
	\$

35.1 Amount of payments for expenditures in connection with matters before legislative bodies, officers or departments of government, if any? \$ _____ 36,047

35.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid
Larry J. Overton and Associates, Inc.	\$ 10,800
Southern Strategy Group, Inc.	\$ 25,247
	\$

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

GENERAL INTERROGATORIES

PART 2 - HEALTH INTERROGATORIES

1.1 Does the reporting entity have any direct Medicare Supplement Insurance in force?

Yes [] No [X]

1.2 If yes, indicate premium earned on U.S. business only.

\$ _____

1.3 What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit?

\$ _____

1.31 Reason for excluding

1.4 Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above.

\$ _____

1.5 Indicate total incurred claims on all Medicare Supplement insurance.

\$ _____

1.6 Individual policies:

Most current three years:

1.61 Total premium earned

\$ _____

1.62 Total incurred claims

\$ _____

1.63 Number of covered lives

All years prior to most current three years:

1.64 Total premium earned

\$ _____

1.65 Total incurred claims

\$ _____

1.66 Number of covered lives

1.7 Group policies:

Most current three years:

1.71 Total premium earned

\$ _____

1.72 Total incurred claims

\$ _____

1.73 Number of covered lives

All years prior to most current three years:

1.74 Total premium earned

\$ _____

1.75 Total incurred claims

\$ _____

1.76 Number of covered lives

2. Health Test:

	1	2
	Current Year	Prior Year
2.1 Premium Numerator	\$ 834,582,443	\$ 423,383,150
2.2 Premium Denominator	\$ 834,582,443	\$ 423,383,150
2.3 Premium Ratio (2.1 / 2.2)	1.000	1.000
2.4 Reserve Numerator	\$ 112,406,875	\$ 54,622,778
2.5 Reserve Denominator	\$ 112,406,875	\$ 54,622,778
2.6 Reserve Ratio (2.4 / 2.5)	1.000	1.000

3.1 Has the reporting entity received any endowment or gift from contracting hospitals, physicians, dentists, or others that is agreed will be returned when, as and if the earnings of the reporting entity permits?

Yes [] No [X]

3.2 If yes, give particulars:

4.1 Have copies of all agreements stating the period and nature of hospitals', physicians', and dentists' care offered to subscribers and dependents been filed with the appropriate regulatory agency?

Yes [X] No []

4.2 If not previously filed, furnish herewith a copy(ies) of such agreement(s). Do these agreements include additional benefits offered?

Yes [X] No []

5.1 Does the reporting entity have stop-loss reinsurance?

Yes [X] No []

5.2 If no, explain:

5.3 Maximum retained risk (see instructions)

5.31 Comprehensive Medical

\$ 350,000

5.32 Medical Only

\$ _____

5.33 Medicare Supplement

\$ _____

5.34 Dental and vision

\$ _____

5.35 Other Limited Benefit Plan

\$ _____

5.36 Other

\$ _____

6. Describe arrangement which the reporting entity may have to protect subscribers and their dependents against the risk of insolvency including hold harmless provisions, conversion privileges with other carriers, agreements with providers to continue rendering services, and any other agreements:

All provider contracts provide for continuation of services regardless of status of payment from the Plan

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc**

GENERAL INTERROGATORIES
PART 2 - HEALTH INTERROGATORIES

7.1 Does the reporting entity set up its claim liability for provider services on a service date basis?

Yes ☒ No ☐

7.2 If no, give details:

8. Provide the following information regarding participating providers:

8.1 Number of providers at start of reporting year

8.2 Number of providers at end of reporting year

12,558

20,028

9.1 Does the reporting entity have business subject to premium rate guarantees?

Yes ☐ No ☒

9.2 If yes, direct premium earned:

9.21 Business with rate guarantees between 15-36 months

9.22 Business with rate guarantees over 36 months

10.1 Does the reporting entity have Incentive Pool, Withhold or Bonus Arrangements in its provider contracts?

Yes ☒ No ☐

10.2 If yes:

10.21 Maximum amount payable bonuses

10.22 Amount actually paid for year bonuses

10.23 Maximum amount payable withholds

10.24 Amount actually paid for year withholds

\$

\$

\$

\$

11.1 Is the reporting entity organized as:

11.12 A Medical Group/Staff Model,

11.13 An Individual Practice Association (IPA), or,

11.14 A Mixed Model (combination of above)?

Yes ☐ No ☒

Yes ☐ No ☒

Yes ☐ No ☒

11.2 Is the reporting entity subject to Minimum Net Worth Requirements?

Yes ☒ No ☐

11.3 If yes, show the name of the state requiring such net worth:

Florida

11.4 If yes, show the amount required.

\$ 17,252,837

11.5 Is this amount included as part of a contingency reserve in stockholder's equity?

Yes ☒ No ☐

11.6 If the amount is calculated, show the calculation:

The State of Florida requires Surplus to exceed a) 2% of annualized revenues (\$834,582,443 x .02 = \$16,691,649), b) 10% of liabilities (\$172,528,370 x .1 = \$17,252,837), or c) \$1,500,000 whichever is greater

12. List service areas in which reporting entity is licensed to operate:

1		
Name of Service Area		
Florida		

13.1 Do you act as a custodian for health savings accounts?

Yes ☐ No ☒

13.2 If yes, please provide the amount of custodial funds held as of the reporting date.

\$

13.3 Do you act as an administrator for health savings accounts?

Yes ☐ No ☒

13.4 If yes, please provide the balance of the funds administered as of the reporting date.

\$

14.1 Are any of the captive affiliates reported on Schedule S, Part 3, authorized reinsurers?

Yes ☐ No ☐ N/A ☒

14.2 If the answer to 14.1 is yes, please provide the following:

1 Company Name	2 NAIC Company Code	3 Domiciliary Jurisdiction	4 Reserve Credit	Assets Supporting Reserve Credit		
				5 Letters of Credit	6 Trust Agreements	7 Other

15. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded).

15.1 Direct Premium Written

15.2 Total Incurred Claims

15.3 Number of Covered Lives

\$

\$

*Ordinary Life Insurance Includes
Term (whether full underwriting, limited underwriting, jet issue, "short form app")
Whole Life (whether full underwriting, limited underwriting, jet issue, "short form app")
Variable Life (with or without secondary guarantee)
Universal Life (with or without secondary guarantee)
Variable Universal Life (with or without secondary guarantee)

Print Date: 04/02/2015 09:45:36 AM

28.1

AHCA ITN 001-17/18

Attachment 2014 Simply Healthcare Plans
Annual Health Statement — Page 61

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc**

FIVE – YEAR HISTORICAL DATA

	1	2	3	4	5
	2014	2013	2012	2011	2010
Balance Sheet (Pages 2 and 3)					
1. Total admitted assets (Page 2, Line 28)	199,847,663	77,612,488	43,491,061	15,867,686	16,316,356
2. Total liabilities (Page 3, Line 24)	172,528,370	64,312,121	32,529,724	11,944,711	8,783,381
3. Statutory surplus	17,252,837	8,467,663	3,252,972	1,875,000	1,875,000
4. Total capital and surplus (Page 3, Line 33)	27,319,293	13,300,367	10,961,337	3,922,975	7,532,974
Income Statement (Page 4)					
5. Total revenues (Line 8)	834,607,654	423,383,150	149,958,347	43,478,597	15,869,680
6. Total medical and hospital expenses (Line 18)	739,324,144	365,609,057	116,526,276	34,415,174	12,100,767
7. Claims adjustment expenses (Line 20)	7,031,268	3,816,454	622,384	172,235	101,737
8. Total administrative expenses (Line 21)	65,803,921	41,421,479	30,496,823	8,439,507	6,867,182
9. Net underwriting gain (loss) (Line 24)	22,448,321	12,536,160	2,312,864	451,681	(3,200,006)
10. Net investment gain (loss) (Line 27)	287,004	165,635	81,785	20,810	33,607
11. Total other income (Lines 28 plus 29)	(99,140)	(85,524)	(83,257)		
12. Net income or (loss) (Line 32)	11,856,730	8,135,542	2,051,006	472,578	(3,166,399)
Cash Flow (Page 6)					
13. Net cash from operations (Line 11)	90,771,219	34,865,839	23,747,224	(374,116)	(6,619,592)
Risk-Based Capital Analysis					
14. Total adjusted capital					
15. Authorized control level risk-based capital					
Enrollment (Exhibit 1)					
16. Total members at end of period (Column 5, Line 7)	116,166	66,244	37,306	22,829	8,473
17. Total members months (Column 6, Line 7)	1,103,246	667,160	380,645	208,708	74,325
Operating Percentage (Page 4) (Item divided by Page 4, sum of Lines 2, 3, and 5) x 100.0					
18. Premiums earned plus risk revenue (Line 2 plus Lines 3 and 5)	100.0	100.0	100.0	100.0	100.0
19. Total hospital and medical plus other non-health (Line 18 plus Line 19)	88.6	86.4	77.7	79.2	76.3
20. Cost containment expenses					
21. Other claims adjustment expenses					0.6
22. Total underwriting deductions (Line 23)	97.3	97.0	98.5	99.0	120.2
23. Total underwriting gain (loss) (Line 24)	2.7	3.0	1.5	1.0	(20.2)
Unpaid Claims Analysis (U&I Exhibit, Part 2B)					
24. Total claims incurred for prior years (Line 13, Col. 5)	56,603,830	15,977,491	7,165,528	4,010,651	8,584,749
25. Estimated liability of unpaid claims-[prior year (Line 13, Col. 6)]	52,349,879	17,898,835	8,143,563	5,441,311	11,759,683
Investments In Parent, Subsidiaries and Affiliates					
26. Affiliated bonds (Sch. D Summary, Line 12, Col. 1)					
27. Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1)					
28. Affiliated common stocks (Sch. D Summary, Line 24, Col. 1)					
29. Affiliated short-term investments (subtotal included in Sch. DA Verification, Col. 5, Line 10)					
30. Affiliated mortgage loans on real estate					
31. All other affiliated					
32. Total of above Lines 26 to 31					
33. Total investment in parent included in Lines 26 to 31 above.					

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3, Accounting Changes and Correction of Errors?

Yes [] No [X]

If no, please explain:

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.



EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

Print Date: 04/02/2015 09:45:36 AM

Report for: 1. Corporation

2.

(LOCATION)

NAIC Group Code 0000

BUSINESS IN THE STATE OF FLORIDA DURING THE YEAR 2014

NAIC Company Code 13726

	1 Total	Comprehensive (Hospital & Medical)		4 Medicare Supplement	5 Vision Only	6 Dental Only	7 Federal Employees Health Benefits Plan	8 Title XVIII Medicare	9 Title XIX Medicaid	10 Other
		2 Individual	3 Group							
Total Members at end of:										
1. Prior Year	66,244	0	0	0	0	0	0	20,852	45,392	0
2. First Quarter	71,964	0	0	0	0	0	0	26,340	45,624	0
3. Second Quarter	57,334	0	0	0	0	0	0	28,073	29,261	0
4. Third Quarter	113,549	0	0	0	0	0	0	28,454	85,095	0
5. Current Year	116,166	0	0	0	0	0	0	27,144	89,022	0
6. Current Year Member Months	1,103,246	0	0	0	0	0	0	327,985	775,261	0
Total Member Ambulatory Encounters For Year:										
7. Physician	972,539	0	0	0	0	0	0	418,024	554,454	61
8. Non-Physician	399,693	0	0	0	0	0	0	235,979	163,714	0
9. Total	1,372,232	0	0	0	0	0	0	654,003	718,168	61
10. Hospital Patient Days Incurred	74,548	0	0	0	0	0	0	38,382	36,166	0
11. Number of Inpatient Admissions	14,321	0	0	0	0	0	0	7,394	6,927	0
12. Health Premiums Written (b)	835,894,546	0	0	0	0	0	0	449,461,130	386,444,161	(10,745)
13. Life Premiums Direct	0	0	0	0	0	0	0	0	0	0
14. Property/Casualty Premiums Written	0	0	0	0	0	0	0	0	0	0
15. Health Premiums Earned	834,571,698	0	0	0	0	0	0	448,681,427	385,901,016	(10,745)
16. Property/Casualty Premiums Earned	0	0	0	0	0	0	0	0	0	0
17. Amount Paid for Provision of Health Care Services	692,762,369	0	0	0	0	0	0	390,523,272	302,239,097	0
18. Amount Incurred for Provision of Health Care Services	739,983,964	0	0	0	0	0	0	393,487,010	346,496,954	0

(a) For health business: number of persons insured under PPO managed care products 0 and number of persons insured under indemnity only products 0.

(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$ 0.

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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

13726201443059100

Report for: 1. Corporation 2. (LOCATION)

NAIC Group Code 0000 BUSINESS IN THE STATE OF TOTAL DURING THE YEAR 2014 NAIC Company Code 13726

	1 Total	Comprehensive (Hospital & Medical)		4 Medicare Supplement	5 Vision Only	6 Dental Only	7 Federal Employees Health Benefits Plan	8 Title XVIII Medicare	9 Title XIX Medicaid	10 Other
		2 Individual	3 Group							
Total Members at end of:										
1. Prior Year	66,244	0	0	0	0	0	0	20,852	45,392	0
2. First Quarter	71,964	0	0	0	0	0	0	26,340	45,624	0
3. Second Quarter	57,334	0	0	0	0	0	0	28,073	29,261	0
4. Third Quarter	113,549	0	0	0	0	0	0	28,454	85,095	0
5. Current Year	116,166	0	0	0	0	0	0	27,144	89,022	0
6. Current Year Member Months	1,103,246	0	0	0	0	0	0	327,985	775,261	0
Total Member Ambulatory Encounters For Year:										
7. Physician	972,539	0	0	0	0	0	0	418,024	554,454	61
8. Non-Physician	399,693	0	0	0	0	0	0	235,979	163,714	0
9. Total	1,372,232	0	0	0	0	0	0	654,003	718,168	61
10. Hospital Patient Days Incurred	74,548	0	0	0	0	0	0	38,382	36,166	0
11. Number of Inpatient Admissions	14,321	0	0	0	0	0	0	7,394	6,927	0
12. Health Premiums Written (b)	835,894,546	0	0	0	0	0	0	449,461,130	386,444,161	(10,745)
13. Life Premiums Direct	0	0	0	0	0	0	0	0	0	0
14. Property/Casualty Premiums Written	0	0	0	0	0	0	0	0	0	0
15. Health Premiums Earned	834,571,698	0	0	0	0	0	0	448,681,427	385,901,016	(10,745)
16. Property/Casualty Premiums Earned	0	0	0	0	0	0	0	0	0	0
17. Amount Paid for Provision of Health Care Services	692,762,369	0	0	0	0	0	0	390,523,272	302,239,097	0
18. Amount Incurred for Provision of Health Care Services	739,983,964	0	0	0	0	0	0	393,487,010	346,496,954	0

(a) For health business: number of persons insured under PPO managed care products 0 and number of persons insured under indemnity only products 0.

(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$ 0.

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.

NONE Schedule S - Part 1 - Section 2

NONE Schedule S - Part 2

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Reinsurance Ceded Accident and Health Insurance Listed by Reinsuring Company as of December 31, Current Year

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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.

NONE Schedule S - Part 4

NONE Schedule S - Part 5

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc**

SCHEDULE S – PART 6

Five-Year Exhibit of Reinsurance Ceded Business
(000 OMITTED)

	1	2	3	4	5
	2014	2013	2012	2011	2010
A. OPERATIONS ITEMS					
1. Premiums			15	7	
2. Title XVIII-Medicare	780	637	231		
3. Title XIX-Medicaid	507	290	259	311	59
4. Commissions and reinsurance expense allowance					
5. Total hospital and medical expenses					
B. BALANCE SHEET ITEMS					
6. Premiums receivable					
7. Claims payable					
8. Reinsurance recoverable on paid losses	17				
9. Experience rating refunds due or unpaid					
10. Commissions and reinsurance expense allowances due					
11. Unauthorized reinsurance offset					
12. Offset for reinsurance with Certified Reinsurers				X X X	X X X
C. UNAUTHORIZED REINSURANCE (DEPOSITS BY AND FUNDS WITHHELD FROM)					
13. Funds deposited by and withheld from (F)					
14. Letters of credit (L)					
15. Trust agreements (T)					
16. Other (O)					
D. REINSURANCE WITH CERTIFIED REINSURERS (DEPOSITS BY AND FUNDS WITHHELD FROM)					
17. Multiple Beneficiary Trust				X X X	X X X
18. Funds deposited by and withheld from (F)				X X X	X X X
19. Letters of credit (L)				X X X	X X X
20. Trust agreements (T)				X X X	X X X
21. Other (O)				X X X	X X X

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc**

SCHEDULE S – PART 7

Restatement of Balance Sheet to Identify Net Credit For Ceded Reinsurance

	1	2	3
	As Reported (net of ceded)	Restatement Adjustments	Restated (gross of ceded)
ASSETS (Page 2, Col. 3)			
1. Cash and invested assets (Line 12)	166,174,031		166,174,031
2. Accident and health premiums due and unpaid (Line 15)	24,977,198		24,977,198
3. Amounts recoverable from reinsurers (Line 16.1)	16,752		16,752
4. Net credit for ceded reinsurance	X X X		
5. All other admitted assets (Balance)	8,679,682		8,679,682
6. Total assets (Line 28)	199,847,663		199,847,663
LIABILITIES, CAPITAL AND SURPLUS (Page 3)			
7. Claims unpaid (Line 1)	88,751,134		88,751,134
8. Accrued medical incentive pool and bonus payments (Line 2)	19,935,533		19,935,533
9. Premiums received in advance (Line 8)	37,952,074		37,952,074
10. Funds held under reinsurance treaties with authorized and unauthorized reinsurers (Line 19, first inset amount plus second inset amount)			
11. Reinsurance in unauthorized companies (Line 20 minus inset amount)			
12. Reinsurance with Certified Reinsurers (Line 20 inset amount)			
13. Funds held under reinsurance treaties with Certified Reinsurers (Line 19 third inset amount)			
14. All other liabilities (Balance)	25,889,629		25,889,629
15. Total liabilities (Line 24)	172,528,370		172,528,370
16. Total capital and surplus (Line 33)	27,319,293	X X X	27,319,293
17. Total liabilities, capital and surplus (Line 34)	199,847,663		199,847,663
NET CREDIT FOR CEDED REINSURANCE			
18. Claims unpaid			
19. Accrued medical incentive pool			
20. Premiums received in advance			
21. Reinsurance recoverable on paid losses			
22. Other ceded reinsurance recoverables			
23. Total ceded reinsurance recoverables			
24. Premiums receivable			
25. Funds held under reinsurance treaties with authorized and unauthorized reinsurers			
26. Unauthorized reinsurance			
27. Reinsurance with Certified Reinsurers			
28. Funds held under reinsurance treaties with Certified Reinsurers			
29. Other ceded reinsurance payables/offsets			
30. Total ceded reinsurance payables/offsets			
31. Total net credit for ceded reinsurance			

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc**

SCHEDULE T - PREMIUMS AND OTHER CONSIDERATIONS
Allocated by States and Territories

	1	Direct Business Only							
		2	3	4	5	6	7	8	9
States, Etc.	Active Status	Accident & Health Premiums	Medicare Title XVIII	Medicaid Title XIX	Federal Employees Health Benefits Plan Premiums	Life & Annuity Premiums & Other Considerations	Property/ Casualty Premiums	Total Columns 2 Through 7	Deposit-Type Contracts
1. Alabama	AL	N							
2. Alaska	AK	N							
3. Arizona	AZ	N							
4. Arkansas	AR	N							
5. California	CA	N							
6. Colorado	CO	N							
7. Connecticut	CT	N							
8. Delaware	DE	N							
9. District of Columbia	DC	N							
10. Florida	FL	L	(10,745)	449,461,130	386,444,161			835,894,546	
11. Georgia	GA	N							
12. Hawaii	HI	N							
13. Idaho	ID	N							
14. Illinois	IL	N							
15. Indiana	IN	N							
16. Iowa	IA	N							
17. Kansas	KS	N							
18. Kentucky	KY	N							
19. Louisiana	LA	N							
20. Maine	ME	N							
21. Maryland	MD	N							
22. Massachusetts	MA	N							
23. Michigan	MI	N							
24. Minnesota	MN	N							
25. Mississippi	MS	N							
26. Missouri	MO	N							
27. Montana	MT	N							
28. Nebraska	NE	N							
29. Nevada	NV	N							
30. New Hampshire	NH	N							
31. New Jersey	NJ	N							
32. New Mexico	NM	N							
33. New York	NY	N							
34. North Carolina	NC	N							
35. North Dakota	ND	N							
36. Ohio	OH	N							
37. Oklahoma	OK	N							
38. Oregon	OR	N							
39. Pennsylvania	PA	N							
40. Rhode Island	RI	N							
41. South Carolina	SC	N							
42. South Dakota	SD	N							
43. Tennessee	TN	N							
44. Texas	TX	N							
45. Utah	UT	N							
46. Vermont	VT	N							
47. Virginia	VA	N							
48. Washington	WA	N							
49. West Virginia	WV	N							
50. Wisconsin	WI	N							
51. Wyoming	WY	N							
52. American Samoa	AS	N							
53. Guam	GU	N							
54. Puerto Rico	PR	N							
55. U.S. Virgin Islands	VI	N							
56. Northern Mariana Islands	MP	N							
57. Canada	CAN	N							
58. Aggregate other alien	OT	X X X							
59. Subtotal	X X X	(10,745)	449,461,130	386,444,161				835,894,546	
60. Reporting entity contributions for Employee Benefit Plans	X X X								
61. Totals (Direct Business)	(a) 1	(10,745)	449,461,130	386,444,161				835,894,546	

DETAILS OF WRITE-INS									
58001.	X X X								
58002.	X X X								
58003.	X X X								
58998. Summary of remaining write-ins for Line 58 from overflow page	X X X								
58999. Totals (Lines 58001 through 58003 plus 58998) (Line 58 above)	X X X								

(L) Licensed or Chartered - Licensed Insurance Carrier or Domiciled RRG; (R) Registered - Non-domiciled RRGs; (Q) Qualified - Qualified or Accredited Reinsurer; (E) Eligible - Reporting Entities eligible or approved to write Surplus Lines in the state; (E) Eligible - Reporting Entities eligible or approved to write Surplus Lines in the state; (N) None of the above - Not allowed to write business in the state.

Explanation of basis of allocation by states, premiums by state, etc.

The Company is licensed and earns premiums only in the State of Florida

(a) Insert the number of L responses except for Canada and Other Alien.

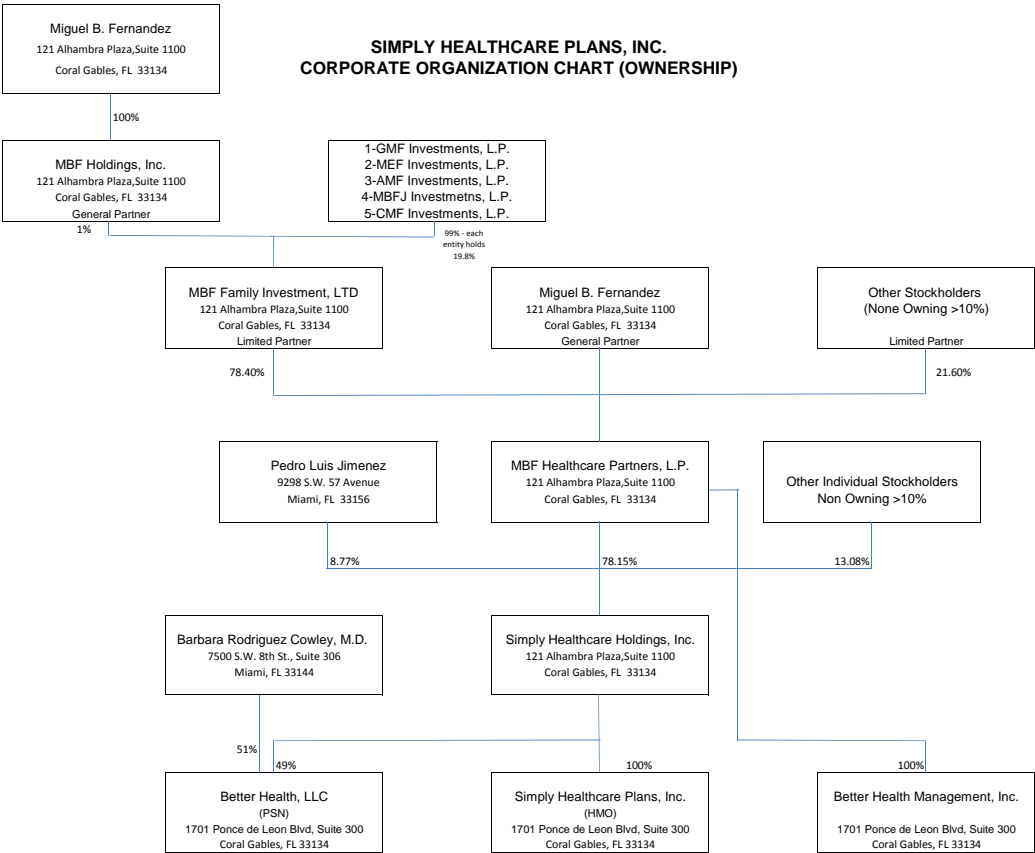
Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.

NONE Schedule T - Part 2

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART



Print Date: 04/02/2015 09:45:38 AM

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

Asterik	Explanation
	NONE

Print Date: 04/02/2015 09:45:38 AM

PART 2 – SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

	Responses
MARCH FILING	
1. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?	YES
2. Will an actuarial opinion be filed by March 1?	YES
3. Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?	See Explanation
4. Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1?	See Explanation
APRIL FILING	
5. Will Management's Discussion and Analysis be filed by April 1?	YES
6. Will the Supplemental Investment Risks Interrogatories be filed by April 1?	YES
7. Will the Accident and Health Policy Experience Exhibit be filed by April 1?	YES
JUNE FILING	
8. Will an audited financial report be filed by June 1?	YES
9. Will Accountants Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?	YES
AUGUST FILING	
10. Will Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile by August 1?	YES

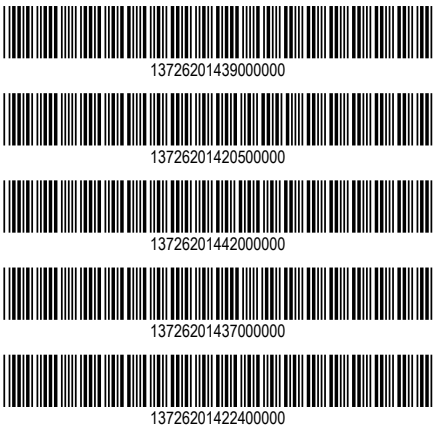
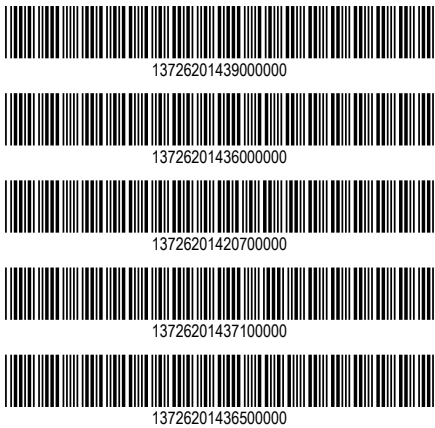
The following supplemental reports are required to be filed as part of your annual statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

MARCH FILING	
11. Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?	See Explanation
12. Will the Supplemental Life data due March 1 be filed with the state of domicile and the NAIC?	NO
13. Will the Supplemental Property/Casualty data due March 1 be filed with the state of domicile and the NAIC?	NO
14. Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1?	See Explanation
15. Will the actuarial opinion on participating and non-participating policies as required in Interrogatories 1 and 2 on Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
16. Will the actuarial opinion on non-guaranteed elements as required in Interrogatory 3 to Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
17. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?	NO
18. Will an approval from the reporting entity's state of domicile for relief related to the five-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1?	NO
19. Will an approval from the reporting entity's state of domicile for relief related to the one-year cooling off period for independent CPA be filed with the NAIC by March 1?	NO
20. Will an approval from the reporting entity's state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?	NO
APRIL FILING	
21. Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?	NO
22. Will the Supplemental Life data due April 1 be filed with the state of domicile and the NAIC?	NO
23. Will the Supplemental Property/Casualty Insurance Expense Exhibit due April 1 be filed with any state that requires it, and, if so, the NAIC?	NO
24. Will the Supplemental Health Care Exhibit be filed with the state of domicile and the NAIC by April 1?	YES
25. Will the regulator only (non-public) Supplemental Health Care Exhibit's Expense Allocation Report be filed with the state of domicile and the NAIC by April 1?	YES
AUGUST FILING	
26. Will Management's Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?	YES
Explanation:	

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc**

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

Explanation 3:	NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE
Explanation 4:	NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE
Explanation 11:	HOWEVER, AS REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE, THE OPINION WILL BE SUBMITTED ON APRIL 1
Explanation 12:	NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE
Explanation 13:	NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE
Explanation 14:	SIMPLY DOES NOT MEET THE REQUIRED NUMBER OF SHAREHOLDERS FOR THIS FILING
Explanation 15:	NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE
Explanation 16:	NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE
Explanation 17:	SIMPLY DOES NOT OFFER A MEDICARE PART D STAND ALONE COVERAGE
Explanation 18:	N/A
Explanation 19:	N/A
Explanation 20:	N/A
Explanation 21:	NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE
Explanation 22:	NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE
Explanation 23:	NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE
Bar Code:	



Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc**

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES



13726201422500000



13726201422600000



13726201430600000



13726201421100000



13726201421300000

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc.**

OVERFLOW PAGE FOR WRITE-INS

Page 2 - Continuation

ASSETS

	Current Year			Prior Year
	1	2	3	4
REMAINING WRITE-INS AGGREGATED AT LINE 25 FOR OTHER THAN INVESTED ASSETS	Assets	Nonadmitted Assets	Net Admitted Assets (Cols. 1 - 2)	Net Admitted Assets
2504. INTANGIBLE ASSETS	83,666	83,666		
2597. Totals (Lines 2504 through 2596) (Page 2, Line 2598)	83,666	83,666		

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc.**

OVERFLOW PAGE FOR WRITE-INS

Page 16 - Continuation

EXHIBIT OF NONADMITTED ASSETS

DETAILS OF WRITE-IN LINES FOR OTHER THAN INVESTED ASSETS AT LINE 25	1 Current Year Total Nonadmitted Assets	2 Prior Year Total Nonadmitted Assets	3 Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
2504. INTANGIBLE ASSETS	83,666	334,667	251,001
2597. Totals (Lines 2504 through 2596) (Page 16, Line 2598)	83,666	334,667	251,001

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc**

SUMMARY INVESTMENT SCHEDULE

Investment Categories	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
	1	2	3	4	5	6
	Amount	Percentage	Amount	Securities Lending Reinvested Collateral Amount	Total (Col. 3 + 4) Amount	Percentage
1. Bonds:						
1.1 U.S. treasury securities	0	0.00	0	0	0	0.00
1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
1.21 Issued by U.S. government agencies	0	0.00	0	0	0	0.00
1.22 Issued by U.S. government sponsored agencies	0	0.00	0	0	0	0.00
1.3 Non-U.S. government (including Canada, excluding mortgage-backed securities)	0	0.00	0	0	0	0.00
1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S.:						
1.41 States, territories and possessions general obligations	1,019,962	0.61	1,019,962	0	1,019,962	0.61
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	1,467,179	0.88	1,467,179	0	1,467,179	0.88
1.43 Revenue and assessment obligations	1,448,457	0.87	1,448,457	0	1,448,457	0.87
1.44 Industrial development and similar obligations	0	0.00	0	0	0	0.00
1.5 Mortgage-backed securities (includes residential and commercial MBS):						
1.51 Pass-through securities:						
1.511 Issued or guaranteed by GNMA	0	0.00	0	0	0	0.00
1.512 Issued or guaranteed by FNMA and FHLMC	0	0.00	0	0	0	0.00
1.513 All other	0	0.00	0	0	0	0.00
1.52 CMOs and REMICs:						
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	0	0.00	0	0	0	0.00
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521	0	0.00	0	0	0	0.00
1.523 All other	0	0.00	0	0	0	0.00
2. Other debt and other fixed income securities (excluding short term):						
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	9,801,250	5.90	9,801,250	0	9,801,250	5.90
2.2 Unaffiliated non-U.S. securities (including Canada)	1,699,776	1.02	1,699,776	0	1,699,776	1.02
2.3 Affiliated securities	0	0.00	0	0	0	0.00
3. Equity interests:						
3.1 Investments in mutual funds	0	0.00	0	0	0	0.00
3.2 Preferred stocks:						
3.21 Affiliated	0	0.00	0	0	0	0.00
3.22 Unaffiliated	0	0.00	0	0	0	0.00
3.3 Publicly traded equity securities (excluding preferred stocks):						
3.31 Affiliated	0	0.00	0	0	0	0.00
3.32 Unaffiliated	0	0.00	0	0	0	0.00
3.4 Other equity securities:						
3.41 Affiliated	0	0.00	0	0	0	0.00
3.42 Unaffiliated	0	0.00	0	0	0	0.00
3.5 Other equity interests including tangible personal property under lease:						
3.51 Affiliated	0	0.00	0	0	0	0.00
3.52 Unaffiliated	0	0.00	0	0	0	0.00
4. Mortgage loans:						
4.1 Construction and land development	0	0.00	0	0	0	0.00
4.2 Agricultural	0	0.00	0	0	0	0.00
4.3 Single family residential properties	0	0.00	0	0	0	0.00
4.4 Multifamily residential properties	0	0.00	0	0	0	0.00
4.5 Commercial loans	0	0.00	0	0	0	0.00
4.6 Mezzanine real estate loans	0	0.00	0	0	0	0.00
5. Real estate investments:						
5.1 Property occupied by company	0	0.00	0	0	0	0.00
5.2 Property held for production of income (including \$ 0 of property acquired in satisfaction of debt)	0	0.00	0	0	0	0.00
5.3 Property held for sale (including \$ 0 property acquired in satisfaction of debt)	0	0.00	0	0	0	0.00
6. Contract loans	0	0.00	0	0	0	0.00
7. Derivatives	0	0.00	0	0	0	0.00
8. Receivables for securities	0	0.00	0	0	0	0.00
9. Securities Lending (Line 10, Asset Page reinvested collateral)	0	0.00	0	X X X	X X X	X X X
10. Cash, cash equivalents and short-term investments	150,737,406	90.71	150,737,406	0	150,737,406	90.71
11. Other invested assets	0	0.00	0	0	0	0.00
12. Total invested assets	166,174,030	100.00	166,174,030	0	166,174,030	100.00

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.

NONE Schedule A and B Verification

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc**

SCHEDULE BA - VERIFICATION BETWEEN YEARS		
Other Long-Term Invested Assets		
1. Book/adjusted carrying value, December 31 of prior year		1,175,000
2. Cost of acquired:		
2.1 Actual cost at time of acquisition (Part 2, Column 8)	0	
2.2 Additional investment made after acquisition (Part 2, Column 9)	0	0
3. Capitalized deferred interest and other:		
3.1 Totals, Part 1, Column 16	0	
3.2 Totals, Part 3, Column 12	0	0
4. Accrual of discount		0
5. Unrealized valuation increase (decrease):		
5.1 Totals, Part 1, Column 13	0	
5.2 Totals, Part 3, Column 9	0	0
6. Total gain (loss) on disposals, Part 3, Column 19		0
7. Deduct amounts received on disposals, Part 3, Column 16		1,175,000
8. Deduct amortization of premium and depreciation		0
9. Total foreign exchange change in book/adjusted carrying value:		
9.1 Totals, Part 1, Column 17	0	
9.2 Totals, Part 3, Column 14	0	0
10. Deduct current year's other-than-temporary impairment recognized:		
10.1 Totals, Part 1, Column 15	0	
10.2 Totals, Part 3, Column 11	0	0
11. Book/adjusted carrying value at the end of current period (Lines 1 + 2 + 3 + 4 + 5 + 6 - 7 - 8 + 9 - 10)		0
12. Deduct total nonadmitted amounts		0
13. Statement value at end of current period (Line 11 minus Line 12)		0

SCHEDULE D - VERIFICATION BETWEEN YEARS		
Bonds and Stocks		
1. Book/adjusted carrying value, December 31 of prior year		2,250,000
2. Cost of bonds and stocks acquired, Part 3, Column 7		15,076,661
3. Accrual of discount		289
4. Unrealized valuation increase (decrease):		
4.1 Part 1, Column 12	0	
4.2 Part 2, Section 1, Column 15	0	
4.3 Part 2, Section 2, Column 13	0	
4.4 Part 4, Column 11	0	0
5. Total gain (loss) on disposals, Part 4, Column 19		11,165
6. Deduction consideration for bonds and stocks disposed of, Part 4, Column 7		1,862,138
7. Deduct amortization of premium		39,352
8. Total foreign exchange change in book/adjusted carrying value:		
8.1 Part 1, Column 15	0	
8.2 Part 2, Section 1, Column 19	0	
8.3 Part 2, Section 2, Column 16	0	
8.4 Part 4, Column 15	0	0
9. Deduct current year's other-than-temporary impairment recognized:		
9.1 Part 1, Column 14	0	
9.2 Part 2, Section 1, Column 17	0	
9.3 Part 2, Section 2, Column 14	0	
9.4 Part 4, Column 13	0	0
10. Book/adjusted carrying value at end of current period (Lines 1 + 2 + 3 + 4 + 5 - 6 - 7 + 8 - 9)		15,436,625
11. Deduct total nonadmitted accounts		0
12. Statement value at end of current period (Line 10 minus Line 11)		15,436,625

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

SCHEDULE D - SUMMARY BY COUNTRY

Long-Term Bonds and Stocks OWNED December 31 of Current Year

Description		1	2	3	4
		Book/Adjusted Carrying Value	Fair Value	Actual Cost	Par Value of Bonds
BONDS Governments (Including all obligations guaranteed by governments)	1. United States	0	0	0	0
	2. Canada	0	0	0	0
	3. Other Countries	0	0	0	0
	4. Totals	0	0	0	0
	U.S. States, Territories and Possessions (Direct and guaranteed)				
	5. Totals	1,019,962	1,020,100	1,022,340	1,000,000
U.S. Political Subdivisions of States, Territories and Possessions (Direct and guaranteed)	6. Totals	1,467,179	1,464,588	1,472,182	1,415,000
U.S. Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	7. Totals	1,448,457	1,447,112	1,458,899	1,370,000
Industrial and Miscellaneous and Hybrid Securities (unaffiliated)	8. United States	9,801,250	9,793,121	9,824,174	9,675,000
	9. Canada	0	0	0	0
	10. Other Countries	1,699,776	1,698,400	1,704,070	1,675,000
	11. Totals	11,501,026	11,491,521	11,528,244	11,350,000
Parent, Subsidiaries and Affiliates	12. Totals	0	0	0	0
	13. Total Bonds	15,436,624	15,423,321	15,481,665	15,135,000
PREFERRED STOCKS Industrial and Miscellaneous (unaffiliated)	14. United States	0	0	0	
	15. Canada	0	0	0	
	16. Other Countries	0	0	0	
	17. Totals	0	0	0	
Parent, Subsidiaries and Affiliates	18. Totals	0	0	0	
	19. Total Preferred Stocks	0	0	0	
COMMON STOCKS Industrial and Miscellaneous (unaffiliated)	20. United States	0	0	0	
	21. Canada	0	0	0	
	22. Other Countries	0	0	0	
	23. Totals	0	0	0	
Parent, Subsidiaries and Affiliates	24. Totals	0	0	0	
	25. Total Common Stocks	0	0	0	
	26. Total Stocks	0	0	0	
	27. Total Bonds and Stocks	15,436,624	15,423,321	15,481,665	

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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.

SCHEDULE D - PART 1A - SECTION 1											
Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations											
NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 9.7	8 Total from Col. 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed (a)
1. U.S. Governments				NONE							
1.1 NAIC 1	0	0	0			0	0.000	0	0.000	0	0
1.2 NAIC 2	0	0	0			0	0.000	0	0.000	0	0
1.3 NAIC 3	0	0	0			0	0.000	0	0.000	0	0
1.4 NAIC 4	0	0	0			0	0.000	0	0.000	0	0
1.5 NAIC 5	0	0	0			0	0.000	0	0.000	0	0
1.6 NAIC 6	0	0	0			0	0.000	0	0.000	0	0
1.7 Totals	0	0	0			0	0.000	0	0.000	0	0
2. All Other Governments				NONE							
2.1 NAIC 1	0	0	0			0	0.000	0	0.000	0	0
2.2 NAIC 2	0	0	0			0	0.000	0	0.000	0	0
2.3 NAIC 3	0	0	0			0	0.000	0	0.000	0	0
2.4 NAIC 4	0	0	0			0	0.000	0	0.000	0	0
2.5 NAIC 5	0	0	0			0	0.000	0	0.000	0	0
2.6 NAIC 6	0	0	0			0	0.000	0	0.000	0	0
2.7 Totals	0	0	0			0	0.000	0	0.000	0	0
3. U.S. States, Territories and Possessions, etc., Guaranteed											
3.1 NAIC 1	0	1,019,962	0	0	0	1,019,962	1.557	1,709,172	44.168	1,019,962	0
3.2 NAIC 2	0	0	0	0	0	0	0.000	0	0.000	0	0
3.3 NAIC 3	0	0	0	0	0	0	0.000	0	0.000	0	0
3.4 NAIC 4	0	0	0	0	0	0	0.000	0	0.000	0	0
3.5 NAIC 5	0	0	0	0	0	0	0.000	0	0.000	0	0
3.6 NAIC 6	0	0	0	0	0	0	0.000	0	0.000	0	0
3.7 Totals	0	1,019,962	0	0	0	1,019,962	1.557	1,709,172	44.168	1,019,962	0
4. U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed											
4.1 NAIC 1	0	1,467,179	0	0	0	1,467,179	2.240	0	0.000	1,467,179	0
4.2 NAIC 2	0	0	0	0	0	0	0.000	0	0.000	0	0
4.3 NAIC 3	0	0	0	0	0	0	0.000	0	0.000	0	0
4.4 NAIC 4	0	0	0	0	0	0	0.000	0	0.000	0	0
4.5 NAIC 5	0	0	0	0	0	0	0.000	0	0.000	0	0
4.6 NAIC 6	0	0	0	0	0	0	0.000	0	0.000	0	0
4.7 Totals	0	1,467,179	0	0	0	1,467,179	2.240	0	0.000	1,467,179	0
5. U.S. Special Revenue & Special Assessment Obligations, etc., Non-Guaranteed											
5.1 NAIC 1	1,500,000	1,448,457	0	0	0	2,948,457	4.502	0	0.000	2,948,457	0
5.2 NAIC 2	0	0	0	0	0	0	0.000	0	0.000	0	0
5.3 NAIC 3	0	0	0	0	0	0	0.000	0	0.000	0	0
5.4 NAIC 4	0	0	0	0	0	0	0.000	0	0.000	0	0
5.5 NAIC 5	0	0	0	0	0	0	0.000	0	0.000	0	0
5.6 NAIC 6	0	0	0	0	0	0	0.000	0	0.000	0	0
5.7 Totals	1,500,000	1,448,457	0	0	0	2,948,457	4.502	0	0.000	2,948,457	0

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

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	1	2	3	4	5	6	7	8	9	10	11
NAIC Designation	1 Year or Less	Over 1 Year Through 5 Years	Over 5 Years Through 10 Years	Over 10 Years Through 20 Years	Over 20 Years	Total Current Year	Col. 6 as a % of Line 9.7	Total from Col. 6 Prior Year	% From Col. 7 Prior Year	Total Publicly Traded	Total Privately Placed (a)
6. Industrial & Miscellaneous (unaffiliated)											
6.1 NAIC 1	53,429,705	6,623,706	0	0	0	60,053,411	91.700	1,656,524	42.808	60,053,411	0
6.2 NAIC 2	0	0	0	0	0	0	0.000	503,975	13.024	0	0
6.3 NAIC 3	0	0	0	0	0	0	0.000	0	0.000	0	0
6.4 NAIC 4	0	0	0	0	0	0	0.000	0	0.000	0	0
6.5 NAIC 5	0	0	0	0	0	0	0.000	0	0.000	0	0
6.6 NAIC 6	0	0	0	0	0	0	0.000	0	0.000	0	0
6.7 Totals	53,429,705	6,623,706	0	0	0	60,053,411	91.700	2,160,499	55.832	60,053,411	0
7. Hybrid Securities											
7.1 NAIC 1	0	0	0	0	0	0	0.000	0	0.000	0	0
7.2 NAIC 2	0	0	0	0	0	0	0.000	0	0.000	0	0
7.3 NAIC 3	0	0	0	0	0	0	0.000	0	0.000	0	0
7.4 NAIC 4	0	0	0	0	0	0	0.000	0	0.000	0	0
7.5 NAIC 5	0	0	0	0	0	0	0.000	0	0.000	0	0
7.6 NAIC 6	0	0	0	0	0	0	0.000	0	0.000	0	0
7.7 Totals	0	0	0	0	0	0	0.000	0	0.000	0	0
8. Parent, Subsidiaries and Affiliates											
8.1 NAIC 1	0	0	0	0	0	0	0.000	0	0.000	0	0
8.2 NAIC 2	0	0	0	0	0	0	0.000	0	0.000	0	0
8.3 NAIC 3	0	0	0	0	0	0	0.000	0	0.000	0	0
8.4 NAIC 4	0	0	0	0	0	0	0.000	0	0.000	0	0
8.5 NAIC 5	0	0	0	0	0	0	0.000	0	0.000	0	0
8.6 NAIC 6	0	0	0	0	0	0	0.000	0	0.000	0	0
8.7 Totals	0	0	0	0	0	0	0.000	0	0.000	0	0

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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

	1	2	3	4	5	6	7	8	9	10	11
NAIC Designation	1 Year or Less	Over 1 Year Through 5 Years	Over 5 Years Through 10 Years	Over 10 Years Through 20 Years	Over 20 Years	Total Current Year	Col. 6 as a % of Line 9.7	Total from Col. 6 Prior Year	% From Col. 7 Prior Year	Total Publicly Traded	Total Privately Placed (a)
9. Total Bonds Current Year											
9.1 NAIC 1	(d) 54,929,705	10,559,305	0	0	0	65,489,009	100.000	X X X	X X X	65,489,009	0
9.2 NAIC 2	(d) 0	0	0	0	0	0	0.000	X X X	X X X	0	0
9.3 NAIC 3	(d) 0	0	0	0	0	0	0.000	X X X	X X X	0	0
9.4 NAIC 4	(d) 0	0	0	0	0	0	0.000	X X X	X X X	0	0
9.5 NAIC 5	(d) 0	0	0	0	0	0	0.000	X X X	X X X	0	0
9.6 NAIC 6	(d) 0	0	0	0	0	(c) 0	0.000	X X X	X X X	0	0
9.7 Totals	54,929,705	10,559,305	0	0	0	(b) 65,489,009	100.000	X X X	X X X	65,489,009	0
9.8 Line 9.7 as a % of Col. 6	83.876	16.124	0.000	0.000	0.000	100.000	X X X	X X X	X X X	100.000	0.000
10. Total Bonds Prior Year											
10.1 NAIC 1	1,115,696	2,250,000	0	0	0	X X X	X X X	3,365,696	86.976	3,365,696	0
10.2 NAIC 2	503,975	0	0	0	0	X X X	X X X	503,975	13.024	503,975	0
10.3 NAIC 3	0	0	0	0	0	X X X	X X X	0	0.000	0	0
10.4 NAIC 4	0	0	0	0	0	X X X	X X X	0	0.000	0	0
10.5 NAIC 5	0	0	0	0	0	X X X	X X X	(c) 0	0.000	0	0
10.6 NAIC 6	0	0	0	0	0	X X X	X X X	(c) 0	0.000	0	0
10.7 Totals	1,619,671	2,250,000	0	0	0	X X X	X X X	(b) 3,869,671	100.000	3,869,671	0
10.8 Line 10.7 as a % of Col. 8	41.856	58.144	0.000	0.000	0.000	X X X	X X X	100.000	X X X	100.000	0.000
11. Total Publicly Traded Bonds											
11.1 NAIC 1	54,929,705	10,559,305	0	0	0	65,489,009	100.000	3,365,696	86.976	65,489,009	X X X
11.2 NAIC 2	0	0	0	0	0	0	0.000	503,975	13.024	0	X X X
11.3 NAIC 3	0	0	0	0	0	0	0.000	0	0.000	0	X X X
11.4 NAIC 4	0	0	0	0	0	0	0.000	0	0.000	0	X X X
11.5 NAIC 5	0	0	0	0	0	0	0.000	0	0.000	0	X X X
11.6 NAIC 6	0	0	0	0	0	0	0.000	0	0.000	0	X X X
11.7 Totals	54,929,705	10,559,305	0	0	0	65,489,009	100.000	3,869,671	100.000	65,489,009	X X X
11.8 Line 11.7 as a % of Col. 6	83.876	16.124	0.000	0.000	0.000	100.000	X X X	X X X	X X X	100.000	X X X
11.9 Line 11.7 as a % of Line 9.7, Col. 6, Section 9	83.876	16.124	0.000	0.000	0.000	100.000	X X X	X X X	X X X	100.000	X X X
12. Total Privately Placed Bonds											
12.1 NAIC 1	0	0	0	0	0	0	0.000	0	0.000	X X X	0
12.2 NAIC 2	0	0	0	0	0	0	0.000	0	0.000	X X X	0
12.3 NAIC 3	0	0	0	0	0	0	0.000	0	0.000	X X X	0
12.4 NAIC 4	0	0	0	0	0	0	0.000	0	0.000	X X X	0
12.5 NAIC 5	0	0	0	0	0	0	0.000	0	0.000	X X X	0
12.6 NAIC 6	0	0	0	0	0	0	0.000	0	0.000	X X X	0
12.7 Totals	0	0	0	0	0	0	0.000	0	0.000	X X X	0
12.8 Line 12.7 as a % of Col. 6	0.000	0.000	0.000	0.000	0.000	0.000	X X X	X X X	X X X	X X X	0.000
12.9 Line 12.7 as a % of Line 9.7, Col. 6, Section 9	0.000	0.000	0.000	0.000	0.000	0.000	X X X	X X X	X X X	X X X	0.000

(a) Includes \$ 0 freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A.
(b) Includes \$ 0 current year, \$ 0 prior year of bonds with Z designations and \$ 0 current year, \$ 0 prior year of bonds with Z* designations. The letter "Z" means the NAIC designation was not assigned by the Securities Valuation Office (SVO) at the date of the statement. "Z*" means the SVO could not evaluate the obligation because valuation procedures for the security class is under regulatory review.
(c) Includes \$ 0 current year, \$ 0 prior year of bonds with 5* designations and \$ 0 current year, \$ 0 prior year of bonds with 6* designations. "5*" means the NAIC designation was assigned by the SVO in reliance on the insurer's certification that the issuer is current in all principal and interest payments. "6*" means the NAIC designation was assigned by the SVO due to inadequate certification of principal and interest payments.
(d) Includes the following amount of non-rated short-term and cash equivalent bonds by NAIC designation: NAIC 1 \$ 0; NAIC 2 \$ 0; NAIC 3 \$ 0; NAIC 4 \$ 0; NAIC 5 \$ 0; NAIC 6 \$ 0.

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SCHEDULE D - PART 1A - SECTION 2											
Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues											
Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 9.5	8 Total from Col. 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed
1. U.S. Governments				NONE							
1.1 Issuer Obligations	0	0	0	0	0	0	0.000	0	0.000	0	0
1.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
1.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
1.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
1.5 Totals	0	0	0	0	0	0	0.000	0	0.000	0	0
2. All Other Governments				NONE							
2.1 Issuer Obligations	0	0	0	0	0	0	0.000	0	0.000	0	0
2.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
2.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
2.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
2.5 Totals	0	0	0	0	0	0	0.000	0	0.000	0	0
3. U.S. States, Territories and Possessions, Guaranteed											
3.1 Issuer Obligations	0	1,019,962	0	0	0	1,019,962	1.557	1,709,172	44.168	1,019,962	0
3.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
3.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
3.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
3.5 Totals	0	1,019,962	0	0	0	1,019,962	1.557	1,709,172	44.168	1,019,962	0
4. U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed											
4.1 Issuer Obligations	0	1,467,179	0	0	0	1,467,179	2.240	0	0.000	1,467,179	0
4.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
4.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
4.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
4.5 Totals	0	1,467,179	0	0	0	1,467,179	2.240	0	0.000	1,467,179	0
5. U.S. Special Revenue & Special Assessment Obligations, etc., Non-Guaranteed											
5.1 Issuer Obligations	1,500,000	1,448,457	0	0	0	2,948,457	4.502	0	0.000	2,948,457	0
5.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
5.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
5.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
5.5 Totals	1,500,000	1,448,457	0	0	0	2,948,457	4.502	0	0.000	2,948,457	0
6. Industrial and Miscellaneous											
6.1 Issuer Obligations	53,429,705	6,623,706	0	0	0	60,053,411	91.700	2,160,499	55.832	60,053,411	0
6.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
6.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
6.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
6.5 Totals	53,429,705	6,623,706	0	0	0	60,053,411	91.700	2,160,499	55.832	60,053,411	0
7. Hybrid Securities				NONE							
7.1 Issuer Obligations	0	0	0	0	0	0	0.000	0	0.000	0	0
7.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
7.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
7.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
7.5 Totals	0	0	0	0	0	0	0.000	0	0.000	0	0
8. Parent, Subsidiaries and Affiliates				NONE							
8.1 Issuer Obligations	0	0	0	0	0	0	0.000	0	0.000	0	0
8.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
8.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
8.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.000	0	0.000	0	0
8.5 Totals	0	0	0	0	0	0	0.000	0	0.000	0	0

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc**

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SCHEDULE D - PART 1A - SECTION 2 (Continued)

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 9.5	8 Total from Col. 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed
9. Total Bonds Current Year											
9.1 Issuer Obligations	54,929,705	10,559,305	0	0	0	65,489,009	100.000	X X X	X X X	65,489,009	0
9.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.000	X X X	X X X	0	0
9.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.000	X X X	X X X	0	0
9.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.000	X X X	X X X	0	0
9.5 Totals	54,929,705	10,559,305	0	0	0	65,489,009	100.000	X X X	X X X	65,489,009	0
9.6 Line 9.5 as a % of Col. 6	83.876	16.124	0.000	0.000	0.000	100.000	X X X	X X X	X X X	100.000	0.000
10. Total Bonds Prior Year											
10.1 Issuer Obligations	1,619,671	2,250,000	0	0	0	X X X	X X X	3,869,671	100.000	3,869,671	0
10.2 Residential Mortgage-Backed Securities	0	0	0	0	0	X X X	X X X	0	0.000	0	0
10.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	X X X	X X X	0	0.000	0	0
10.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	X X X	X X X	0	0.000	0	0
10.5 Totals	1,619,671	2,250,000	0	0	0	X X X	X X X	3,869,671	100.000	3,869,671	0
10.6 Line 10.5 as a % of Col. 8	41.856	58.144	0.000	0.000	0.000	X X X	X X X	100.000	X X X	100.000	0.000
11. Total Publicly Traded Bonds											
11.1 Issuer Obligations	54,929,705	10,559,305	0	0	0	65,489,009	100.000	3,869,671	100.000	65,489,009	X X X
11.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	X X X
11.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	0	X X X
11.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.000	0	0.000	0	X X X
11.5 Totals	54,929,705	10,559,305	0	0	0	65,489,009	100.000	3,869,671	100.000	65,489,009	X X X
11.6 Line 11.5 as a % of Col. 6	83.876	16.124	0.000	0.000	0.000	100.000	X X X	X X X	X X X	100.000	X X X
11.7 Line 11.5 as a % of Line 9.5, Col. 6, Section 9	83.876	16.124	0.000	0.000	0.000	100.000	X X X	X X X	X X X	100.000	X X X
12. Total Privately Placed Bonds											
12.1 Issuer Obligations	0	0	0	0	0	0	0.000	0	0.000	X X X	0
12.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	X X X	0
12.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.000	0	0.000	X X X	0
12.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.000	0	0.000	X X X	0
12.5 Totals	0	0	0	0	0	0	0.000	0	0.000	X X X	0
12.6 Line 12.5 as a % of Col. 6	0.000	0.000	0.000	0.000	0.000	0.000	X X X	X X X	X X X	X X X	0.000
12.7 Line 12.5 as a % of Line 9.5, Col. 6, Section 9	0.000	0.000	0.000	0.000	0.000	0.000	X X X	X X X	X X X	X X X	0.000

NONE

AHCA ITN 001-17/18

Attachment 2014 Simply Healthcare Plans
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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

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SCHEDULE DA - VERIFICATION BETWEEN YEARS

Short-Term Investments

	1	2	3	4	5
	Total	Bonds	Mortgage Loans	Other Short-Term Investment Assets (a)	Investments in Parent, Subsidiaries and Affiliates
1. Book/adjusted carrying value, December 31 of prior year	1,107,949	1,107,949	0	0	0
2. Cost of short-term investments acquired	71,744,976	71,744,976	0	0	0
3. Accrual of discount	0	0	0	0	0
4. Unrealized valuation increase (decrease)	0	0	0	0	0
5. Total gain (loss) on disposals	0	0	0	0	0
6. Deduct consideration received on disposals	24,239,689	24,239,689	0	0	0
7. Deduct amortization of premium	60,851	60,851	0	0	0
8. Total foreign exchange change in book/adjusted carrying value	0	0	0	0	0
9. Deduct current year's other than temporary impairment recognized	0	0	0	0	0
10. Book adjusted carrying value at end of current period (Lines 1 + 2 + 3 + 4 + 5 - 6 - 7 + 8 - 9)	48,552,385	48,552,385	0	0	0
11. Deduct total nonadmitted amounts	0	0	0	0	0
12. Statement value at end of current period (Line 10 minus Line 11)	48,552,385	48,552,385	0	0	0

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(a) Indicate the category of such assets, for example, joint ventures, transportation equipment: _____.

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.

- NONE Schedule DB - Part A and B Verification**
- NONE Schedule DB - Part C - Section 1**
- NONE Schedule DB - Part C - Section 2**
- NONE Schedule DB - Verification**

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc**

SCHEDULE E - VERIFICATION BETWEEN YEARS

(Cash Equivalents)

	1	2	3
	Total	Bonds	Other (a)
1. Book/adjusted carrying value, December 31 of prior year	759,144	759,144	
2. Cost of cash equivalents acquired	1,504,320	1,504,320	
3. Accrual of discount			
4. Unrealized valuation increase (decrease)			
5. Total gain (loss) on disposals			
6. Deduct consideration received on disposals	759,144	759,144	
7. Deduct amortization of premium	4,320	4,320	
8. Total foreign exchange change in book/adjusted carrying value			
9. Deduct current year's other-than-temporary impairment recognized			
10. Book/adjusted carrying value at end of current period (Lines 1 + 2 + 3 + 4 + 5 - 6 - 7 + 8 - 9)	1,500,000	1,500,000	
11. Deduct total nonadmitted amounts			
12. Statement value at end of current period (Line 10 minus Line 11)	1,500,000	1,500,000	

(a) Indicate the category of such investments, for example, joint ventures, transportation equipment:

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc.**

- NONE Schedule A - Part 1**
- NONE Schedule A - Part 2**
- NONE Schedule A - Part 3**
- NONE Schedule B - Part 1**
- NONE Schedule B - Part 2**
- NONE Schedule B - Part 3**
- NONE Schedule BA - Part 1**
- NONE Schedule BA - Part 2**

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Showing Other Long-Term Invested Assets DISPOSED, Transferred or Repaid During the Current Year

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Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.																					
SCHEDULE D - PART 1																					
Showing All Long-Term BONDS Owned December 31 of Current Year																					
1	2	Codes			6	7	Fair Value		10	11	Change in Book/Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	F o r e i g n	Bond CHAR	NAIC Designation	Actual Cost	Rate Used To Obtain Fair Value	Fair Value	Par Value	Book / Adjusted Carrying Value	Unrealized Valuation Increase / (Decrease)	Current Year's (Amortization) / Accretion	Current Year's Other -Than- Temporary Impairment Recognized	Total Foreign Exchange Change in B./A.C.V.	Rate of	Effective Rate of	When Paid	Admitted Amount Due & Accrued	Amount Rec. During Year	Acquired	Stated Contractual Maturity Date
677521-3S-3	OHIO ST-A				1FE	1,022,340	102.010	1,020,100	1,000,000	1,019,962		(2,378)			2.000	0.281	MS	6,667		11/06/2014	03/01/2016
1199999	U.S. States, Territories and Possessions (Direct and Guaranteed)				Issuer Obligatio	1,022,340	X X X	1,020,100	1,000,000	1,019,962		(2,378)			X X X	X X X	X X X	6,667		X X X	X X X
1799999	Subtotals – States, Territories and Possessions (Direct and Guaranteed)					1,022,340	X X X	1,020,100	1,000,000	1,019,962		(2,378)			X X X	X X X	X X X	6,667		X X X	X X X
881847-RR-0	TEXARKANA ISD-REF				1FE	531,206	101.784	529,277	520,000	530,129		(1,077)			2.000	0.261	FA	2,196		10/29/2014	02/15/2016
889278-UL-9	TOLEDO				1FE	940,976	104.504	935,311	895,000	937,050		(3,926)			3.000	0.531	JD	2,238	4,400	10/22/2014	12/01/2016
1899999	U.S. Political Subdivisions - Issuer Obligations					1,472,182	X X X	1,464,588	1,415,000	1,467,179		(5,003)			X X X	X X X	X X X	4,434	4,400	X X X	X X X
2499999	Subtotals – U.S. Political Subdivisions of States, Territories and Possessions (Dire					1,472,182	X X X	1,464,588	1,415,000	1,467,179		(5,003)			X X X	X X X	X X X	4,434	4,400	X X X	X X X
649674-JB-5	NYC HLTH-A				1FE	923,009	105.102	914,387	870,000	915,748		(7,261)			5.000	0.300	FA	16,433		10/22/2014	02/15/2016
72178R-AQ-8	PIMA CNTY REGL TRANSN				1FE	535,890	106.545	532,725	500,000	532,709		(3,181)			5.000	0.360	JD	2,083	12,500	11/06/2014	06/01/2016
2599999	U.S. Special Revenue - Issuer Obligations					1,458,899	X X X	1,447,112	1,370,000	1,448,457		(10,442)			X X X	X X X	X X X	18,516	12,500	X X X	X X X
3199999	Subtotals – U.S. Special Revenue					1,458,899	X X X	1,447,112	1,370,000	1,448,457		(10,442)			X X X	X X X	X X X	18,516	12,500	X X X	X X X
02005Q-W8-2	Ally Bank				1	250,000	100.000	250,000	250,000	250,000					0.600	0.600	MN	251	1,500	04/24/2013	05/01/2015
02587D-NB-0	American Express Centurion Bank	\$			1FE	250,000	100.000	250,000	250,000	250,000					0.600	0.600	MN	247	1,500	04/24/2013	05/04/2015
03784J-CX-0	Apple Bank for Savings				1	125,000	100.000	125,000	125,000	125,000					0.350	0.350	MAT	52		11/14/2014	11/19/2015
03784J-CY-8	Apple Bank for Savings				1	125,000	100.000	125,000	125,000	125,000					0.400	0.400	MN	59		11/14/2014	12/31/2015
06051G-ER-6	BANK OF AMERICA CORP				1FE	1,012,990	100.408	1,004,080	1,000,000	1,007,864		(5,326)			1.500	0.500	AO	3,417	7,500	06/16/2014	10/09/2015
06426T-BA-6	Bank of China Limited		R		1FE	250,000	100.000	250,000	250,000	250,000					0.400	0.400	MAT	118		11/14/2014	11/19/2015
054937-AE-7	BB&T CORPORATION				1FE	1,051,990	104.068	1,040,680	1,000,000	1,044,656		(7,334)			5.200	0.601	JD	1,156	26,000	10/30/2014	12/23/2015
05568P-2Y-2	BMW Bank of North America		R		1FE	175,000	100.000	175,000	175,000	175,000					0.450	0.450	MS	205	788	04/24/2013	03/30/2015
101120-DC-4	Boston Private Bank & Trust Company				1	250,000	100.000	250,000	250,000	250,000					0.500	0.500	MN	140		11/14/2014	05/23/2016
140420-QC-7	Capital One Bank	\$			1FE	250,000	100.000	250,000	250,000	250,000					0.950	0.950	AO	501		10/07/2014	10/17/2016
173010-WD-7	CITIGROUP INC				1FE	407,000	100.077	400,308	400,000	400,000					1.986	1.982	FMAN	728	8,201	04/24/2013	02/27/2015
20033A-JP-2	Comenity Capital Bank				1	250,000	100.000	250,000	250,000	250,000					0.750	0.750	MON	41	154	11/14/2014	05/24/2016
254671-NL-0	Discover Bank				1	250,000	100.000	250,000	250,000	250,000					0.500	0.500	MN	209	1,250	04/24/2013	05/01/2015
29976D-TY-6	EverBank				1	299,000	100.000	250,000	250,000	250,000					0.400	0.400	MAT	214		10/07/2014	10/15/2015
30246A-DK-1	F&M Bank				1	250,000	100.000	250,000	250,000	250,000					0.550	0.550	MON	49	113	11/14/2014	05/19/2016
33767A-FQ-9	First Federal Savings Bank of Puerto Ric				1	250,000	100.000	250,000	250,000	250,000					0.850	0.850	MON	76	175	11/14/2014	05/19/2016

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

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1	2	Codes			6	7	Fair Value		10	11	Change in Book/Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	F o r e i g n	Bond CHAR	NAIC Designation	Actual Cost	Rate Used To Obtain Fair Value	Fair Value	Par Value	Book / Adjusted Carrying Value	Unrealized Valuation Increase / (Decrease)	Current Year's (Amortization) / Accretion	Current Year's Other -Than- Temporary Impairment Recognized	Total Foreign Exchange Change in B./A.C.V.	Rate of	Effective Rate of	When Paid	Admitted Amount Due & Accrued	Amount Rec. During Year	Acquired	Stated Contractual Maturity Date
33583C-LA-5	First Niagara Bank, National Association	\$			1FE	250,000	100.000	250,000	250,000	250,000					0.550	0.550	MN	128		11/14/2014	05/31/2016
35137Q-BA-1	Fox Chase Bank				1	250,000	100.000	250,000	250,000	250,000					0.550	0.550	MON	15	230	10/07/2014	04/28/2016
36162Y-WK-5	GE Capital Bank				1	250,000	100.000	250,000	250,000	250,000					1.000	1.000	AO	568		10/07/2014	10/11/2016
36962G-SN-0	GENERAL ELEC CAP CORP				1FE	1,040,000	103.963	1,039,630	1,000,000	1,039,494		(506)			2.900	0.923	JJ	13,856		12/17/2014	01/09/2017
38147J-EA-6	Goldman Sachs Bank USA				1	250,000	100.000	250,000	250,000	250,000					0.550	0.550	MN	230	1,375	04/24/2013	05/01/2015
406216-BB-6	HALLIBURTON COMPANY				1FE	426,692	100.047	425,200	425,000	426,664		(27)			1.000	0.750	FA	1,771		12/17/2014	08/01/2016
46623E-JW-0	JPMORGAN CHASE & CO				1FE	501,950	99.993	499,965	500,000	500,000					0.800	0.800	AO	756	4,000	04/24/2013	04/23/2015
549103-QJ-1	Luana Savings Bank				1	250,000	100.000	250,000	250,000	250,000					0.650	0.650	MN	254		10/07/2014	11/07/2016
56034W-AH-4	Main Street Bank Corp.				1	250,000	100.000	250,000	250,000	250,000					0.900	0.900	JAJO	475		10/07/2014	12/16/2016
59013J-BN-8	Merrick Bank Corporation				1	250,000	100.000	250,000	250,000	250,000					0.800	0.800	MON	60	334	10/07/2014	10/21/2016
69478Q-CE-8	Pacific Premier Bank				1	250,000	100.000	250,000	250,000	250,000					0.700	0.700	MON	38	292	10/07/2014	10/24/2016
71270Q-JA-5	People's United Bank				1	250,000	100.000	250,000	250,000	250,000					0.900	0.900	AO	481		10/07/2014	10/17/2016
78658Q-GP-2	Safra National Bank of New York				1	250,000	100.000	250,000	250,000	250,000					0.650	0.650	AO	347		10/07/2014	04/15/2016
89233P-4R-4	TOYOTA MOTOR CREDIT CORP		R		1FE	1,029,070	102.340	1,023,400	1,000,000	1,024,776		(4,294)			2.800	0.381	JJ	13,222		10/22/2014	01/11/2016
983024-AJ-9	WYETH LLC				1FE	633,552	105.543	633,258	600,000	632,772		(780)			5.500	0.601	FA	12,467		12/17/2014	02/15/2016
3299999	Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations					11,528,244	X X X	11,491,521	11,350,000	11,501,026		(18,267)			X X X	X X X	X X X	52,131	53,412	X X X	X X X
3899999	Subtotals - Industrial and Miscellaneous (Unaffiliated)					11,528,244	X X X	11,491,521	11,350,000	11,501,026		(18,267)			X X X	X X X	X X X	52,131	53,412	X X X	X X X
7799999	Totals - Issuer Obligations					15,481,665	X X X	15,423,321	15,135,000	15,436,624		(36,090)			X X X	X X X	X X X	81,748	70,312	X X X	X X X
8399999	Total Bonds					15,481,665	X X X	15,423,321	15,135,000	15,436,624		(36,090)			X X X	X X X	X X X	81,748	70,312	X X X	X X X

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.

NONE Schedule D - Part 2 - Section 1

NONE Schedule D - Part 2 - Section 2

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc

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SCHEDULE D - PART 3

Showing all Long-Term Bonds and Stocks ACQUIRED During Current Year

1 CUSIP Identification	2 Description	3 Foreign	4 Date Acquired	5 Name of Vendor	6 Number of Shares of Stock	7 Actual Cost	8 Par Value	9 Paid for Accrued Interest and Dividends
677521-3S-3	OHIO ST-A		11/06/2014	Fifth Third Bank Sec		1,022,340	1,000,000.00	3,944
1799999	Subtotal - Bonds - U.S. States, Territories and Possessions				X X X	1,022,340	1,000,000.00	3,944
881847-RR-0	TEXARKANA ISD-REF		10/29/2014	Fifth Third Bank Sec		531,206	520,000.00	953
889278-UL-9	TOLEDO		10/22/2014	Fifth Third Bank Sec		940,976	895,000.00	1,865
2499999	Subtotal - Bonds - U.S. Political Subdivisions of States				X X X	1,472,182	1,415,000.00	2,818
649674-JB-5	NYC HLTH-A		10/22/2014	Fifth Third Bank Sec		923,009	870,000.00	8,700
72178R-AQ-8	PIMA CNTY REGL TRANSN		11/06/2014	Fifth Third Bank Sec		535,890	500,000.00	11,181
3199999	Subtotal - Bonds - U.S. Special Revenue and Special Assessment and all Non-Guaranteed Obligations				X X X	1,458,899	1,370,000.00	19,881
02005Q-W8-2	Ally Bank		01/03/2014	Reclassification		250,000	250,000.00	
02587D-NB-0	American Express Centurion Bank		01/03/2014	Reclassification		250,000	250,000.00	
03784J-CX-0	Apple Bank for Savings		11/14/2014	Unknown		125,000	125,000.00	
03784J-CY-8	Apple Bank for Savings		11/14/2014	Unknown		125,000	125,000.00	
06051G-ER-6	BANK OF AMERICA CORP		06/16/2014	Fifth Third Bank Sec		1,012,990	1,000,000.00	2,917
59018Y-TZ-4	BANK OF AMERICA CORP		01/03/2014	Reclassification		256,524	250,000.00	
06426T-BA-6	Bank of China Limited	R	11/14/2014	Unknown		250,000	250,000.00	
054937-AE-7	BB&T CORPORATION		10/30/2014	Fifth Third Bank Sec		1,051,990	1,000,000.00	18,922
05568P-2Y-2	BMW Bank of North America	R	01/03/2014	Reclassification		175,000	175,000.00	
101120-DC-4	Boston Private Bank & Trust Company		11/14/2014	Unknown		250,000	250,000.00	
140420-QC-7	Capital One Bank, (USA), National Associ		10/07/2014	Unknown		250,000	250,000.00	
20033A-JP-2	Comenity Capital Bank		11/14/2014	Unknown		250,000	250,000.00	
254671-NL-0	Discover Bank		01/03/2014	Reclassification		250,000	250,000.00	
29976D-TY-6	EverBank		10/07/2014	Unknown		250,000	250,000.00	
30246A-DK-1	F&M Bank		11/14/2014	Unknown		250,000	250,000.00	
33767A-FQ-9	First Federal Savings Bank of Puerto Ric		11/14/2014	Unknown		250,000	250,000.00	
33583C-LA-5	First Niagara Bank, National Association		11/14/2014	Unknown		250,000	250,000.00	
35137Q-BA-1	Fox Chase Bank		10/07/2014	Unknown		250,000	250,000.00	
36162Y-WK-5	GE Capital Bank		10/07/2014	Unknown		250,000	250,000.00	
36962G-5N-0	GENERAL ELEC CAP CORP		12/17/2014	Not Available		1,040,000	1,000,000.00	13,131
38147J-EA-6	Goldman Sachs Bank USA		01/03/2014	Reclassification		250,000	250,000.00	
406216-BB-6	HALLIBURTON COMPANY		12/17/2014	Not Available		426,692	425,000.00	1,665
549103-QJ-1	Luana Savings Bank		10/07/2014	Unknown		250,000	250,000.00	
56034W-AH-4	Main Street Bank Corp.		10/07/2014	Unknown		250,000	250,000.00	
59013J-BN-8	Merrick Bank Corporation		10/07/2014	Unknown		250,000	250,000.00	
69478Q-CE-8	Pacific Premier Bank		10/07/2014	Unknown		250,000	250,000.00	
71270Q-JA-5	People's United Bank		10/07/2014	Unknown		250,000	250,000.00	
78658Q-GP-2	Safra National Bank of New York	R	10/07/2014	Unknown		250,000	250,000.00	

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Showing all Long-Term Bonds and Stocks ACQUIRED During Current Year

E13.1

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E14

AHCA ITN 001-17/18

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.

NONE Schedule D - Part 5

NONE Schedule D - Part 6 - Section 1 and 2

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Showing all SHORT-TERM INVESTMENTS Owned December 31 of Current Year

E17

Annual Statement for the year 2014 of the Simply Healthcare Plans, Inc.

- NONE Schedule DB - Part A - Section 1**
- NONE Schedule DB - Part A - Section 2**
- NONE Schedule DB - Part B - Section 1**
- NONE Schedule DB - Part B - Section 2**
- NONE Schedule DB - Part D - Section 1**
- NONE Schedule DB - Part D - Section 2**
- NONE Schedule DL - Part 1**
- NONE Schedule DL - Part 2**

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E27

[illegible]

Annual Statement for the year 2014 of the **Simply Healthcare Plans, Inc**

SCHEDULE E – PART 3 – SPECIAL DEPOSITS

	1	2	Deposits For the Benefit of All Policyholders		All Other Special Deposits	
			3	4	5	6
States, etc.	Type of Deposit	Purpose of Deposit	Book/Adjusted Carrying Value	Fair Value	Book/Adjusted Carrying Value	Fair Value
1. Alabama	AL					
2. Alaska	AK					
3. Arizona	AZ					
4. Arkansas	AR					
5. California	CA					
6. Colorado	CO					
7. Connecticut	CT					
8. Delaware	DE					
9. District of Columbia	DC					
10. Florida	FL	O INSOLVENCY	6,187,905	6,187,905		
11. Georgia	GA					
12. Hawaii	HI					
13. Idaho	ID					
14. Illinois	IL					
15. Indiana	IN					
16. Iowa	IA					
17. Kansas	KS					
18. Kentucky	KY					
19. Louisiana	LA					
20. Maine	ME					
21. Maryland	MD					
22. Massachusetts	MA					
23. Michigan	MI					
24. Minnesota	MN					
25. Mississippi	MS					
26. Missouri	MO					
27. Montana	MT					
28. Nebraska	NE					
29. Nevada	NV					
30. New Hampshire	NH					
31. New Jersey	NJ					
32. New Mexico	NM					
33. New York	NY					
34. North Carolina	NC					
35. North Dakota	ND					
36. Ohio	OH					
37. Oklahoma	OK					
38. Oregon	OR					
39. Pennsylvania	PA					
40. Rhode Island	RI					
41. South Carolina	SC					
42. South Dakota	SD					
43. Tennessee	TN					
44. Texas	TX					
45. Utah	UT					
46. Vermont	VT					
47. Virginia	VA					
48. Washington	WA					
49. West Virginia	WV					
50. Wisconsin	WI					
51. Wyoming	WY					
52. American Samoa	AS					
53. Guam	GU					
54. Puerto Rico	PR					
55. US Virgin Islands	VI					
56. Northern Mariana Islands	MP					
57. Canada	CAN					
58. Aggregate Other Alien and Other	OT	X X X				
59. Total	X X X	X X X	6,187,905	6,187,905		

DETAILS OF WRITE-INS						
5801.		NONE				
5802.						
5803.						
5898. Sum of remaining write-ins for Line 58 from overflow page	X X X		X X X			
5899. Totals (Lines 5801 - 5803 + 5898) (Line 58 above)	X X X	X X X				

Annual Statement for the year 2014 of the

Simply Healthcare Plans, Inc.

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SMMC MMA

- ☒ Yes
☐ No

SMMC LTC

- ☐ Yes
☒ No

HEALTH PLAN NAME

Calendar Year: **2014**

Better Health, Inc.

ADDRESS

1701 Ponce de Leon, Blvd, Suite 300, Coral Gables, FL 33134 (street, city, zip)

PARENT COMPANY NAME

Simply Healthcare Holdings, Inc.

CONTACT PERSON: Kevin Wirges

TELEPHONE: 305-921-2654

FAX: 305-408-5848

E-MAIL ADDRESS: kwirges@betterhealthflorida.com

PRESIDENT, C.E.O.

Lourdes T. Rivas

OFFICERS AND DIRECTORS

Name:	Title:
1. Jorge Rico	VP & Secretary
2. Marcio Cabrera	Treasurer & CFO
3. Vicky Camero	Compliance Officer
4. Barbara Cowley, MD, FACP	Chief Medical Officer
5.	
6.	
7.	
8.	
9.	
10.	

Company Filing Status: (1) For-Profit (2) Not-For-Profit

1

**Does the MCO contract with
a Federally Qualified Health Center / Rural Health Clinic
IF YES, Please complete the FQHC/RHC worksheet**

(1) YES (2) NO

1

***Name of FQHC's**

***Name of RHC's**

1. Tampa Family Health Centers, Inc.	
2. Central Florida Health Care Inc	
3. Broward Community And Family Health Centers Inc	
4. Miami Beach Community Health Center Inc	
5. Central Florida Family Health Center Inc	

FOR THE QUARTER ENDING

12/31/2014

CEO/PRESIDENT'S SIGNATURE

AUTHORITY GRANTED BY :

AGENCY FOR HEALTH CARE ADMINISTRATION

*For additional lines to list FQHCs & RHCs, please use the blank spreadsheet at the end of this template.

		Enter data in highlighted cells					Enter data in highlighted cells				
		2014					2014				
Quarter Ending:		MAR 31st					JUN 30th				
12/31/2014											
		COMMERCIAL	MEDICAID	JMMC MMA	JMMC LTC	MEDICARE	COMMERCIAL	MEDICAID	JMMC MMA	JMMC LTC	MEDICARE
CLAIMS PAYABLE:											
1-30 DAYS		0	0	0	0	0	0	0	437,378	0	0
31-60 DAYS		0	0	0	0	0	0	0	0	0	0
61-90 DAYS		0	0	0	0	0	0	0	0	0	0
OVER 90 DAYS		0	0	0	0	0	0	0	0	0	0
Total claims payable		0	0	0	0	0	0	0	437,378	0	0
INCURRED BUT NOT REPORTED:											
INPATIENT CLAIMS		0	0	0	0	0	0	0	1,550,077	0	0
PHYSICIAN CLAIMS		0	0	0	0	0	0	0	693,560	0	0
REFERRAL CLAIMS		0	0	0	0	0	0	0	0	0	0
OTHER MEDICAL		0	0	0	0	0	0	0	1,076,034	0	0
Total incurred but not reported		0	0	0	0	0	0	0	3,319,671	0	0
TOTAL CLAIMS PAYABLE & IBNR		0	0	0	0	0	0	0	3,757,048	0	0

		Enter data in highlighted cells					Enter data in highlighted cells				
		2014					2014				
Quarter Ending:		SEP 30th					DEC 31st				
12/31/2014											
		COMMERCIAL	MEDICAID	JMMC MMA	JMMC LTC	MEDICARE	COMMERCIAL	MEDICAID	JMMC MMA	JMMC LTC	MEDICARE
CLAIMS PAYABLE:											
1-30 DAYS		0	0	3,547,095	0	0	0	0	3,210,246	0	0
31-60 DAYS		0	0	954,355	0	0	0	0	655,442	0	0
61-90 DAYS		0	0	24,095	0	0	0	0	6,495	0	0
OVER 90 DAYS		0	0	369	0	0	0	0	12,755	0	0
Total claims payable		0	0	4,525,915	0	0	0	0	3,884,938	0	0
INCURRED BUT NOT REPORTED:											
INPATIENT CLAIMS		0	0	11,566,159	0	0	0	0	9,581,076	0	0
PHYSICIAN CLAIMS		0	0	4,587,502	0	0	0	0	6,493,627	0	0
REFERRAL CLAIMS		0	0	0	0	0	0	0	0	0	0
OTHER MEDICAL		0	0	3,737,014	0	0	0	0	3,288,760	0	0
Total incurred but not reported		0	0	19,890,676	0	0	0	0	19,363,462	0	0
TOTAL CLAIMS PAYABLE & IBNR		0	0	24,416,590	0	0	0	0	23,248,399	0	0

TOTAL ENROLLMENT

2014

Enter data in highlighted cells. Be sure that you input enrollment for SMMC lines only by Region and enrollment for all other lines by county.

Better Health, Inc.
12/31/2014

MAR 31ST

MEDICAID

JUN 30TH

MEDICAID

	COMMERCIAL	MEDICARE	SMMC MMA	SMMC LTC	MEDICAID	75% OF	COMMERCIAL	MEDICARE	SMMC MMA	SMMC LTC	MEDICAID	75% OF
	BY COUNTY	BY COUNTY	BY REGION	BY REGION	BY COUNTY	TOTAL	BY COUNTY	BY COUNTY	BY REGION	BY REGION	BY COUNTY	TOTAL
REGION 1	0	0	0	0	0	NO	0	0	0	0	0	NO
ESCAMBIA	0	0	0	0	0	NO	0	0	0	0	0	NO
OKALOOSA	0	0	0	0	0	NO	0	0	0	0	0	NO
SANTA ROSA	0	0	0	0	0	NO	0	0	0	0	0	NO
WALTON	0	0	0	0	0	NO	0	0	0	0	0	NO
REGION 2	0	0	0	0	0	NO	0	0	0	0	0	NO
BAY	0	0	0	0	0	NO	0	0	0	0	0	NO
CALHOUN	0	0	0	0	0	NO	0	0	0	0	0	NO
FRANKLIN	0	0	0	0	0	NO	0	0	0	0	0	NO
GADSDEN	0	0	0	0	0	NO	0	0	0	0	0	NO
GULF	0	0	0	0	0	NO	0	0	0	0	0	NO
HOLMES	0	0	0	0	0	NO	0	0	0	0	0	NO
JACKSON	0	0	0	0	0	NO	0	0	0	0	0	NO
JEFFERSON	0	0	0	0	0	NO	0	0	0	0	0	NO
LEON	0	0	0	0	0	NO	0	0	0	0	0	NO
LIBERTY	0	0	0	0	0	NO	0	0	0	0	0	NO
MADISON	0	0	0	0	0	NO	0	0	0	0	0	NO
TAYLOR	0	0	0	0	0	NO	0	0	0	0	0	NO
WAKULLA	0	0	0	0	0	NO	0	0	0	0	0	NO
WASHINGTON	0	0	0	0	0	NO	0	0	0	0	0	NO
REGION 3	0	0	0	0	0	NO	0	0	0	0	0	NO
ALACHUA	0	0	0	0	0	NO	0	0	0	0	0	NO
BRADFORD	0	0	0	0	0	NO	0	0	0	0	0	NO
CITRUS	0	0	0	0	0	NO	0	0	0	0	0	NO
COLUMBIA	0	0	0	0	0	NO	0	0	0	0	0	NO
DIXIE	0	0	0	0	0	NO	0	0	0	0	0	NO
GILCHRIST	0	0	0	0	0	NO	0	0	0	0	0	NO
HAMILTON	0	0	0	0	0	NO	0	0	0	0	0	NO
HERNANDO	0	0	0	0	0	NO	0	0	0	0	0	NO
LAFAYETTE	0	0	0	0	0	NO	0	0	0	0	0	NO
LAKE	0	0	0	0	0	NO	0	0	0	0	0	NO
LEVY	0	0	0	0	0	NO	0	0	0	0	0	NO
MARION	0	0	0	0	0	NO	0	0	0	0	0	NO
PUTNAM	0	0	0	0	0	NO	0	0	0	0	0	NO
SUMTER	0	0	0	0	0	NO	0	0	0	0	0	NO
SUWANNEE	0	0	0	0	0	NO	0	0	0	0	0	NO
UNION	0	0	0	0	0	NO	0	0	0	0	0	NO
REGION 4	0	0	0	0	0	NO	0	0	0	0	0	NO
BAKER	0	0	0	0	0	NO	0	0	0	0	0	NO
CLAY	0	0	0	0	0	NO	0	0	0	0	0	NO
DUVAL	0	0	0	0	0	NO	0	0	0	0	0	NO
FLAGLER	0	0	0	0	0	NO	0	0	0	0	0	NO
NASSAU	0	0	0	0	0	NO	0	0	0	0	0	NO
ST. JOHNS	0	0	0	0	0	NO	0	0	0	0	0	NO
VOLUSIA	0	0	0	0	0	NO	0	0	0	0	0	NO
REGION 5	0	0	0	0	0	NO	0	0	0	0	0	NO
PASCO	0	0	0	0	0	NO	0	0	0	0	0	NO
PINELLAS	0	0	0	0	0	NO	0	0	0	0	0	NO
REGION 6	0	0	0	0	0	NO	0	0	19,277	0	0	YES
HARDEE	0	0	0	0	0	NO	0	0	0	0	0	NO
HIGHLANDS	0	0	0	0	0	NO	0	0	0	0	0	NO
HILLSBOROUGH	0	0	0	0	0	NO	0	0	0	0	0	NO
MANATEE	0	0	0	0	0	NO	0	0	0	0	0	NO
POLK	0	0	0	0	0	NO	0	0	0	0	0	NO
REGION 7	0	0	0	0	0	NO	0	0	0	0	0	NO
BREVARD	0	0	0	0	0	NO	0	0	0	0	0	NO
ORANGE	0	0	0	0	0	NO	0	0	0	0	0	NO
OSCEOLA	0	0	0	0	0	NO	0	0	0	0	0	NO
SEMINOLE	0	0	0	0	0	NO	0	0	0	0	0	NO
REGION 8	0	0	0	0	0	NO	0	0	0	0	0	NO
CHARLOTTE	0	0	0	0	0	NO	0	0	0	0	0	NO
COLLIER	0	0	0	0	0	NO	0	0	0	0	0	NO
DESOTO	0	0	0	0	0	NO	0	0	0	0	0	NO
GLADES	0	0	0	0	0	NO	0	0	0	0	0	NO
HENDRY	0	0	0	0	0	NO	0	0	0	0	0	NO
LEE	0	0	0	0	0	NO	0	0	0	0	0	NO
SARASOTA	0	0	0	0	0	NO	0	0	0	0	0	NO
REGION 9	0	0	0	0	0	NO	0	0	0	0	0	NO
INDIAN RIVER	0	0	0	0	0	NO	0	0	0	0	0	NO
MARTIN	0	0	0	0	0	NO	0	0	0	0	0	NO
OKEECHOBEE	0	0	0	0	0	NO	0	0	0	0	0	NO
PALM BEACH	0	0	0	0	0	NO	0	0	0	0	0	NO
ST. LUCIE	0	0	0	0	0	NO	0	0	0	0	0	NO
REGION 10	0	0	0	0	0	NO	0	0	0	0	0	NO
BROWARD	0	0	0	0	42,866	YES	0	0	0	0	38,585	YES
REGION 11	0	0	0	0	0	NO	0	0	0	0	0	NO
MIAMI-DADE	0	0	0	0	0	NO	0	0	0	0	0	NO
MONROE	0	0	0	0	0	NO	0	0	0	0	0	NO
TOTAL	0	0	0	0	42,866	YES	0	0	19,277	0	38,585	YES

	0 SEP 30TH						0 DEC 31ST					
	COMMERCIAL	MEDICARE	SMMC	MMA	SMMC	MEDICAID	COMMERCIAL	MEDICARE	SMMC	MMA	SMMC	MEDICAID
	BY COUNTY	BY COUNTY	BY REGION	BY REGION	BY REGION	BY COUNTY	BY COUNTY	BY COUNTY	BY REGION	BY REGION	BY REGION	BY COUNTY
						78% OF TOTAL						78% OF TOTAL
REGION 1	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
ESCAMBIA	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
OKALOOSA	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
SANTA ROSA	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
WALTON	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
REGION 2	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
BAY	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
CALHOUN	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
FRANKLIN	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
GADSDEN	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
GULF	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
HOLMES	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
JACKSON	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
JEFFERSON	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
LEON	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
LIBERTY	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
MADISON	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
TAYLOR	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
WAKULLA	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
WASHINGTON	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
REGION 3	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
ALACHUA	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
BRADFORD	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
CITRUS	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
COLUMBIA	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
DIXIE	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
GILCHRIST	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
HAMILTON	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
HERNANDO	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
LAFAYETTE	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
LAKE	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
LEVY	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
MARION	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
PUTNAM	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
SUMTER	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
SUWANNEE	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
UNION	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
REGION 4	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
BAKER	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
CLAY	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
DUVAL	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
FLAGLER	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
NASSAU	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
ST. JOHNS	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
VOLUSIA	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
REGION 5	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
PASCO	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
PINELLAS	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
REGION 6	0	0	18,814	0	0	0 YES	0	0	18,541	0	0	0 YES
HARDEE	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
HIGHLANDS	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
HILLSBOROUGH	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
MANATEE	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
POLK	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
REGION 7	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
BREVARD	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
ORANGE	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
OSCEOLA	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
SEMINOLE	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
REGION 8	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
CHARLOTTE	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
COLLIER	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
DESOTO	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
GLADES	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
HENDRY	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
LEE	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
SARASOTA	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
REGION 9	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
INDIAN RIVER	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
MARTIN	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
OKEECHOBEE	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
PALM BEACH	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
ST. LUCIE	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
REGION 10	0	0	68,006	0	0	0 YES	0	0	69,563	0	0	0 YES
BROWARD	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
REGION 11	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
MIAMI-DADE	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
MONROE	0	0	0	0	0	0 NO	0	0	0	0	0	0 NO
TOTAL	0	0	86,820	0	0	0 YES	0	0	88,104	0	0	0 YES

REVENUES AND EXPENSES		Enter data in highlighted cells.				
Better Health, Inc.						
	12/31/2014	2014	2014	2014	2014	2014
COMMERCIAL		MAR 31ST	JUN 30TH	SEPT 30TH	DEC 31ST	YEAR TO DATE
PREMIUM		0	0	0	0	0
FEE-FOR-SERVICE		0	0	0	0	0
COPAYMENTS		0	0	0	0	0
INTEREST		0	0	0	0	0
COB & SUBROGATION		0	0	0	0	0
REINSURANCE RECOVERIES		0	0	0	0	0
AGGREGATE WRITE-INS (WRITE-INS COMM)		0	0	0	0	0
TOTAL REVENUE.....		0	0	0	0	0
PHYSICIAN SERVICES		0	0	0	0	0
OTHER PROFESSIONAL SERVICES		0	0	0	0	0
OUTSIDE REFERRALS		0	0	0	0	0
EMERGENCY ROOM, OUT-OF-AREA		0	0	0	0	0
OCCUPANCY , DEPR AND AMORT (M&E)		0	0	0	0	0
INPATIENT		0	0	0	0	0
REINSURANCE EXPENSES		0	0	0	0	0
OTHER MEDICAL		0	0	0	0	0
INCENTIVE POOL ADJUSTMENT		0	0	0	0	0
TOTAL MEDICAL AND HOSPITAL.....		0	0	0	0	0
COMPENSATION		0	0	0	0	0
INTEREST EXPENSE		0	0	0	0	0
OCCUPANCY, DEPR, AND AMORT		0	0	0	0	0
MARKETING		0	0	0	0	0
AGGREGATE WRITE-INS (WRITE-INS COMM)		0	0	0	0	0
TOTAL ADMINISTRATION EXP.....		0	0	0	0	0
TOTAL EXPENSES.....		0	0	0	0	0
INCOME (LOSS).....		0	0	0	0	0
MEDICAL & HOSPITAL / TOTAL PREMIUMS		0.00%	0.00%	0.00%	0.00%	0.00%
ADMINISTRATION / TOTAL PREMIUMS		0.00%	0.00%	0.00%	0.00%	0.00%
COMPENSATION / TOTAL ADMINISTRATION		0.00%	0.00%	0.00%	0.00%	0.00%
INTEREST / TOTAL ADMINISTRATION		0.00%	0.00%	0.00%	0.00%	0.00%
MARKETING / TOTAL ADMINISTRATION		0.00%	0.00%	0.00%	0.00%	0.00%
RETURN ON REVENUE		0.00%	0.00%	0.00%	0.00%	0.00%

AGGREGATE WRITE-INS:

Enter data in highlighted cells.

Better Health, Inc.

12/31/2014

COMMERCIAL

FOR REVENUES:

	2014 MAR 31ST	2014 JUN 30TH	2014 SEP 30TH	2014 DEC 31ST	2014 YEAR TO DATE
1. Inter-company investment income	0	0	0	0	0
2. Joint venture income	0	0	0	0	0
3. Gain/(loss) on sale of assets	0	0	0	0	0
4.	0	0	0	0	0
5.	0	0	0	0	0
6.	0	0	0	0	0
TOTAL	0	0	0	0	0

FOR OTHER ADMIN EXPENSES:

1. Postage/office rent/telephone	0	0	0	0	0
2. Legal/ accounting fees	0	0	0	0	0
3. Consulting fees	0	0	0	0	0
4. Management fees	0	0	0	0	0
5. Maintenance/misc	0	0	0	0	0
6.	0	0	0	0	0
TOTAL	0	0	0	0	0

REVENUES AND EXPENSES		Enter data in highlighted cells.				
Better Health, Inc.						
12/31/2014		2014	2014	2014	2014	2014
MEDICARE		MAR 31ST	JUN 30TH	SEPT 30TH	DEC 31ST	YEAR TO DATE
PREMIUM		0	0	0	0	0
FEE-FOR-SERVICE		0	0	0	0	0
COPAYMENTS		0	0	0	0	0
INTEREST		0	0	0	0	0
COB & SUBROGATION		0	0	0	0	0
REINSURANCE RECOVERIES		0	0	0	0	0
AGGREGATE WRITE-INS (WRITE-INS MCARE)		0	0	0	0	0
TOTAL REVENUE.....		0	0	0	0	0
PHYSICIAN SERVICES		0	0	0	0	0
OTHER PROFESSIONAL SERVICES		0	0	0	0	0
OUTSIDE REFERRALS		0	0	0	0	0
EMERGENCY ROOM, OUT-OF-AREA		0	0	0	0	0
OCCUPANCY , DEPR AND AMORT (M&E)		0	0	0	0	0
INPATIENT		0	0	0	0	0
REINSURANCE EXPENSES		0	0	0	0	0
OTHER MEDICAL		0	0	0	0	0
INCENTIVE POOL ADJUSTMENT		0	0	0	0	0
TOTAL MEDICAL AND HOSPITAL.....		0	0	0	0	0
COMPENSATION		0	0	0	0	0
INTEREST EXPENSE		0	0	0	0	0
OCCUPANCY, DEPR, AND AMORT		0	0	0	0	0
MARKETING		0	0	0	0	0
AGGREGATE WRITE-INS (WRITE-INS MCARE)		0	0	0	0	0
TOTAL ADMINISTRATION EXP.....		0	0	0	0	0
TOTAL EXPENSES.....		0	0	0	0	0
INCOME (LOSS).....		0	0	0	0	0
MEDICAL & HOSPITAL / TOTAL PREMIUMS		0.00%	0.00%	0.00%	0.00%	0.00%
ADMINISTRATION / TOTAL PREMIUMS		0.00%	0.00%	0.00%	0.00%	0.00%
COMPENSATION / TOTAL ADMINISTRATION		0.00%	0.00%	0.00%	0.00%	0.00%
INTEREST/ TOTAL ADMINISTRATION		0.00%	0.00%	0.00%	0.00%	0.00%
MARKETING / TOTAL ADMINISTRATION		0.00%	0.00%	0.00%	0.00%	0.00%
RETURN ON REVENUE		0.00%	0.00%	0.00%	0.00%	0.00%

AGGREGATE WRITE-INS:		<i>Enter data in highlighted cells.</i>				
Better Health, Inc.						
	12/31/2014	2014	2014	2014	2014	2014
	MEDICARE	MAR 31ST	JUN 30TH	SEP 30TH	DEC 31ST	YEAR TO DATE
<i>FOR REVENUES:</i>						
1.	Inter-company investment income	0	0	0	0	0
2.	Joint venture income	0	0	0	0	0
3.	Gain/(loss) on sale of assets	0	0	0	0	0
4.		0	0	0	0	0
5.		0	0	0	0	0
6.		0	0	0	0	0
	TOTAL	0	0	0	0	0
<i>FOR OTHER ADMIN EXPENSES:</i>						
1.	Postage/office rent/telephone	0	0	0	0	0
2.	Legal/ accounting fees	0	0	0	0	0
3.	Consulting fees	0	0	0	0	0
4.	Management fees	0	0	0	0	0
5.	Maintenance/misc	0	0	0	0	0
6.		0	0	0	0	0
	TOTAL	0	0	0	0	0

SMMC-LTC PROGRAM

REVENUES AND EXPENSES

Better Health, Inc.

Enter data in YELLOW highlighted cells.

12/31/2014 SMMC LTC	2014 MAR 31ST	PMPM	2014 JUN 30TH	PMPM	2014 SEPT 30TH	PMPM	2014 DEC 31ST	PMPM	2014 YEAR TO DATE	PMPM
SMMC-LTC Member Months	0		0		0		0		0	
CAPITATION PREMIUM	0		0		0		0		0	
FEE-FOR-SERVICE	0		0		0		0		0	
COPAYMENTS	0		0		0		0		0	
INTEREST	0		0		0		0		0	
COB & SUBROGATION	0		0		0		0		0	
REINSURANCE RECOVERIES	0		0		0		0		0	
AGGREGATE WRITE-INS (WRITE-INS SMMC LTC)	0		0		0		0		0	
TOTAL REVENUE.....	0		0		0		0		0	
PHYSICIAN SERVICES	0		0		0		0		0	
CASE MANAGEMENT	0		0		0		0		0	
OTHER PROFESSIONAL SERVICES	0		0		0		0		0	
REFERRALS	0		0		0		0		0	
EMERGENCY ROOM SERVICES	0		0		0		0		0	
OCCUPANCY, DEPR AND AMORT (M&E)	0		0		0		0		0	
INPATIENT	0		0		0		0		0	
REINSURANCE EXPENSES	0		0		0		0		0	
OTHER MEDICAL (ACUTE)	0		0		0		0		0	
TOTAL LONG TERM CARE	0		0		0		0		0	
ALF Expenses	0		0		0		0		0	
SNF Expenses	0		0		0		0		0	
Other Facility Expenses	0		0		0		0		0	
TOTAL FACILITY CARE EXPENSES	0		0		0		0		0	
TOTAL MEDICAL AND HOSPITAL.....	0		0		0		0		0	
COMPENSATION	0		0		0		0		0	
INTEREST EXPENSE	0		0		0		0		0	
OCCUPANCY, DEPR, AND AMORT	0		0		0		0		0	
COMMUNITY OUTREACH/MARKETING	0		0		0		0		0	
AGGREGATE WRITE-INS (WRITE-INS SMMC LTC)	0		0		0		0		0	
TOTAL ADMINISTRATION EXP.....	0		0		0		0		0	
TOTAL EXPENSES.....	0		0		0		0		0	
INCOME (LOSS).....	0		0		0		0		0	
MEDICAL & HOSPITAL / TOTAL CAPITATION PREMIUMS	0.00%		0.00%		0.00%		0.00%		0.00%	
MEDICAL & HOSPITAL / TOTAL FEE FOR SERVICE REVENUE	0.00%		0.00%		0.00%		0.00%		0.00%	
ADMINISTRATION / TOTAL CAPITATION PREMIUMS	0.00%		0.00%		0.00%		0.00%		0.00%	
ADMINISTRATION / TOTAL FEE FOR SERVICE REVENUE	0.00%		0.00%		0.00%		0.00%		0.00%	
COMPENSATION / TOTAL ADMINISTRATION	0.00%		0.00%		0.00%		0.00%		0.00%	
INTEREST / TOTAL ADMINISTRATION	0.00%		0.00%		0.00%		0.00%		0.00%	
COMMUNITY OUTREACH / TOTAL ADMINISTRATION	0.00%		0.00%		0.00%		0.00%		0.00%	
RETURN ON REVENUE	0.00%		0.00%		0.00%		0.00%		0.00%	

SMMC-LTC PROGRAM

AGGREGATE WRITE-INS:

Enter data in highlighted cells.

Better Health, Inc.

	42004	2014	2014	2014	2014	2014
	SMMC LTC	MAR-31ST	JUN-30TH	SEP-30TH	DEC-31ST	YEAR TO DATE
<i>FOR REVENUES:</i>						
1. Inter-company investment income		0	0	0	0	0
2. Joint venture income		0	0	0	0	0
3. Gain/(loss) on sale of assets		0	0	0	0	0
4.		0	0	0	0	0
5.		0	0	0	0	0
6.		0	0	0	0	0
TOTAL		0	0	0	0	0
<i>FOR OTHER ADMIN EXPENSES:</i>						
1. Postage/office rent/telephone		0	0	0	0	0
2. Legal/ accounting fees		0	0	0	0	0
3. Consulting fees		0	0	0	0	0
4. Management fees		0	0	0	0	0
5. Maintenance/misc		0	0	0	0	0
6.		0	0	0	0	0
TOTAL		0	0	0	0	0

REVENUES AND EXPENSES		Enter data in YELLOW highlighted cells.				
Better Health, Inc.						
12/31/2014		2014	2014	2014	2014	2014
SMMC MMA		MAR 31ST	JUN 30TH	SEPT 30TH	DEC 31ST	YEAR TO DATE
PREMIUM		0	5,275,108	63,501,361	65,487,955	134,264,425
FEE-FOR-SERVICE		0	0	0	0	0
COPAYMENTS		0	0	0	0	0
INTEREST		0	281	2,120	2,057	4,457
COB & SUBROGATION		0	0	0	0	0
REINSURANCE RECOVERIES		0	0	0	21,917	21,917
AGGREGATE WRITE-INS (WRITE-INS MCAID)		0	0	0	0	0
TOTAL REVENUE.....		0	5,275,389	63,503,481	65,511,929	134,290,800
PHYSICIAN SERVICES		0	1,222,758	23,466,662	27,085,762	51,775,181
OTHER PROFESSIONAL SERVICES		0	1,107,893	11,715,843	13,311,145	26,134,882
OUTSIDE REFERRALS		0	0	0	0	0
EMERGENCY ROOM, OUT-OF-AREA		0	0	0	0	0
OCCUPANCY , DEPR AND AMORT (M&E)		0	0	0	0	0
INPATIENT		0	1,125,435	23,436,962	18,936,648	43,499,046
REINSURANCE EXPENSES		0	10,607	159,651	154,640	324,898
OTHER MEDICAL		0	0	0	0	0
INCENTIVE POOL ADJUSTMENT		0	0	61,044	157,480	218,524
TOTAL MEDICAL AND HOSPITAL.....		0	3,466,694	58,840,162	59,645,675	121,952,531
COMPENSATION		0	0	0	30,012	30,012
INTEREST EXPENSE		0	0	0	107,429	107,429
OCCUPANCY, DEPR, AND AMORT		0	0	0	0	0
MARKETING/COMMUNITY OUTREACH		0	0	0	0	0
AGGREGATE WRITE-INS (WRITE-INS MCAID)		0	700,940	5,833,230	7,340,948	13,875,118
TOTAL ADMINISTRATION EXP.....		0	700,940	5,833,230	7,478,390	14,012,560
TOTAL EXPENSES.....		0	4,167,633	64,673,393	67,124,065	135,965,091
INCOME (LOSS).....		0	1,107,756	(1,169,912)	(1,612,135)	(1,674,291)
MEDICAL & HOSPITAL / TOTAL PREMIUMS		0.00%	65.72%	92.66%	91.08%	90.83%
ADMINISTRATION / TOTAL PREMIUMS		0.00%	13.29%	9.19%	11.42%	10.44%
COMPENSATION / TOTAL ADMINISTRATION		0.00%	0.00%	0.00%	0.40%	0.21%
INTEREST/ TOTAL ADMINISTRATION		0.00%	0.00%	0.00%	1.44%	0.77%
MARKETING / TOTAL ADMINISTRATION		0.00%	0.00%	0.00%	0.00%	0.00%
RETURN ON REVENUE		0.00%	21.00%	-1.84%	-2.46%	-1.25%

AGGREGATE WRITE-INS:

Enter data in highlighted cells.

Better Health, Inc.

	42004	2014 MAR-31ST	2014 JUN-30TH	2014 SEP-30TH	2014 DEC-31ST	2014 YEAR TO DATE
SMMC MMA						
<i>FOR REVENUES:</i>						
1. Inter-company investment income		0	0	0	0	0
2. Joint venture income		0	0	0	0	0
3. Gain/(loss) on sale of assets		0	0	0	0	0
4.		0	0	0	0	0
5.		0	0	0	0	0
6.		0	0	0	0	0
TOTAL		0	0	0	0	0
<i>FOR OTHER ADMIN EXPENSES:</i>						
1. Postage/office rent/telephone		0	0	0	0	0
2. Legal/ accounting fees		0	0	0	0	0
3. Consulting fees		0	0	0	3,750	3,750
4. Management fees		0	700,940	5,833,230	5,681,945	12,216,115
5. Maintenance/misc		0	0	0	0	0
6. Other Expenses		0	0	0	1,655,254	1,655,254
TOTAL		0	700,940	5,833,230	7,340,948	13,875,118

REVENUES AND EXPENSES		Enter data in YELLOW highlighted cells.				
Better Health, Inc.						
12/31/2014		2014	2014	2014	2014	2014
MEDICAID		MAR 31ST	JUN 30TH	SEPT 30TH	DEC 31ST	YEAR TO DATE
PREMIUM		6,725,488	6,212,358	27,627	122,516	13,087,989
FEE-FOR-SERVICE		0	0	0	0	0
COPAYMENTS		0	0	0	0	0
INTEREST		609	331	10	0	950
COB & SUBROGATION		0	0	0	0	0
REINSURANCE RECOVERIES		0	0	0	0	0
AGGREGATE WRITE-INS (WRITE-INS MCAID)		1,931,701	8,985,322	1,873,696	2,866,655	15,657,374
TOTAL REVENUE.....		8,657,798	15,198,011	1,901,333	2,989,171	28,746,314
PHYSICIAN SERVICES		766,928	1,152,927	(3,842)	48,985	1,964,998
OTHER PROFESSIONAL SERVICES		2,689,791	2,196,286	15,432	28,388	4,929,897
OUTSIDE REFERRALS		0	0	0	0	0
EMERGENCY ROOM, OUT-OF-AREA		0	0	0	0	0
OCCUPANCY , DEPR AND AMORT (M&E)		0	0	0	0	0
INPATIENT		0	0	0	0	0
REINSURANCE EXPENSES		0	0	0	0	0
OTHER MEDICAL		0	0	0	0	0
INCENTIVE POOL ADJUSTMENT		0	0	0	0	0
TOTAL MEDICAL AND HOSPITAL.....		3,456,719	3,349,213	11,590	77,374	6,894,895
COMPENSATION		553,864	441,985	193,741	0	1,189,589
INTEREST EXPENSE		0	0	0	0	0
OCCUPANCY, DEPR, AND AMORT		0	0	0	0	0
COMMUNITY/MARKETING		0	0	0	0	0
AGGREGATE WRITE-INS (WRITE-INS MCAID)		3,918,509	21,787,741	120,928	0	25,827,178
TOTAL ADMINISTRATION EXP.....		4,472,372	22,229,726	314,669	0	27,016,767
TOTAL EXPENSES.....		7,929,091	25,578,938	326,259	77,374	33,911,662
INCOME (LOSS).....		728,707	(10,380,928)	1,575,074	2,911,798	(5,165,349)
MEDICAL & HOSPITAL / TOTAL PREMIUMS		51.40%	53.91%	41.95%	63.15%	52.68%
ADMINISTRATION / TOTAL PREMIUMS		66.50%	357.83%	1138.98%	0.00%	206.42%
COMPENSATION / TOTAL ADMINISTRATION		12.38%	1.99%	61.57%	0.00%	4.40%
INTEREST/ TOTAL ADMINISTRATION		0.00%	0.00%	0.00%	0.00%	0.00%
MARKETING / TOTAL ADMINISTRATION		0.00%	0.00%	0.00%	0.00%	0.00%
RETURN ON REVENUE		8.42%	-68.30%	82.84%	97.41%	-17.97%

AGGREGATE WRITE-INS:		<i>Enter data in highlighted cells.</i>				
Better Health, Inc.						
	42004	2014	2014	2014	2014	2014
	MEDICAID	MAR-31ST	JUN-30TH	SEP-30TH	DEC-31ST	YEAR TO DATE
<i>FOR REVENUES:</i>						
1.	Inter-company investment income	0	0	0	0	0
2.	Joint venture income	0	0	0	0	0
3.	Gain/(loss) on sale of assets	0	0	0	0	0
4.	PSN Est. Reconciliation Receivable	(1,077,862)	7,176,571	1,567,237	2,866,655	10,532,601
5.	Simply Better Health PSNME Revenue	3,009,564	1,808,751	306,459	0	5,124,773
6.		0	0	0	0	0
	TOTAL	1,931,701	8,985,322	1,873,696	2,866,655	15,657,374
<i>FOR OTHER ADMIN EXPENSES:</i>						
1.	Postage/office rent/telephone	10,366	73	5,210	0	15,649
2.	Legal/ accounting fees	0	405	0	0	405
3.	Consulting fees	8,750	3,750	3,750	0	16,250
4.	Management fees	3,000,000	21,277,110	0	0	24,277,110
5.	Maintenance/misc	802,550	482,334	83,825	0	1,368,709
6.	Other Expenses	96,843	24,069	28,143	0	149,055
	TOTAL	3,918,509	21,787,741	120,928	0	25,827,178

12/31/14		NOTE: Please enter data in YELLOW highlighted cells. (Begin with Row 15 end with Row 196)						
42004		MAR 31ST	JUN 30TH	VARIANCE	SEPT 30TH	VARIANCE	DEC 31ST	VARIANCE YEAR TO DATE
REVENUES AND EXPENSES		2014	2014	%	2014	%	2014	2014
ENROLLMENT:								
COMMERCIAL								
MEDICARE								
SMMC MMA								
SMMC LTC								
MEDICAID								
TOTAL ENROLLMENT [SEE TAB]								
CASH AND EQUIVALENTS								
SHORT-TERM INVESTMENTS								
PREMIUMS RECEIVABLE								
INTEREST RECEIVABLE								
OTHER RECEIVABLES								
PREPAID EXPENSES								
AGGREGATE WRITE-INS [SEE TAB]								
TOTAL CURRENT ASSETS								
RESTRICTED FUNDS (AHCA MEDICAL/SMMC)								
RESTRICTED FUNDS (DFS-OIR)								
RESTRICTED FUNDS (DOEA)								
LOAN ESCROW								
L-T INVESTMENTS								
INTANGIBLES/GOODWILL								
AGGREGATE WRITE-INS [SEE TAB]								
TOTAL OTHER ASSETS								
LAND								
BUILDINGS & IMPROVEMENTS								
CONSTRUCTION IN PROGRESS								
FURNITURE AND EQUIPMENT								
LEASEHOLD IMPROVEMENTS								
AGGREGATE WRITE-INS [SEE TAB]								
TOTAL PROPERTY AND EQUIPMENT								
TOTAL ASSETS								
ACCOUNTS PAYABLE								
CLAIMS PAYABLE (REPORTED)								
ACCRUED INPATIENT CLAIMS (IBNR)								
ACCRUED PHYSICIAN CLAIMS (IBNR)								
ACCRUED REFERRAL CLAIMS (IBNR)								
ACCRUED OTHER MEDICAL (IBNR)								
ACCRUED PROVIDER INCENTIVE POOL								
UNEARNED PREMIUMS								
LOANS AND NOTES PAYABLE								
AGGREGATE WRITE-INS [SEE TAB]								
TOTAL CURRENT LIABILITIES								
LOANS AND NOTES PAYABLE L-T								
STATUTORY LIABILITIES								
AGGREGATE WRITE-INS [SEE TAB]								
TOTAL OTHER LIABILITIES								
TOTAL LIABILITIES								
CONTRIBUTED CAPITAL								
COMMON STOCK								
PREFERRED STOCK								
PAID IN SURPLUS								
SURPLUS NOTES								
UNASSIGNED SURPLUS								
AGGREGATE WRITE-INS [SEE TAB]								
TOTAL NET WORTH								
TOTAL LIABILITIES AND NET WORTH								

<div>12/31/14</div> <div>42004</div> <div>NOTE: Please enter data in YELLOW highlighted cells. (Begin with Row 15 end with Row 196)</div>								
REVENUES AND EXPENSES	MAR 31ST 2014	JUN 30TH 2014	VARIANCE %	SEPT 30TH 2014	VARIANCE %	DEC 31ST 2014	VARIANCE %	YEAR TO DATE 2014
COMMERCIAL								
FEE-FOR-SERVICE								
COPAYMENTS								
TITLE XVIII - MEDICARE								
TITLE XIX - SMMC MMA		5,275,108		63,501,361	1104%	65,487,955	3%	134,264,425
TITLE XIX - SMMC LTC								
TITLE XIX - MEDICAID	6,725,488	6,212,358	-8%	27,627	-100%	122,516	343%	13,087,989
INTEREST	609	612	1%	2,130	248%	2,057	-3%	5,407
COB & SUBROGATION								
REINSURANCE RECOVERIES						21,917		21,917
AGGREGATE WRITE-INS [SEE TAB]	1,931,701	8,985,322	365%	1,873,696	-79%	2,866,655	53%	15,657,374
TOTAL REVENUE	8,657,798	20,473,400	136%	65,404,814	219%	68,501,101	5%	163,037,113
PHYSICIAN SERVICES	766,928	2,375,685	210%	23,462,819	888%	27,134,747	16%	53,740,179
CASE MANAGEMENT (SMMC LTC)								
OTHER PROFESSIONAL SERVICES	2,689,791	3,304,179	23%	11,731,276	255%	13,339,533	14%	31,064,779
OUTSIDE REFERRALS								
EMERGENCY ROOM, OUT-OF-AREA								
OCCUPANCY, DEPR AND AMORT (M&E)								
INPATIENT		1,125,435		23,436,962	1982%	18,936,648	-19%	43,499,046
REINSURANCE EXPENSES		10,607		159,651	1405%	154,640	-3%	324,898
OTHER MEDICAL								
TOTAL LONG TERM CARE (SMMC LTC)								
TOTAL FACILITY CARE EXPENSES (SMMC LTC)								
INCENTIVE POOL ADJUSTMENT				61,044		157,480	158%	218,524
TOTAL MEDICAL AND HOSPITAL	3,456,719	6,815,907	97%	58,851,752	763%	59,723,049	1%	128,847,426
COMPENSATION	553,864	441,985	-20%	193,741	-56%	30,012	-85%	1,219,601
INTEREST EXPENSE						107,429		107,429
OCCUPANCY, DEPR, AND AMORT								
COMMUNITY OUTREACH/MARKETING								
AGGREGATE WRITE-INS [SEE TAB]	3,918,509	22,488,680	474%	5,954,158	-74%	7,340,948	23%	39,702,296
TOTAL ADMINISTRATION EXP	4,472,372	22,930,665	413%	6,147,899	-73%	7,478,390	22%	41,029,327
TOTAL EXPENSES	7,929,091	29,746,572	275%	64,999,652	119%	67,201,438	3%	169,876,753
INCOME (LOSS)	728,707	(9,273,172)	-1373%	405,163	-104%	1,299,662	221%	(6,839,640)
EXTRAORDINARY ITEM								
PROVISION FOR TAXES	866,444	(4,148,852)	-579%	601,846	-115%	2,680,563	345%	
NET INCOME (LOSS)	(137,738)	(5,124,319)	3620%	(196,683)	-96%	(1,380,900)	602%	(6,839,640)
CURRENT RATIO	99.63%	161.11%	61.70%	107.67%	-33.17%	89.29%	-17.07%	89.29%
DEBT / EQUITY	34.36%	54.68%	59.17%	172.97%	216.30%	273.35%	58.04%	273.35%
TOTAL DEBT/ PREMIUM INCOME	124.94%	86.79%	-30.53%	52.10%	-39.97%	73.97%	41.98%	32.94%
S-T INVESTMENTS/TOTAL ASSETS								
L-T INVESTMENTS/TOTAL ASSETS								
CLAIMS PAYABLE/ CURRENT LIAB.		4.39%		13.67%	211.72%	8.00%	-41.46%	8.00%
INPATIENT CLAIMS (IBNR)/CURRENT LIAB		15.55%		34.95%	124.78%	19.74%	-43.51%	19.74%
PHYSICIAN CLAIMS (IBNR)/CURRENT LIAB		6.96%		13.86%	99.26%	13.38%	-3.47%	13.38%
REFERRAL CLAIMS (IBNR)/CURRENT LIAB								
LOANS & NOTES PAYABLE/TOTAL LIAB								
MEDICAID PREMIUMS / TOTAL PREMIUMS	100.00%	100.00%		100.00%		100.00%		100.00%
MEDICAL & HOSPITAL / TOTAL PREMIUMS	51.40%	59.33%	15.44%	92.64%	56.13%	91.03%	-1.74%	87.44%
FEE-FOR-SERVICE/TOTAL REVENUES								
ADMINISTRATION / TOTAL PREMIUMS	66.50%	199.61%	200.18%	9.68%	-95.15%	11.40%	17.78%	27.84%
COMPENSATION / TOTAL ADMINISTRATION	12.38%	1.93%	-84.44%	3.15%	63.49%	0.40%	-87.27%	2.97%
INTEREST/ TOTAL ADMINISTRATION						1.44%		0.26%
MARKETING/Community Outreach / TOTAL ADMINISTRATION								
RETURN ON EQUITY	-0.56%	-28.11%	4890.29%	-1.03%	-96.34%	-7.78%	656.70%	-38.52%
RETURN ON REVENUE	-1.59%	-25.03%	1473.26%	-0.30%	-98.80%	-2.02%	570.36%	-4.20%
GAINS FROM OPERATIONS	8.42%	-45.29%	-638.14%	0.62%	-101.37%	1.90%	206.28%	-4.20%
SURPLUS REQUIRED (see row 200 below)	1,500,000	1,500,000		3,309,779	120.65%	4,853,222	46.63%	4,853,222
ACTUAL SURPLUS/NET WORTH	24,456,466	18,232,696	-25.45%	19,135,464	4.95%	17,754,564	-7.22%	17,754,564
EXCESS/(DEFICIT)	22,956,466	16,732,696	-27.11%	15,825,685	-5.42%	12,901,341	-18.48%	12,901,341

12/31/14		NOTE: Please enter data in YELLOW highlighted cells. (Begin with Row 15 end with Row 196)							
42004		MAR 31ST	JUN 30TH	VARIANCE	SEPT 30TH	VARIANCE	DEC 31ST	VARIANCE	YEAR TO DATE
REVENUES AND EXPENSES		2014	2014	%	2014	%	2014	%	2014
CHANGES IN FINANCIAL POSITION & NET WORTH									
SOURCES:									
1.	NET INCOME (LOSS)	(137,738)	(5,124,319)	3620%	(196,683)	-96%	(1,380,900)	602%	(6,839,640)
NOT AFFECTING WORKING CAPITAL:									
2.	DEPRECIATION AND AMORTIZATION								
3.	DEFERRED TAXES								
4.	DECREASE (INCREASE) IN UNCOLLECTED PREMIUM								
5.	INCREASE IN CURRENT LIABILITIES								
6.	DECREASE (INCREASE) IN PREPAID & OTHERS								
OTHER ADDITIONS TO WORKING CAPITAL:									
7.	PROCEEDS FROM BORROWING								
8.	CAPITAL CONTRIBUTIONS								
9.									
10.									
11.									
TOTAL SOURCES OF FUNDS		(137,738)	(5,124,319)	3620%	(196,683)	-96%	(1,380,900)	602%	(6,839,640)
APPLICATIONS:									
11.	ADDITIONS TO PROPERTY & EQUIPMENT								
12.	REDUCTIONS IN L-T DEBT								
13.									
14.									
15.									
TOTAL APPLICATION OF FUNDS									
INCREASE/(DECREASE) IN WORKING CAPITAL		(137,738)	(5,124,319)	3620%	(196,683)	-96%	(1,380,900)	602%	(6,839,640)
NET WORTH:									
1.	NET WORTH BEGINNING OF PERIOD		24,456,466		18,232,696	-25%	19,135,464	5%	
2.	INCREASE (DECREASE) IN CONTRIBUTED CAPITAL.....								
3.	INCREASE (DECREASE) IN PREFERRED STOCK.....								
4.	INCREASE (DECREASE) IN COMMON STOCK.....								
5.	INCREASE (DECREASE) IN PAID-IN SURPLUS.....								
6.	INCREASE (DECREASE) IN UNASSIGNED SURPLUS:								
6(A)	NET INCOME (LOSS)	(137,738)	(5,124,319)	3620%	(196,683)	-96%	(1,380,900)	602%	(6,839,640)
6(B)	DIVIDENDS TO STOCKHOLDERS								
6(C)	INTEREST ON SURPLUS NOTES								
6(D)	INCREASE (DECREASE) IN NON-ADMITTED								
6(E)	INCREASE IN DEFERRED TAXES								
NET WORTH END OF PERIOD.....		24,456,466	18,232,696	-25%	19,135,464	5%	17,754,564	-7%	17,754,564

Required Surplus calculation 641.225,F.S., Greater of:						
\$1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
10% of total Liabilities	840,251.98	997,052.74	3,309,779.02	4,853,222.23	4,853,222.23	4,853,222.23
2% of total annualized premium	538,039.04	728,518.16	2,179,785.14	2,947,048.29	2,947,048.29	2,947,048.29
\$0 minimum - written guarantee agreement						
Required Surplus:	1,500,000.00	1,500,000.00	3,309,779.02	4,853,222.23	4,853,222.23	4,853,222.23
Annualized Premiums	6,725,487.96	11,487,466.08	63,528,988.56	65,610,471.76	147,352,414.36	147,352,414.36
*2%	538,039.04	728,518.16	2,179,785.14	2,947,048.29	2,947,048.29	2,947,048.29

AGGREGATE WRITE-INS:

Enter data in highlighted cells.

Better Health, Inc.		2014	2014	2014	2014	2014
12/31/2014		MAR 31ST	JUN 30TH	SEP 30TH	DEC 31ST	YEAR TO DATE
FOR CURRENT ASSETS:						
1.	Due from affiliates	0	0	0	0	0
2.	Advances receivable	0	0	0	0	0
3.	Tax receivable	0	4,032,408	3,430,563	750,000	750,000
4.		0	0	0	0	0
5.		0	0	0	0	0
6.		0	0	0	0	0
TOTAL		0	4,032,408	3,430,563	750,000	750,000
FOR OTHER ASSETS:						
1.	Security deposits	4,667,142	300,000	0	300,000	300,000
2.	Due from affiliates	67,211	68,639	65,237	64,241	64,241
3.	Inventory	0	0	0	0	0
4.	Healthcare and other receivables	19,214,390	11,232,748	12,673,733	15,674,532	15,674,532
5.		0	0	0	0	0
6.		0	0	0	0	0
TOTAL		23,948,743	11,601,387	12,738,970	16,038,773	16,038,773
FOR PROPERTY & EQUIP:						
1.	Computer software	0	0	0	0	0
2.	Vehicles	0	0	0	0	0
3.		0	0	0	0	0
4.		0	0	0	0	0
5.		0	0	0	0	0
6.		0	0	0	0	0
TOTAL		0	0	0	0	0
FOR CURRENT LIAB:						
1.	1 Accrued salaries	54,368	73,838	5,884	1,261	1,261
2.	2 Income tax payable	0	0	0	0	0
3.	3 Due to affiliates	3,114,109	1,830,000	2,027,372	1,998,563	1,998,563
4.	Healthcare & other payables	3,935,443	4,205,669	4,360,250	3,920,799	3,920,799
5.	Deferred Tax Liability	866,444	0	0	0	0
6.		0	0	0	0	0
TOTAL		7,970,365	6,109,507	6,393,506	5,920,622	5,920,622
FOR OTHER LIAB:						
1.	Due to affiliates	0	0	0	0	0
2.	Other contingencies	0	0	0	0	0
3.		0	0	0	0	0
4.		0	0	0	0	0
5.		0	0	0	0	0
6.		0	0	0	0	0
TOTAL		0	0	0	0	0
FOR NET WORTH:						
1.	Non-admitted assets (DFS-OIR)	0	0	0	0	0
2.		0	0	0	0	0
3.		0	0	0	0	0
4.		0	0	0	0	0
5.		0	0	0	0	0
6.		0	0	0	0	0
TOTAL		0	0	0	0	0

Medical Costs associated with:
Federally Qualified Health Centers
& Rural Health Clinics

Better Health, Inc.

12/31/2014

Enter data in highlighted cells.

MEDICAID:

	2014 Mar-31 FQHC	2014 Mar-31 RHC	2014 Jun-30 FQHC	Jul-06 Jun-30 RHC	2014 Sep-30 FQHC	2014 Sep-30 RHC	2014 Dec-31 FQHC	2014 Dec-31 RHC	2014 Y-T-D FQHC	2014 Y-T-D RHC
Number of Enrollees	1,212	-	1,017	-	-	-	-	-	2,229	-
PHYSICIAN SERVICES - capitated basis	\$ 5,120	\$ -	\$ 4,164	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 9,284	\$ -
PHYSICIAN SERVICES - discounted ffs/per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
INPATIENT SERVICES - capitated basis	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
INPATIENT SERVICES - discounted ffs/per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
OTHER PROF. SERVICES - capitated basis	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
OTHER PROF. SERVICES - discounted ffs/per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Medicaid Costs	\$ 5,120	\$ -	\$ 4,164	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 9,284	\$ -
PMPM	\$ 1.41	\$ -	\$ 1.36	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1.39	\$ -

SMMC MMA

Number of Enrollees	-	-	1,056	-	4,272	-	4,673	-	10,001	-
PHYSICIAN SERVICES - capitated basis	\$ -	\$ -	\$ 10,526	\$ -	\$ 31,988	\$ -	\$ 28,516	\$ -	\$ 71,030	\$ -
PHYSICIAN SERVICES - discounted ffs/per diem	\$ -	\$ -	\$ 1,295	\$ -	\$ 19,765	\$ -	\$ 15,372	\$ -	\$ 36,432	\$ -
INPATIENT SERVICES - capitated basis	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
INPATIENT SERVICES - discounted ffs/per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
OTHER PROF. SERVICES - capitated basis	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
OTHER PROF. SERVICES - discounted ffs/per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Medicaid Costs	\$ -	\$ -	\$ 11,821	\$ -	\$ 51,753	\$ -	\$ 43,888	\$ -	\$ 107,462	\$ -
PMPM	\$ -	\$ -	\$ 3.73	\$ -	\$ 4.04	\$ -	\$ 3.13	\$ -	\$ 3.58	\$ -

SMMC LTC

Number of Enrollees	-	-	-	-	-	-	-	-	-	-
PHYSICIAN SERVICES - capitated basis	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
PHYSICIAN SERVICES - discounted ffs/per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
INPATIENT SERVICES - capitated basis	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
INPATIENT SERVICES - discounted ffs/per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
OTHER PROF. SERVICES - capitated basis	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
OTHER PROF. SERVICES - discounted ffs/per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Medicaid Costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
PMPM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

COMMERCIAL:

Number of Enrollees	-	-	-	-	-	-	-	-	-	-
PHYSICIAN SERVICES - capitated basis	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
PHYSICIAN SERVICES - discounted ffs/per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
INPATIENT SERVICES - capitated basis	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
INPATIENT SERVICES - discounted ffs/per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
OTHER PROF. SERVICES - capitated basis	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
OTHER PROF. SERVICES - discounted ffs/per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Commercial Costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
PMPM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

MEDICARE:

Number of Enrollees	-	-	-	-	-	-	-	-	-	-
PHYSICIAN SERVICES - capitated basis	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
PHYSICIAN SERVICES - discounted ffs/per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
INPATIENT SERVICES - capitated basis	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
INPATIENT SERVICES - discounted ffs/per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
OTHER PROF. SERVICES - capitated basis	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
OTHER PROF. SERVICES - discounted ffs/per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Medicare Costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
PMPM	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total FQHC & RHC Costs	\$ 5,120	\$ -	\$ 15,985	\$ -	\$ 51,753	\$ -	\$ 43,888	\$ -	\$ 116,746	\$ -
Total PMPM	\$ 1.41	\$ -	\$ 2.57	\$ -	\$ 4.04	\$ -	\$ 3.13	\$ -	\$ 3.18	\$ -

ANNUAL STATEMENT

OF THE

Better Health, Inc.

of **Miami**

in the state of **Florida**

TO THE

Insurance Department

OF THE

State of Florida

FOR THE YEAR ENDED

December 31, 2015

HEALTH

2015

Print Date: 04/01/2016 11:47:49 AM



15480201520100100

ANNUAL STATEMENT
For the Year Ended December 31, 2015
OF THE CONDITION AND AFFAIRS OF THE

Better Health, Inc.

NAIC Group Code	4806	4806	NAIC Company Code	15480	Employer's ID Number	20-4883379																		
	(Current Period)	(Prior Period)																						
Organized under the Laws of	Florida, State of Domicile or Port of Entry																							
Country of Domicile	United States of America																							
Licensed as business type:	<table border="0"> <tr> <td>Life, Accident & Health</td> <td><input type="checkbox"/></td> <td>Property/Casualty</td> <td><input type="checkbox"/></td> <td>Hospital, Medical & Dental Service or Indemnity</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Dental Service Corporation</td> <td><input type="checkbox"/></td> <td>Viator Service Corporation</td> <td><input type="checkbox"/></td> <td>Health Maintenance Organization</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>Other</td> <td><input type="checkbox"/></td> <td>Is HMO Federally Qualified?</td> <td>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></td> <td colspan="2"></td> </tr> </table>						Life, Accident & Health	<input type="checkbox"/>	Property/Casualty	<input type="checkbox"/>	Hospital, Medical & Dental Service or Indemnity	<input type="checkbox"/>	Dental Service Corporation	<input type="checkbox"/>	Viator Service Corporation	<input type="checkbox"/>	Health Maintenance Organization	<input checked="" type="checkbox"/>	Other	<input type="checkbox"/>	Is HMO Federally Qualified?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
Life, Accident & Health	<input type="checkbox"/>	Property/Casualty	<input type="checkbox"/>	Hospital, Medical & Dental Service or Indemnity	<input type="checkbox"/>																			
Dental Service Corporation	<input type="checkbox"/>	Viator Service Corporation	<input type="checkbox"/>	Health Maintenance Organization	<input checked="" type="checkbox"/>																			
Other	<input type="checkbox"/>	Is HMO Federally Qualified?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>																					
Incorporated/Organized	February 26, 2014		Commenced Business		February 1, 2015																			
Statutory Home Office	9250 W. Plover St. Suite 600		Miami, FLORIDA, US		33174																			
	(Street and Number)		(City or Town, State, Country and Zip Code)																					
Main Administrative Office	4425 Corporation Lane		Virginia Beach, VIRGINIA, US		23462																			
	(Street and Number)		(City or Town, State, Country and Zip Code)																					
Mail Address	4425 Corporation Lane		Virginia Beach, VIRGINIA, US		23462																			
	(Street and Number or P.O. Box)		(City or Town, State, Country and Zip Code)																					
Primary Location of Books and Records	4425 Corporation Lane		Virginia Beach, VIRGINIA, US		23462																			
	(Street and Number)		(City or Town, State, Country and Zip Code)																					
Internet Web Site Address	http://www.betterhealthinc.com/																							
Statutory Statement Contact	Bette Lou Gruneth		757-518-3638		757-557-4712																			
	(Name)		(Area Code) (Telephone Number)		(Extension)																			
	Bette Gruneth@bettergroup.com		757-557-4712		757-557-4712																			
	(E-Mail Address)		(Area Code) (Telephone Number)		(Extension)																			

OFFICERS

	Name	Title
1	Louise Tome-Rivas	CEO & President
2	Kathleen S. Kuster	Secretary
3	Dr. David Kretschmer	Treasurer
4	Holly J. Prince	CFO

VICE-PRESIDENTS

Name	Title	Name	Title
Vincent Panton	Chief Medical Officer	Eric K. Nobis	Assistant Treasurer

DIRECTORS OR TRUSTEES

Name	Title	Name	Title
Louise Tome-Rivas	Catherine I. Kaleschak	Carter A. Beck	

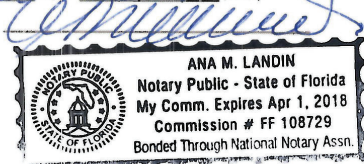
State of Florida

County of Miami-Dade ss

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanation therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

(Signature)	(Signature)	(Signature)
Louise Tome-Rivas	Kathleen S. Kuster	Holly J. Prince
(Printed Name)	(Printed Name)	(Printed Name)
1	2	3
CEO & President	Secretary	CFO
(Title)	(Title)	(Title)

Subscribed and sworn to (or affirmed) before me this on this day of March 2016 by



a. Is this an original filing? ☒ Yes ☐ No
b. If no: 1. State the amendment number
2. Date filed
3. Number of pages attached

Annual Statement for the year 2015 of the **Better Health, Inc.****ASSETS**

	Current Year			Prior Year
	1	2	3	4
	Assets	Nonadmitted Assets	Net Admitted Assets (Cols. 1 - 2)	Net Admitted Assets
1. Bonds (Schedule D)	0	0	0	0
2. Stocks (Schedule D):				
2.1 Preferred stocks	0	0	0	0
2.2 Common stocks	0	0	0	0
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens	0	0	0	0
3.2 Other than first liens	0	0	0	0
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less \$ 0 encumbrances)	0	0	0	0
4.2 Properties held for the production of income (less \$ 0 encumbrances)	0	0	0	0
4.3 Properties held for sale (less \$ 0 encumbrances)	0	0	0	0
5. Cash (\$ 43,761,382, Schedule E - Part 1), cash equivalents (\$ 0, Schedule E - Part 2), and short-term investments (\$ 0, Schedule DA)	43,761,382	0	43,761,382	43,811,687
6. Contract loans (including \$ 0 premium notes)	0	0	0	0
7. Derivatives (Schedule DB)	0	0	0	0
8. Other invested assets (Schedule BA)	0	0	0	0
9. Receivables for securities	0	0	0	0
10. Securities lending reinvested collateral assets (Schedule DL)	0	0	0	0
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	43,761,382	0	43,761,382	43,811,687
13. Title plants less \$ 0 charged off (for Title insurers only)	0	0	0	0
14. Investment income due and accrued	893	0	893	0
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	1,638,392	0	1,638,392	5,976,091
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including \$ 0 earned but unbilled premiums)	0	0	0	0
15.3 Accrued retrospective premiums (\$ 0) and contracts subject to redetermination (\$ 0)	2,378,748	0	2,378,748	11,215,853
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers	97,362	0	97,362	21,917
16.2 Funds held by or deposited with reinsured companies	0	0	0	0
16.3 Other amounts receivable under reinsurance contracts	0	0	0	0
17. Amounts receivable relating to uninsured plans	0	0	0	0
18.1 Current federal and foreign income tax recoverable and interest thereon	1,962,380	0	1,962,380	750,000
18.2 Net deferred tax asset	0	0	0	0
19. Guaranty funds receivable or on deposit	0	0	0	0
20. Electronic data processing equipment and software	0	0	0	0
21. Furniture and equipment, including health care delivery assets (\$ 0)	0	0	0	0
22. Net adjustment in assets and liabilities due to foreign exchange rates	0	0	0	0
23. Receivables from parent, subsidiaries and affiliates	131,531	131,531	0	0
24. Health care (\$ 834,919) and other amounts receivable	1,377,606	542,687	834,919	140,711
25. Aggregate write-ins for other-than-invested assets	31,940	31,940	0	0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	51,380,234	706,158	50,674,076	61,916,259
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0	0	0
28. Total (Lines 26 and 27)	51,380,234	706,158	50,674,076	61,916,259

DETAILS OF WRITE-IN LINES				
1101.	0	0	0	0
1102.	0	0	0	0
1103.	0	0	0	0
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)	0	0	0	0
2501. Prepaid Assets	31,940	31,940	0	0
2502.	0	0	0	0
2503.	0	0	0	0
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	31,940	31,940	0	0

Annual Statement for the year 2015 of the **Better Health, Inc.**

LIABILITIES, CAPITAL AND SURPLUS

	Current Year			Prior Year
	1 Covered	2 Uncovered	3 Total	4 Total
1. Claims unpaid (less \$ 0 reinsurance ceded)	29,012,287	0	29,012,287	23,194,097
2. Accrued medical incentive pool and bonus amounts	4,884,467	0	4,884,467	3,016,484
3. Unpaid claims adjustment expenses	980,650	0	980,650	299,565
4. Aggregate health policy reserves, including the liability of \$ 0 for medical loss ratio rebate per the Public Health Services Act	306,539	0	306,539	0
5. Aggregate life policy reserves	0	0	0	0
6. Property/casualty unearned premium reserves	0	0	0	0
7. Aggregate health claim reserves	0	0	0	0
8. Premiums received in advance	0	0	0	18,847,678
9. General expenses due or accrued	220,374	0	220,374	360,503
10.1. Current federal and foreign income tax payable and interest thereon (including \$ 0 on realized gains (losses))	0	0	0	0
10.2. Net deferred tax liability	0	0	0	0
11. Ceded reinsurance premiums payable	0	0	0	0
12. Amounts withheld or retained for the account of others	0	0	0	0
13. Remittances and items not allocated	0	0	0	0
14. Borrowed money (including \$ 0 current) and interest thereon \$ 0 (including \$ 0 current)	0	0	0	0
15. Amounts due to parent, subsidiaries and affiliates	55,827	0	55,827	380,042
16. Derivatives	0	0	0	0
17. Payable for securities	0	0	0	0
18. Payable for securities lending	0	0	0	0
19. Funds held under reinsurance treaties (with \$ 0 authorized reinsurers, \$ 0 unauthorized reinsurers and \$ 0 certified reinsurers)	0	0	0	0
20. Reinsurance in unauthorized and certified \$ (0) companies	0	0	0	0
21. Net adjustments in assets and liabilities due to foreign exchange rates	0	0	0	0
22. Liability for amounts held under uninsured plans	0	0	0	0
23. Aggregate write-ins for other liabilities (including \$ 0 current)	0	0	0	0
24. Total liabilities (Lines 1 to 23)	35,460,144	0	35,460,144	46,098,369
25. Aggregate write-ins for special surplus funds	X X X	X X X	4,874,590	0
26. Common capital stock	X X X	X X X	10	10
27. Preferred capital stock	X X X	X X X	0	0
28. Gross paid in and contributed surplus	X X X	X X X	995,001	995,001
29. Surplus notes	X X X	X X X	10,500,000	10,500,000
30. Aggregate write-ins for other than special surplus funds	X X X	X X X	0	0
31. Unassigned funds (surplus)	X X X	X X X	(1,155,669)	4,322,879
32. Less treasury stock, at cost:				
32.1 0 shares common (value included in Line 26 \$ 0)	X X X	X X X	0	0
32.2 0 shares preferred (value included in Line 27 \$ 0)	X X X	X X X	0	0
33. Total capital and surplus (Lines 25 to 31 minus Line 32)	X X X	X X X	15,213,932	15,817,890
34. Total liabilities, capital and surplus (Lines 24 and 33)	X X X	X X X	50,674,076	61,916,259

DETAILS OF WRITE-IN LINES				
2301.	0	0	0	0
2302.	0	0	0	0
2303.	0	0	0	0
2398. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399. Totals (Lines 2301 through 2303 plus 2398) (Line 23 above)	0	0	0	0
2501. Special Reserve for ACA tax 2016 Payment Year / 2015 Fee Year	X X X	X X X	4,874,590	0
2502.	X X X	X X X	0	0
2503.	X X X	X X X	0	0
2598. Summary of remaining write-ins for Line 25 from overflow page	X X X	X X X	0	0
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	X X X	X X X	4,874,590	0
3001.	X X X	X X X	0	0
3002.	X X X	X X X	0	0
3003.	X X X	X X X	0	0
3098. Summary of remaining write-ins for Line 30 from overflow page	X X X	X X X	0	0
3099. Totals (Lines 3001 through 3003 plus 3098) (Line 30 above)	X X X	X X X	0	0

Annual Statement for the year 2015 of the **Better Health, Inc.****STATEMENT OF REVENUE AND EXPENSES**

	Current Year		Prior Year
	1 Uncovered	2 Total	3 Total
1. Member Months	X X X	1,115,606	1,456,851
2. Net premium income (including \$ 0 non-health premium income)	X X X	267,338,684	158,608,233
3. Change in unearned premium reserves and reserve for rate credits	X X X		
4. Fee-for-service (net of \$ 0 medical expenses)	X X X		
5. Risk revenue	X X X		
6. Aggregate write-ins for other health care related revenues	X X X		
7. Aggregate write-ins for other non-health revenues	X X X		
8. Total revenues (Lines 2 to 7)	X X X	267,338,684	158,608,233
Hospital and Medical:			
9. Hospital/medical benefits		119,165,008	60,911,300
10. Other professional services		64,641,127	43,854,852
11. Outside referrals			
12. Emergency room and out-of-area			
13. Prescription drugs		51,433,149	21,888,077
14. Aggregate write-ins for other hospital and medical			
15. Incentive pool, withhold adjustments and bonus amounts		3,056,009	1,052,967
16. Subtotal (Lines 9 to 15)		238,295,293	127,707,196
Less:			
17. Net reinsurance recoveries		103,104	21,917
18. Total hospital and medical (Lines 16 minus 17)		238,192,189	127,685,279
19. Non-health claims (net)			
20. Claims adjustment expenses, including \$ 4,602,900 cost containment expenses		6,341,286	3,875,346
21. General administrative expenses		23,717,325	35,485,219
22. Increase in reserves for life and accident and health contracts (including \$ 0 increase in reserves for life only)			
23. Total underwriting deductions (Lines 18 through 22)		268,250,800	167,045,844
24. Net underwriting gain or (loss) (Lines 8 minus 23)	X X X	(912,116)	(8,437,611)
25. Net investment income earned (Exhibit of Net Investment Income, Line 17)		10,272	5,407
26. Net realized capital gains (losses) less capital gains tax of \$ 0			
27. Net investment gains (losses) (Lines 25 plus 26)		10,272	5,407
28. Net gain or (loss) from agents' or premium balances charged off [(amount recovered \$ 0) (amount charged off \$ 0)]			
29. Aggregate write-ins for other income or expenses		(124,300)	(50,241)
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	X X X	(1,026,144)	(8,482,445)
31. Federal and foreign income taxes incurred	X X X	(834,476)	
32. Net income (loss) (Lines 30 minus 31)	X X X	(191,668)	(8,482,445)

DETAILS OF WRITE-IN LINES			
0601.	X X X		
0602.	X X X		
0603.	X X X		
0698. Summary of remaining write-ins for Line 06 from overflow page	X X X		
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 06 above)	X X X		
0701.	X X X		
0702.	X X X		
0703.	X X X		
0798. Summary of remaining write-ins for Line 07 from overflow page	X X X		
0799. Totals (Lines 0701 through 0703 plus 0798) (Line 07 above)	X X X		
1401.			
1402.			
1403.			
1498. Summary of remaining write-ins for Line 14 from overflow page			
1499. Totals (Lines 1401 through 1403 plus 1498) (Line 14 above)			
2901. Fines & Penalties		(124,300)	(50,241)
2902.			
2903.			
2998. Summary of remaining write-ins for Line 29 from overflow page			
2999. Totals (Lines 2901 through 2903 plus 2998) (Line 29 above)		(124,300)	(50,241)

Annual Statement for the year 2015 of the **Better Health, Inc.**

STATEMENT OF REVENUE AND EXPENSES (Continued)

	1	2
	Current Year	Prior Year
CAPITAL & SURPLUS ACCOUNT		
33. Capital and surplus prior reporting year	15,817,890	18,279,338
34. Net income or (loss) from Line 32	(191,668)	(8,482,445)
35. Change in valuation basis of aggregate policy and claim reserves		
36. Change in net unrealized capital gains (losses) less capital gains tax of \$	0	
37. Change in net unrealized foreign exchange capital gain or (loss)		
38. Change in net deferred income tax		
39. Change in nonadmitted assets	(412,290)	6,020,997
40. Change in unauthorized and certified reinsurance		
41. Change in treasury stock		
42. Change in surplus notes		
43. Cumulative effect of changes in accounting principles		
44. Capital Changes:		
44.1 Paid in		
44.2 Transferred from surplus (Stock Dividend)		
44.3 Transferred to surplus		
45. Surplus adjustments:		
45.1 Paid in		
45.2 Transferred to capital (Stock Dividend)		
45.3 Transferred from capital		
46. Dividends to stockholders		
47. Aggregate write-ins for gains or (losses) in surplus		
48. Net change in capital and surplus (Lines 34 to 47)	(603,958)	(2,461,448)
49. Capital and surplus end of reporting year (Line 33 plus 48)	15,213,932	15,817,890
DETAILS OF WRITE-IN LINES		
4701.		
4702.		
4703.		
4798. Summary of remaining write-ins for Line 47 from overflow page		
4799. Totals (Lines 4701 through 4703 plus 4798) (Line 47 above)		

Annual Statement for the year 2015 of the **Better Health, Inc.**

CASH FLOW

	1	2
	Current Year	Prior Year
Cash from Operations		
1. Premiums collected net of reinsurance	262,028,176	176,080,600
2. Net investment income	9,379	5,407
3. Miscellaneous income	0	0
4. Total (Lines 1 through 3)	262,037,555	176,086,007
5. Benefit and loss related payments	231,603,368	100,871,782
6. Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts	0	0
7. Commissions, expenses paid and aggregate write-ins for deductions	29,641,955	39,130,216
8. Dividends paid to policyholders	0	0
9. Federal and foreign income taxes paid (recovered) net of \$ 0 tax on capital gains (losses)	377,904	750,000
10. Total (Lines 5 through 9)	261,623,227	140,751,998
11. Net cash from operations (Line 4 minus Line 10)	414,328	35,334,009
Cash from Investments		
12. Proceeds from investments sold, matured or repaid:		
12.1 Bonds	0	0
12.2 Stocks	0	0
12.3 Mortgage loans	0	0
12.4 Real estate	0	0
12.5 Other invested assets	0	0
12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	0	0
12.7 Miscellaneous proceeds	0	0
12.8 Total investment proceeds (Lines 12.1 to 12.7)	0	0
13. Cost of investments acquired (long-term only):		
13.1 Bonds	0	0
13.2 Stocks	0	0
13.3 Mortgage loans	0	0
13.4 Real estate	0	0
13.5 Other invested assets	0	0
13.6 Miscellaneous applications	0	0
13.7 Total investments acquired (Lines 13.1 to 13.6)	0	0
14. Net increase (decrease) in contract loans and premium notes	0	0
15. Net cash from investments (Line 12.8 minus Line 13.7 minus Line 14)	0	0
Cash from Financing and Miscellaneous Sources		
16. Cash provided (applied):		
16.1 Surplus notes, capital notes	0	0
16.2 Capital and paid in surplus, less treasury stock	0	0
16.3 Borrowed funds	0	0
16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	0
16.5 Dividends to stockholders	0	0
16.6 Other cash provided (applied)	(464,633)	6,435,771
17. Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6)	(464,633)	6,435,771
RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS		
18. Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	(50,305)	41,769,780
19. Cash, cash equivalents and short-term investments:		
19.1 Beginning of year	43,811,687	2,041,907
19.2 End of year (Line 18 plus Line 19.1)	43,761,382	43,811,687
Note: Supplemental disclosures of cash flow information for non-cash transactions:		
20.0001	0	0
20.0002	0	0
20.0003	0	0

Annual Statement for the year 2015 of the **Better Health, Inc.**

ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Net premium income	267,338,684	0	0	0	0	0	0	267,338,684	0	0
2. Change in unearned premium reserves and reserve for rate credit	0	0	0	0	0	0	0	0	0	0
3. Fee-for-service (net of \$ 0 medical expenses)	0	0	0	0	0	0	0	0	0	XXX
4. Risk revenue	0	0	0	0	0	0	0	0	0	XXX
5. Aggregate write-ins for other health care related revenues	0	0	0	0	0	0	0	0	0	XXX
6. Aggregate write-ins for other non-health care related revenues	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
7. Total revenues (Lines 1 to 6)	267,338,684	0	0	0	0	0	0	267,338,684	0	0
8. Hospital/medical benefits	119,165,008	0	0	0	0	0	0	119,165,008	0	XXX
9. Other professional services	64,641,127	0	0	0	0	0	0	64,641,127	0	XXX
10. Outside referrals	0	0	0	0	0	0	0	0	0	XXX
11. Emergency room and out-of-area	0	0	0	0	0	0	0	0	0	XXX
12. Prescription drugs	51,433,149	0	0	0	0	0	0	51,433,149	0	XXX
13. Aggregate write-ins for other hospital and medical	0	0	0	0	0	0	0	0	0	XXX
14. Incentive pool, withhold adjustments and bonus amounts	3,056,009	0	0	0	0	0	0	3,056,009	0	XXX
15. Subtotal (Lines 8 to 14)	238,295,293	0	0	0	0	0	0	238,295,293	0	XXX
16. Net reinsurance recoveries	103,104	0	0	0	0	0	0	103,104	0	XXX
17. Total hospital and medical (Lines 15 minus 16)	238,192,189	0	0	0	0	0	0	238,192,189	0	XXX
18. Non-health claims (net)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
19. Claims adjustment expenses including \$ 4,602,900 cost containment expenses	6,341,286	0	0	0	0	0	0	6,341,286	0	0
20. General administrative expenses	23,717,325	0	0	0	0	0	0	23,717,325	0	0
21. Increase in reserves for accident and health contracts	0	0	0	0	0	0	0	0	0	XXX
22. Increase in reserves for life contracts	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
23. Total underwriting deductions (Lines 17 to 22)	268,250,800	0	0	0	0	0	0	268,250,800	0	0
24. Net underwriting gain or (loss) (Line 7 minus Line 23)	(912,116)	0	0	0	0	0	0	(912,116)	0	0

DETAILS OF WRITE-IN LINES										
0501.	0	0	0	0	0	0	0	0	0	XXX
0502.	0	0	0	0	0	0	0	0	0	XXX
0503.	0	0	0	0	0	0	0	0	0	XXX
0598. Summary of remaining write-ins for Line 05 from overflow page	0	0	0	0	0	0	0	0	0	XXX
0599. Totals (Lines 0501 through 0503 plus 0598) (Line 05 above)	0	0	0	0	0	0	0	0	0	XXX
0601.	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
0602.	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
0603.	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
0698. Summary of remaining write-ins for Line 06 from overflow page	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 06 above)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
1301.	0	0	0	0	0	0	0	0	0	XXX
1302.	0	0	0	0	0	0	0	0	0	XXX
1303.	0	0	0	0	0	0	0	0	0	XXX
1398. Summary of remaining write-ins for Line 13 from overflow page	0	0	0	0	0	0	0	0	0	XXX
1399. Totals (Lines 1301 through 1303 plus 1398) (Line 13 above)	0	0	0	0	0	0	0	0	0	XXX

Annual Statement for the year 2015 of the **Better Health, Inc.**

UNDERWRITING AND INVESTMENT EXHIBIT

PART 1 – PREMIUMS

Line of Business	1 Direct Business	2 Reinsurance Assumed	3 Reinsurance Ceded	4 Net Premium Income (Cols. 1 + 2 - 3)
1. Comprehensive (hospital and medical)				
2. Medicare Supplement				
3. Dental only				
4. Vision only				
5. Federal Employees Health Benefits Plan				
6. Title XVIII – Medicare				
7. Title XIX – Medicaid	268,049,800		711,116	267,338,684
8. Other health				
9. Health subtotal (Lines 1 through 8)	268,049,800		711,116	267,338,684
10. Life				
11. Property/casualty				
12. Totals (Lines 9 to 11)	268,049,800		711,116	267,338,684

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Annual Statement for the year 2015 of the **Better Health, Inc.**

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2 – CLAIMS INCURRED DURING THE YEAR

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Payments during the year:										
1.1 Direct	230,250,145	0	0	0	0	0	0	230,250,145	0	0
1.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
1.3 Reinsurance ceded	27,660	0	0	0	0	0	0	27,660	0	0
1.4 Net	230,222,485	0	0	0	0	0	0	230,222,485	0	0
2. Paid medical incentive pools and bonuses	1,262,250	0	0	0	0	0	0	1,262,250	0	0
3. Claim liability December 31, current year from Part 2A:										
3.1 Direct	29,012,287	0	0	0	0	0	0	29,012,287	0	0
3.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
3.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
3.4 Net	29,012,287	0	0	0	0	0	0	29,012,287	0	0
4. Claim reserve December 31, current year from Part 2D:										
4.1 Direct	0	0	0	0	0	0	0	0	0	0
4.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
4.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
4.4 Net	0	0	0	0	0	0	0	0	0	0
5. Accrued medical incentive pools and bonuses, current year	4,884,467	0	0	0	0	0	0	4,884,467	0	0
6. Net healthcare receivables (a)	903,272	0	0	0	0	0	0	903,272	0	0
7. Amounts recoverable from reinsurers December 31, current year	97,362	0	0	0	0	0	0	97,362	0	0
8. Claim liability December 31, prior year from Part 2A:										
8.1 Direct	23,194,097	0	0	0	0	0	0	23,194,097	0	0
8.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
8.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
8.4 Net	23,194,097	0	0	0	0	0	0	23,194,097	0	0
9. Claim reserve December 31, prior year from Part 2D:										
9.1 Direct	0	0	0	0	0	0	0	0	0	0
9.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
9.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
9.4 Net	0	0	0	0	0	0	0	0	0	0
10. Accrued medical incentive pools and bonuses, prior year	3,016,486	0	0	0	0	0	0	3,016,486	0	0
11. Amounts recoverable from reinsurers December 31, prior year	21,917	0	0	0	0	0	0	21,917	0	0
12. Incurred benefits:										
12.1 Direct	235,165,063	0	0	0	0	0	0	235,165,063	0	0
12.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
12.3 Reinsurance ceded	103,105	0	0	0	0	0	0	103,105	0	0
12.4 Net	235,061,958	0	0	0	0	0	0	235,061,958	0	0
13. Incurred medical incentive pools and bonuses	3,130,231	0	0	0	0	0	0	3,130,231	0	0

(a) Excludes \$ 0 loans or advances to providers not yet expensed.

Annual Statement for the year 2015 of the Better Health, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2A – CLAIMS LIABILITY END OF CURRENT YEAR

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Reported in Process of Adjustment:										
1.1 Direct	3,904,408							3,904,408		
1.2 Reinsurance assumed										
1.3 Reinsurance ceded										
1.4 Net	3,904,408							3,904,408		
2. Incurred but Unreported:										
2.1 Direct	25,107,879							25,107,879		
2.2 Reinsurance assumed										
2.3 Reinsurance ceded										
2.4 Net	25,107,879							25,107,879		
3. Amounts Withheld from Paid Claims and Capitulations:										
3.1 Direct										
3.2 Reinsurance assumed										
3.3 Reinsurance ceded										
3.4 Net										
4. TOTALS:										
4.1 Direct	29,012,287							29,012,287		
4.2 Reinsurance assumed										
4.3 Reinsurance ceded										
4.4 Net	29,012,287							29,012,287		

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Annual Statement for the year 2015 of the **Better Health, Inc.**

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2B – ANALYSIS OF CLAIMS UNPAID – PRIOR YEAR-NET OF REINSURANCE

Line of Business	Claims Paid During the Year		Claim Reserve and Claim Liability December 31 of Current Year		5 Claims Incurred in Prior Years (Columns 1 + 3)	6 Estimated Claim Reserve and Claim Liability December 31 of Prior Year
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid December 31 of Prior Year	4 On Claims Incurred During the Year		
1. Comprehensive (hospital and medical)	0	0	0	0	0	0
2. Medicare Supplement	0	0	0	0	0	0
3. Dental only	0	0	0	0	0	0
4. Vision only	0	0	0	0	0	0
5. Federal Employees Health Benefits Plan	0	0	0	0	0	0
6. Title XVIII – Medicare	0	0	0	0	0	0
7. Title XIX – Medicaid	22,750,654	207,740,555	645,627	28,366,660	23,396,281	23,194,097
8. Other health	0	0	0	0	0	0
9. Health subtotal (Lines 1 to 8)	22,750,654	207,740,555	645,627	28,366,660	23,396,281	23,194,097
10. Health care receivables (a)	18,230	131,861	302	1,474,665	18,532	377,615
11. Other non-health	0	0	0	0	0	0
12. Medical incentive pools and bonus amounts	156,282	1,105,968	1,869,075	3,015,392	2,025,357	3,016,484
13. Totals (Lines 9 - 10 + 11 + 12)	22,888,706	208,714,662	2,514,400	29,907,387	25,403,106	25,832,966

(a) Excludes \$ 0 loans or advances to providers not yet expensed.

Annual Statement for the year 2015 of the **Better Health, Inc.**

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Hospital & Medical

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X	NONE			0
4. 2013	X X X				0
5. 2014	X X X				0
6. 2015	X X X				0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X	NONE			0
4. 2013	X X X				0
5. 2014	X X X				0
6. 2015	X X X				0

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2014	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2015	0	0	0	0.000	0	0.000	0	0	0	0.000

Annual Statement for the year 2015 of the **Better Health, Inc.**

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Medicare Supplement

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X	NONE		0	0
4. 2013	X X X			0	0
5. 2014	X X X			0	0
6. 2015	X X X			0	0
		X X X	X X X	X X X	

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X	NONE		0	0
4. 2013	X X X			0	0
5. 2014	X X X			0	0
6. 2015	X X X			0	0
		X X X	X X X	X X X	

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2014	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2015	0	0	0	0.000	0	0.000	0	0	0	0.000
				NONE						

Annual Statement for the year 2015 of the **Better Health, Inc.**

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Dental Only

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X				0
4. 2013	X X X	X X X			0
5. 2014	X X X	X X X	X X X		0
6. 2015	X X X	X X X	X X X	X X X	0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X				0
4. 2013	X X X	X X X			0
5. 2014	X X X	X X X	X X X		0
6. 2015	X X X	X X X	X X X	X X X	0

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2014	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2015	0	0	0	0.000	0	0.000	0	0	0	0.000

Annual Statement for the year 2015 of the **Better Health, Inc.**

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Vision Only

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X				0
4. 2013	X X X	X X X			0
5. 2014	X X X	X X X	X X X		0
6. 2015	X X X	X X X	X X X	X X X	0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X				0
4. 2013	X X X	X X X			0
5. 2014	X X X	X X X	X X X		0
6. 2015	X X X	X X X	X X X	X X X	0

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2014	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2015	0	0	0	0.000	0	0.000	0	0	0	0.000

Annual Statement for the year 2015 of the **Better Health, Inc.**

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Fed Emp Health Benefits Plan

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X	NONE		0	0
4. 2013	X X X			0	0
5. 2014	X X X			0	0
6. 2015	X X X			X X X	0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X	NONE		0	0
4. 2013	X X X			0	0
5. 2014	X X X			0	0
6. 2015	X X X			X X X	0

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2014	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2015	0	0	0	0.000	0	0.000	0	0	0	0.000

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Annual Statement for the year 2015 of the **Better Health, Inc.**

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Title XVIII - Medicare

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X	NONE		0	0
4. 2013	X X X			0	0
5. 2014	X X X			0	0
6. 2015	X X X			X X X	0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X	NONE		0	0
4. 2013	X X X			0	0
5. 2014	X X X			0	0
6. 2015	X X X			X X X	0

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2014	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2015	0	0	0	0.000	0	0.000	0	0	0	0.000

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Annual Statement for the year 2015 of the **Better Health, Inc.**

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Title XIX - Medicaid

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X	0	0	0	0
4. 2013	X X X	X X X	0	0	0
5. 2014	X X X	X X X	X X X	100,872	22,889
6. 2015	X X X	X X X	X X X	X X X	208,715

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X	0	0	0	0
4. 2013	X X X	X X X	0	0	0
5. 2014	X X X	X X X	X X X	128,501	(430)
6. 2015	X X X	X X X	X X X	X X X	238,279

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2014	158,608	123,761	3,903	3.154	127,664	80.490	815	0	128,479	81.004
5. 2015	267,339	208,715	5,361	2.569	214,076	80.077	33,081	981	248,138	92.818

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Annual Statement for the year 2015 of the **Better Health, Inc.**

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Other

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X	NONE			0
4. 2013	X X X				0
5. 2014	X X X				0
6. 2015	X X X				0

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X	NONE			0
4. 2013	X X X				0
5. 2014	X X X				0
6. 2015	X X X				0

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2014	0	0	0	0.000	0	0.000	0	0	0	0.000
5. 2015	0	0	0	0.000	0	0.000	0	0	0	0.000

Annual Statement for the year 2015 of the **Better Health, Inc.**

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2C – DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)
Grand Total

Section A – Paid Health Claims

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X	0	0	0	0
4. 2013	X X X	X X X	0	0	0
5. 2014	X X X	X X X	X X X	100,872	22,889
6. 2015	X X X	X X X	X X X	X X X	208,715

Section B – Incurred Health Claims

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	0	0	0	0	0
2. 2011	0	0	0	0	0
3. 2012	X X X	0	0	0	0
4. 2013	X X X	X X X	0	0	0
5. 2014	X X X	X X X	X X X	128,501	(430)
6. 2015	X X X	X X X	X X X	X X X	238,279

Section C – Incurred Year Health Claims and Claims Adjustment Expense Ratio

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payments	3 Claim Adjustment Expense Payments	4 (Col. 3 / 2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5 / 1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5 + 7 + 8)	10 (Col. 9 / 1) Percent
1. 2011	0	0	0	0.000	0	0.000	0	0	0	0.000
2. 2012	0	0	0	0.000	0	0.000	0	0	0	0.000
3. 2013	0	0	0	0.000	0	0.000	0	0	0	0.000
4. 2014	158,608	123,761	3,903	3.154	127,664	80.490	815	0	128,479	81.004
5. 2015	267,339	208,715	5,361	2.569	214,076	80.077	33,081	981	248,138	92.818

Annual Statement for the year 2015 of the **Better Health, Inc.**

UNDERWRITING AND INVESTMENT EXHIBIT
PART 2D – AGGREGATE RESERVE FOR ACCIDENT AND HEALTH CONTRACTS ONLY

	1	2	3	4	5	6	7	8	9
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
1. Unearned premium reserves	0	0	0	0	0	0	0	0	0
2. Additional policy reserves (a)	306,539	0	0	0	0	0	0	306,539	0
3. Reserve for future contingent benefits	0	0	0	0	0	0	0	0	0
4. Reserve for rate credits or experience rating refunds (including \$ 0 for investment income)	0	0	0	0	0	0	0	0	0
5. Aggregate write-ins for other policy reserves	0	0	0	0	0	0	0	0	0
6. Totals (gross)	306,539	0	0	0	0	0	0	306,539	0
7. Reinsurance ceded	0	0	0	0	0	0	0	0	0
8. Totals (Net) (Page 3, Line 4)	306,539	0	0	0	0	0	0	306,539	0
9. Present value of amounts not yet due on claims	0	0	0	0	0	0	0	0	0
10. Reserve for future contingent benefits	0	0	0	0	0	0	0	0	0
11. Aggregate write-ins for other claim reserves	0	0	0	0	0	0	0	0	0
12. Totals (gross)	0	0	0	0	0	0	0	0	0
13. Reinsurance ceded	0	0	0	0	0	0	0	0	0
14. Totals (Net) (Page 3, Line 7)	0	0	0	0	0	0	0	0	0

DETAILS OF WRITE-IN LINES									
0501.	0	0	0	0	0	0	0	0	0
0502.	0	0	0	0	0	0	0	0	0
0503.	0	0	0	0	0	0	0	0	0
0598. Summary of remaining write-ins for Line 05 from overflow page	0	0	0	0	0	0	0	0	0
0599. Totals (Lines 0501 through 0503 plus 0598) (Line 05 above)	0	0	0	0	0	0	0	0	0
1101.	0	0	0	0	0	0	0	0	0
1102.	0	0	0	0	0	0	0	0	0
1103.	0	0	0	0	0	0	0	0	0
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0	0	0	0	0	0
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)	0	0	0	0	0	0	0	0	0

(a) Includes \$ 0 premium deficiency reserve.

Annual Statement for the year 2015 of the **Better Health, Inc.**

UNDERWRITING AND INVESTMENT EXHIBIT
PART 3 – ANALYSIS OF EXPENSES

	Claim Adjustment Expenses		3	4	5
	1	2			
	Cost Containment Expenses	Other Claim Adjustment Expenses	General Administrative Expenses	Investment Expenses	Total
1. Rent (\$ 0 for occupancy of own building)					
2. Salaries, wages and other benefits	3,661,833	727,683	13,368,077		17,757,593
3. Commissions (less \$ 0 ceded plus \$ 0 assumed)					
4. Legal fees and expenses			475		475
5. Certifications and accreditation fees			19,222		19,222
6. Auditing, actuarial and other consulting services	21,284	77,624	1,759,668		1,858,576
7. Traveling expenses	29,782	4,147	338,684		372,613
8. Marketing and advertising	503	22	1,152,132		1,152,657
9. Postage, express and telephone	641		61,029		61,670
10. Printing and office supplies	216,021	338,212	954,124		1,508,357
11. Occupancy, depreciation and amortization	597,854	121,461	(228,682)		490,633
12. Equipment					
13. Cost or depreciation of EDP equipment and software	74,982	440,825	2,734,843		3,250,650
14. Outsourced services including EDP, claims, and other services		28,412			28,412
15. Boards, bureaus and association fees					
16. Insurance, except on real estate			(17,666)		(17,666)
17. Collection and bank service charges			4,405		4,405
18. Group service and administration fees			797,687		797,687
19. Reimbursements by uninsured plans					
20. Reimbursements from fiscal intermediaries					
21. Real estate expenses					
22. Real estate taxes					
23. Taxes, licenses and fees:					
23.1 State and local insurance taxes			78,429		78,429
23.2 State premium taxes					
23.3 Regulatory authority licenses and fees					
23.4 Payroll taxes			1,781		1,781
23.5 Other (excluding federal income and real estate taxes)			2,562,490		2,562,490
24. Investment expenses not included elsewhere					
25. Aggregate write-ins for expenses			130,627		130,627
26. Total expenses incurred (Lines 1 to 25)	4,602,900	1,738,386	23,717,325	(a)	30,058,611
27. Less expenses unpaid December 31, current year	794,016	186,634	220,374		1,201,024
28. Add expenses unpaid December 31, prior year	242,553	57,012	360,503		660,068
29. Amounts receivable relating to uninsured plans, prior year					
30. Amounts receivable relating to uninsured plans, current year					
31. Total expenses paid (Lines 26 minus 27 plus 28 minus 29 plus 30)	4,051,437	1,608,764	23,857,454		29,517,655

DETAILS OF WRITE-IN LINES					
2501. Interest Expense			130,627		130,627
2502.					
2503.					
2598. Summary of remaining write-ins for Line 25 from overflow page					
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)			130,627		130,627

(a) Includes management fees of \$ 26,160,316 to affiliates and \$ 0 to non-affiliates.

Annual Statement for the year 2015 of the **Better Health, Inc.****EXHIBIT OF NET INVESTMENT INCOME**

	1 Collected During Year	2 Earned During Year
1. U.S. Government bonds	(a) 0	0
1.1 Bonds exempt from U.S. tax	(a) 0	0
1.2 Other bonds (unaffiliated)	(a) 0	0
1.3 Bonds of affiliates	(a) 0	0
2.1 Preferred stocks (unaffiliated)	(b) 0	0
2.11 Preferred stocks of affiliates	(b) 0	0
2.2 Common stocks (unaffiliated)	0	0
2.21 Common stocks of affiliates	0	0
3. Mortgage loans	(c) 0	0
4. Real estate	(d) 0	0
5. Contract loans	0	0
6. Cash, cash equivalents and short-term investments	(e) 9,379	10,272
7. Derivative instruments	(f) 0	0
8. Other invested assets	0	0
9. Aggregate write-ins for investment income	0	0
10. Total gross investment income	9,379	10,272
11. Investment expenses		(g) 0
12. Investment taxes, licenses and fees, excluding federal income taxes		(g) 0
13. Interest expense		(h) 0
14. Depreciation on real estate and other invested assets		(i) 0
15. Aggregate write-ins for deductions from investment income		0
16. Total deductions (Lines 11 through 15)		0
17. Net investment income (Line 10 minus Line 16)		10,272

DETAILS OF WRITE-IN LINES			
0901.		0	0
0902.		0	0
0903.		0	0
0998. Summary of remaining write-ins for Line 09 from overflow page		0	0
0999. Totals (Lines 0901 through 0903 plus 0998) (Line 09 above)		0	0
1501.		0	0
1502.		0	0
1503.		0	0
1598. Summary of remaining write-ins for Line 15 from overflow page		0	0
1599. Totals (Lines 1501 through 1503 plus 1598) (Line 15 above)		0	0

- (a) Includes \$ 0 accrual of discount less \$ 0 amortization of premium and less \$ 0 paid for accrued interest on purchases.
- (b) Includes \$ 0 accrual of discount less \$ 0 amortization of premium and less \$ 0 paid for accrued dividends on purchases.
- (c) Includes \$ 0 accrual of discount less \$ 0 amortization of premium and less \$ 0 paid for accrued interest on purchases.
- (d) Includes \$ 0 for company's occupancy of its own buildings; and excludes \$ 0 interest on encumbrances.
- (e) Includes \$ 0 accrual of discount less \$ 0 amortization of premium and less \$ 0 paid for accrued interest on purchases.
- (f) Includes \$ 0 accrual of discount less \$ 0 amortization of premium.
- (g) Includes \$ 0 investment expenses and \$ 0 investment taxes, licenses and fees, excluding federal income taxes, attributable to segregated and Separate Accounts.
- (h) Includes \$ 0 interest on surplus notes and \$ 0 interest on capital notes.
- (i) Includes \$ 0 depreciation on real estate and \$ 0 depreciation on other invested assets.

EXHIBIT OF CAPITAL GAINS (LOSSES)

	1 Realized Gain (Loss) on Sales or Maturity	2 Other Realized Adjustments	3 Total Realized Capital Gain (Loss) (Columns 1 + 2)	4 Change in Unrealized Capital Gain (Loss)	5 Change in Unrealized Foreign Exchange Capital Gain (Loss)
1. U.S. Government bonds	0	0	0	0	0
1.1 Bonds exempt from U.S. tax	0	0	0	0	0
1.2 Other bonds (unaffiliated)	0	0	0	0	0
1.3 Bonds of affiliates	0	0	0	0	0
2.1 Preferred stocks (unaffiliated)	0	0	0	0	0
2.11 Preferred stocks of affiliates	0	0	0	0	0
2.2 Common stocks (unaffiliated)	0	0	0	0	0
2.21 Common stocks of affiliates	0	0	0	0	0
3. Mortgage loans	0	0	0	0	0
4. Real estate	0	0	0	0	0
5. Contract loans	0	0	0	0	0
6. Cash, cash equivalents and short-term investments	0	0	0	0	0
7. Derivative instruments	0	0	0	0	0
8. Other invested assets	0	0	0	0	0
9. Aggregate write-ins for capital gains (losses)	0	0	0	0	0
10. Total capital gains (losses)	0	0	0	0	0

DETAILS OF WRITE-IN LINES					
0901.		0	0	0	0
0902.		0	0	0	0
0903.		0	0	0	0
0998. Summary of remaining write-ins for Line 09 from overflow page		0	0	0	0
0999. Totals (Lines 0901 through 0903 plus 0998) (Line 09 above)		0	0	0	0

Annual Statement for the year 2015 of the **Better Health, Inc.**

EXHIBIT OF NONADMITTED ASSETS

	1 Current Year Total Nonadmitted Assets	2 Prior Year Total Nonadmitted Assets	3 Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
1. Bonds (Schedule D)			
2. Stocks (Schedule D):			
2.1 Preferred stocks			
2.2 Common stocks			
3. Mortgage loans on real estate (Schedule B):			
3.1 First liens			
3.2 Other than first liens			
4. Real estate (Schedule A):			
4.1 Properties occupied by the company			
4.2 Properties held for the production of income			
4.3 Properties held for sale			
5. Cash (Schedule E - Part 1), cash equivalents (Schedule E - Part 2) and short-term investments (Schedule DA)			
6. Contract loans			
7. Derivatives (Schedule DB)			
8. Other invested assets (Schedule BA)			
9. Receivables for securities			
10. Securities lending reinvested collateral assets (Schedule DL)			
11. Aggregate write-ins for invested assets			
12. Subtotals, cash and invested assets (Lines 1 to 11)			
13. Title plants (for Title insurers only)			
14. Investment income due and accrued			
15. Premiums and considerations:			
15.1 Uncollected premiums and agents' balances in the course of collection			
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due			
15.3 Accrued retrospective premiums and contracts subject to redetermination			
16. Reinsurance:			
16.1 Amounts recoverable from reinsurers			
16.2 Funds held by or deposited with reinsured companies			
16.3 Other amounts receivable under reinsurance contracts			
17. Amounts receivable relating to uninsured plans			
18.1 Current federal and foreign income tax recoverable and interest thereon			
18.2 Net deferred tax asset			
19. Guaranty funds receivable or on deposit			
20. Electronic data processing equipment and software			
21. Furniture and equipment, including health care delivery assets			
22. Net adjustment in assets and liabilities due to foreign exchange rates			
23. Receivables from parent, subsidiaries and affiliates	131,531	64,241	(67,290)
24. Health care and other amounts receivable	542,687	219,393	(323,294)
25. Aggregate write-ins for other-than-invested assets	31,940	10,235	(21,705)
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	706,158	293,869	(412,289)
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts			
28. Total (Lines 26 and 27)	706,158	293,869	(412,289)

DETAILS OF WRITE-IN LINES			
1101.			
1102.			
1103.			
1198. Summary of remaining write-ins for Line 11 from overflow page			
1199. Totals (Lines 1101 through 1103 plus 1198) (Line 11 above)			
2501. Prepaid Assets	31,940	10,235	(21,705)
2502.			
2503.			
2598. Summary of remaining write-ins for Line 25 from overflow page			
2599. Totals (Lines 2501 through 2503 plus 2598) (Line 25 above)	31,940	10,235	(21,705)

NONE

Annual Statement for the year 2015 of the **Better Health, Inc.**

EXHIBIT 1 – ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS ONLY

Source of Enrollment	Total Members at End of					6 Current Year Member Months
	1 Prior Year	2 First Quarter	3 Second Quarter	4 Third Quarter	5 Current Year	
1. Health Maintenance Organizations	0	90,685	92,676	94,862	95,517	1,115,606
2. Provider Service Organizations	88,104	0	0	0	0	0
3. Preferred Provider Organizations	0	0	0	0	0	0
4. Point of Service	0	0	0	0	0	0
5. Indemnity Only	0	0	0	0	0	0
6. Aggregate write-ins for other lines of business	0	0	0	0	0	0
7. Total	88,104	90,685	92,676	94,862	95,517	1,115,606

DETAILS OF WRITE-IN LINES						
0601.	0	0	0	0	0	0
0602.	0	NONE	0	0	0	0
0603.	0		0	0	0	0
0698. Summary of remaining write-ins for Line 06 from overflow page	0		0	0	0	0
0699. Totals (Lines 0601 through 0603 plus 0698) (Line 06 above)	0		0	0	0	0

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EXHIBIT 3 – HEALTH CARE RECEIVABLES

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Annual Statement for the year 2015 of the **Better Health, Inc.**

EXHIBIT 3A – ANALYSIS OF HEALTH CARE RECEIVABLES COLLECTED AND ACCRUED

Type of Health Care Receivable	Health Care Receivables Collected During the Year		Health Care Receivables Accrued as of December 31 of Current Year		5	6
	1 On Amounts Accrued Prior to January 1 of Current Year	2 On Amounts Accrued During the Year	3 On Amounts Accrued December 31 of Prior Year	4 On Amounts Accrued During the Year	Health Care Receivables in Prior Years (Cols. 1 + 3)	Estimated Health Care Receivables Accrued as of December 31 of Prior Year
1. Pharmaceutical rebate receivables						
2. Claim overpayment receivables	18,230	104,201	303	1,258,670	18,533	311,288
3. Loans and advances to providers						
4. Capitation arrangement receivables						
5. Risk sharing receivables				118,632		44,111
6. Other health care receivables						
7. Total (Lines 1 through 6)	18,230	104,201	303	1,377,302	18,533	355,399

Note that the accrued amounts in Columns 3, 4 and 6 are the total health care receivables, not just the admitted portion.

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Aging Analysis of Unpaid Claims

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Annual Statement for the year 2015 of the **Better Health, Inc.**

NONE Exhibit 8 - Furniture, Equipment, and Supplies Owned

Annual Statement for the year 2015 of the Better Health, Inc.

NOTES TO FINANCIAL STATEMENTS

1. Significant Accounting Policies

A. Accounting Practices

The accompanying financial statements of have been prepared in conformity with the National Association of Insurance Commissioners' ("NAIC") Annual Statement Instructions and in accordance with accounting practices prescribed by the NAIC Accounting Practice and Procedures Manual ("NAIC SAP"), subject to any deviations prescribed or permitted by the Florida Department of Financial Services ("Florida DFS"). A reconciliation of the Company's net income and capital and surplus between NAIC SAP and practices prescribed and permitted by the State of Florida is shown below:

		<u>2015</u>	<u>2014</u>
Net Income	State of Domicile		
1 Net Income state basis	FL	(191,668)	(8,482,445)
2 State Prescribed Practices (Income):		-	-
3 State Permitted Practices (Income):		-	-
4 Net Income, NAIC SAP		<u>(191,668)</u>	<u>(8,482,445)</u>
Surplus	State of Domicile		
5 Statutory Surplus state basis	FL	15,213,932	15,817,890
6 State Prescribed Practices (Surplus):		-	-
7 State Permitted Practices (Surplus):		-	-
8 Statutory Surplus, NAIC SAP		<u>15,213,932</u>	<u>15,817,890</u>

B. Use of Estimates in the Preparation of the Financial Statements

Preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

C. Accounting Policy

Health premium revenues, based on membership records and premiums rates for each membership category within each county, are recognized as revenue during the period in which the Company is obligated to provide service to members. Premiums are reported net of excess loss reinsurance ceded and experience rating refunds. Premiums paid before the effective service month are recorded on the balance sheet as premiums received in advance and are subsequently credited to income as earned during the coverage period. Premium rates are subject to approval by the Florida Agency for Healthcare Administration ("AHCA"). Costs, such as premium taxes and other underwriting expenses are charged to operations as incurred.

In addition, the Company uses the following accounting policies:

- Short-term investments include investments with maturities of less than one year at the date of acquisition and are reported at amortized cost, which approximates fair value. Non-investment grade short-term investments are stated at the lower of amortized cost or fair value.
- Investment grade bonds not backed by other loans are stated at amortized cost, with amortization calculated based on the modified scientific method, using lower of yield to call or yield to maturity. Non-investment grade bonds are stated at the lower of amortized cost or fair value as determined by various third-party pricing sources.
- Common stocks of unaffiliated companies are stated at fair value based upon security ratings prescribed by various third-party pricing sources.
- The Company has no investments in preferred stocks.
- The Company has no mortgage loans - real estate.
- The Company has no investments in Loan-backed securities.
- The Company has no investments in subsidiaries, controlled and affiliated companies.
- The Company has no investments in joint ventures, partnerships or limited liability companies.
- The Company has no derivative instruments.
- The Company does not anticipate investment income as a factor in the premium deficiency calculations.
- Unpaid claims and claims adjustment expenses include management's best estimate of amounts based on historical claim development patterns and certain individual case estimates. The established liability considers health benefit provisions, business practices, economic conditions and other factors that may materially affect the cost, frequency and severity of claims. Liabilities for unpaid claims and claim adjustment expenses are based on assumptions and estimates, and while management believes such estimates are reasonable, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for

Annual Statement for the year 2015 of the Better Health, Inc.

NOTES TO FINANCIAL STATEMENTS

establishing the resulting liabilities are continually reviewed and changes in estimates are incorporated into current period estimates.

12. The Company has not modified its capitalization policy from the prior period.
13. Pharmacy rebate receivables are recorded when earned based upon actual rebate receivables billed and an estimate of receivables based upon current utilization of specific pharmaceuticals and provider contract terms. All pharmaceutical rebates receivables are considered non-admitted due to their collectability beyond 90 days.

D. Going Concern

Not Applicable.

Concentration of Credit Risk

A portion of the Company's revenue is earned under the Company's Medicaid contract with the Florida Agency for Healthcare Administration ("AHCA") (representing approximately 60% and 46% of year to date revenues for the quarter ending December 31, 2015 and year ending December 31, 2014, respectively.) The Medicaid contract expires on December 31, 2018, but can be terminated at any time by AHCA with thirty days written notice. Changes in Medicaid funding could adversely impact the Company.

Financial instruments which potentially subject the Company to concentrations of credit risk consist principally of cash deposits in excess of the FDIC insured limit of \$250,000. The Company generally limits exposure by placing deposits with several quality financial institutions. However, at times, such cash balances may be in excess of insured amounts.

2. Accounting Changes and Corrections of Errors

There were no accounting changes or corrections of errors during the years ended December 31, 2015 and 2014.

3. Business Combinations and Goodwill

A. Statutory Purchase Method

Not applicable.

B. Statutory Merger

Not applicable.

C. Assumption Reinsurance

Not applicable.

D. Impairment Loss

Not applicable.

4. Discontinued Operations

The Company had no operations that were discontinued during 2015 or 2014.

5. Investment

A. Mortgage Loans, including Mezzanine Real Estate Loans

The Company did not have investments in mortgage loans at December 31, 2015 or 2014.

B. Debt Restructuring

The Company did not have invested assets that were restructured debt at December 31, 2015 or 2014.

C. Reverse Mortgages

The Company did not have investments in reverse mortgages at December 31, 2015 or 2014.

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NOTES TO FINANCIAL STATEMENTS

D. Loan-Backed Securities

The Company did not have investments in loan-backed securities at December 31, 2015 or 2014.

E. Repurchase Agreements and/or Securities Lending Transactions

The Company did not enter into repurchase agreements or securities lending transactions at December 31, 2015 or 2014.

F. Real Estate

The Company did not have investments in real estate and did not engage in retail land sales operations during 2015 or 2014.

G. Low-income housing tax credits (LIHTC)

The Company did not invest in properties generating low-income housing tax credits during 2015 or 2014.

H. Restricted Assets

1. Restricted Assets (Including Pledged):

	1	2	3	4	5	6
Restricted Asset Category	Total Gross Restricted from Current Year	Total Gross Restricted from Prior Year	Increase / (Decrease) (1 minus 2)	Total Current Year Admitted Restricted	Percentage Gross Restricted to Total Assets	Percentage Admitted Restricted to Total Assets
a. Subject to contractual obligation for which liability is not shown						
b. Collateral held under security lending agreements						
c. Subject to repurchase agreements						
d. Subject to reverse repurchase agreements						
e. Subject to dollar repurchase agreements						
f. Subject to dollar reverse repurchase agreements						
g. Placed under option contracts						
h. Letter stock or securities restricted as to sale						
i. On deposit with states	300,000	300,000	0	300,000	0.58%	0.600%
j. On deposit with other regulatory bodies	538,757	538,757	0	538,757	1.05%	1.063%
k. Pledged as collateral not captured in other cat.						
l. Other restricted Assets						
m. Total Restricted Assets	838,757	838,757	0	838,757	1.63%	1.655%

2. Details of Assets Pledged as Collateral Not Captured in Other Categories

Not applicable.

3. Detail of Other Restricted Assets (Contracts that Share Similar Characteristics, Such as Reinsurance and Derivatives, Are Reported in the Aggregate)

Not applicable.

I. Working Capital Finance Investments

The Company did not have any working capital finance investments as December 31, 2015 and 2014.

J. Offsetting and Netting of Assets and Liabilities

Annual Statement for the year 2015 of the Better Health, Inc.

NOTES TO FINANCIAL STATEMENTS

The Company did not have any offsetting and netting of assets and liabilities at December 31, 2015 and 2014.

K. Structured Notes

The Company did not have any structured notes at December 31, 2015 and 2014.

6. Joint Ventures, Partnerships and Limited Liability Companies

- A. The Company has no investments in joint ventures, partnerships, or limited liability companies that exceeded 10% of its admitted assets at December 31, 2015 or 2014.
- B. The Company did not recognize impairment write downs for its investments in joint ventures, partnerships or limited liability companies during 2015 or 2014.

7. Investment Income

- A. All investment income due and accrued with amounts that are over 90 days past due is non-admitted.
- B. There was \$0 and \$0 respectively at December 31, 2015 and 2014, of non-admitted accrued investment interest income.

8. Derivative Instruments

The Company has no derivative instruments.

9. Income Taxes

- A. The components of the net deferred tax asset/(liability) at December 31, 2015 are as follows:

01.	12/31/2015			12/31/2014		
	(1)	(2)	(3)	(4)	(5)	(6)
	Ordinary	Capital	(Col 1 + 2) Total	Ordinary	Capital	(Col 4 + 5) Total
a. Gross Deferred Tax Assets	\$ 3,263,929	-	3,263,929	3,841,191	-	3,841,191
b. Statutory Valuation Allowance Adjustments	\$ 2,969,929	-	2,969,929	3,841,191	-	3,841,191
c. Adjusted Gross Deferred Tax Assets (1a - 1b)	\$ 294,000	-	294,000	-	-	-
d. Deferred Tax Assets Nonadmitted	\$ -	-	-	-	-	-
e. Subtotal Net Admitted Deferred Tax Asset (1c - 1d)	\$ 294,000	-	294,000	-	-	-
f. Deferred Tax Liabilities	\$ 294,000	-	294,000	-	-	-
g. Net Admitted Deferred Tax Asset / (Net Deferred Tax Liability) (1e - 1f)	\$ -	-	-	-	-	-

01.	Change		
	(7)	(8)	(9)
	(Col 1 - 4) Ordinary	(Col 2 - 5) Capital	(Col 7 + 8) Total
a. Gross Deferred Tax Assets	\$ (577,262)	-	(577,262)
b. Statutory Valuation Allowance Adjustments	\$ (871,262)	-	(871,262)
c. Adjusted Gross Deferred Tax Assets (1a - 1b)	\$ 294,000	-	294,000
d. Deferred Tax Assets Nonadmitted	\$ 0	-	-
e. Subtotal Net Admitted Deferred Tax Asset (1c - 1d)	\$ 294,000	-	294,000
f. Deferred Tax Liabilities	\$ 294,000	-	294,000
g. Net Admitted Deferred Tax Asset /			

Annual Statement for the year 2015 of the **Better Health, Inc.**

NOTES TO FINANCIAL STATEMENTS

(Net Deferred Tax Liability) (1e - 1f)		\$	-	-	-
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02.		12/31/2015			12/31/2014		
		(1)	(2)	(3) (Col 1 + 2)	(4)	(5) Capit al	(6) (Col 4 + 5)
		Ordinary	Capital	Total	Ordinary		Total
a.	Admission Calc. Components SSAP No. 101 Federal Income Taxes Paid In Prior Years Recoverable Through Loss Carrybacks.	\$	-	-	-	-	-
b.	Adjusted Gross Deferred Tax Assets Expected To Be Realized (Excluding The Amount Of Deferred Tax Assets From 2(a) above) After Application of the Threshold Limitation. (The Lesser of 2(b)1 and 2(b)2 Below)	\$	-	-	-	-	-
1.	Adjusted Gross Deferred Tax Assets to be Realized Following the Balance Sheet Date.	\$	-	-	-	-	-
2.	Adjusted Gross Deferred Tax Assets Allowed per Limitation Threshold	\$	X X X	X X X	-	X X X	X X
c.	Adjusted Gross Deferred Tax Assets (Excluding the Amount Of Deferred Tax Assets From 2(a) and 2(b) above) Offset byGross Deferred Tax Liabilities.	\$	-	-	-	-	-
d.	Deferred Tax Assets Admitted as the result of application of SSAPNo. 101. Total (2(a) + 2(b) + 2(c))	\$	-	-	-	-	-

02.		Change		
		(7)	(8)	(9) (Col 2 - 5)
		(Col 1 - 4) Ordinary	Capital	Total
a.	Admission Calc. Components SSAP No. 101 Federal Income Taxes Paid In Prior Years Recoverable Through Loss Carrybacks.	\$	-	-
b.	Adjusted Gross Deferred Tax Assets Expected To Be Realized (Excluding The Amount Of Deferred Tax Assets From 2(a) above) After Application of the Threshold Limitation. (The Lesser of 2(b)1 and 2(b)2 Below)	\$	-	-
1.	Adjusted Gross Deferred Tax Assets to be Realized Following the Balance Sheet Date.	\$	-	-
2.	Adjusted Gross Deferred Tax Assets Allowed per Limitation Threshold	\$	X X X	X X X
c.	Adjusted Gross Deferred Tax Assets (Excluding the Amount Of Deferred Tax Assets From 2(a) and 2(b) above) Offset byGross Deferred Tax Liabilities.	\$	294,000	-
d.	Deferred Tax Assets Admitted as the result of application of SSAPNo. 101. Total (2(a) + 2(b) + 2(c))	\$	294,000	-

03.		2015	2014
a.	Ratio Percentage Used to Determine Recover Period And Threshold Limitation Amount.	0.000	0.000
b.	Amount Of Adjusted Capital And Surplus Used To Determine Recovery Period And Threshold Limitation In 2(b)2 Above.	\$ 15,213,932.41	0.00

Annual Statement for the year 2015 of the **Better Health, Inc.**

NOTES TO FINANCIAL STATEMENTS

	12/31/2015		12/31/2014		Change	
	(1)	(2)	(3)	(4)	(5)	(6)
4. Impact of Tax Planning Strategies						
a. Determination of Adjusted Gross Deferred Tax Assets and Net Admitted Deferred Tax Assets, By Tax Character As A Percentage.					(Col 1 - 3)	(Col 2 - 4)
	Ordinary	Capital	Ordinary	Capital	Ordinary	Capital
1. Adjusted Gross DTAs Amount From Note 9A1(c)	\$ 294,000	-	-	-	294,000	-
2. Percentage of Adjusted Gross DTAs By Tax Character Attributable To The Impact of Tax Planning Strategies	\$ 0.000%	0.00%	0.000%	0.00%	0.000%	0.000%
3. Net Admitted Adjusted Gross DTAs Amount from Note 9A1(c)	\$ 294,000	-	-	-	294,000	-
4. Percentage of Net Admitted Adjusted Gross DTAs by Tax Character Attributable To The Impact of Tax Planning Strategies	\$ 0.000%	0.00%	0.000%	0.00%	0.000%	0.000%
b. Does the Company's Tax-planning Strategies include the use of reinsurance?	NO					

B. Regarding deferred tax liabilities that are not recognized

None

C. Current income tax incurred consist of the following major components:

		(1)	(2)	(3)
		12/31/2015	12/31/2014	(Col 1 - 2) Change
1. Current Income Tax				
a. Federal.....	\$	(770,105)	-	(770,105)
b. Foreign.....	\$	-	-	-
c. Subtotal.....	\$	(770,105)	-	(770,105)
d. Federal Income Tax on net capital gains.....	\$	-	-	-
e. Utilization of capital loss carry-forwards.....	\$	(64,370)	-	(64,370)
f. Other.....	\$	-	-	-
g. Federal and foreign income taxes incurred.....	\$	(834,475)	-	(834,475)
2. Deferred Tax Assets:				
a. Ordinary				
(1) Discounting of unpaid losses.....	\$	101,270	26,178	75,092
(2) Unearned premium reserve.....	\$	-	1,454,098	(1,454,098)
(3) Policyholder reserves.....	\$	-	-	-
(4) Investments.....	\$	-	-	-
(5) Deferred acquisition costs.....	\$	-	-	-
(6) Policyholder dividends accrual.....	\$	-	-	-
(7) Fixed assets.....	\$	-	-	-
(8) Compensation and benefits accrual.....	\$	-	-	-
(9) Pension accrual.....	\$	-	-	-
(10) Receivables - nonadmitted.....	\$	235,976	-	235,976
(11) Net operating loss carry-forward.....	\$	1,984,683	1,318,816	665,867
(12) Tax credit carry-forward.....	\$	-	-	-
(13) Other (including items <5% of total ordinary tax assets).....	\$	942,000	1,042,099	(100,099)
(99) Subtotal.....	\$	3,263,929	3,841,191	(577,262)
b. Statutory valuation allowance adjustment.....	\$	2,969,929	3,841,191	(871,262)
c. Nonadmitted.....	\$	-	-	-
d. Admitted ordinary deferred tax assets (2a99 - 2b - 2c).....	\$	294,000	-	294,000

Annual Statement for the year 2015 of the **Better Health, Inc.**

NOTES TO FINANCIAL STATEMENTS

e. Capital:

(1) Investments.....	\$	-	-	-
(2) Net capital loss carry-forward.....	\$	-	-	-
(3) Real estate.....	\$	-	-	-
(4) Other (including items <5% of total capital tax assets).....	\$	-	-	-
(99) Subtotal.....	\$	-	-	-

f. Statutory valuation allowance adjustment.....	\$	-	-	-
g. Nonadmitted.....	\$	-	-	-
h. Admitted capital deferred tax assets (2e99 - 2f - 2g).....	\$	-	-	-
i. Admitted deferred tax assets (2d + 2h).....	\$	294,000	-	294,000

3. Deferred Tax Liabilities:

a. Ordinary

(1) Investments.....	\$	-	-	-
(2) Fixed assets.....	\$	-	-	-
(3) Deferred and uncollected premium.....	\$	-	-	-
(4) Policyholder reserves.....	\$	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities).....	\$	294,000	-	294,000
(99) Subtotal.....	\$	294,000	-	294,000

b. Capital:

(1) Investments.....	\$	-	-	-
(2) Real Estate.....	\$	-	-	-
(3) Other (including items <5% of total capital tax liabilities).....	\$	-	-	-
(99) Subtotal.....	\$	-	-	-

c. Deferred tax liabilities (3a99 + 3b99).....	\$	294,000	-	294,000
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4. Net deferred tax assets/liabilities (2i - 3c).....	\$	-	-	-
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D. The Company's income tax expense and change in deferred income taxes differs from the amount obtained by applying the federal statutory income tax rate of 35% for the year ended December 31 as follows:

Annual Statement for the year 2015 of the Better Health, Inc.

NOTES TO FINANCIAL STATEMENTS

	2015	2014
Tax expense computed using federal statutory rate	\$ (359,150)	\$ (2,968,856)
Change in nonadmitted assets	(247,155)	-
Tax exempt income and dividend received deduction net of proration	-	-
Prior year true-ups and adjustments	(183,469)	-
Interest (FIT and SIT)	-	-
Tax settlements and contingencies	-	-
Intercompany transfers and adjustments	-	-
IMR/AMR tax	-	-
Intercompany dividends	-	-
Valuation allowance	(871,262)	3,841,191
ACA health insurer fee	896,872	-
Change in taxable status	-	(621,292)
Write-in	-	-
Write-in	-	-
Other	(70,311)	(251,043)
Total	<u>\$ (834,475)</u>	<u>\$ -</u>
Federal income taxes incurred	\$ (834,475)	\$ -
Change in net deferred income taxes	-	-
Total statutory income taxes	<u>\$ (834,475)</u>	<u>\$ -</u>

E. Operating loss carryforwards:

- The Company has no operating loss carryforwards and no tax credit carryforwards as of December 31, 2015.
- The following are income taxes incurred in the current and prior year(s) that will be available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2015	\$ -	\$ -	\$ -
2014	-	-	-
2013	-	-	-

- The Company has no protective tax deposits reported as admitted assets under Section 6603 of the Internal Revenue Code as of December 31, 2015 and 2014.

Annual Statement for the year 2015 of the **Better Health, Inc.**

NOTES TO FINANCIAL STATEMENTS

- F. The following companies will be included in the consolidated federal income tax return with their parent Anthem, Inc. as of December 31, 2015, and either are current members of the consolidated tax sharing agreement or are in the process of being added to the consolidated tax sharing agreement. Allocation of federal income taxes with affiliates subject to the tax sharing agreement is based upon separate income tax return calculations with credit for net losses that can be used on a consolidated basis. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

Annual Statement for the year 2015 of the Better Health, Inc.

NOTES TO FINANCIAL STATEMENTS

American Imaging Management, Inc.	DeCare Dental Health International, LLC
AMERIGROUP Community Care of New Mexico, Inc.	DeCare Dental Networks, LLC
AMERIGROUP Corporation	DeCare Dental, LLC
AMERIGROUP Florida, Inc.	Designated Agent Company, Inc.
Amerigroup Insurance Company	EHC Benefits Agency, Inc.
AMERIGROUP Iowa, Inc.	Empire HealthChoice Assurance, Inc.
Amerigroup Kansas, Inc.	Empire HealthChoice HMO, Inc.
AMERIGROUP Louisiana, Inc.	Forty-Four Forty-Four Forest Park Redevelopment Corp
AMERIGROUP Maryland, Inc.	Golden West Health Plan, Inc.
AMERIGROUP Nevada, Inc.	Government Health Services, LLC
AMERIGROUP New Jersey, Inc.	Greater Georgia Life Insurance Company
AMERIGROUP Ohio, Inc.	Health Core, Inc.
AMERIGROUP Pennsylvania, Inc.	Health Management Corporation
Amerigroup Services, Inc.	HealthKeepers, Inc.
AMERIGROUP Tennessee, Inc.	HealthLink HMO, Inc.
AMERIGROUP Texas, Inc.	HealthLink, Inc.
AMERIGROUP Washington, Inc.	HealthPlus HP, LLC (fka AMERIGROUP New York, LLC)
AMGP Georgia Managed Care Company, Inc.	Healthy Alliance Life Insurance Company
Anthem Blue Cross Life and Health Insurance Company	HMO Colorado, Inc.
Anthem Financial, Inc.	HMO Missouri, Inc.
Anthem Health Insurance Company of Nevada	Imaging Management Holdings, LLC
Anthem Health Plans of Kentucky, Inc.	Imaging Providers of Texas
Anthem Health Plans of Maine, Inc.	Matthew Thornton Health Plan, Inc.
Anthem Health Plans of New Hampshire, Inc.	National Government Services, Inc.
Anthem Health Plans of Virginia, Inc.	OneNation Insurance Company
Anthem Health Plans, Inc.	Park Square Holdings, Inc.
Anthem Holding Corp.	Park Square I, Inc.
Anthem Insurance Companies, Inc.	Park Square II, Inc.
Anthem Kentucky Managed Care Plan, Inc.	PHP Holdings, Inc.
Anthem Life & Disability Insurance Company	R&P Realty, Inc.
Anthem Southeast, Inc.	Resolution Health, Inc.
Anthem UM Services, Inc.	RightCHOICE Managed Care, Inc.
Anthem, Inc.	Rocky Mountain Hospital and Medical Service, Inc.
Arcus Enterprises, Inc.	SellCore, Inc.
ARCUS HealthyLiving Services, Inc.	Simply Healthcare Holdings, Inc.
Associated Group, Inc.	Simply Healthcare Plans, Inc.
Better Health, Inc.	Southeast Services, Inc.
Blue Cross and Blue Shield of Georgia, Inc.	State Sponsored Business UM Services, Inc.
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	The Anthem Companies of California, Inc.
Blue Cross Blue Shield of Wisconsin	The Anthem Companies, Inc.
Blue Cross of California	Tidgewell Associates, Inc.
Blue Cross of California Partnership Plan, Inc.	TrustSolutions, LLC
CareMore Health Group, Inc.	UNICARE Health Plan of Kansas, Inc.
CareMore Health Plan	UNICARE Health Plan of West Virginia, Inc.
CareMore Health Plan of Arizona, Inc.	UNICARE Health Plans of Texas, Inc.
CareMore Health Plan of Colorado, Inc.	UNICARE Illinois Services, Inc.
CareMore Health Plan of Georgia, Inc.	UNICARE Life & Health Insurance Company
CareMore Health Plan of Nevada	UNICARE National Services, Inc.
CareMore Health Plan of Texas, Inc.	UNICARE Specialty Services, Inc.
CareMore Health System	UtiliMed IPA, Inc.
CareMore Holdings, Inc.	WellPoint Behavioral Health, Inc.
Carulean Companies, Inc.	WellPoint California Services, Inc.
Claim Management Services, Inc.	WellPoint Dental Services, Inc.
Community Insurance Company	WellPoint Holding Corporation
Compcare Health Services Insurance Corporation	WellPoint Information Technology Services, Inc.
Crossroads Acquisition Corp	WellPoint Insurance Services, Inc.
DeCare Analytics, LLC	WellPoint Military Care Corporation

G. Not applicable.

10. Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

A. Nature of the Relationship

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NOTES TO FINANCIAL STATEMENTS

The Company is a Florida domiciled stock insurance company and is a wholly-owned subsidiary of ATH Holding Company, LLC ("ATH Holding"), which is an indirect wholly-owned subsidiary of Anthem, Inc. ("Anthem"), a publicly traded company.

Better Health, Inc. (the "Company") was originally formed in 2006 as Better Health, LLC. (a Limited Liability Company) and provides health insurance coverage for Florida's Medicaid recipients. Effective February 26, 2014, the Company filed a Certificate of Conversion to change its corporate structure from a Limited Liability Company to C Corporation and is currently operating as Better Health, Inc. The company became a licensed HMO in the state of Florida effective February 1, 2015.

In 2012, the Florida Agency for Health Care Administration ("AHCA") selected the Company to serve as the PSN Managing Entity (d/b/a/ "Simply Better Health") for Florida's MediPass program. As of December 31, 2013, the Company was servicing 31 rural counties with 134,000 recipients and 5,000 providers. Simply Better Health provided three administrative services: case management, utilization review and quality management. This contract sunset on July 31, 2014 with the implementation of final regions in the Florida Statewide Medicaid Managed Care - Managed Medical Assistance Program (the "MMA Program").

On April 11, 2013, the Company entered into an agreement with their affiliate, Simply Healthcare Plans, Inc. ("Simply"), whereby both companies agreed to purchase and sell Medicaid members in different regions in the state of Florida. The purchase agreement of the Medicaid members was transferred at their respective and fair values which resulted in a receivable balance of approximately \$70,000 due to the Company which is considered a non-admitted asset for purposes of these financial statements.

In January 2014, the Company entered into two contracts with AHCA to provide managed care services to Medicaid beneficiaries under the MMA Program. In connection with these contracts, the Company began providing services to beneficiaries in Regions 6 and 10 on June 1, 2014 and July 1, 2014, respectively. The Company earns premium income from these contracts and bears the underwriting risk. Premiums are generally paid at the beginning of the coverage month and recognized as revenue at the commencement of the coverage month.

Prior to the implementation of the MMA Program, the Company provided services to Medicaid beneficiaries under its PSN contract. Under the PSN contract, AHCA paid the Company 18.73% of what a Health Maintenance Organization ("HMO") would be paid for the same membership (the "Per Capita Capitation Benchmark" or "PCCB"). This per member per month fee was generally paid at the beginning of the coverage month and recognized as revenue at the commencement of the coverage month. AHCA kept the remaining 81.27% of implied premiums to pay the claims that the Company submitted on a regular, at least once a week, basis. The Company in return received a weekly Electronic Remittance Voucher (ERV) file from AHCA detailing what was paid or denied. The Company used this data to complete a monthly internal estimate of the amount of implied premium consumed by actual claims payments and estimated incurred but not reported claims. With this data, a reconciliation was completed from August through September each year that took what the Company would have received as an HMO versus what AHCA paid.

Simply Healthcare Holdings, Inc. (parent company of Better Health, Inc.) (the "Parent") entered into a merger agreement with Anthem, Inc. As a result of this merger, Anthem, Inc. acquired 100% of the stock of the Parent. During 2015 and prior to the merger, Parent acquired the 51% interest of Barbara R. Cowley, MD in Better Health, Inc. and as a result Parent wholly-owned Better Health, Inc. prior to the merger with Anthem, Inc. Based on receipt of all federal and state regulatory approvals, the acquisition was finalized and closed on February 17, 2015.

On July 24, 2015, the Company's ultimate parent company, Anthem Inc. ("Anthem"), and Cigna Corporation ("Cigna") entered into an Agreement and Plan of Merger dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and a direct wholly-owned subsidiary of Anthem, pursuant to which Anthem will acquire all outstanding shares of Cigna.

The acquisition is expected to close in the second half of 2016 and is subject to certain state regulatory approvals, standard closing conditions, customary approvals required under the Hart-Scott-Rodino Antitrust Improvements Act and the approval of both the Anthem, Inc. shareholders and Cigna's stockholders.

B. Significant Transactions for Each Period

The following significant transactions took place between the Company and its affiliates:

The Company received no capital contributions from its parent for the year ended December 31, 2015 and December 31, 2014.

The Company paid no dividends for the years ended December 31, 2015 and 2014.

C. Intercompany Management and Service Arrangements

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NOTES TO FINANCIAL STATEMENTS

The Company entered into a Management Services Agreement with Simply, a related party through common ownership, in which Simply provides services to administer a significant portion of Better Health's benefits and business support services. In addition, the Company is entitled to pay reimbursements for reasonable expenses incurred in furtherance of operating the Company in so much as the expenses exceed the amount of the management fee. Expenses incurred under this agreement for the periods ending September 30, 2015 and December 31, 2014 totaled approximately \$26,160,000 and \$36,493,000, respectively, are included in the caption general and administrative expenses in the accompanying statements of operations.

D. Amounts Due to or from Related Parties

At December 31, 2015 and 2014, the Company reported \$55,827 and \$380,042 due to affiliates, respectively. The payable balances represent intercompany transactions that will be settled in accordance with the settlement terms of the intercompany agreement.

E. Guarantees or Contingencies for Related Parties

The Company did not enter into guarantees or undertakings for the benefit of an affiliate which would result in a material contingent exposure of the Company's or any affiliated insurer's assets or liabilities.

F. Management and Service Contracts and Cost Sharing Arrangements

Effective January 1, 2016 the Company entered into an administrative services agreement with its affiliated companies. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The costs and expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Costs include expenses such as salaries, employee benefits, communications, advertising, consulting services, billing, accounting, underwriting, and product development, which support the Company's operations. These costs are allocated based on various utilization statistics.

G. Nature of Control Relationships that Could Affect Operations or Financial Position

The Company's ultimate parent is Anthem, Inc.

H. Amount deducted for Investment in Upstream Company

The Company does not own shares of upstream intermediate entities or Anthem.

I. Detail of Investments in Affiliates Greater than 10% of Admitted Assets

The Company does not have investment in affiliates greater than 10% of admitted assets.

J. Write-down for Impairments of Investments in Subsidiaries, Controlled or Affiliated Companies

The Company did not write-down any investments in subsidiaries, controlled or affiliated companies as of December 31, 2015 and 2014.

K. Investment in a Foreign Insurance Subsidiary

The Company does not have investments in foreign insurance subsidiaries.

L. Investment in Downstream Non-insurance Holding Companies

The Company does not have investments in downstream non-insurance holding companies.

11. Debt

A. Capital Notes

The Company had no capital notes outstanding at December 31, 2015 and 2014.

B. All Other Debt

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NOTES TO FINANCIAL STATEMENTS

The Company had no other debt outstanding at December 31, 2015 and 2014.

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

A. Defined Benefit Plan

Not applicable – See Note 12G.

B. Not applicable – See Note 12G.

C. Not applicable – See Note 12G.

D. Not applicable – See Note 12G.

E. Defined Contribution Plan

Not applicable – See Note 12G.

F. Multiemployer Plan

The Company does not participate in a multiemployer plan.

G. Consolidated/Holding Company Plans

The Company participates in a deferred compensation plan sponsored by Anthem which covers certain employees. The deferred amounts are payable according to the terms and subject to the conditions of said deferred compensation agreements. Anthem allocates a share of the total accumulated costs of this plan to the Company based on the number of allocated employees subject to the deferred compensation agreements. During 2015 and 2014, these costs totaled \$0 and \$0. The Company has no legal obligation for benefits under this plan.

The Company participates in the Anthem 401(k) Retirement Savings Plan, sponsored by ATH Holding and covering substantially all employees. Voluntary employee contributions are matched by ATH Holding subject to certain limitations. ATH Holding allocates a share of the total accumulated costs of this plan to the Company based on the number of allocated employees. During 2015 and 2014, these costs totaled \$0 and \$0, respectively. The Company has no legal obligation for benefits under these plans.

H. Post Employment Benefits and Compensated Absences

Liabilities for earned not yet taken vacation and severance benefits have been accrued as of December 31, 2015 and 2014.

I. Impact of Medicare Modernization Act on Postretirement Benefits (INT 04-17)

Not applicable.

13. Capital and Surplus, Shareholders' Dividend Restrictions and Quasi-Reorganizations

1. Outstanding Shares

As of December 31, 2015 the Company has 1,000 shares authorized, 1,000 issued and outstanding. All shares are Class A shares.

2. Preferred Stock

The Company has no preferred stock outstanding.

3. Dividend Restrictions

Per the Florida Statute 641.365, there are certain limitations exist on the Company's ability to pay dividends to its parent. The Company may pay funds only from accumulated surplus funds that were derived from realized net operating profits on its business and net realized capital gains. Prior written approval by the Florida DFS is required for payment of any dividend which would result in these accumulated surplus funds being less than zero. Florida DFS approval is not required if the dividend to be paid is less than the greater of 1) ten percent

Annual Statement for the year 2015 of the Better Health, Inc.

NOTES TO FINANCIAL STATEMENTS

of the Company's accumulated surplus or 2) the Company's entire net operating profit, including realized capital gains, for the immediately preceding calendar year.

4. Dividends Paid

No ordinary dividends were paid by the Company as of December 31, 2015.

5. Maximum Ordinary Dividends During 2016

Within the limitations of (3) above, the Company may pay no dividends during 2015 without prior approval.

6. Unassigned Surplus Restrictions

Unassigned surplus funds are not restricted at December 31, 2015.

7. Mutual Surplus Advances

Not applicable.

8. Company Stock Held for Special Purpose

There are no shares of stock held for special purposes at December 31, 2015.

9. Changes in Special Surplus Funds

The changes in balances of special surplus funds from the prior year are due to amounts segregated for the estimated 2016 Affordable Care Act ("ACA") health insurer fee.

10. Changes in Unassigned Funds

The portion of unassigned funds represented by cumulative unrealized gains and losses was \$0 at December 31, 2015.

11. Surplus Notes

The Company received the following surplus debentures or similar obligations:

Date Issued	Interest Rate	Par Value (Face Amount of Notes)	Carrying Value of Note	Interest And/Or Principal Paid Current Year	Total Interest And/Or Principal Paid	Unapproved Interest And/Or Principal	Date of Maturity
12/20/2012	8%	2,500,000	2,500,000	-	-	606,028	12/31/2015
12/31/2012	8%	2,500,000	2,500,000	-	-	600,000	12/31/2015
02/25/2013	8%	5,000,000	5,000,000	-	-	1,252,493	12/31/2015
	Total	10,000,000	10,000,000			2,458,521	

As of December 3, 2015, the Company had entered into promissory surplus notes to related parties totaling \$10,500,000. The notes bear interest at the rate of 8% per annum, however, in accordance with statutory accounting principles set forth in SSAP No. 41 interest shall not be recorded as a liability or an expense until such interest has been approved by the Office of Insurance Regulation for payment.

As of December 31, 2015 and December 31, 2014, the Company did not seek nor did the Office of Insurance Regulation approve any interest payments. As of December 31, 2015 and December 31, 2014, the "unapproved" cumulative interest relating to the surplus notes is approximately \$2,249,000 and \$1,619,000, respectively.

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NOTES TO FINANCIAL STATEMENTS

Payment of principal and interest on the surplus notes are subordinated to claims of all policyholders, creditors, and other liabilities of the Company.

12. Restatement due to Prior Quasi-reorganization

The Company has no restatements due to prior quasi-reorganizations.

13. Quasi-reorganization over Prior 10 years

The Company has not been involved in a quasi-reorganization during the past 10 years.

14. Contingencies

A. Contingent Commitments

The Company has no contingent commitments at December 31, 2015.

B. Assessments

1. The Company is subject to guaranty fund and other assessments by the state(s) in which it writes business. Guaranty fund assessments are accrued at the time of insolvencies. Other assessments are accrued either at the time of the assessment or at the time the losses are incurred.

The State of Florida has not issued a guaranty fund assessment, and the Company has not recorded a liability for an assessment as of December 31, 2015.

2. .Not applicable.

C. Gain Contingencies

The Company has no gain contingencies at December 31, 2015.

D. Claims-Related Extra Contractual Obligations and Bad Faith Losses Stemming from Lawsuits

Not applicable.

E. Joint and Several Liabilities

Not applicable.

F. All Other Contingencies

In February 2015, Anthem reported that it was the target of a sophisticated external cyber-attack. The attackers gained unauthorized access to certain of Anthem's information technology systems and obtained personal information related to many individuals and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that Anthem will not identify additional information that was accessed or obtained.

Anthem has continued to implement security enhancements since this incident and is supporting federal law enforcement efforts to identify the responsible parties. Upon discovery of the cyber-attack, Anthem took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate its systems and identify solutions based on the evolving landscape. Anthem is providing credit monitoring and identity protection services to those who have been affected by this cyber-attack. Anthem has incurred expenses subsequent to the cyber-attack to investigate and remediate this matter and expects to continue to incur expenses of this nature in the foreseeable future. Anthem will recognize these expenses in the periods in which they are incurred.

Actions have been filed in various federal and state courts, and other claims have been or may be asserted against Anthem on behalf of current or former members, current or former employees, other individuals, shareholders or

Annual Statement for the year 2015 of the Better Health, Inc.

NOTES TO FINANCIAL STATEMENTS

others seeking damages or other related relief, allegedly arising out of the cyber-attack. State and federal agencies, including state insurance regulators, state attorneys general, the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigation, are investigating events related to the cyber-attack, including how it occurred, its consequences and Anthem's responses. Although Anthem is cooperating in these investigations, Anthem may be subject to fines or other obligations, which may have an adverse effect on how Anthem operates its business and results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation in February 2015 and was subsequently heard by the Panel in May 2015. In June 2015, the Panel entered its order transferring the consolidated matter to the U.S. District Court for the Northern District of California. The U.S. District Court entered its Case Management Order in September 2015. Anthem has filed a Motion to Dismiss several of the counts that are before the U.S. District Court. There remain a few state court cases that are presently proceeding outside of the Multidistrict Litigation.

Anthem has contingency plans and insurance coverage for certain expenses and potential liabilities of this nature. The coverage has been sufficient to cover the majority of claims and liabilities incurred to date. While a loss from these matters is reasonably possible, Anthem cannot reasonably estimate a range of possible losses because the investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

The Company is involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental and administrative proceedings. These investigations, audits and reviews include routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and Federal Agencies. Such investigations could result in the imposition of civil or criminal fines, penalties and other sanctions. The Company believes that any liability that may result from any one of these actions is unlikely to have a material adverse effect on the Company's financial position or results of operations.

At December 31, 2015 and 2014, the Company reported admitted assets of \$4,949,421 and \$17,354,572 respectively in premium receivables due from policyholders and agents, other receivables and receivables due from uninsured plans. The receivables are not deemed to be uncollectible, therefore, no provision for uncollectible amounts have been recorded. The potential for any additional loss is not believed to be material to the Company's financial condition.

15. Leases

A. Lessee Operating Lease

1. The Company did not have any operating leases at December 31, 2015.
2. Not applicable at December 31, 2015.
3. The Company is not involved in any material sales-leaseback transactions at December 31, 2015.

B. Lessor Leases

1. The Company has not entered into any operating leases.
2. The Company has not entered into any leverage leases

16. Information about Financial Instruments with Off-Balance-Sheet Risk and Financial Instruments with Concentrations of Credit Risk

The Company has no significant financial instruments with off-balance sheet risk.

Financial instruments that potentially subject the Company to concentration of credit risk consist primarily of investment securities. All investment securities are managed by professional investment managers within policies authorized by the board of directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. As of December 31, 2015, there were no significant concentrations.

17. Sales, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. Transfers of Receivables Reported as Sales

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Not applicable at December 31, 2015 and 2014.

B. Transfer and Servicing of Financial Assets

1– 7. Not applicable.

C. Wash Sales

1. In the course of the Company's asset management, securities may be sold and reacquired within 30 days of the sale date to enhance the yield on the investments.
2. At December 31, 2015 and 2014, there were no wash sales involving securities with an NAIC designation of 3 or below or unrated.

18. Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

A. Administrative Services Only ("ASO") Plans

Not applicable in December 31, 2015 and 2014.

B. Administrative Services Contract ("ASC") Plans

Not applicable in December 31, 2015 and 2014.

C. Medicare or Other Similarly Structured Cost-Based Reimbursement Contract

Not applicable at December 31, 2015 and 2014.

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

No premiums were written by managing general agents or third party administrators during the years ended December 31, 2015 and 2014.

20. Fair Value Measurement

A. Fair Value Measure

1. Fair Value Measurements at Reporting Date

(1)		(2)	(3)	(4)	(5)
Description		(Level 1)	(Level 2)	(Level 3)	Total
a. Assets at fair Value					
None		0	0	0	0
		\$ 0	0	0	0
Total assets at fair value		\$ 0	0	0	0
b. Liabilities at fair value					
None		0	0	0	0
		0	0	0	0
Total liabilities at fair value		\$ 0	0	0	0

2. The Company does not have assets or liabilities within Level 3 fair value hierarchy.
3. The Company's policy is to recognize transfers between Levels, if any, as of the beginning of the reporting period.
4. Fair values of fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level 1 or Level 2 inputs, for the determination of fair value to facilitate fair value measurements and disclosures. United States Government securities represent Level 1 securities, while Level 2 securities primarily include corporate securities, securities from states, municipalities and political subdivisions and residential mortgage-backed securities. For Securities

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NOTES TO FINANCIAL STATEMENTS

not actively traded, the third party pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds.

Fair values of equity securities are generally designated as Level 1 and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level 2. The Company has certain equity securities, including private equity securities, for which the fair value is estimated based on each security's current condition and future cash flow projections. Such securities are designated Level 3. The fair values of these private equity securities are generally based on either broker quotes or discounted cash flow projections using assumptions for inputs such as the weighted-average cost of capital, long-term revenue growth rates and earnings before interest, taxes, depreciation and amortization, or revenue multiples that are not observable in the markets.

There have been no significant changes in the valuation techniques during the current period.

B. Fair Value Measurements Under Other Accounting Pronouncements

Not applicable at December 31, 2015 and 2014.

C. Financial Instruments

Not applicable at December 31, 2015

D. Not Practicable to Estimate Fair Value

The Company does not have assets or liabilities that are not practicable to estimate fair value.

21. Other Items

A. Unusual or Infrequent Items

Not applicable at December 31, 2015 and 2014.

B. Troubled Debt Restructuring: Debtors

Not applicable at December 31, 2015 and 2014.

C. Other Disclosures

Not applicable at December 31, 2015 and 2014.

D. Business Interruption Insurance Recoveries

The Company has reported no recoveries for business interruption for the years ended December 31, 2015 and 2014.

E. State Transferable and Non-Transferable Tax Credits

The Company did not have state transferable tax credits at December 31, 2015 and 2014.

F. Subprime Mortgage-Related Risk Exposure

1. The Company's investment strategy of providing safety and preservation of capital, sufficient liquidity to meet cash flow requirements and the attainment of a competitive after-tax investment return is supported by a well diversified portfolio consisting of many different types of investments. The portion of the Company's investment portfolio with subprime mortgage-related risk exposure is relatively small in comparison to the overall investment portfolio, and consists of investment grade securities with no exposure to collateralized debt obligations. All mortgage related investments are monitored closely as part of the quarterly investment review performed by the Anthem Investment Impairment Review Committee.

Annual Statement for the year 2015 of the Better Health, Inc.

NOTES TO FINANCIAL STATEMENTS

2. The Company did not carry investments in subprime mortgage loans in its portfolio at December 31, 2015 or 2014.
3. The Company did not have subprime mortgage-related risk exposure at December 31, 2015 or 2014.
4. The Company did not underwrite Mortgage Guaranty or Financial Guaranty insurance coverage at December 31, 2015.

G. Retained Assets

The Company did not have any retained assets at December 31, 2015 and 2014.

22. Events Subsequent

The Company is subject to an annual fee under section 9010 of the Affordable Care Act ("ACA"). A health insurance company's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. The Company has written health insurance subject to the ACA assessment and expects to conduct health insurance business in 2016. The Company reflected its estimated portion of the fee payable on September 30, 2016 in special surplus. The annual fee under section 9010 of the ACA has been suspended for 2017 and will resume for 2018 and beyond.

	Current Year	Prior Year
A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the Federal Affordable Care Act (YES/NO)?	YES	
B. ACA fee assessment payable for the upcoming year	\$ 4,874,590	2,562,490
C. ACA fee assessment paid	\$ 2,562,490	0
D. Premium written subject to ACA 9010 assessment	\$ 263,262,026	162,684,891
E. Total Adjusted Capital before surplus adjustment (Five-Year Historical Line 14)	\$ 16,557,167	
F. Total Adjusted Capital after surplus adjustment (Five-Year Historical Line 14 minus 22B above)	\$ 11,682,577	
G. Authorized Control Level (Five-Year Historical Line 15)	\$ 10,529,760	
H. Would reporting the ACA assessment as of Dec. 31, 2015 have triggered an RBC action level (YES/NO)?	NO	

Subsequent events have been considered through March 31, 2016 for the statutory statement issued on March 31, 2016. There were no other events occurring subsequent to December 31, 2015 requiring recognition or disclosure.

23. Reinsurance

A. Ceded Reinsurance Report

Section 1 – General Interrogatories

1. Are any of the reinsurers that are listed in Schedule S as non-affiliated owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?
Yes () No (X)
2. Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled, directly or indirectly, by an insured, a beneficiary, a creditor or an insured or any other person not primarily engaged in the insurance business?

Annual Statement for the year 2015 of the Better Health, Inc.

NOTES TO FINANCIAL STATEMENTS

Yes ☐ No ☒

Section 2 – Ceded Reinsurance Report – Part A

1. Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credits?

Yes ☐ No ☒

3. Does the reporting entity have any reinsurance agreements in effect such that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same insurer, exceed the total direct premium collected under reinsured policies?

Yes ☐ No ☒

Section 3 – Ceded Reinsurance Report – Part B

1. What is the estimated amount of the aggregate reduction in surplus, (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2) above of termination of ALL reinsurance agreements, by either party, as of the date of this statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

Not Applicable.

2. Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement include policies or contract that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes ☐ No ☒

B. Uncollectible Reinsurance

The Company has no uncollectible reinsurance at December 31, 2015 and 2014.

C. Commutation of Ceded Reinsurance

The Company has not commuted ceded reinsurance during 2015 and 2014.

D. Certified Reinsurer Rating Downgraded or Status Subject Revocation

The Company has no downgraded certified reinsurer ratings or status subject revocations during 2015 and 2014.

24. Retrospectively Rated Contracts & Contracts Subject to Redetermination

- A. The Company's contracts with AHCA include provisions for which the premiums vary based on loss experience. The Company estimates retrospective premium adjustments through the review of each retrospectively rated account, comparing the claim development with that anticipated in the policy contracts.
- B. The Company records accrued retrospective premium as an adjustment to earned premium.
- C. The amount of net premiums written by the Company at December 31, 2015 and 2014 that were subject to retrospective rating features was \$268,049,800 and \$158,933,131 respectively, which represents 100% and 100% of the total net premiums written. No other net premiums written by the Company are subject to retrospective rating features.
- D. Not Applicable
- E. Risk-Sharing Provisions of the Affordable Care Act ("ACA")
1. Did the reporting entity write accident and health insurance premium which is subject to the Affordable Care Act risk sharing provisions (YES/NO)? No
2. Impact of Risk-Sharing Provisions of the Affordable Care Act on Admitted Assets, Liabilities and Revenue for the Current Year

Annual Statement for the year 2015 of the Better Health, Inc.

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Not applicable.

3. Roll-forward of prior year ACA risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balance.

Not applicable.

25. Change in Incurred Claims and Claims Adjustment Expenses

The estimated cost of claims and claim adjustment expense attributable to insured events of prior years decreased by \$429,860 during 2015. This is approximately 1.6% of unpaid claims and claim adjustment expense of \$26,510,146 as of December 31, 2014. The surplus reflects the decreases in estimated claims expenses as a result of claim payments during the year, and as additional information is received regarding claims incurred prior to 2015. Recent claim development trends are also taken into account in evaluating the overall adequacy of unpaid claims and claim adjustment expense.

26. Intercompany Pooling Arrangements

Not applicable at December 31, 2015 and 2014.

27. Structured Settlements

Not applicable at December 31, 2015 and 2014.

28. Health Care Receivables

A. Pharmaceutical Rebate Receivables

Not applicable at December 31, 2015 and 2014.

B. Risk Sharing Receivables

Risk Sharing receivables are accounted for as non-admitted assets at December 31, 2015.

29. Participating Policies

Not applicable at December 31, 2015 and 2014.

30. Premium Deficiency Reserve

1. Liability carried for premium deficiency reserve	\$	-
2. Date of the most recent evaluation of this liability		12/31/2015
3. Was anticipated investment income utilized in the calculation	Yes	<u>No</u>

31. Anticipated Salvage and Subrogation

Not applicable at December 31, 2015 and 2014.

Annual Statement for the year 2015 of the **Better Health, Inc.**

GENERAL INTERROGATORIES

PART 1 – COMMON INTERROGATORIES

GENERAL

- 1.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? Yes ☒ No ☐
- If yes, complete Schedule Y, Parts 1, 1A and 2.
- 1.2 If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations? Yes ☒ No ☐ N/A ☐
- 1.3 State Regulating? _____
- 2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? Yes ☐ No ☒
- 2.2 If yes, date of change: _____
- 3.1 State as of what date the latest financial examination of the reporting entity was made or is being made. _____
- 3.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released. _____
- 3.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date). _____
- 3.4 By what department or departments?

- 3.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with departments? Yes ☐ No ☐ N/A ☒
- 3.6 Have all of the recommendations within the latest financial examination report been complied with? Yes ☐ No ☐ N/A ☒
- 4.1 During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity) receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
- 4.11 sales of new business? Yes ☐ No ☒
- 4.12 renewals? Yes ☐ No ☒
- 4.2 During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
- 4.21 sales of new business? Yes ☐ No ☒
- 4.22 renewals? Yes ☐ No ☒
- 5.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? Yes ☒ No ☐
- 5.2 If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.

1 Name of Entity	2 NAIC Company Code	3 State of Domicile
_____	_____	_____
_____	_____	_____

Annual Statement for the year 2015 of the **Better Health, Inc.**

GENERAL INTERROGATORIES

6.1 Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? Yes ☐ No ☒

6.2 If yes, give full information:

.....
.....
.....

7.1 Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity? Yes ☐ No ☒

7.2 If yes,

7.21 State the percentage of foreign control.

0.00 %

7.22 State the nationality(s) of the foreign person(s) or entity(s); or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact and identify the type of entity(s) (e.g., individual, corporation, government, manager or attorney-in-fact).

1 Nationality	2 Type of Entity
.....
.....

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? Yes ☐ No ☒

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

.....
.....
.....

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? Yes ☐ No ☒

8.4 If response to 8.3 is yes, please provide the names and locations (city and state of the main office) of any affiliates regulated by a federal financial regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC
.....
.....

9. What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?

Ernst & Young LLP, 111 Monument Circle #4000, Indianapolis, IN 46204
.....
.....

10.1 Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation? Yes ☐ No ☒

10.2 If response to 10.1 is yes, provide information related to this exemption:

.....
.....
.....

10.3 Has the insurer been granted any exemptions related to the other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 18A of the Model Regulation, or substantially similar state law or regulation? Yes ☐ No ☒

10.4 If response to 10.3 is yes, provide information related to this exemption:

.....
.....
.....

Annual Statement for the year 2015 of the **Better Health, Inc.**

GENERAL INTERROGATORIES

10.5 Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws? Yes ☒ No ☐ N/A ☐

10.6 If the response to 10.5 is no or n/a, please explain.

.....
.....
.....

11. What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?

Brian Weible, Wakely Consulting Group, 19321 US Highway 19N, Suite 515, Clearwater, FL 33764

.....
.....

12.1 Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly? Yes ☐ No ☒

12.11 Name of real estate holding company

12.12 Number of parcels involved

12.13 Total book/adjusted carrying value

	0
\$	0

12.2 If yes, provide explanation:

.....
.....
.....

13. FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:

13.1 What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?

.....
.....
.....

13.2 Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located?

Yes ☒ No ☐

13.3 Have there been any changes made to any of the trust indentures during the year?

Yes ☐ No ☒

13.4 If answer to (13.3) is yes, has the domiciliary or entry state approved the changes?

Yes ☐ No ☐ N/A ☒

14.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards?

- Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
- Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
- Compliance with applicable governmental laws, rules, and regulations;
- The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
- Accountability for adherence to the code.

Yes ☒ No ☐

14.11 If the response to 14.1 is no, please explain:

.....
.....
.....

14.2 Has the code of ethics for senior managers been amended?

Yes ☐ No ☒

14.21 If the response to 14.2 is yes, provide information related to amendment(s).

.....
.....
.....

Annual Statement for the year 2015 of the **Better Health, Inc.**

GENERAL INTERROGATORIES

14.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes ☐ No ☒

14.31 If the response to 14.3 is yes, provide the nature of any waiver(s).

.....
.....
.....

15.1 Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List? Yes ☐ No ☒

15.2 If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.

1 American Bankers Association (ABA) Routing Number	2 Issuing or Confirming Bank Name	3 Circumstances That Can Trigger the Letter of Credit	4 Amount
0			0
0			0
0			0

BOARD OF DIRECTORS

16. Is the purchase or sale of all investments of the reporting entity passed upon either by the board of directors or a subordinate committee thereof? Yes ☒ No ☐

17. Does the reporting entity keep a complete permanent record of the proceedings of its board of directors and all subordinate committees thereof? Yes ☒ No ☐

18. Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict or is likely to conflict with the official duties of such person? Yes ☒ No ☐

FINANCIAL

19. Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)? Yes ☐ No ☒

20.1 Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):

20.11 To directors or other officers	\$ 0
20.12 To stockholders not officers	\$ 0
20.13 Trustees, supreme or grand (Fraternal only)	\$ 0

20.2 Total amount of loans outstanding at the end of year (inclusive of Separate Accounts, exclusive of policy loans):

20.21 To directors or other officers	\$ 0
20.22 To stockholders not officers	\$ 0
20.23 Trustees, supreme or grand (Fraternal only)	\$ 0

21.1 Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reported in the statement? Yes ☐ No ☒

21.2 If yes, state the amount thereof at December 31 of the current year:

21.21 Rented from others	\$ 0
21.22 Borrowed from others	\$ 0
21.23 Leased from others	\$ 0
21.24 Other	\$ 0

22.1 Does this statement include payments for assessments as described in the Annual Statement Instructions other than guaranty fund or guaranty association assessments? Yes ☐ No ☒

Annual Statement for the year 2015 of the **Better Health, Inc.**

GENERAL INTERROGATORIES

22.2 If answer is yes:

22.21 Amount paid as losses or risk adjustment	\$	0
22.22 Amount paid as expenses	\$	0
22.23 Other amounts paid	\$	0

23.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement?

Yes ☐ No ☒

23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount:

\$ 0

INVESTMENT

24.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date? (other than securities lending programs addressed in 24.03)

Yes ☒ No ☐

24.02 If no, give full and complete information, relating thereto:

.....
.....
.....

24.03 For security lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet. (an alternative is to reference Note 17 where this information is also provided)

.....
.....
.....

24.04 Does the company's security lending program meet the requirements for a conforming program as outlined in the Risk-Based Capital Instructions?

Yes ☐ No ☐ N/A ☒

24.05 If answer to 24.04 is yes, report amount of collateral for conforming programs.

\$ 0

24.06 If answer to 24.04 is no, report amount of collateral for other programs.

\$ 0

24.07 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract?

Yes ☐ No ☐ N/A ☒

24.08 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%?

Yes ☐ No ☐ N/A ☒

24.09 Does the reporting entity or the reporting entity's securities lending agent utilize the Master Securities Lending Agreement (MSLA) to conduct securities lending?

Yes ☐ No ☐ N/A ☒

24.10 For the reporting entity's security lending program, state the amount of the following as of December 31 of the current year:

24.101 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2 \$ 0

24.102 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2 \$ 0

24.103 Total payable for securities lending reported on the liability page \$ 0

25.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity or has the reporting entity sold or transferred any assets subject to a put option contract that is currently in force? (Exclude securities subject to Interrogatory 21.1 and 24.03).

Yes ☒ No ☐

Annual Statement for the year 2015 of the **Better Health, Inc.****GENERAL INTERROGATORIES**

25.2 If yes, state the amount thereof at December 31 of the current year:

25.21	Subject to repurchase agreements	\$ 0
25.22	Subject to reverse repurchase agreements	\$ 0
25.23	Subject to dollar repurchase agreements	\$ 0
25.24	Subject to reverse dollar repurchase agreements	\$ 0
25.25	Placed under option agreements	\$ 0
25.26	Letter stock or securities restricted as to sale - excluding FHLB Capital Stock	\$ 0
25.27	FHLB Capital Stock	\$ 0
25.28	On deposit with states	\$ 300,000
25.29	On deposit with other regulatory bodies	\$ 538,757
25.30	Pledged as collateral - excluding collateral pledged to an FHLB	\$ 0
25.31	Pledged as collateral to FHLB - including assets backing funding agreements	\$ 0
25.32	Other	\$ 0

25.3 For category (25.26) provide the following:

1 Nature of Restriction	2 Description	3 Amount
		0
		0
		0

26.1 Does the reporting entity have any hedging transactions reported on Schedule DB? Yes [] No [X]

26.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes [] No [] N/A [X]
If no, attach a description with this statement.

27.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity? Yes [] No [X]

27.2 If yes, state the amount thereof at December 31 of the current year. \$ 0

28. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? Yes [X] No []

28.01 For agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian's Address
N/A	The Company has not invested in Securities.

28.02 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

28.03 Have there been any changes, including name changes, in the custodian(s) identified in 28.01 during the current year? Yes [] No [X]

Annual Statement for the year 2015 of the **Better Health, Inc.****GENERAL INTERROGATORIES**

28.04 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

28.05 Identify all investment advisors, broker/dealers or individuals acting on behalf of broker/dealers that have access to the investment accounts, handle securities and have authority to make investments on behalf of the reporting entity:

1 Central Registration Depository Number(s)	2 Name	3 Address

29.1 Does the reporting entity have any diversified mutual funds reported in Schedule D – Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5 (b) (1)])?

Yes [] No [X]

29.2 If yes, complete the following schedule:

1 CUSIP #	2 Name of Mutual Fund	3 Book/Adjusted Carrying Value
		0
		0
		0
29.2999 TOTAL		0

29.3 For each mutual fund listed in the table above, complete the following schedule:

1 Name of Mutual Fund (from above table)	2 Name of Significant Holding of the Mutual Fund	3 Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	4 Date of Valuation
		0	
		0	
		0	

30. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

	1 Statement (Admitted) Value	2 Fair Value	3 Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
30.1 Bonds	0	0	0
30.2 Preferred stocks	0	0	0
30.3 Totals	0	0	0

30.4 Describe the sources or methods utilized in determining the fair values:
The Company has not invested in Securities.

31.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D?

Yes [] No [X]

31.2 If the answer to 31.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source?

Yes [] No [X]

Annual Statement for the year 2015 of the **Better Health, Inc.**

GENERAL INTERROGATORIES

31.3 If the answer to 31.2 is no, describe the reporting entity's process for determining a reliable pricing

source for purposes of disclosure of fair value for Schedule D:

The Company has not invested in Securities.

32.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed?

Yes [X] No []

32.2 If no, list exceptions:

OTHER

33.1 Amount of payments to trade associations, service organizations and statistical or Rating Bureaus, if any?

\$ 0

33.2 List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations and statistical or rating bureaus during the period covered by this statement.

1 Name	2 Amount Paid
	\$ 0
	\$ 0
	\$ 0

34.1 Amount of payments for legal expenses, if any?

\$ 0

34.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.

1 Name	2 Amount Paid
	\$ 0
	\$ 0
	\$ 0

35.1 Amount of payments for expenditures in connection with matters before legislative bodies, officers or departments of government, if any?

\$ 0

35.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid
	\$ 0
	\$ 0
	\$ 0

Annual Statement for the year 2015 of the **Better Health, Inc.****GENERAL INTERROGATORIES**
PART 2 - HEALTH INTERROGATORIES

1.1 Does the reporting entity have any direct Medicare Supplement Insurance in force? Yes [] No [X]

1.2 If yes, indicate premium earned on U.S. business only. \$ 0

1.3 What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit? \$ 0

1.31 Reason for excluding

1.4 Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above. \$ 0

1.5 Indicate total incurred claims on all Medicare Supplement insurance. \$ 0

1.6 Individual policies:

Most current three years:

1.61 Total premium earned \$ 0

1.62 Total incurred claims \$ 0

1.63 Number of covered lives 0

All years prior to most current three years:

1.64 Total premium earned \$ 0

1.65 Total incurred claims \$ 0

1.66 Number of covered lives 0

1.7 Group policies:

Most current three years:

1.71 Total premium earned \$ 0

1.72 Total incurred claims \$ 0

1.73 Number of covered lives 0

All years prior to most current three years:

1.74 Total premium earned \$ 0

1.75 Total incurred claims \$ 0

1.76 Number of covered lives 0

2. Health Test:

	1 Current Year	2 Prior Year
2.1 Premium Numerator	\$ 267,338,684	\$ 158,608,233
2.2 Premium Denominator	\$ 267,338,684	\$ 158,608,233
2.3 Premium Ratio (2.1 / 2.2)	1.000	1.000
2.4 Reserve Numerator	\$ 34,203,293	\$ 26,510,581
2.5 Reserve Denominator	\$ 34,203,293	\$ 26,510,581
2.6 Reserve Ratio (2.4 / 2.5)	1.000	1.000

3.1 Has the reporting entity received any endowment or gift from contracting hospitals, physicians, dentists, or others that is agreed will be returned when, as and if the earnings of the reporting entity permits? Yes [] No [X]

3.2 If yes, give particulars:

4.1 Have copies of all agreements stating the period and nature of hospitals', physicians', and dentists' care offered to subscribers and dependents been filed with the appropriate regulatory agency? Yes [X] No []

4.2 If not previously filed, furnish herewith a copy(ies) of such agreement(s). Do these agreements include additional benefits offered? Yes [X] No []

5.1 Does the reporting entity have stop-loss reinsurance? Yes [X] No []

5.2 If no, explain:

5.3 Maximum retained risk (see instructions)

5.31 Comprehensive Medical \$ 350,000

5.32 Medical Only \$ 0

5.33 Medicare Supplement \$ 0

5.34 Dental and vision \$ 0

5.35 Other Limited Benefit Plan \$ 0

5.36 Other \$ 0

6. Describe arrangement which the reporting entity may have to protect subscribers and their dependents against the risk of insolvency including hold harmless provisions, conversion privileges with other carriers, agreements with providers to continue rendering services, and any other agreements:
All provider contracts provide for continuation of services regardless of status of payment from the Plan.

Annual Statement for the year 2015 of the **Better Health, Inc.****GENERAL INTERROGATORIES**
PART 2 - HEALTH INTERROGATORIES

7.1 Does the reporting entity set up its claim liability for provider services on a service date basis?

Yes ☒ No ☐

7.2 If no, give details:

.....

.....

.....

8. Provide the following information regarding participating providers:

8.1 Number of providers at start of reporting year

11,147

8.2 Number of providers at end of reporting year

5,126

9.1 Does the reporting entity have business subject to premium rate guarantees?

Yes ☐ No ☒

9.2 If yes, direct premium earned:

9.21 Business with rate guarantees between 15-36 months

0

9.22 Business with rate guarantees over 36 months

0

10.1 Does the reporting entity have Incentive Pool, Withhold or Bonus Arrangements in its provider contracts?

Yes ☒ No ☐

10.2 If yes:

10.21 Maximum amount payable bonuses

\$ 0

10.22 Amount actually paid for year bonuses

\$ 0

10.23 Maximum amount payable withholds

\$ 0

10.24 Amount actually paid for year withholds

\$ 0

11.1 Is the reporting entity organized as:

11.12 A Medical Group/Staff Model,

Yes ☐ No ☒

11.13 An Individual Practice Association (IPA), or,

Yes ☐ No ☒

11.14 A Mixed Model (combination of above)?

Yes ☐ No ☒

11.2 Is the reporting entity subject to Statutory Minimum Capital and Surplus Requirements?

Yes ☒ No ☐

11.3 If yes, show the name of the state requiring such minimum capital and surplus:

Florida

11.4 If yes, show the amount required.

\$ 5,346,774

11.5 Is this amount included as part of a contingency reserve in stockholder's equity?

Yes ☐ No ☒

11.6 If the amount is calculated, show the calculation:

The State of Florida requires Surplus to exceed a) 2% of annualized revenues (\$263,262,026 x .02 = \$5,265,241), b) 10% of liabilities

(\$35,153,605 x .1 = \$3,515,361), or c) \$1,500,000 whichever is greater

12. List service areas in which reporting entity is licensed to operate:

1		
Name of Service Area		

13.1 Do you act as a custodian for health savings accounts?

Yes ☐ No ☒

13.2 If yes, please provide the amount of custodial funds held as of the reporting date.

\$ 0

13.3 Do you act as an administrator for health savings accounts?

Yes ☐ No ☒

13.4 If yes, please provide the balance of the funds administered as of the reporting date.

\$ 0

14.1 Are any of the captive affiliates reported on Schedule S, Part 3, authorized reinsurers?

Yes ☐ No ☒ N/A ☐

14.2 If the answer to 14.1 is yes, please provide the following:

1 Company Name	2 NAIC Company Code	3 Domiciliary Jurisdiction	4 Reserve Credit	Assets Supporting Reserve Credit		
				5 Letters of Credit	6 Trust Agreements	7 Other
			0	0	0	0
			0	0	0	0
			0	0	0	0

15. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded).

15.1 Direct Premium Written

\$ 0

15.2 Total Incurred Claims

\$ 0

15.3 Number of Covered Lives

0

***Ordinary Life Insurance Includes**

Term (whether full underwriting, limited underwriting, jet issue, "short form app")

Whole Life (whether full underwriting, limited underwriting, jet issue, "short form app")

Variable Life (with or without secondary guarantee)

Universal Life (with or without secondary guarantee)

Variable Universal Life (with or without secondary guarantee)

Annual Statement for the year 2015 of the **Better Health, Inc.**

FIVE – YEAR HISTORICAL DATA

	1	2	3	4	5
	2015	2014	2013	2012	2011
Balance Sheet (Pages 2 and 3)					
1. Total admitted assets (Page 2, Line 28)	50,674,076	61,916,259	0	0	0
2. Total liabilities (Page 3, Line 24)	35,460,144	35,460,144	0	0	0
3. Statutory minimum capital and surplus requirement	5,346,774	4,609,837	0	0	0
4. Total capital and surplus (Page 3, Line 33)	15,213,932	15,817,890	0	0	0
Income Statement (Page 4)					
5. Total revenues (Line 8)	267,338,684	158,608,233	0	0	0
6. Total medical and hospital expenses (Line 18)	238,192,189	127,685,279	0	0	0
7. Claims adjustment expenses (Line 20)	6,341,286	3,875,346	0	0	0
8. Total administrative expenses (Line 21)	23,717,325	35,485,219	0	0	0
9. Net underwriting gain (loss) (Line 24)	(912,116)	(8,437,611)	0	0	0
10. Net investment gain (loss) (Line 27)	10,272	5,407	0	0	0
11. Total other income (Lines 28 plus 29)	(124,300)	(50,241)	0	0	0
12. Net income or (loss) (Line 32)	(191,668)	(8,482,445)	0	0	0
Cash Flow (Page 6)					
13. Net cash from operations (Line 11)	414,328	35,334,009	0	0	0
Risk-Based Capital Analysis					
14. Total adjusted capital	16,557,167	0	0	0	0
15. Authorized control level risk-based capital	10,529,760	0	0	0	0
Enrollment (Exhibit 1)					
16. Total members at end of period (Column 5, Line 7)	95,517	88,014	0	0	0
17. Total members months (Column 6, Line 7)	1,115,606	0	0	0	0
Operating Percentage (Page 4)					
(Item divided by Page 4, sum of Lines 2, 3, and 5) x 100.0					
18. Premiums earned plus risk revenue (Line 2 plus Lines 3 and 5)	100.0	100.0	100.0	100.0	100.0
19. Total hospital and medical plus other non-health (Line 18 plus Line 19)	89.1	80.5	0.0	0.0	0.0
20. Cost containment expenses	1.8	0.0	0.0	0.0	0.0
21. Other claims adjustment expenses	0.7	2.4	0.0	0.0	0.0
22. Total underwriting deductions (Line 23)	100.3	105.3	0.0	0.0	0.0
23. Total underwriting gain (loss) (Line 24)	(0.3)	(5.3)	0.0	0.0	0.0
Unpaid Claims Analysis					
(U&I Exhibit, Part 2B)					
24. Total claims incurred for prior years (Line 13, Col. 5)	25,403,106	0	0	0	0
25. Estimated liability of unpaid claims-[prior year (Line 13, Col. 6)]	25,832,966	0	0	0	0
Investments in Parent, Subsidiaries and Affiliates					
26. Affiliated bonds (Sch. D Summary, Line 12, Col. 1)	0	0	0	0	0
27. Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1)	0	0	0	0	0
28. Affiliated common stocks (Sch. D Summary, Line 24, Col. 1)	0	0	0	0	0
29. Affiliated short-term investments (subtotal included in Sch. DA Verification, Col. 5, Line 10)	0	0	0	0	0
30. Affiliated mortgage loans on real estate	0	0	0	0	0
31. All other affiliated	0	0	0	0	0
32. Total of above Lines 26 to 31	0	0	0	0	0
33. Total investment in parent included in Lines 26 to 31 above.	0	0	0	0	0

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3, Accounting Changes and Correction of Errors?

Yes [] No [X]

If no, please explain:

.....
.....
.....
.....

Annual Statement for the year 2015 of the **Better Health, Inc.**



15480201543010100

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

Report for: 1. Corporation

2.

(LOCATION)

NAIC Group Code 4806

BUSINESS IN THE STATE OF FLORIDA DURING THE YEAR 2015

NAIC Company Code 15480

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	1 Total	Comprehensive (Hospital & Medical)		4 Medicare Supplement	5 Vision Only	6 Dental Only	7 Federal Employees Health Benefits Plan	8 Title XVIII Medicare	9 Title XIX Medicaid	10 Other
		2 Individual	3 Group							
Total Members at end of:										
1. Prior Year	88,014	0	0	0	0	0	0	0	88,014	0
2. First Quarter	90,685	0	0	0	0	0	0	0	90,685	0
3. Second Quarter	92,676	0	0	0	0	0	0	0	92,676	0
4. Third Quarter	94,862	0	0	0	0	0	0	0	94,862	0
5. Current Year	95,517	0	0	0	0	0	0	0	95,517	0
6. Current Year Member Months	1,115,606	0	0	0	0	0	0	0	1,115,606	0
Total Member Ambulatory Encounters For Year:										
7. Physician	577,425	0	0	0	0	0	0	0	577,425	0
8. Non-Physician	309,687	0	0	0	0	0	0	0	309,687	0
9. Total	887,112	0	0	0	0	0	0	0	887,112	0
10. Hospital Patient Days Incurred	39,289	0	0	0	0	0	0	0	39,289	0
11. Number of Inpatient Admissions	8,206	0	0	0	0	0	0	0	8,206	0
12. Health Premiums Written (b)	268,049,800	0	0	0	0	0	0	0	268,049,800	0
13. Life Premiums Direct	0	0	0	0	0	0	0	0	0	0
14. Property/Casualty Premiums Written	0	0	0	0	0	0	0	0	0	0
15. Health Premiums Earned	268,049,800	0	0	0	0	0	0	0	268,049,800	0
16. Property/Casualty Premiums Earned	0	0	0	0	0	0	0	0	0	0
17. Amount Paid for Provision of Health Care Services	231,603,366	0	0	0	0	0	0	0	231,603,366	0
18. Amount Incurred for Provision of Health Care Services	238,295,293	0	0	0	0	0	0	0	238,295,293	0

(a) For health business: number of persons insured under PPO managed care products 0 and number of persons insured under indemnity only products 0.

(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$ 0.

Annual Statement for the year 2015 of the **Better Health, Inc.**



EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

Report for: 1. Corporation

2.

(LOCATION)

NAIC Group Code 4806

BUSINESS IN THE STATE OF TOTAL DURING THE YEAR 2015

NAIC Company Code 15480

Print Date: 04/01/2016 11:48:43 AM

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	1 Total	Comprehensive (Hospital & Medical)		4 Medicare Supplement	5 Vision Only	6 Dental Only	7 Federal Employees Health Benefits Plan	8 Title XVIII Medicare	9 Title XIX Medicaid	10 Other
		2 Individual	3 Group							
Total Members at end of:										
1. Prior Year	88,014	0	0	0	0	0	0	0	88,014	0
2. First Quarter	90,685	0	0	0	0	0	0	0	90,685	0
3. Second Quarter	92,676	0	0	0	0	0	0	0	92,676	0
4. Third Quarter	94,862	0	0	0	0	0	0	0	94,862	0
5. Current Year	95,517	0	0	0	0	0	0	0	95,517	0
6. Current Year Member Months	1,115,606	0	0	0	0	0	0	0	1,115,606	0
Total Member Ambulatory Encounters For Year:										
7. Physician	577,425	0	0	0	0	0	0	0	577,425	0
8. Non-Physician	309,687	0	0	0	0	0	0	0	309,687	0
9. Total	887,112	0	0	0	0	0	0	0	887,112	0
10. Hospital Patient Days Incurred	39,289	0	0	0	0	0	0	0	39,289	0
11. Number of Inpatient Admissions	8,206	0	0	0	0	0	0	0	8,206	0
12. Health Premiums Written (b)	268,049,800	0	0	0	0	0	0	0	268,049,800	0
13. Life Premiums Direct	0	0	0	0	0	0	0	0	0	0
14. Property/Casualty Premiums Written	0	0	0	0	0	0	0	0	0	0
15. Health Premiums Earned	268,049,800	0	0	0	0	0	0	0	268,049,800	0
16. Property/Casualty Premiums Earned	0	0	0	0	0	0	0	0	0	0
17. Amount Paid for Provision of Health Care Services	231,603,366	0	0	0	0	0	0	0	231,603,366	0
18. Amount Incurred for Provision of Health Care Services	238,295,293	0	0	0	0	0	0	0	238,295,293	0

(a) For health business: number of persons insured under PPO managed care products 0 and number of persons insured under indemnity only products 0.

(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$ 0.

Annual Statement for the year 2015 of the **Better Health, Inc.**

NONE Schedule S - Part 1 - Section 2

NONE Schedule S - Part 2

Annual Statement for the year 2015 of the **Better Health, Inc.**

SCHEDULE S - PART 3 - SECTION 2

Reinsurance Ceded Accident and Health Insurance Listed by Reinsuring Company as of December 31, Current Year

1 NAIC Company Code	2 ID Number	3 Effective Date	4 Name of Company	5 Domiciliary Jurisdiction	6 Type of Reinsurance Ceded	7 Type of Business Ceded	8 Premiums	9 Unearned Premiums (Estimated)	10 Reserve Credit Taken Other than for Unearned Premiums	Outstanding Surplus Relief		13 Modified Coinsurance Reserve	14 Funds Withheld Under Coinsurance
										11 Current Year	12 Prior Year		
11835	04-1590940	08/01/2015	Partner Re America Insurance Company	DE	SSL/I	MC	711,116	0	0	0	0	0	0
0899999	General Account - Authorized - Non-Affiliates - U.S. Non-Affiliates					X X X	711,116	0	0	0	0	0	0
1099999	General Account - Authorized - Non-Affiliates - Total Authorized Non-Affiliates					X X X	711,116	0	0	0	0	0	0
1199999	General Account - Authorized - Total General Account Authorized					X X X	711,116	0	0	0	0	0	0
3499999	General Account - Total General Account Authorized, Unauthorized and Certified					X X X	711,116	0	0	0	0	0	0
6999999	Total U.S.					X X X	711,116	0	0	0	0	0	0
9999999	Totals					X X X	711,116	0	0	0	0	0	0

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Annual Statement for the year 2015 of the **Better Health, Inc.**

NONE **Schedule S - Part 4**

NONE **Schedule S - Part 5**

Annual Statement for the year 2015 of the **Better Health, Inc.**

SCHEDULE S – PART 6

Five-Year Exhibit of Reinsurance Ceded Business
(000 OMITTED)

	1	2	3	4	5
	2015	2014	2013	2012	2011
A. OPERATIONS ITEMS					
1. Premiums	0	0	0	0	0
2. Title XVIII-Medicare	0	0	0	0	0
3. Title XIX-Medicaid	711	0	0	0	0
4. Commissions and reinsurance expense allowance	0	0	0	0	0
5. Total hospital and medical expenses	0	0	0	0	0
B. BALANCE SHEET ITEMS					
6. Premiums receivable	0	0	0	0	0
7. Claims payable	0	0	0	0	0
8. Reinsurance recoverable on paid losses	97	0	0	0	0
9. Experience rating refunds due or unpaid	0	0	0	0	0
10. Commissions and reinsurance expense allowances due	0	0	0	0	0
11. Unauthorized reinsurance offset	0	0	0	0	0
12. Offset for reinsurance with Certified Reinsurers	0	0	0	0	XXX
C. UNAUTHORIZED REINSURANCE (DEPOSITS BY AND FUNDS WITHHELD FROM)					
13. Funds deposited by and withheld from (F)	0	0	0	0	0
14. Letters of credit (L)	0	0	0	0	0
15. Trust agreements (T)	0	0	0	0	0
16. Other (O)	0	0	0	0	0
D. REINSURANCE WITH CERTIFIED REINSURERS (DEPOSITS BY AND FUNDS WITHHELD FROM)					
17. Multiple Beneficiary Trust	0	0	0	0	XXX
18. Funds deposited by and withheld from (F)	0	0	0	0	XXX
19. Letters of credit (L)	0	0	0	0	XXX
20. Trust agreements (T)	0	0	0	0	XXX
21. Other (O)	0	0	0	0	XXX

Annual Statement for the year 2015 of the **Better Health, Inc.**

SCHEDULE S – PART 7

Restatement of Balance Sheet to Identify Net Credit For Ceded Reinsurance

	1	2	3
	As Reported (net of ceded)	Restatement Adjustments	Restated (gross of ceded)
ASSETS (Page 2, Col. 3)			
1. Cash and invested assets (Line 12)	43,761,382	0	43,761,382
2. Accident and health premiums due and unpaid (Line 15)	4,017,140	0	4,017,140
3. Amounts recoverable from reinsurers (Line 16.1)	97,362	0	97,362
4. Net credit for ceded reinsurance	X X X	0	0
5. All other admitted assets (Balance)	2,798,192	0	2,798,192
6. Total assets (Line 28)	50,674,076	0	50,674,076
LIABILITIES, CAPITAL AND SURPLUS (Page 3)			
7. Claims unpaid (Line 1)	29,012,287	0	29,012,287
8. Accrued medical incentive pool and bonus payments (Line 2)	4,884,467	0	4,884,467
9. Premiums received in advance (Line 8)	0	0	0
10. Funds held under reinsurance treaties with authorized and unauthorized reinsurers (Line 19, first inset amount plus second inset amount)	0	0	0
11. Reinsurance in unauthorized companies (Line 20 minus inset amount)	0	0	0
12. Reinsurance with Certified Reinsurers (Line 20 inset amount)	0	0	0
13. Funds held under reinsurance treaties with Certified Reinsurers (Line 19 third inset amount)	0	0	0
14. All other liabilities (Balance)	1,563,390	0	1,563,390
15. Total liabilities (Line 24)	35,460,144	0	35,460,144
16. Total capital and surplus (Line 33)	15,213,932	X X X	15,213,932
17. Total liabilities, capital and surplus (Line 34)	50,674,076	0	50,674,076
NET CREDIT FOR CEDED REINSURANCE			
18. Claims unpaid	0		
19. Accrued medical incentive pool	0		
20. Premiums received in advance	0		
21. Reinsurance recoverable on paid losses	0		
22. Other ceded reinsurance recoverables	0		
23. Total ceded reinsurance recoverables	0		
24. Premiums receivable	0		
25. Funds held under reinsurance treaties with authorized and unauthorized reinsurers	0		
26. Unauthorized reinsurance	0		
27. Reinsurance with Certified Reinsurers	0		
28. Funds held under reinsurance treaties with Certified Reinsurers	0		
29. Other ceded reinsurance payables/offsets	0		
30. Total ceded reinsurance payables/offsets	0		
31. Total net credit for ceded reinsurance	0		

Annual Statement for the year 2015 of the **Better Health, Inc.****SCHEDULE T - PREMIUMS AND OTHER CONSIDERATIONS**
Allocated by States and Territories

1 States, Etc.	Active Status	Direct Business Only							
		2 Accident & Health Premiums	3 Medicare Title XVIII	4 Medicaid Title XIX	5 Federal Employees Health Benefits Plan Premiums	6 Life & Annuity Premiums & Other Considerations	7 Property/Casualty Premiums	8 Total Columns 2 Through 7	9 Deposit-Type Contracts
1. Alabama	AL	N							
2. Alaska	AK	N							
3. Arizona	AZ	N							
4. Arkansas	AR	N							
5. California	CA	N							
6. Colorado	CO	N							
7. Connecticut	CT	N							
8. Delaware	DE	N							
9. District of Columbia	DC	N							
10. Florida	FL	L		268,049,800				268,049,800	
11. Georgia	GA	N							
12. Hawaii	HI	N							
13. Idaho	ID	N							
14. Illinois	IL	N							
15. Indiana	IN	N							
16. Iowa	IA	N							
17. Kansas	KS	N							
18. Kentucky	KY	N							
19. Louisiana	LA	N							
20. Maine	ME	N							
21. Maryland	MD	N							
22. Massachusetts	MA	N							
23. Michigan	MI	N							
24. Minnesota	MN	N							
25. Mississippi	MS	N							
26. Missouri	MO	N							
27. Montana	MT	N							
28. Nebraska	NE	N							
29. Nevada	NV	N							
30. New Hampshire	NH	N							
31. New Jersey	NJ	N							
32. New Mexico	NM	N							
33. New York	NY	N							
34. North Carolina	NC	N							
35. North Dakota	ND	N							
36. Ohio	OH	N							
37. Oklahoma	OK	N							
38. Oregon	OR	N							
39. Pennsylvania	PA	N							
40. Rhode Island	RI	N							
41. South Carolina	SC	N							
42. South Dakota	SD	N							
43. Tennessee	TN	N							
44. Texas	TX	N							
45. Utah	UT	N							
46. Vermont	VT	N							
47. Virginia	VA	N							
48. Washington	WA	N							
49. West Virginia	WV	N							
50. Wisconsin	WI	N							
51. Wyoming	WY	N							
52. American Samoa	AS	N							
53. Guam	GU	N							
54. Puerto Rico	PR	N							
55. U.S. Virgin Islands	VI	N							
56. Northern Mariana Islands	MP	N							
57. Canada	CAN	N							
58. Aggregate other alien	OT	XXX							
59. Subtotal		XXX		268,049,800				268,049,800	
60. Reporting entity contributions for Employee Benefit Plans		XXX							
61. Totals (Direct Business)	(a) 1			268,049,800				268,049,800	

DETAILS OF WRITE-INS									
58001.		XXX							
58002.		XXX							
58003.		XXX							
58998.	Summary of remaining write-ins for Line 58 from overflow page	XXX							
58999.	Totals (Lines 58001 through 58003 plus 58998) (Line 58 above)	XXX							

(L) Licensed or Chartered - Licensed Insurance Carrier or Domiciled RRG; (R) Registered - Non-domiciled RRGs; (Q) Qualified - Qualified or Accredited Reinsurer; (E) Eligible - Reporting Entities eligible or approved to write Surplus Lines in the state; (E) Eligible - Reporting Entities eligible or approved to write Surplus Lines in the state; (N) None of the above - Not allowed to write business in the state.

Explanation of basis of allocation by states, premiums by state, etc.

The Company is licensed as an HMO only in the State of Florida.

(a) Insert the number of L responses except for Canada and Other Alien.

Annual Statement for the year 2015 of the **Better Health, Inc.**

SCHEDULE T - PART 2
INTERSTATE COMPACT – EXHIBIT OF PREMIUMS WRITTEN
Allocated By States and Territories

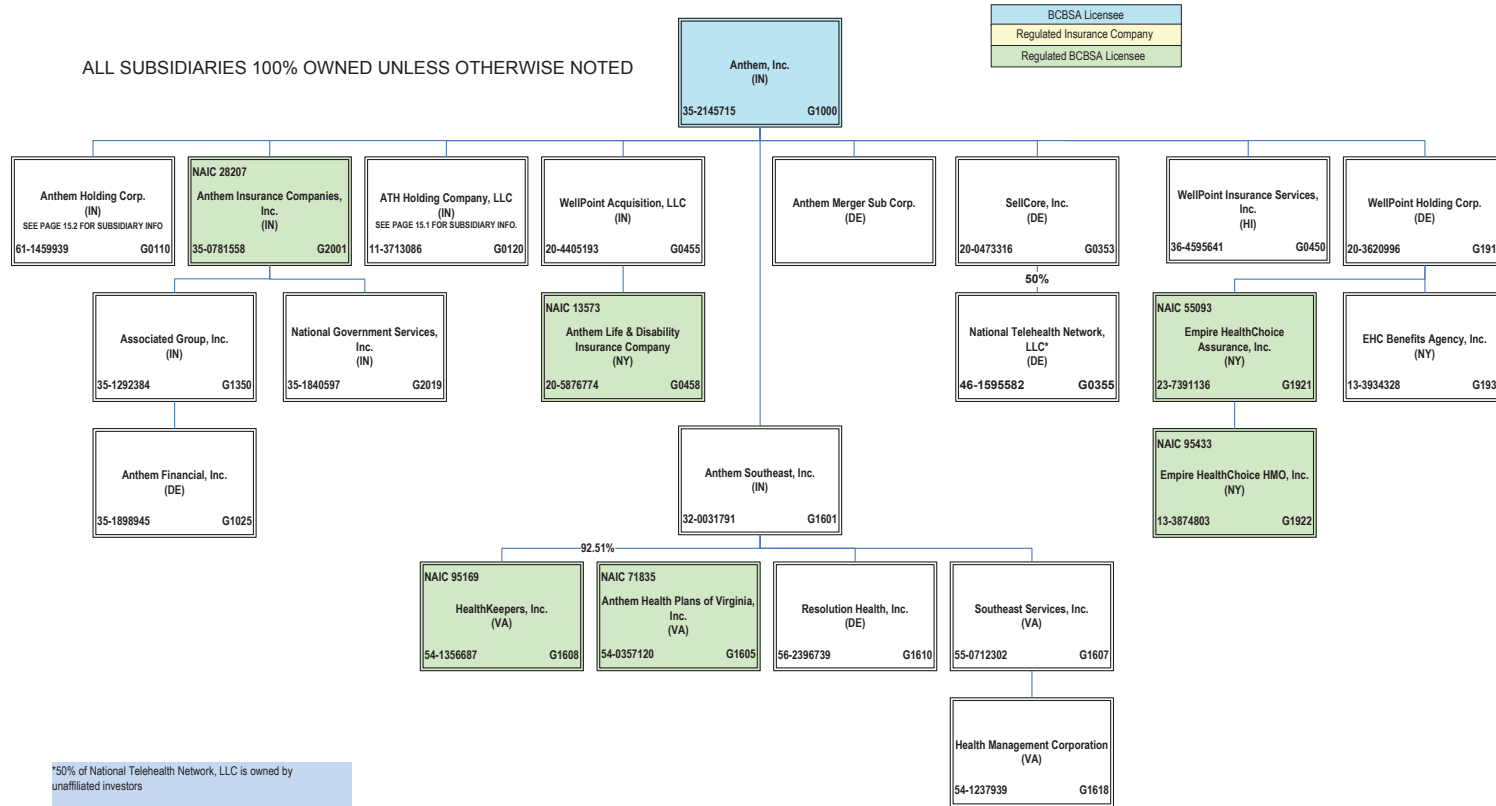
States, Etc.		Direct Business Only					
		1 Life (Group and Individual)	2 Annuities (Group and Individual)	3 Disability Income (Group and Individual)	4 Long-Term Care (Group and Individual)	5 Deposit-Type Contracts	6 Totals
1. Alabama	AL	0	0	0	0	0	0
2. Alaska	AK	0	0	0	0	0	0
3. Arizona	AZ	0	0	0	0	0	0
4. Arkansas	AR	0	0	0	0	0	0
5. California	CA	0	0	0	0	0	0
6. Colorado	CO	0	0	0	0	0	0
7. Connecticut	CT	0	0	0	0	0	0
8. Delaware	DE	0	0	0	0	0	0
9. District of Columbia	DC	0	0	0	0	0	0
10. Florida	FL	0	0	0	0	0	0
11. Georgia	GA	0	0	0	0	0	0
12. Hawaii	HI	0	0	0	0	0	0
13. Idaho	ID	0	0	0	0	0	0
14. Illinois	IL	0	0	0	0	0	0
15. Indiana	IN	0	0	0	0	0	0
16. Iowa	IA	0	0	0	0	0	0
17. Kansas	KS	0	0	0	0	0	0
18. Kentucky	KY	0	0	0	0	0	0
19. Louisiana	LA	0	0	0	0	0	0
20. Maine	ME	0	0	0	0	0	0
21. Maryland	MD	0	0	0	0	0	0
22. Massachusetts	MA	0	0	0	0	0	0
23. Michigan	MI	0	0	0	0	0	0
24. Minnesota	MN	0	0	0	0	0	0
25. Mississippi	MS	0	0	0	0	0	0
26. Missouri	MO	0	0	0	0	0	0
27. Montana	MT	0	0	0	0	0	0
28. Nebraska	NE	0	0	0	0	0	0
29. Nevada	NV	0	0	0	0	0	0
30. New Hampshire	NH	0	0	0	0	0	0
31. New Jersey	NJ	0	0	0	0	0	0
32. New Mexico	NM	0	0	0	0	0	0
33. New York	NY	0	0	0	0	0	0
34. North Carolina	NC	0	0	0	0	0	0
35. North Dakota	ND	0	0	0	0	0	0
36. Ohio	OH	0	0	0	0	0	0
37. Oklahoma	OK	0	0	0	0	0	0
38. Oregon	OR	0	0	0	0	0	0
39. Pennsylvania	PA	0	0	0	0	0	0
40. Rhode Island	RI	0	0	0	0	0	0
41. South Carolina	SC	0	0	0	0	0	0
42. South Dakota	SD	0	0	0	0	0	0
43. Tennessee	TN	0	0	0	0	0	0
44. Texas	TX	0	0	0	0	0	0
45. Utah	UT	0	0	0	0	0	0
46. Vermont	VT	0	0	0	0	0	0
47. Virginia	VA	0	0	0	0	0	0
48. Washington	WA	0	0	0	0	0	0
49. West Virginia	WV	0	0	0	0	0	0
50. Wisconsin	WI	0	0	0	0	0	0
51. Wyoming	WY	0	0	0	0	0	0
52. American Samoa	AS	0	0	0	0	0	0
53. Guam	GU	0	0	0	0	0	0
54. Puerto Rico	PR	0	0	0	0	0	0
55. U.S. Virgin Islands	VI	0	0	0	0	0	0
56. Northern Mariana Islands	MP	0	0	0	0	0	0
57. Canada	CAN	0	0	0	0	0	0
58. Aggregate Other Alien	OT	0	0	0	0	0	0
59. Totals		0	0	0	0	0	0

NONE

Annual Statement for the year 2015 of the **Better Health, Inc.**

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART



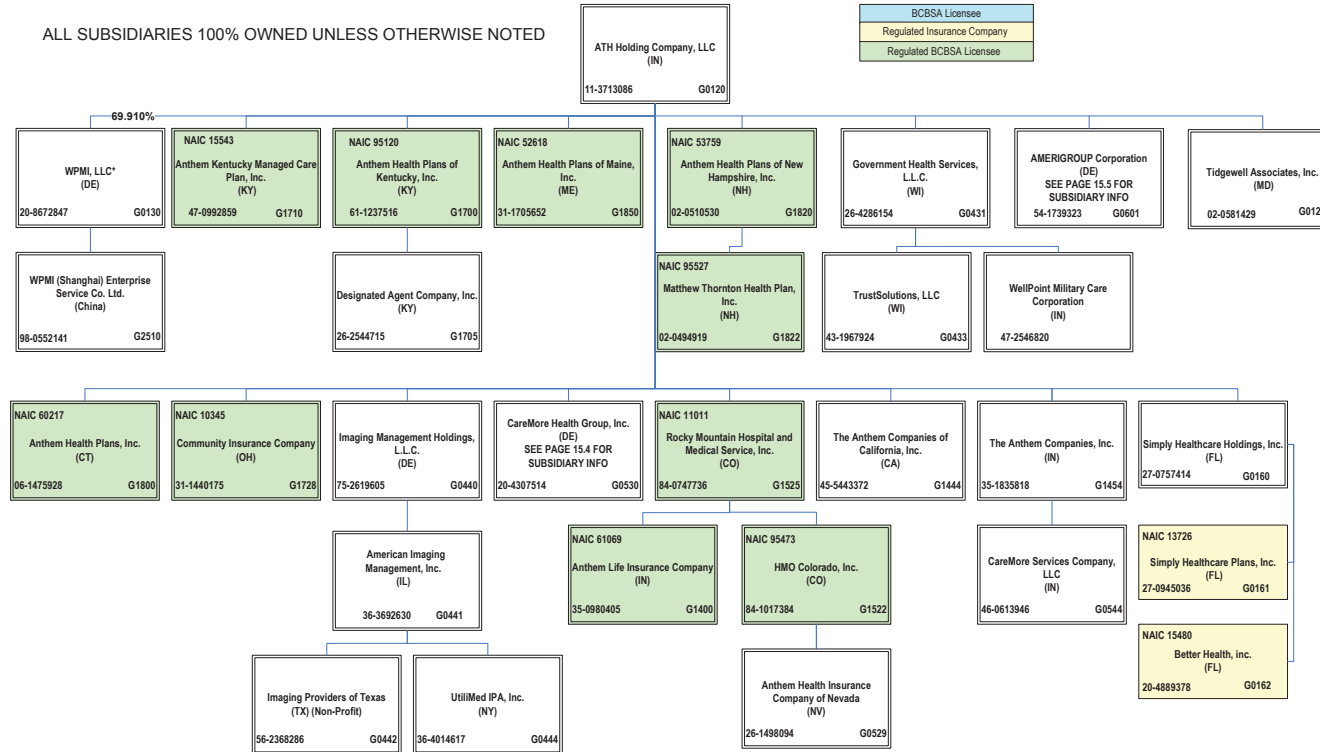
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Annual Statement for the year 2015 of the Better Health, Inc.

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

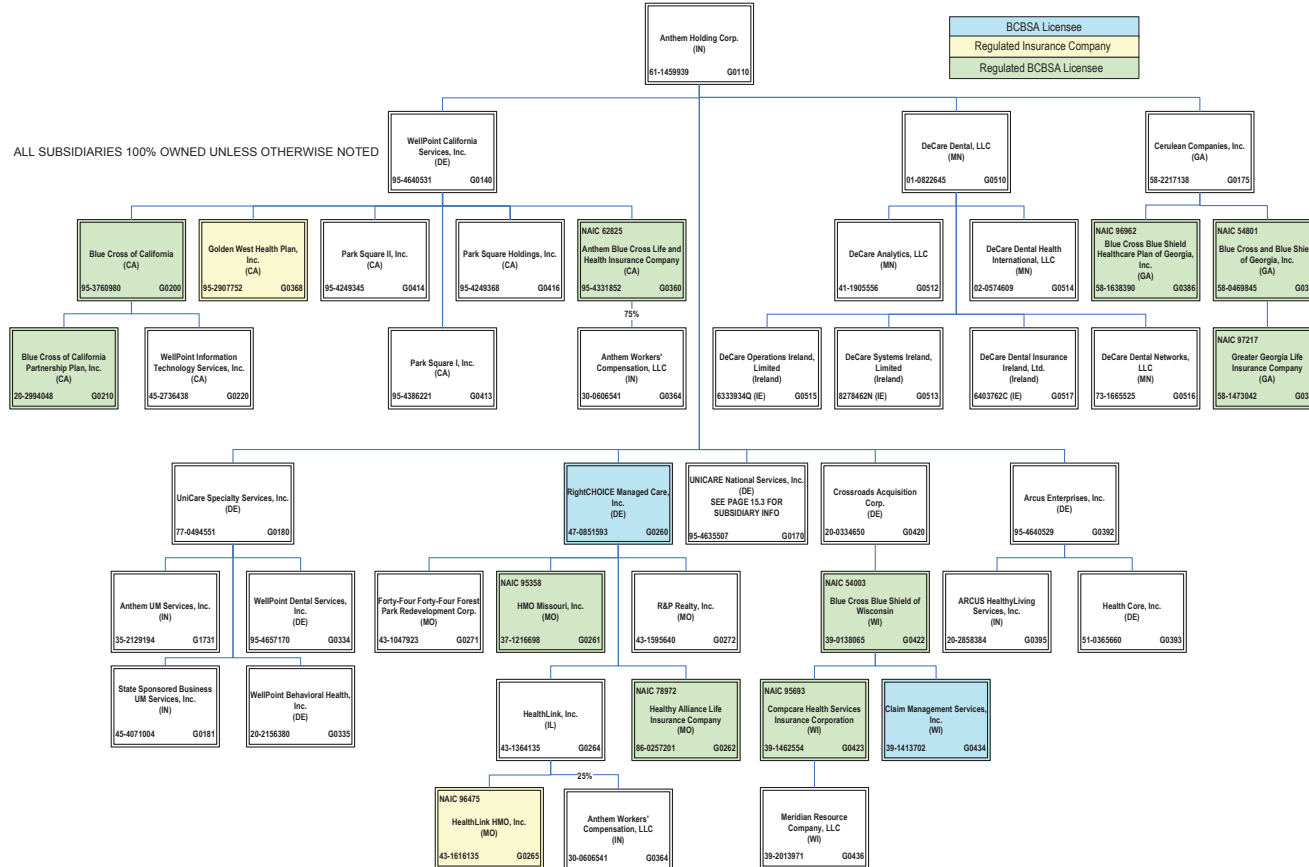


*30.09% of WPMI, LLC is owned by unaffiliated investors

Annual Statement for the year 2015 of the Better Health, Inc.

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

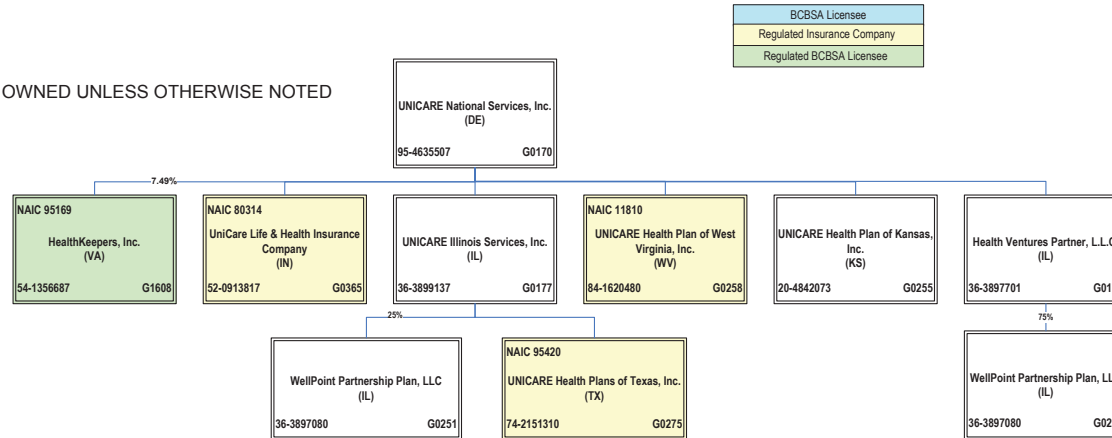


Annual Statement for the year 2015 of the **Better Health, Inc.**

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED UNLESS OTHERWISE NOTED

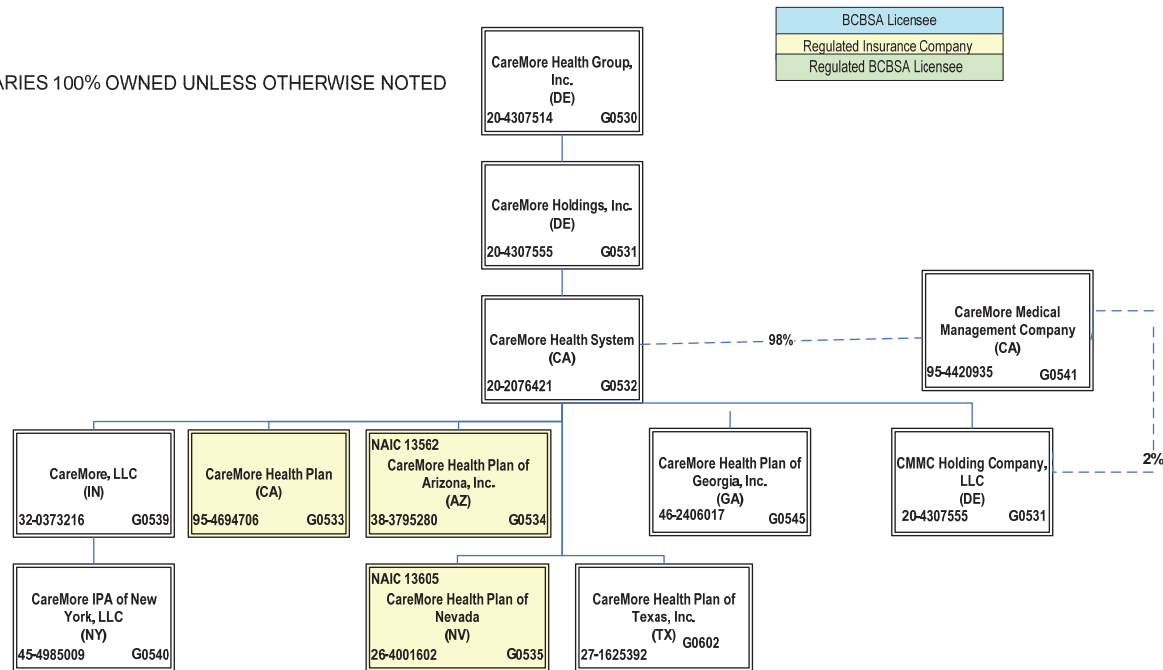


Annual Statement for the year 2015 of the Better Health, Inc.

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART

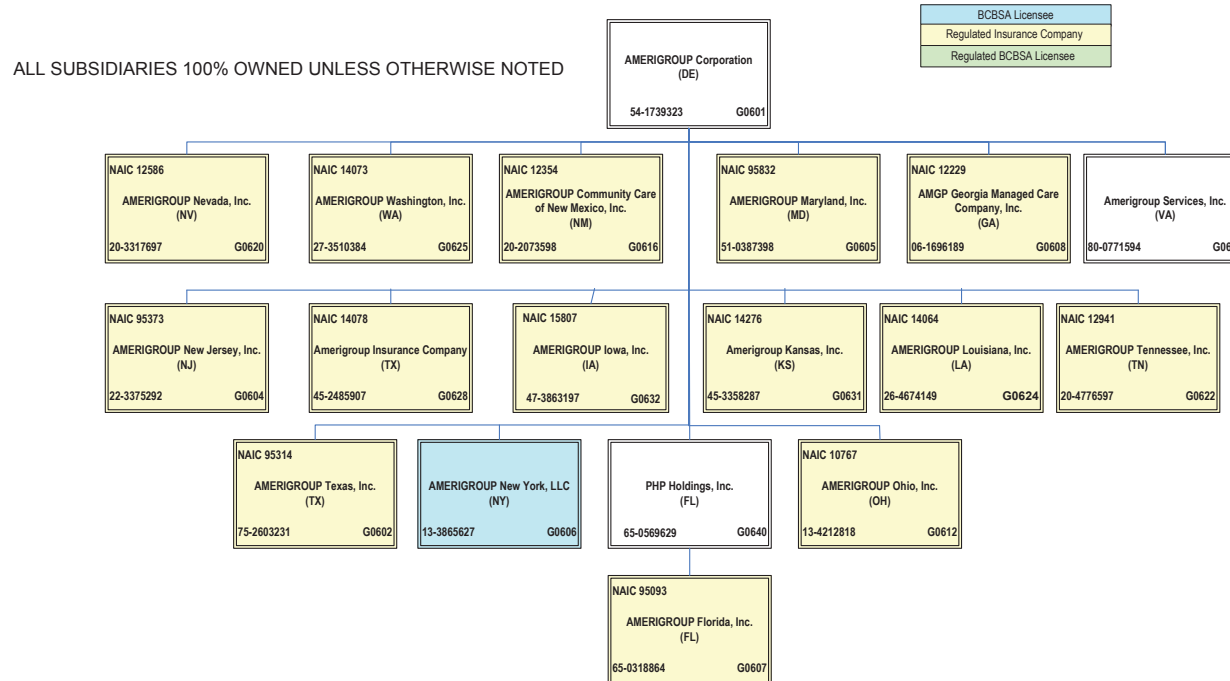
ALL SUBSIDIARIES 100% OWNED UNLESS OTHERWISE NOTED



Annual Statement for the year 2015 of the **Better Health, Inc.**

SCHEDULE Y - INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 - ORGANIZATIONAL CHART



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Annual Statement for the year 2015 of the **Better Health, Inc.****SCHEDULE Y****PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM**

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1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Group Code	Group Name	NAIC Com- pany Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity / Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	*
0671	Anthem, Inc.	0	36-3692630				American Imaging Management, Inc.	IL	NIA	Imaging Management Holdings, L.L.C.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	12354	20-2073598				AMERIGROUP Community Care of New Mexico, Inc.	NM	IA	AMERIGROUP Corporation	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	54-1739323				AMERIGROUP Corporation	DE	NIA	ATH Holding Company, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	95093	65-0318864				AMERIGROUP Florida, Inc.	FL	IA	PHP Holdings, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	14078	45-2485907				Amerigroup Insurance Company	TX	IA	AMERIGROUP Corporation	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	15807	47-3863197				AMERIGROUP Iowa, Inc.	IA	IA	AMERIGROUP Corporation	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	14276	45-3358287				Amerigroup Kansas, Inc.	KS	IA	AMERIGROUP Corporation	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	14064	26-4674149				AMERIGROUP Louisiana, Inc.	LA	IA	AMERIGROUP Corporation	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	95832	51-0387398				AMERIGROUP Maryland, Inc.	MD	IA	AMERIGROUP Corporation	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	12586	20-3317697				AMERIGROUP Nevada, Inc.	NV	IA	AMERIGROUP Corporation	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	95373	22-3375292				AMERIGROUP New Jersey, Inc.	NJ	IA	AMERIGROUP Corporation	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	10767	13-4212818				AMERIGROUP Ohio, Inc.	OH	IA	AMERIGROUP Corporation	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	80-0771594				Amerigroup Services, Inc.	VA	NIA	AMERIGROUP Corporation	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	12941	20-4776597				AMERIGROUP Tennessee, Inc.	TN	IA	AMERIGROUP Corporation	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	95314	75-2603231				AMERIGROUP Texas, Inc.	TX	IA	AMERIGROUP Corporation	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	14073	27-3510384				AMERIGROUP Washington, Inc.	WA	IA	AMERIGROUP Corporation	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	12229	06-1696189				AMOP Georgia Managed Care Company, Inc.	GA	IA	AMERIGROUP Corporation	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	62825	95-4331852				Anthem Blue Cross Life and Health Insurance Com	CA	IA	WellPoint California Services, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	35-1898945				Anthem Financial, Inc.	DE	NIA	Associated Group, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	26-1498094				Anthem Health Insurance Company of Nevada	NV	NIA	HMO Colorado, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	95120	61-1237516				Anthem Health Plans of Kentucky, Inc.	KY	IA	ATH Holding Company, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	52618	31-1705852				Anthem Health Plans of Maine, Inc.	ME	IA	ATH Holding Company, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	53759	02-0510530				Anthem Health Plans of New Hampshire, Inc.	NH	IA	ATH Holding Company, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	71835	54-0357120				Anthem Health Plans of Virginia, Inc.	VA	IA	Anthem Southeast, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	60217	06-1475928				Anthem Health Plans, Inc.	CT	IA	ATH Holding Company, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	61-1459939				Anthem Holding Corp.	IN	NIA	Anthem, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	35-2145715		6324	New York Stock Exch	Anthem, Inc.	IN	UIP				Anthem, Inc.	
0671	Anthem, Inc.	28207	35-0781558				Anthem Insurance Companies, Inc.	IN	IA	Anthem, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	15543	47-0992859				Anthem Kentucky Managed Care Plan, Inc.	KY	IA	ATH Holding Company, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	13573	20-5876774				Anthem Life & Disability Insurance Company	NY	IA	WellPoint Acquisition, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	61069	35-0980405				Anthem Life Insurance Company	IN	IA	Rocky Mountain Hospital and Medical Service, Inc	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0					Anthem Merger Sub Corp.	DE	NIA	Anthem, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	32-0031791				Anthem Southeast, Inc.	IN	NIA	Anthem, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	35-2129194				Anthem UM Services, Inc.	IN	NIA	UNICARE Specialty Services, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	30-0606541				Anthem Workers' Compensation, LLC	IN	NIA	Anthem Blue Cross Life and Health Insurance Co	Ownership	75.0	Anthem, Inc.	
0671	Anthem, Inc.	0	30-0606541				Anthem Workers' Compensation, LLC	IN	NIA	HealthLink, Inc.	Ownership	25.0	Anthem, Inc.	
0671	Anthem, Inc.	0	95-4640529				Arcus Enterprises, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	20-2858384				ARCUS HealthLiving Services, Inc.	IN	NIA	Arcus Enterprises, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	35-1292384				Associated Group, Inc.	IN	NIA	Anthem Insurance Companies, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	11-3713086				ATH Holding Company, LLC	IN	UIP	Anthem, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	15480	20-4889378				Better Health, Inc.	FL	RE	Simply Healthcare Holdings, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	54801	58-0469845				Blue Cross and Blue Shield of Georgia, Inc.	GA	IA	Cerulean Companies, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	96962	58-1638390				Blue Cross Blue Shield Healthcare Plan of Georgia,	GA	IA	Cerulean Companies, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	54003	39-0138065				Blue Cross Blue Shield of Wisconsin	WI	IA	Crossroads Acquisition Corp.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	95-3760980				Blue Cross of California	CA	IA	WellPoint California Services, Inc.	Ownership	100.0	Anthem, Inc.	101

Annual Statement for the year 2015 of the **Better Health, Inc.****SCHEDULE Y****PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM**

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1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity / Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	*
0671	Anthem, Inc.	0	20-2994048				Blue Cross of California Partnership Plan, Inc.	CA	IA	Blue Cross of California	Ownership	100.0	Anthem, Inc.	102
0671	Anthem, Inc.	0	20-4307514				CareMore Health Group, Inc.	DE	NIA	ATH Holding Company, LLC	Ownership	100.0	Anthem, Inc.	103
0671	Anthem, Inc.	0	95-4694706				CareMore Health Plan	CA	IA	CareMore Health System	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	13562	38-3795280				CareMore Health Plan of Arizona, Inc.	AZ	IA	CareMore Health System	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	46-2406017				CareMore Health Plan of Georgia, Inc.	GA	NIA	CareMore Health System	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	13605	26-4001602				CareMore Health Plan of Nevada	NV	IA	CareMore Health System	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	27-1625392				CareMore Health Plan of Texas, Inc.	TX	NIA	CareMore Health System	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	20-4307555				CareMore Holdings, Inc.	DE	NIA	CareMore Health Group, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	45-4985009				CareMore IPA of New York, LLC	NY	NIA	CareMore, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	32-0373216				CareMore, LLC	IN	NIA	CareMore Health System	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	20-2076421				CareMore Health System	CA	NIA	CareMore Holdings, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	95-4420935				CareMore Medical Management Company	CA	NIA	CareMore Health System	Ownership	98.0	Anthem, Inc.	
0671	Anthem, Inc.	0	95-4420935				CareMore Medical Management Company	CA	NIA	CMHC Holding Company, LLC	Ownership	2.0	Anthem, Inc.	
0671	Anthem, Inc.	0	46-0613946				CareMore Services Company, LLC	IN	NIA	The Anthem Companies, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	58-2217138				Cerulean Companies, Inc.	GA	NIA	Anthem Holding Corp.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	39-1413702				Claim Management Services, Inc.	WI	NIA	Blue Cross Blue Shield of Wisconsin	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	20-4307555				CMHC Holding Company, LLC	DE	NIA	CareMore Health System	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	10345	31-1440175				Community Insurance Company	OH	IA	ATH Holding Company, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	95693	39-1462554				Compcare Health Services Insurance Corporation	WI	IA	Blue Cross Blue Shield of Wisconsin	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	20-0334650				Crossroads Acquisition Corp.	DE	NIA	Anthem Holding Corp.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	41-1905556				DeCare Analytics, LLC	MN	NIA	DeCare Dental, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	02-0574609				DeCare Dental Health International, LLC	MN	NIA	DeCare Dental, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0					DeCare Dental Insurance Ireland, Ltd.	IRL	NIA	DeCare Dental, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	73-1665525				DeCare Dental Networks, LLC	MN	NIA	DeCare Dental, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	01-0822645				DeCare Dental, LLC	MN	NIA	Anthem Holding Corp.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0					DeCare Operations Ireland, Limited	IRL	NIA	DeCare Dental, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0					DeCare Systems Ireland, Limited	IRL	NIA	DeCare Dental, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	26-2544715				Designated Agent Company, Inc.	KY	NIA	Anthem Health Plans of Kentucky, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	13-3934328				EHC Benefits Agency, Inc.	NY	NIA	WellPoint Holding Corp	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	55093	23-7391136				Empire HealthChoice Assurance, Inc.	NY	IA	WellPoint Holding Corp	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	95433	13-3874803				Empire HealthChoice HMO, Inc.	NY	IA	Empire HealthChoice Assurance, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	43-1047923				Forty-Four Forty-Four Forest Park Redevelopment	MO	NIA	RightCHOICE Managed Care, Inc.	Ownership	100.0	Anthem, Inc.	104
0671	Anthem, Inc.	0	95-2907752				Golden West Health Plan, Inc.	CA	IA	WellPoint California Services, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	26-4286154				Government Health Services, LLC	WI	NIA	ATH Holding Company, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	97217	58-1473042				Greater Georgia Life Insurance Company	GA	IA	Blue Cross and Blue Shield of Georgia, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	51-0365660				Health Core, Inc.	DE	NIA	Arcus Enterprises, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	54-1237939				Health Management Corporation	VA	NIA	Southeast Services, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	36-3897701				Health Ventures Partner, L.L.C.	IL	NIA	UNICARE National Services, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	95169	54-1366687				HealthKeepers, Inc.	VA	IA	Anthem Southeast, Inc.	Ownership	92.5	Anthem, Inc.	
0671	Anthem, Inc.	95169	54-1366687				HealthKeepers, Inc.	VA	IA	UNICARE National Services, Inc.	Ownership	7.5	Anthem, Inc.	
0671	Anthem, Inc.	96475	43-1616135				HealthLink HMO, Inc.	MO	IA	HealthLink, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	43-1364135				HealthLink, Inc.	IL	NIA	RightCHOICE Managed Care, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	13-3865627				HealthPlus HP, LLC	NY	IA	AMERIGROUP Corporation	Ownership	100.0	Anthem, Inc.	100
0671	Anthem, Inc.	78972	86-0257201				Healthy Alliance Life Insurance Company	MO	IA	RightCHOICE Managed Care, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	95473	84-1017384				HMO Colorado, Inc.	CO	IA	Rocky Mountain Hospital and Medical Service, Inc.	Ownership	100.0	Anthem, Inc.	

Annual Statement for the year 2015 of the **Better Health, Inc.****SCHEDULE Y****PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM**

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1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Group Code	Group Name	NAIC Com- pany Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity / Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	*
0671	Anthem, Inc.	95358	37-1216698				HMO Missouri, Inc.	MO	IA	RightCHOICE Managed Care, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	75-2619605				Imaging Management Holdings, L.L.C.	DE	NIA	ATH Holding Company, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	56-2368286				Imaging Providers of Texas (non-profit)	TX	NIA	American Imaging Management, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	95527	02-0494919				Matthew Thornton Health Plan, Inc.	NH	IA	Anthem Health Plans of New Hampshire, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	39-2013971				Meridian Resource Company, LLC	WI	NIA	CompCare Health Services Insurance Corporation	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	35-1840597				National Government Services, Inc.	IN	NIA	Anthem Insurance Companies, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	46-1595582				National Telehealth Network, LLC	DE	NIA	Sellcore, Inc.	Ownership	50.0	Anthem, Inc.	105
0671	Anthem, Inc.	0	95-4249368				Park Square Holdings, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	95-4386221				Park Square I, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	95-4249345				Park Square II, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	65-0569629				PHP Holdings, Inc.	FL	NIA	AMERIGROUP Corporation	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	43-1595640				R & P Realty, Inc.	MO	NIA	RightCHOICE Managed Care, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	56-2396739				Resolution Health, Inc.	DE	NIA	Anthem Southeast, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	47-0851593				RightCHOICE Managed Care, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	11011	84-0747736				Rocky Mountain Hospital and Medical Service, Inc.	CO	IA	ATH Holding Company, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	20-0473316				SellCore, Inc.	DE	NIA	Anthem, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	27-0757414				Simply Healthcare Holdings, Inc.	FL	UDP	ATH Holding Company, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	13726	27-0945036				Simply Healthcare Plans, Inc.	FL	IA	Simply Healthcare Holdings, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	55-0712302				Southeast Services, Inc.	VA	NIA	Anthem Southeast, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	45-4071004				State Sponsored Business UM Services, Inc.	IN	NIA	UNICARE Specialty Services, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	35-1835818				The Anthem Companies, Inc.	IN	NIA	ATH Holding Company, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	45-5443372				The Anthem Companies of California, Inc.	CA	NIA	ATH Holding Company, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	02-0581429				Tidgewell Associates, Inc.	MD	NIA	ATH Holding Company, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	43-1967924				TrustSolutions, LLC	WI	NIA	Government Health Services, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	11810	84-1620480				UNICARE Health Plan of West Virginia, Inc.	WV	IA	UNICARE National Services, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	74-2151310				UNICARE Health Plans of Texas, Inc.	TX	IA	UNICARE Illinois Services, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	36-3899137				UNICARE Illinois Services, Inc.	IL	NIA	UNICARE National Services, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	80314	52-0913817				UNICARE Life & Health Insurance Company	IN	IA	UNICARE National Services, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	95-4635507				UNICARE National Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	77-0494551				UNICARE Specialty Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	36-4014617				UTIIMED IPA, Inc.	NY	NIA	American Imaging Management, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	20-4405193				WellPoint Acquisition, LLC	IN	NIA	Anthem, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	20-2156380				WellPoint Behavioral Health, Inc.	DE	NIA	UNICARE Specialty Services, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	95-4640531				WellPoint California Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	95-4657170				WellPoint Dental Services, Inc.	DE	NIA	UNICARE Specialty Services, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	20-3620996				WellPoint Holding Corp	DE	NIA	Anthem, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	45-2736438				WellPoint Information Technology Services, Inc.	CA	NIA	Blue Cross of California	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	36-4595641				WellPoint Insurance Services, Inc.	HI	NIA	Anthem, Inc.	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	47-2546820				WellPoint Military Care Corporation	IN	NIA	Government Health Services, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	36-3897080				WellPoint Partnership Plan, LLC	IL	NIA	Health Ventures Partner, L.L.C.	Ownership	75.0	Anthem, Inc.	
0671	Anthem, Inc.	0	36-3897080				WellPoint Partnership Plan, LLC	IL	NIA	UNICARE Illinois Services, Inc.	Ownership	25.0	Anthem, Inc.	
0671	Anthem, Inc.	0	98-0552141				WPMI (Shanghai) Enterprise Service Co. Ltd.	CHN	NIA	WPMI, LLC	Ownership	100.0	Anthem, Inc.	
0671	Anthem, Inc.	0	20-8672847				WPMI, LLC	DE	NIA	ATH Holding Company, LLC	Ownership	69.9	Anthem, Inc.	106

SCHEDULE Y

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Annual Statement for the year 2015 of the **Better Health, Inc.**

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

	Responses
MARCH FILING	
1. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?	See Explanation
2. Will an actuarial opinion be filed by March 1?	YES
3. Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?	See Explanation
4. Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1?	See Explanation
APRIL FILING	
5. Will Management's Discussion and Analysis be filed by April 1?	YES
6. Will the Supplemental Investment Risks Interrogatories be filed by April 1?	YES
7. Will the Accident and Health Policy Experience Exhibit be filed by April 1?	YES
JUNE FILING	
8. Will an audited financial report be filed by June 1?	YES
9. Will Accountants Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?	YES
AUGUST FILING	
10. Will Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile by August 1?	YES

The following supplemental reports are required to be filed as part of your annual statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

MARCH FILING	
11. Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?	See Explanation
12. Will the Supplemental Life data due March 1 be filed with the state of domicile and the NAIC?	NO
13. Will the Supplemental Property/Casualty data due March 1 be filed with the state of domicile and the NAIC?	NO
14. Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1?	See Explanation
15. Will the actuarial opinion on participating and non-participating policies as required in Interrogatories 1 and 2 on Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
16. Will the actuarial opinion on non-guaranteed elements as required in Interrogatory 3 to Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
17. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?	NO
18. Will an approval from the reporting entity's state of domicile for relief related to the five-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1?	NO
19. Will an approval from the reporting entity's state of domicile for relief related to the one-year cooling off period for independent CPA be filed with the NAIC by March 1?	NO
20. Will an approval from the reporting entity's state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?	NO
APRIL FILING	
21. Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?	NO
22. Will the Supplemental Life data due April 1 be filed with the state of domicile and the NAIC?	NO
23. Will the Supplemental Property/Casualty Insurance Expense Exhibit due April 1 be filed with any state that requires it, and, if so, the NAIC?	NO
24. Will the Supplemental Health Care Exhibit be filed with the state of domicile and the NAIC by April 1?	YES
25. Will the regulator only (non-public) Supplemental Health Care Exhibit's Expense Allocation Report be filed with the state of domicile and the NAIC by April 1?	YES
AUGUST FILING	
26. Will Management's Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?	YES

Explanation:

Annual Statement for the year 2015 of the **Better Health, Inc.**

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

Explanation 1: Better Health has no employees. All services are provided under a management agreement with Simply Healthcare Plans, Inc.

Explanation 3: NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE

Explanation 4: NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE

Explanation 11: THE REPORT IS NOT DUE TO THE STATE OF FLORIDA ON MARCH 1. HOWEVER, AS REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE, THE OPINION WILL BE SUBMITTED ON APRIL 1

Explanation 12: NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE

Explanation 13: NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE

Explanation 14: SIMPLY DOES NOT MEET THE REQUIRED NUMBER OF SHAREHOLDERS FOR THIS FILING

Explanation 15: NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE

Explanation 16: NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE

Explanation 17: NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE

Explanation 18: N/A

Explanation 19: N/A

Explanation 20: N/A

Explanation 21: NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE

Explanation 22: NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE

Explanation 23: NOT REQUIRED BY THE STATE OF FLORIDA DEPARTMENT OF INSURANCE

Bar Code:



1548020154600000



1548020153900000



1548020152050000



1548020154200000



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Annual Statement for the year 2015 of the **Better Health, Inc.**

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES



15480201537000000



15480201522400000



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Annual Statement for the year 2015 of the **Better Health, Inc.**

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Annual Statement for the year 2015 of the **Better Health, Inc.**

SUMMARY INVESTMENT SCHEDULE

Investment Categories	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
	1 Amount	2 Percentage	3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage
1. Bonds:						
1.1 U.S. treasury securities	0	0.00	0	0	0	0.00
1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
1.21 Issued by U.S. government agencies	0	0.00	0	0	0	0.00
1.22 Issued by U.S. government sponsored agencies	0	0.00	0	0	0	0.00
1.3 Non-U.S. government (including Canada, excluding mortgage-backed securities)	0	0.00	0	0	0	0.00
1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S.:						
1.41 States, territories and possessions general obligations	0	0.00	0	0	0	0.00
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	0	0.00	0	0	0	0.00
1.43 Revenue and assessment obligations	0	0.00	0	0	0	0.00
1.44 Industrial development and similar obligations	0	0.00	0	0	0	0.00
1.5 Mortgage-backed securities (includes residential and commercial MBS):						
1.51 Pass-through securities:						
1.511 Issued or guaranteed by GNMA	0	0.00	0	0	0	0.00
1.512 Issued or guaranteed by FNMA and FHLMC	0	0.00	0	0	0	0.00
1.513 All other	0	0.00	0	0	0	0.00
1.52 CMOs and REMICs:						
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	0	0.00	0	0	0	0.00
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521	0	0.00	0	0	0	0.00
1.523 All other	0	0.00	0	0	0	0.00
2. Other debt and other fixed income securities (excluding short term):						
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	0	0.00	0	0	0	0.00
2.2 Unaffiliated non-U.S. securities (including Canada)	0	0.00	0	0	0	0.00
2.3 Affiliated securities	0	0.00	0	0	0	0.00
3. Equity interests:						
3.1 Investments in mutual funds	0	0.00	0	0	0	0.00
3.2 Preferred stocks:						
3.21 Affiliated	0	0.00	0	0	0	0.00
3.22 Unaffiliated	0	0.00	0	0	0	0.00
3.3 Publicly traded equity securities (excluding preferred stocks):						
3.31 Affiliated	0	0.00	0	0	0	0.00
3.32 Unaffiliated	0	0.00	0	0	0	0.00
3.4 Other equity securities:						
3.41 Affiliated	0	0.00	0	0	0	0.00
3.42 Unaffiliated	0	0.00	0	0	0	0.00
3.5 Other equity interests including tangible personal property under lease:						
3.51 Affiliated	0	0.00	0	0	0	0.00
3.52 Unaffiliated	0	0.00	0	0	0	0.00
4. Mortgage loans:						
4.1 Construction and land development	0	0.00	0	0	0	0.00
4.2 Agricultural	0	0.00	0	0	0	0.00
4.3 Single family residential properties	0	0.00	0	0	0	0.00
4.4 Multifamily residential properties	0	0.00	0	0	0	0.00
4.5 Commercial loans	0	0.00	0	0	0	0.00
4.6 Mezzanine real estate loans	0	0.00	0	0	0	0.00
5. Real estate investments:						
5.1 Property occupied by company	0	0.00	0	0	0	0.00
5.2 Property held for production of income (including \$ 0 of property acquired in satisfaction of debt)	0	0.00	0	0	0	0.00
5.3 Property held for sale (including \$ 0 property acquired in satisfaction of debt)	0	0.00	0	0	0	0.00
6. Contract loans	0	0.00	0	0	0	0.00
7. Derivatives	0	0.00	0	0	0	0.00
8. Receivables for securities	0	0.00	0	0	0	0.00
9. Securities Lending (Line 10, Asset Page reinvested collateral)	0	0.00	0	X X X	X X X	X X X
10. Cash, cash equivalents and short-term investments	43,761,382	100.00	43,761,382	0	43,761,382	100.00
11. Other invested assets	0	0.00	0	0	0	0.00
12. Total invested assets	43,761,382	100.00	43,761,382	0	43,761,382	100.00

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Annual Statement for the year 2015 of the **Better Health, Inc.**

NONE	Schedule A and B Verification
NONE	Schedule BA and D Verification
NONE	Schedule D - Summary
NONE	Schedule D - Part 1A - Sect 1 (3 pgs)
NONE	Schedule D - Part 1A - Sect 2 (2 pgs)
NONE	Schedule DA Verification
NONE	Schedule DB - Part A and B Verification
NONE	Schedule DB - Part C - Section 1
NONE	Schedule DB - Part C - Section 2
NONE	Schedule DB - Verification

Annual Statement for the year 2015 of the **Better Health, Inc.**

SCHEDULE E - VERIFICATION BETWEEN YEARS

(Cash Equivalents)

	1	2	3
	Total	Bonds	Other (a)
1. Book/adjusted carrying value, December 31 of prior year			
2. Cost of cash equivalents acquired			
3. Accrual of discount			
4. Unrealized valuation increase (decrease)			
5. Total gain (loss) on disposals			
6. Deduct consideration received on disposals			
7. Deduct amortization of premium			
8. Total foreign exchange change in book/adjusted carrying value			
9. Deduct current year's other-than-temporary impairment recognized			
10. Book/adjusted carrying value at end of current period (Lines 1 + 2 + 3 + 4 + 5 - 6 - 7 + 8 - 9)			
11. Deduct total nonadmitted amounts			
12. Statement value at end of current period (Line 10 minus Line 11)			

NONE

(a) Indicate the category of such investments, for example, joint ventures, transportation equipment:

Annual Statement for the year 2015 of the Better Health, Inc.

NONE	Schedule A - Part 1
NONE	Schedule A - Part 2
NONE	Schedule A - Part 3
NONE	Schedule B - Part 1
NONE	Schedule B - Part 2
NONE	Schedule B - Part 3
NONE	Schedule BA - Part 1
NONE	Schedule BA - Part 2
NONE	Schedule BA - Part 3
NONE	Schedule D - Part 1
NONE	Schedule D - Part 2 - Section 1
NONE	Schedule D - Part 2 - Section 2
NONE	Schedule D - Part 3
NONE	Schedule D - Part 4
NONE	Schedule D - Part 5
NONE	Schedule D - Part 6 - Section 1 and 2
NONE	Schedule DA - Part 1
NONE	Schedule DB - Part A - Section 1
NONE	Schedule DB - Part A - Section 2
NONE	Schedule DB - Part B - Section 1
NONE	Schedule DB - Part B - Section 2
NONE	Schedule DB - Part D - Section 1
NONE	Schedule DB - Part D - Section 2
NONE	Schedule DL - Part 1
NONE	Schedule DL - Part 2

SCHEDULE E - PART 1 - CASH

[illegible]

1. January	27,426,952	4. April	48,036,902	7. July	30,188,631	10. October	35,746,666
2. February	29,998,234	5. May	31,727,143	8. August	27,247,275	11. November	37,281,626
3. March	31,310,046	6. June	30,573,787	9. September	29,262,577	12. December	43,761,388

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NONE

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Annual Statement for the year 2015 of the **Better Health, Inc.**

SCHEDULE E – PART 3 – SPECIAL DEPOSITS

States, etc.	1 Type of Deposit	2 Purpose of Deposit	Deposits For the Benefit of All Policyholders		All Other Special Deposits	
			3 Book/Adjusted Carrying Value	4 Fair Value	5 Book/Adjusted Carrying Value	6 Fair Value
1. Alabama	AL		0	0	0	0
2. Alaska	AK		0	0	0	0
3. Arizona	AZ		0	0	0	0
4. Arkansas	AR		0	0	0	0
5. California	CA		0	0	0	0
6. Colorado	CO		0	0	0	0
7. Connecticut	CT		0	0	0	0
8. Delaware	DE		0	0	0	0
9. District of Columbia	DC		0	0	0	0
10. Florida	FL	O Insolvency	838,757	838,757	0	0
11. Georgia	GA		0	0	0	0
12. Hawaii	HI		0	0	0	0
13. Idaho	ID		0	0	0	0
14. Illinois	IL		0	0	0	0
15. Indiana	IN		0	0	0	0
16. Iowa	IA		0	0	0	0
17. Kansas	KS		0	0	0	0
18. Kentucky	KY		0	0	0	0
19. Louisiana	LA		0	0	0	0
20. Maine	ME		0	0	0	0
21. Maryland	MD		0	0	0	0
22. Massachusetts	MA		0	0	0	0
23. Michigan	MI		0	0	0	0
24. Minnesota	MN		0	0	0	0
25. Mississippi	MS		0	0	0	0
26. Missouri	MO		0	0	0	0
27. Montana	MT		0	0	0	0
28. Nebraska	NE		0	0	0	0
29. Nevada	NV		0	0	0	0
30. New Hampshire	NH		0	0	0	0
31. New Jersey	NJ		0	0	0	0
32. New Mexico	NM		0	0	0	0
33. New York	NY		0	0	0	0
34. North Carolina	NC		0	0	0	0
35. North Dakota	ND		0	0	0	0
36. Ohio	OH		0	0	0	0
37. Oklahoma	OK		0	0	0	0
38. Oregon	OR		0	0	0	0
39. Pennsylvania	PA		0	0	0	0
40. Rhode Island	RI		0	0	0	0
41. South Carolina	SC		0	0	0	0
42. South Dakota	SD		0	0	0	0
43. Tennessee	TN		0	0	0	0
44. Texas	TX		0	0	0	0
45. Utah	UT		0	0	0	0
46. Vermont	VT		0	0	0	0
47. Virginia	VA		0	0	0	0
48. Washington	WA		0	0	0	0
49. West Virginia	WV		0	0	0	0
50. Wisconsin	WI		0	0	0	0
51. Wyoming	WY		0	0	0	0
52. American Samoa	AS		0	0	0	0
53. Guam	GU		0	0	0	0
54. Puerto Rico	PR		0	0	0	0
55. US Virgin Islands	VI		0	0	0	0
56. Northern Mariana Islands	MP		0	0	0	0
57. Canada	CAN		0	0	0	0
58. Aggregate Other Alien and Other	OT	X X X	0	0	0	0
59. Total	X X X	X X X	838,757	838,757	0	0

DETAILS OF WRITE-INS						
5801.			0	0	0	0
5802.			0	0	0	0
5803.			0	0	0	0
5898. Sum of remaining write-ins for Line 58 from overflow page	X X X	X X X	0	0	0	0
5899. Totals (Lines 5801 - 5803 + 5898) (Line 58 above)	X X X	X X X	0	0	0	0

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Annual Statement for the year 2015 of the **Better Health, Inc.**

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ANNUAL STATEMENT

OF THE

Better Health, Inc.

of

Miami

in the state of

Florida

TO THE

Insurance Department

OF THE STATE OF

Florida

FOR THE YEAR ENDED
DECEMBER 31, 2016

2016

HEALTH

2016



HEALTH ANNUAL STATEMENT

FOR THE YEAR ENDED DECEMBER 31, 2016
OF THE CONDITION AND AFFAIRS OF THE

Better Health, Inc.

NAIC Group Code 0671 (Current) 0671 (Prior) NAIC Company Code 15480 Employer's ID Number 20-4889378

Organized under the Laws of Florida, State of Domicile or Port of Entry FL

Country of Domicile United States of America

Licensed as business type: Health Maintenance Organization

Is HMO Federally Qualified? Yes ☐ No ☒ [X]

Incorporated/Organized 02/26/2014 Commenced Business 02/01/2015

Statutory Home Office 9250 W Flagler Street, Suite 600 (Street and Number) Miami, FL, US 33174 (City or Town, State, Country and Zip Code)

Main Administrative Office 4425 Corporation Lane (Street and Number) Virginia Beach, VA, US 23462 (City or Town, State, Country and Zip Code) 757-490-6900 (Area Code) (Telephone Number)

Mail Address 4425 Corporation Lane (Street and Number or P.O. Box) Virginia Beach, VA, US 23462 (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 4425 Corporation Lane (Street and Number) Virginia Beach, VA, US 23462 (City or Town, State, Country and Zip Code) 757-490-6900 (Area Code) (Telephone Number)

Internet Website Address www.betterhealthflorida.com

Statutory Statement Contact Bette Lou Gronseth (Name) 757-518-3638 (Area Code) (Telephone Number)
Bette.Gronseth@amerigroup.com (E-mail Address) 757-557-6742 (FAX Number)

OFFICERS

CEO & President Maria Lourdes Rivas Secretary Kathleen Susan Kiefer
CFO Holly Jean Prince Treasurer Robert David Kretschmer

OTHER

Vincent Pantone, Chief Medical Officer Eric Kenneth Noble, Assistant Treasurer

DIRECTORS OR TRUSTEES

Maria Lourdes Rivas Catherine Irene Kelaghan Carter Allen Beck

State of Florida SS:
County of Miami-Dade

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy, except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Maria Lourdes Rivas
CEO & President

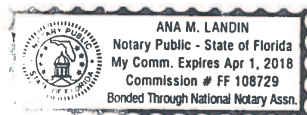
Kathleen S Kiefer
Secretary

Holly J Prince
CFO

Subscribed and sworn to before me this

2nd day of March
Alma M. Landin

- a. Is this an original filing? Yes ☒ No ☐ [X]
b. If no,
1. State the amendment number
2. Date filed
3. Number of pages attached



ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

ASSETS

	Current Year		3 Net Admitted Assets (Cols. 1 - 2)	Prior Year 4 Net Admitted Assets
	1 Assets	2 Nonadmitted Assets		
1. Bonds (Schedule D) .....			.0	.0
2. Stocks (Schedule D):				
2.1 Preferred stocks .....			.0	.0
2.2 Common stocks .....			.0	.0
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens .....			.0	.0
3.2 Other than first liens.....			.0	.0
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less \$ encumbrances) .....			.0	.0
4.2 Properties held for the production of income (less \$ encumbrances) .....			.0	.0
4.3 Properties held for sale (less \$ encumbrances) .....			.0	.0
5. Cash (\$65,720,382 , Schedule E - Part 1), cash equivalents (\$, Schedule E - Part 2) and short-term investments (\$, Schedule DA)	65,720,382		65,720,382	43,761,382
6. Contract loans, (including \$ premium notes) .....			.0	.0
7. Derivatives (Schedule DB) .....			.0	.0
8. Other invested assets (Schedule BA) .....			.0	.0
9. Receivables for securities .....			.0	.0
10. Securities lending reinvested collateral assets (Schedule DL) .....			.0	.0
11. Aggregate write-ins for invested assets .....	.0	.0	.0	.0
12. Subtotals, cash and invested assets (Lines 1 to 11)	65,720,382	.0	65,720,382	43,761,382
13. Title plants less \$ charged off (for Title insurers only) .....			.0	.0
14. Investment income due and accrued .....			.0	893
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	3,167,576		3,167,576	1,638,392
15.2 Deferred premiums and agents' balances and installments booked but deferred and not yet due (including \$ earned but unbilled premiums) .....			.0	.0
15.3 Accrued retrospective premiums (\$) and contracts subject to redetermination (\$ ..... ) .....			.0	2,378,748
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers	1,261,693		1,261,693	97,362
16.2 Funds held by or deposited with reinsured companies .....			.0	.0
16.3 Other amounts receivable under reinsurance contracts .....			.0	.0
17. Amounts receivable relating to uninsured plans .....			.0	.0
18.1 Current federal and foreign income tax recoverable and interest thereon	557,846		557,846	1,962,380
18.2 Net deferred tax asset	2,117,449	73,531	2,043,918	.0
19. Guaranty funds receivable or on deposit .....			.0	.0
20. Electronic data processing equipment and software .....			.0	.0
21. Furniture and equipment, including health care delivery assets (\$ ..... ) .....			.0	.0
22. Net adjustment in assets and liabilities due to foreign exchange rates .....			.0	.0
23. Receivables from parent, subsidiaries and affiliates	5,364	5,364	.0	.0
24. Health care (\$) and other amounts receivable	209,295	209,295	.0	834,919
25. Aggregate write-ins for other than invested assets	21,293	21,293	.0	.0
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	73,060,898	309,483	72,751,415	50,674,076
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts .....			.0	.0
28. Total (Lines 26 and 27)	73,060,898	309,483	72,751,415	50,674,076
DETAILS OF WRITE-INS				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page .....	.0	.0	.0	.0
1199. Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	0	0	0	0
2501. Prepaid Assets	21,293	21,293	.0	.0
2502.				
2503.				
2598. Summary of remaining write-ins for Line 25 from overflow page .....	.0	.0	.0	.0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	21,293	21,293	0	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

LIABILITIES, CAPITAL AND SURPLUS

	Current Year			Prior Year
	1 Covered	2 Uncovered	3 Total	4 Total
1. Claims unpaid (less \$0 reinsurance ceded)	33,109,006		33,109,006	29,012,287
2. Accrued medical incentive pool and bonus amounts	2,647,384		2,647,384	4,884,467
3. Unpaid claims adjustment expenses	1,070,712		1,070,712	980,650
4. Aggregate health policy reserves, including the liability of \$0 for medical loss ratio rebate per the Public Health Service Act	2,826,759		2,826,759	306,539
5. Aggregate life policy reserves.....			0	0
6. Property/casualty unearned premium reserves.....			0	0
7. Aggregate health claim reserves.....	409,051		409,051	0
8. Premiums received in advance			0	0
9. General expenses due or accrued.....	199,652		199,652	220,374
10.1 Current federal and foreign income tax payable and interest thereon (including \$ on realized capital gains (losses))	0		0	0
10.2 Net deferred tax liability.....	0		0	0
11. Ceded reinsurance premiums payable.....	0		0	0
12. Amounts withheld or retained for the account of others.....	0		0	0
13. Remittances and items not allocated.....	0		0	0
14. Borrowed money (including \$ current) and interest thereon \$ (including \$ current).....	0		0	0
15. Amounts due to parent, subsidiaries and affiliates.....	909,401		909,401	55,827
16. Derivatives.....	0		0	0
17. Payable for securities.....	0		0	0
18. Payable for securities lending	0		0	0
19. Funds held under reinsurance treaties (with \$ authorized reinsurers, \$0 unauthorized reinsurers and \$0 certified reinsurers).....	0		0	0
20. Reinsurance in unauthorized and certified (\$) companies	0		0	0
21. Net adjustments in assets and liabilities due to foreign exchange rates	0		0	0
22. Liability for amounts held under uninsured plans.....	50,769		50,769	0
23. Aggregate write-ins for other liabilities (including \$41,553 current).....	613,934	0	613,934	0
24. Total liabilities (Lines 1 to 23).....	41,836,668	0	41,836,668	35,460,144
25. Aggregate write-ins for special surplus funds.....	XXX	XXX	0	4,874,590
26. Common capital stock	XXX	XXX	10	10
27. Preferred capital stock	XXX	XXX		
28. Gross paid in and contributed surplus.....	XXX	XXX	995,001	995,001
29. Surplus notes.....	XXX	XXX	10,500,000	10,500,000
30. Aggregate write-ins for other than special surplus funds.....	XXX	XXX	0	0
31. Unassigned funds (surplus).....	XXX	XXX	19,419,736	(1,155,669)
32. Less treasury stock, at cost: 32.1..... shares common (value included in Line 26 \$).....	XXX	XXX		
32.2..... shares preferred (value included in Line 27 \$).....	XXX	XXX		
33. Total capital and surplus (Lines 25 to 31 minus Line 32).....	XXX	XXX	30,914,747	15,213,932
34. Total liabilities, capital and surplus (Lines 24 and 33).....	XXX	XXX	72,751,415	50,674,076
DETAILS OF WRITE-INS				
2301. Escheat liabilities	586,632		586,632	
2302. Other Premium Liabilities	27,302		27,302	
2303.				
2398. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399. Totals (Lines 2301 thru 2303 plus 2398)(Line 23 above)	613,934	0	613,934	0
2501. Special Reserve for ACA tax 2016 Payment Year / 2015 Fee Year	XXX	XXX		4,874,590
2502.	XXX	XXX		
2503.	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	XXX	XXX	0	4,874,590
3001.	XXX	XXX		
3002.	XXX	XXX		
3003.	XXX	XXX		
3098. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099. Totals (Lines 3001 thru 3003 plus 3098)(Line 30 above)	XXX	XXX	0	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

STATEMENT OF REVENUE AND EXPENSES

	Current Year		Prior Year
	1 Uncovered	2 Total	3 Total
1. Member Months.....	XXX	1,220,936	1,115,606
2. Net premium income (including \$ non-health premium income)	XXX	321,690,311	267,338,684
3. Change in unearned premium reserves and reserve for rate credits	XXX	(2,520,220)	.0
4. Fee-for-service (net of \$ medical expenses).....	XXX	.0	.0
5. Risk revenue	XXX	.0	.0
6. Aggregate write-ins for other health care related revenues	XXX	.0	.0
7. Aggregate write-ins for other non-health revenues	XXX	.0	.0
8. Total revenues (Lines 2 to 7)	XXX	319,170,091	267,338,684
Hospital and Medical:			
9. Hospital/medical benefits		109,795,470	119,165,008
10. Other professional services		72,882,773	64,641,127
11. Outside referrals .....		.0	.0
12. Emergency room and out-of-area		24,138,390	.0
13. Prescription drugs		56,111,972	51,433,149
14. Aggregate write-ins for other hospital and medical.....	.0	.0	.0
15. Incentive pool, withhold adjustments and bonus amounts		(1,024,525)	3,056,009
16. Subtotal (Lines 9 to 15) .....	.0	261,904,080	238,295,293
Less:			
17. Net reinsurance recoveries		1,488,554	103,104
18. Total hospital and medical (Lines 16 minus 17) .....	.0	260,415,526	238,192,189
19. Non-health claims (net) .....			.0
20. Claims adjustment expenses, including \$10,169,035 cost containment expenses		16,235,723	6,341,286
21. General administrative expenses		20,411,814	23,717,325
22. Increase in reserves for life and accident and health contracts (including \$ increase in reserves for life only) .....		.0	.0
23. Total underwriting deductions (Lines 18 through 22).....	.0	297,063,063	268,250,800
24. Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	22,107,028	(912,116)
25. Net investment income earned (Exhibit of Net Investment Income, Line 17)		9,580	10,272
26. Net realized capital gains (losses) less capital gains tax of \$			
27. Net investment gains (losses) (Lines 25 plus 26) .....	.0	9,580	10,272
28. Net gain or (loss) from agents' or premium balances charged off [(amount recovered \$) (amount charged off \$)]			
29. Aggregate write-ins for other income or expenses .....	.0	(24,200)	(124,300)
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	22,092,408	(1,026,144)
31. Federal and foreign income taxes incurred	XXX	8,905,717	(834,476)
32. Net income (loss) (Lines 30 minus 31)	XXX	13,186,691	(191,668)
DETAILS OF WRITE-INS			
0601.	XXX		
0602.	XXX		
0603.	XXX		
0698. Summary of remaining write-ins for Line 6 from overflow page	XXX	.0	.0
0699. Totals (Lines 0601 thru 0603 plus 0698)(Line 6 above)	XXX	0	0
0701.	XXX		
0702.	XXX		
0703.	XXX		
0798. Summary of remaining write-ins for Line 7 from overflow page	XXX	.0	.0
0799. Totals (Lines 0701 thru 0703 plus 0798)(Line 7 above)	XXX	0	0
1401.			
1402.			
1403.			
1498. Summary of remaining write-ins for Line 14 from overflow page .....	.0	.0	.0
1499. Totals (Lines 1401 thru 1403 plus 1498)(Line 14 above)	0	0	0
2901. Fines & Penalties		(24,200)	(124,300)
2902.			
2903.			
2998. Summary of remaining write-ins for Line 29 from overflow page .....	.0	.0	.0
2999. Totals (Lines 2901 thru 2903 plus 2998)(Line 29 above)	0	(24,200)	(124,300)

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

STATEMENT OF REVENUE AND EXPENSES (Continued)

	1 Current Year	2 Prior Year
CAPITAL AND SURPLUS ACCOUNT		
33. Capital and surplus prior reporting year.....	15,213,932	15,817,890
34. Net income or (loss) from Line 32	13,186,691	(191,668)
35. Change in valuation basis of aggregate policy and claim reserves		
36. Change in net unrealized capital gains (losses) less capital gains tax of \$		
37. Change in net unrealized foreign exchange capital gain or (loss)		
38. Change in net deferred income tax	2,117,449	
39. Change in nonadmitted assets	396,675	(412,290)
40. Change in unauthorized and certified reinsurance	0	0
41. Change in treasury stock	0	0
42. Change in surplus notes	0	0
43. Cumulative effect of changes in accounting principles.....		
44. Capital Changes:		
44.1 Paid in	0	0
44.2 Transferred from surplus (Stock Dividend).....	0	0
44.3 Transferred to surplus.....		
45. Surplus adjustments:		
45.1 Paid in	0	0
45.2 Transferred to capital (Stock Dividend)		
45.3 Transferred from capital		
46. Dividends to stockholders		
47. Aggregate write-ins for gains or (losses) in surplus	0	0
48. Net change in capital and surplus (Lines 34 to 47)	15,700,815	(603,958)
49. Capital and surplus end of reporting period (Line 33 plus 48)	30,914,747	15,213,932
DETAILS OF WRITE-INS		
4701.		
4702.		
4703.		
4798. Summary of remaining write-ins for Line 47 from overflow page	0	0
4799. Totals (Lines 4701 thru 4703 plus 4798)(Line 47 above)	0	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

CASH FLOW

	1 Current Year	2 Prior Year
Cash from Operations		
1. Premiums collected net of reinsurance	322,539,875	262,028,176
2. Net investment income	10,473	9,379
3. Miscellaneous income	0	0
4. Total (Lines 1 through 3)	322,550,348	262,037,555
5. Benefit and loss related payments	258,142,859	231,603,368
6. Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts		
7. Commissions, expenses paid and aggregate write-ins for deductions	36,551,628	29,641,955
8. Dividends paid to policyholders		
9. Federal and foreign income taxes paid (recovered) net of \$ tax on capital gains (losses)	7,501,183	377,904
10. Total (Lines 5 through 9)	302,195,670	261,623,227
11. Net cash from operations (Line 4 minus Line 10)	20,354,678	414,328
Cash from Investments		
12. Proceeds from investments sold, matured or repaid:		
12.1 Bonds	0	0
12.2 Stocks	0	0
12.3 Mortgage loans	0	0
12.4 Real estate	0	0
12.5 Other invested assets	0	0
12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	0	0
12.7 Miscellaneous proceeds	0	0
12.8 Total investment proceeds (Lines 12.1 to 12.7)	0	0
13. Cost of investments acquired (long-term only):		
13.1 Bonds	0	0
13.2 Stocks	0	0
13.3 Mortgage loans	0	0
13.4 Real estate	0	0
13.5 Other invested assets	0	0
13.6 Miscellaneous applications	0	0
13.7 Total investments acquired (Lines 13.1 to 13.6)	0	0
14. Net increase (decrease) in contract loans and premium notes	0	0
15. Net cash from investments (Line 12.8 minus Line 13.7 minus Line 14)	0	0
Cash from Financing and Miscellaneous Sources		
16. Cash provided (applied):		
16.1 Surplus notes, capital notes	0	0
16.2 Capital and paid in surplus, less treasury stock	0	0
16.3 Borrowed funds	0	0
16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	0
16.5 Dividends to stockholders	0	0
16.6 Other cash provided (applied)	1,604,322	(464,633)
17. Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6)	1,604,322	(464,633)
RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS		
18. Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	21,959,000	(50,305)
19. Cash, cash equivalents and short-term investments:		
19.1 Beginning of year	43,761,382	43,811,687
19.2 End of year (Line 18 plus Line 19.1)	65,720,382	43,761,382

Note: Supplemental disclosures of cash flow information for non-cash transactions:

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Net premium income	321,690,311							321,690,311		
2. Change in unearned premium reserves and reserve for rate credit	(2,520,220)							(2,520,220)		
3. Fee-for-service (net of \$ medical expenses)	0									XXX
4. Risk revenue	0									XXX
5. Aggregate write-ins for other health care related revenues	0	0	0	0	0	0	0	0	0	XXX
6. Aggregate write-ins for other non-health care related revenues	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
7. Total revenues (Lines 1 to 6)	319,170,091	0	0	0	0	0	0	319,170,091	0	0
8. Hospital/medical benefits	109,795,470							109,795,470		XXX
9. Other professional services	72,882,773							72,882,773		XXX
10. Outside referrals	0									XXX
11. Emergency room and out-of-area	24,138,390							24,138,390		XXX
12. Prescription drugs	56,111,972							56,111,972		XXX
13. Aggregate write-ins for other hospital and medical	0	0	0	0	0	0	0	0	0	XXX
14. Incentive pool, withhold adjustments and bonus amounts	(1,024,525)							(1,024,525)		XXX
15. Subtotal (Lines 8 to 14)	261,904,080	0	0	0	0	0	0	261,904,080	0	XXX
16. Net reinsurance recoveries	1,488,554							1,488,554		XXX
17. Total medical and hospital (Lines 15 minus 16)	260,415,526	0	0	0	0	0	0	260,415,526	0	XXX
18. Non-health claims (net)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
19. Claims adjustment expenses including \$ cost containment expenses	16,235,723							16,235,723		
20. General administrative expenses	20,411,814							20,411,814		
21. Increase in reserves for accident and health contracts	0									XXX
22. Increase in reserves for life contracts	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
23. Total underwriting deductions (Lines 17 to 22)	297,063,063	0	0	0	0	0	0	297,063,063	0	0
24. Total underwriting gain or (loss) (Line 7 minus Line 23)	22,107,028	0	0	0	0	0	0	22,107,028	0	0
DETAILS OF WRITE-INS										
0501.										XXX
0502.										XXX
0503.										XXX
0598. Summary of remaining write-ins for Line 5 from overflow page	0	0	0	0	0	0	0	0	0	XXX
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above)	0	0	0	0	0	0	0	0	0	XXX
0601.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0602.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0603.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0698. Summary of remaining write-ins for Line 6 from overflow page	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
1301.										XXX
1302.										XXX
1303.										XXX
1398. Summary of remaining write-ins for Line 13 from overflow page	0	0	0	0	0	0	0	0	0	XXX
1399. Totals (Lines 1301 thru 1303 plus 1398) (Line 13 above)	0	0	0	0	0	0	0	0	0	XXX

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
UNDERWRITING AND INVESTMENT EXHIBIT
PART 1 - PREMIUMS

Line of Business	1 Direct Business	2 Reinsurance Assumed	3 Reinsurance Ceded	4 Net Premium Income (Cols. 1 + 2 - 3)
1. Comprehensive (hospital and medical)				0
2. Medicare Supplement				0
3. Dental only				0
4. Vision only				0
5. Federal Employees Health Benefits Plan	0			0
6. Title XVIII - Medicare	0			0
7. Title XIX - Medicaid	322,105,018		414,707	321,690,311
8. Other health				0
9. Health subtotal (Lines 1 through 8)	322,105,018	0	414,707	321,690,311
10. Life	0			0
11. Property/casualty	0			0
12. Totals (Lines 9 to 11)	322,105,018	0	414,707	321,690,311

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2 - CLAIMS INCURRED DURING THE YEAR

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Payments during the year:										
1.1 Direct	257,254,524							257,254,524		
1.2 Reinsurance assumed	0							0		
1.3 Reinsurance ceded	324,223							324,223		
1.4 Net	256,930,301	0	0	0	0	0	0	256,930,301	0	0
2. Paid medical incentive pools and bonuses	1,212,558							1,212,558		
3. Claim liability December 31, current year from Part 2A:										
3.1 Direct	33,109,006	0	0	0	0	0	0	33,109,006	0	0
3.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
3.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
3.4 Net	33,109,006	0	0	0	0	0	0	33,109,006	0	0
4. Claim reserve December 31, current year from Part 2D:										
4.1 Direct	409,051							409,051		
4.2 Reinsurance assumed	0							0		
4.3 Reinsurance ceded	0							0		
4.4 Net	409,051	0	0	0	0	0	0	409,051	0	0
5. Accrued medical incentive pools and bonuses, current year	2,647,384							2,647,384		
6. Net healthcare receivables (a)	(1,168,311)							(1,168,311)		
7. Amounts recoverable from reinsurers December 31, current year	1,261,693							1,261,693		
8. Claim liability December 31, prior year from Part 2A:										
8.1 Direct	29,012,287	0	0	0	0	0	0	29,012,287	0	0
8.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
8.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
8.4 Net	29,012,287	0	0	0	0	0	0	29,012,287	0	0
9. Claim reserve December 31, prior year from Part 2D:										
9.1 Direct	0							0		
9.2 Reinsurance assumed	0							0		
9.3 Reinsurance ceded	0							0		
9.4 Net	0	0	0	0	0	0	0	0	0	0
10. Accrued medical incentive pools and bonuses, prior year	4,884,467	0	0	0	0	0	0	4,884,467	0	0
11. Amounts recoverable from reinsurers December 31, prior year	97,362	0	0	0	0	0	0	97,362	0	0
12. Incurred Benefits:										
12.1 Direct	262,928,605	0	0	0	0	0	0	262,928,605	0	0
12.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
12.3 Reinsurance ceded	1,488,554	0	0	0	0	0	0	1,488,554	0	0
12.4 Net	261,440,051	0	0	0	0	0	0	261,440,051	0	0
13. Incurred medical incentive pools and bonuses	(1,024,525)	0	0	0	0	0	0	(1,024,525)	0	0

(a) Excludes \$ loans or advances to providers not yet expensed.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2A - CLAIMS LIABILITY END OF CURRENT YEAR

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Reported in Process of Adjustment:										
1.1 Direct	5,851,558							5,851,558		
1.2 Reinsurance assumed .....	.0									
1.3 Reinsurance ceded .....	.0									
1.4 Net	5,851,558	.0	.0	.0	.0	.0	.0	5,851,558	.0	.0
2. Incurred but Unreported:										
2.1 Direct	27,257,448							27,257,448		
2.2 Reinsurance assumed .....	.0									
2.3 Reinsurance ceded .....	.0									
2.4 Net	27,257,448	.0	.0	.0	.0	.0	.0	27,257,448	.0	.0
3. Amounts Withheld from Paid Claims and Capitations:										
3.1 Direct .....	.0									
3.2 Reinsurance assumed .....	.0									
3.3 Reinsurance ceded .....	.0									
3.4 Net .....	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
4. TOTALS:										
4.1 Direct	33,109,006	.0	.0	.0	.0	.0	.0	33,109,006	.0	.0
4.2 Reinsurance assumed0	.0	.0	.0	.0	.0	.0	.0	.0	.0
4.3 Reinsurance ceded0	.0	.0	.0	.0	.0	.0	.0	.0	.0
4.4 Net	33,109,006	0	0	0	0	0	0	33,109,006	0	0

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
UNDERWRITING AND INVESTMENT EXHIBIT
PART 2B - ANALYSIS OF CLAIMS UNPAID - PRIOR YEAR - NET OF REINSURANCE

Line of Business	Claims Paid During the Year		Claim Reserve and Claim Liability December 31 of Current Year		5 Claims Incurred In Prior Years (Columns 1 + 3)	6 Estimated Claim Reserve and Claim Liability December 31 of Prior Year
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid December 31 of Prior Year	4 On Claims Incurred During the Year		
1. Comprehensive (hospital and medical)					0	0
2. Medicare Supplement					0	0
3. Dental Only					0	0
4. Vision Only					0	0
5. Federal Employees Health Benefits Plan					0	0
6. Title XVIII - Medicare					0	0
7. Title XIX - Medicaid	25,853,940	231,289,636	577,198	32,940,859	26,431,138	29,012,287
8. Other health					0	0
9. Health subtotal (Lines 1 to 8)	25,853,940	231,289,636	577,198	32,940,859	26,431,138	29,012,287
10. Healthcare receivables (a)	0	209,295			0	0
11. Other non-health					0	0
12. Medical incentive pools and bonus amounts	77,034	1,135,524	347,966	2,299,418	425,000	4,884,467
13. Totals (Lines 9 - 10 + 11 + 12)	25,930,974	232,215,865	925,164	35,240,277	26,856,138	33,896,754

(a) Excludes \$ loans or advances to providers not yet expensed.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS

(000 Omitted)

Section A - Paid Health Claims - Title XIX

Year in Which Losses Were Incurred		Cumulative Net Amounts Paid				
		1 2012	2 2013	3 2014	4 2015	5 2016
1. Prior		0	0	0	0	
2. 2012						
3. 2013		XXX				
4. 2014		XXX	XXX	100,872	123,761	123,745
5. 2015		XXX	XXX	XXX	208,715	234,662
6. 2016		XXX	XXX	XXX	XXX	232,216

Section B - Incurred Health Claims - Title XIX

Year in Which Losses Were Incurred		Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
		1 2012	2 2013	3 2014	4 2015	5 2016
1. Prior		0	0	0	0	
2. 2012						
3. 2013		XXX				
4. 2014		XXX	XXX	128,501	124,576	123,745
5. 2015		XXX	XXX	XXX	241,796	235,587
6. 2016		XXX	XXX	XXX	XXX	267,456

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Title XIX

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2012	0			0.0	0	0.0			0	0.0
2. 2013	0			0.0	0	0.0			0	0.0
3. 2014	158,608	123,745	3,488	2.8	127,233	80.2			127,233	80.2
4. 2015	267,339	234,662	5,660	2.4	240,322	89.9	925	27	241,274	90.3
5. 2016	319,170	232,216	16,146	7.0	248,362	77.8	35,240	1,043	284,645	89.2

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS

(000 Omitted)

Section A - Paid Health Claims - Grand Total

Year in Which Losses Were Incurred		Cumulative Net Amounts Paid				
		1 2012	2 2013	3 2014	4 2015	5 2016
1. Prior0	.0	.0	.0	.0
2. 20120	.0	.0	.0	.0
3. 2013		XXX	.0	.0	.0	.0
4. 2014		XXX	XXX	100,872	123,761	123,745
5. 2015		XXX	XXX	XXX	208,715	234,662
6. 2016		XXX	XXX	XXX	XXX	232,216

Section B - Incurred Health Claims - Grand Total

Year in Which Losses Were Incurred		Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
		1 2012	2 2013	3 2014	4 2015	5 2016
1. Prior .....		.0	.0	.0	.0	.0
2. 2012 .....		.0	.0	.0	.0	.0
3. 2013		XXX	.0	.0	.0	.0
4. 2014		XXX	XXX	128,501	124,576	123,745
5. 2015		XXX	XXX	XXX	241,796	235,587
6. 2016		XXX	XXX	XXX	XXX	267,456

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Grand Total

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2012 .....	.0	.0	.0	.0.0	.0	.0.0	.0	.0	.0	.0.0
2. 2013 .....	.0	.0	.0	.0.0	.0	.0.0	.0	.0	.0	.0.0
3. 2014	158,608	123,745	3,488	2.8	127,233	80.2	.0	.0	127,233	80.2
4. 2015	267,339	234,662	5,660	2.4	240,322	89.9	925	27	241,274	90.3
5. 2016	319,170	232,216	16,146	7.0	248,362	77.8	35,240	1,043	284,645	89.2

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2D - AGGREGATE RESERVE FOR ACCIDENT AND HEALTH CONTRACTS ONLY

	1	2	3	4	5	6	7	8	9
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
1. Unearned premium reserves0								
2. Additional policy reserves (a)0								
3. Reserve for future contingent benefits .....	.0								
4. Reserve for rate credits or experience rating refunds (including \$) for investment income	2,826,759							2,826,759	
5. Aggregate write-ins for other policy reserves .....	.0	.0	.0	.0	.0	.0	.0	.0	.0
6. Totals (gross)	2,826,759	.0	.0	.0	.0	.0	.0	2,826,759	.0
7. Reinsurance ceded .....	.0								
8. Totals (Net)(Page 3, Line 4)	2,826,759	.0	.0	.0	.0	.0	.0	2,826,759	.0
9. Present value of amounts not yet due on claims .....	.0								
10. Reserve for future contingent benefits	409,051							409,051	
11. Aggregate write-ins for other claim reserves .....	.0	.0	.0	.0	.0	.0	.0	.0	.0
12. Totals (gross)	409,051	.0	.0	.0	.0	.0	.0	409,051	.0
13. Reinsurance ceded .....	.0								
14. Totals (Net)(Page 3, Line 7)	409,051	0	0	0	0	0	0	409,051	0
DETAILS OF WRITE-INS									
0501.									
0502.									
0503.									
0598. Summary of remaining write-ins for Line 5 from overflow page .....	.0	.0	.0	.0	.0	.0	.0	.0	.0
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above)	0	0	0	0	0	0	0	0	0
1101.									
1102.									
1103.									
1198. Summary of remaining write-ins for Line 11 from overflow page .....	.0	.0	.0	.0	.0	.0	.0	.0	.0
1199. Totals (Lines 1101 thru 1103 plus 1198) (Line 11 above)	0	0	0	0	0	0	0	0	0

(a) Includes \$ premium deficiency reserve.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 3 - ANALYSIS OF EXPENSES					
	Claim Adjustment Expenses		3 General Administrative Expenses	4 Investment Expenses	5 Total
	1 Cost Containment Expenses	2 Other Claim Adjustment Expenses			
1. Rent (\$ for occupancy of own building)	7	9,172	539,027		548,206
2. Salary, wages and other benefits	8,747,629	3,720,260	5,893,016		18,360,905
3. Commissions (less \$ ceded plus \$ assumed)	0	0	0		0
4. Legal fees and expenses	7,801	136	15,722		23,659
5. Certifications and accreditation fees	0	0	0		0
6. Auditing, actuarial and other consulting services	265,876	211,217	282,912		760,005
7. Traveling expenses	114,330	8,938	85,821		209,089
8. Marketing and advertising	20,341	9,742	1,769,552		1,799,635
9. Postage, express and telephone	270,510	116,575	778,855		1,165,940
10. Printing and office supplies	20,019	221,962	34,459		276,440
11. Occupancy, depreciation and amortization	0	0	0		0
12. Equipment	(240)	(5,492)	122,006		116,274
13. Cost or depreciation of EDP equipment and software	23,462	731,226	2,456,357		3,211,045
14. Outsourced services including EDP, claims, and other services	107,840	126,700	662,348		896,888
15. Boards, bureaus and association fees	0	0	13,163		13,163
16. Insurance, except on real estate	0	22	174,479		174,501
17. Collection and bank service charges	0	0	68,907		68,907
18. Group service and administration fees	0	0	0		0
19. Reimbursements by uninsured plans	0	0	0		0
20. Reimbursements from fiscal intermediaries	0	0	0		0
21. Real estate expenses	5	0	212,541		212,546
22. Real estate taxes	0	0	0		0
23. Taxes, licenses and fees:					
23.1 State and local insurance taxes	144	0	1,400,645		1,400,789
23.2 State premium taxes	0	0	0		0
23.3 Regulatory authority licenses and fees	45,665	95	44,405		90,165
23.4 Payroll taxes	544,697	232,788	353,642		1,131,127
23.5 Other (excluding federal income and real estate taxes)	0	0	5,301,813		5,301,813
24. Investment expenses not included elsewhere	0	0	0		0
25. Aggregate write-ins for expenses	949	683,347	202,144	0	886,440
26. Total expenses incurred (Lines 1 to 25)	10,169,035	6,066,688	20,411,814	0	(a) 36,647,537
27. Less expenses unpaid December 31, current year ..		1,070,712	199,652		1,270,364
28. Add expenses unpaid December 31, prior year	794,016	186,634	220,374	0	1,201,024
29. Amounts receivable relating to uninsured plans, prior year	0	0	0	0	0
30. Amounts receivable relating to uninsured plans, current year					0
31. Total expenses paid (Lines 26 minus 27 plus 28 minus 29 plus 30)	10,963,051	5,182,610	20,432,536	0	36,578,197
DETAILS OF WRITE-INS					
2501. Misc Expense	949	683,347	202,144		886,440
2502.					
2503.					
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	949	683,347	202,144	0	886,440

(a) Includes management fees of \$ 33,707,985 to affiliates and \$ to non-affiliates.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

EXHIBIT OF NET INVESTMENT INCOME

	1	2
	Collected During Year	Earned During Year
1. U.S. government bonds	(a)	
1.1 Bonds exempt from U.S. tax	(a)	
1.2 Other bonds (unaffiliated)	(a)	
1.3 Bonds of affiliates	(a)	
2.1 Preferred stocks (unaffiliated)	(b)	
2.11 Preferred stocks of affiliates	(b)	
2.2 Common stocks (unaffiliated)		
2.21 Common stocks of affiliates		
3. Mortgage loans	(c)	
4. Real estate	(d)	
5. Contract Loans		
6. Cash, cash equivalents and short-term investments	(e)	
7. Derivative instruments	(f)	
8. Other invested assets		
9. Aggregate write-ins for investment income	0	9,580
10. Total gross investment income	0	9,580
11. Investment expenses		(g) 0
12. Investment taxes, licenses and fees, excluding federal income taxes		(g) 0
13. Interest expense		(h) 0
14. Depreciation on real estate and other invested assets		(i) 0
15. Aggregate write-ins for deductions from investment income		0
16. Total deductions (Lines 11 through 15)		0
17. Net investment income (Line 10 minus Line 16)		9,580
DETAILS OF WRITE-INS		
0901. State Income Received		3,756
0902. Interest Income-Other		5,824
0903.		
0998. Summary of remaining write-ins for Line 9 from overflow page	0	0
0999. Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)	0	9,580
1501.		
1502.		
1503.		
1598. Summary of remaining write-ins for Line 15 from overflow page		0
1599. Totals (Lines 1501 thru 1503 plus 1598) (Line 15, above)		0

- (a) Includes \$ accrual of discount less \$ amortization of premium and less \$ paid for accrued interest on purchases.
- (b) Includes \$ accrual of discount less \$ amortization of premium and less \$ paid for accrued dividends on purchases.
- (c) Includes \$ accrual of discount less \$ amortization of premium and less \$ paid for accrued interest on purchases.
- (d) Includes \$ for company's occupancy of its own buildings; and excludes \$ interest on encumbrances.
- (e) Includes \$ accrual of discount less \$ amortization of premium and less \$ paid for accrued interest on purchases.
- (f) Includes \$ accrual of discount less \$ amortization of premium.
- (g) Includes \$ investment expenses and \$ investment taxes, licenses and fees, excluding federal income taxes, attributable to segregated and Separate Accounts.
- (h) Includes \$ interest on surplus notes and \$ interest on capital notes.
- (i) Includes \$ depreciation on real estate and \$ depreciation on other invested assets.

EXHIBIT OF CAPITAL GAINS (LOSSES)

	1	2	3	4	5
	Realized Gain (Loss) On Sales or Maturity	Other Realized Adjustments	Total Realized Capital Gain (Loss) (Columns 1 + 2)	Change in Unrealized Capital Gain (Loss)	Change in Unrealized Foreign Exchange Capital Gain (Loss)
1. U.S. Government bonds					
1.1 Bonds exempt from U.S. tax					
1.2 Other bonds (unaffiliated)					
1.3 Bonds of affiliates					
2.1 Preferred stocks (unaffiliated)					
2.11 Preferred stocks of affiliates					
2.2 Common stocks (unaffiliated)					
2.21 Common stocks of affiliates					
3. Mortgage loans					
4. Real estate					
5. Contract loans					
6. Cash, cash equivalents and short-term investments					
7. Derivative instruments					
8. Other invested assets					
9. Aggregate write-ins for capital gains (losses)					
10. Total capital gains (losses)					
DETAILS OF WRITE-INS					
0901.					
0902.					
0903.					
0998. Summary of remaining write-ins for Line 9 from overflow page					
0999. Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)					

NONE

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

EXHIBIT OF NON-ADMITTED ASSETS

	1 Current Year Total Nonadmitted Assets	2 Prior Year Total Nonadmitted Assets	3 Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
1. Bonds (Schedule D) .....		.0	.0
2. Stocks (Schedule D):			
2.1 Preferred stocks .....		.0	.0
2.2 Common stocks .....		.0	.0
3. Mortgage loans on real estate (Schedule B):			
3.1 First liens .....		.0	.0
3.2 Other than first liens.....		.0	.0
4. Real estate (Schedule A):			
4.1 Properties occupied by the company .....		.0	.0
4.2 Properties held for the production of income.....		.0	.0
4.3 Properties held for sale .....		.0	.0
5. Cash (Schedule E - Part 1), cash equivalents (Schedule E - Part 2) and short-term investments (Schedule DA) .....		.0	.0
6. Contract loans .....		.0	.0
7. Derivatives (Schedule DB) .....		.0	.0
8. Other invested assets (Schedule BA) .....		.0	.0
9. Receivables for securities .....		.0	.0
10. Securities lending reinvested collateral assets (Schedule DL) .....		.0	.0
11. Aggregate write-ins for invested assets .....	.0	.0	.0
12. Subtotals, cash and invested assets (Lines 1 to 11) .....	.0	.0	.0
13. Title plants (for Title insurers only) .....		.0	.0
14. Investment income due and accrued .....		.0	.0
15. Premiums and considerations:			
15.1 Uncollected premiums and agents' balances in the course of collection .....		.0	.0
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due .....		.0	.0
15.3 Accrued retrospective premiums and contracts subject to redetermination .....		.0	.0
16. Reinsurance:			
16.1 Amounts recoverable from reinsurers .....		.0	.0
16.2 Funds held by or deposited with reinsured companies .....		.0	.0
16.3 Other amounts receivable under reinsurance contracts .....		.0	.0
17. Amounts receivable relating to uninsured plans .....		.0	.0
18.1 Current federal and foreign income tax recoverable and interest thereon .....		.0	.0
18.2 Net deferred tax asset	73,531	.0	(73,531)
19. Guaranty funds receivable or on deposit .....		.0	.0
20. Electronic data processing equipment and software .....		.0	.0
21. Furniture and equipment, including health care delivery assets .....		.0	.0
22. Net adjustment in assets and liabilities due to foreign exchange rates .....		.0	.0
23. Receivable from parent, subsidiaries and affiliates	5,364	131,531	126,167
24. Health care and other amounts receivable	209,295	542,687	333,392
25. Aggregate write-ins for other than invested assets	21,293	31,940	10,647
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	309,483	706,158	396,675
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts .....		.0	.0
28. Total (Lines 26 and 27)	309,483	706,158	396,675
DETAILS OF WRITE-INS			
1101.			
1102.			
1103.			
1198. Summary of remaining write-ins for Line 11 from overflow page .....	.0	.0	.0
1199. Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above) .....	.0	.0	.0
2501. Prepaid Assets	21,293	31,940	10,647
2502.			
2503.			
2598. Summary of remaining write-ins for Line 25 from overflow page .....	.0	.0	.0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	21,293	31,940	10,647

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

EXHIBIT 1 - ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS ONLY

Source of Enrollment	Total Members at End of					6 Current Year Member Months
	1 Prior Year	2 First Quarter	3 Second Quarter	4 Third Quarter	5 Current Year	
1. Health Maintenance Organizations	95,517	98,827	100,363	100,981	103,318	1,220,936
2. Provider Service Organizations	0					
3. Preferred Provider Organizations						
4. Point of Service						
5. Indemnity Only						
6. Aggregate write-ins for other lines of business.....	0	0	0	0	0	0
7. Total	95,517	98,827	100,363	100,981	103,318	1,220,936
DETAILS OF WRITE-INS						
0601.						
0602.						
0603.						
0698. Summary of remaining write-ins for Line 6 from overflow page	0	0	0	0	0	0
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	0	0	0	0	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

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EXHIBIT 3 - HEALTH CARE RECEIVABLES

[illegible]

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

EXHIBIT 3A - ANALYSIS OF HEALTH CARE RECEIVABLES COLLECTED AND ACCRUED

Type of Health Care Receivable	Health Care Receivables Collected During the Year		Health Care Receivables Accrued as of December 31 of Current Year		5	6
	1 On Amounts Accrued Prior to January 1 of Current Year	2 On Amounts Accrued During the Year	3 On Amounts Accrued December 31 of Prior Year	4 On Amounts Accrued During the Year	Health Care Receivables in Prior Years (Columns 1 + 3)	Estimated Health Care Receivables Accrued as of December 31 of Prior Year
1. Pharmaceutical rebate receivables					0	0
2. Claim overpayment receivables	1,258,974	757,665		135,627	1,258,974	1,258,973
3. Loans and advances to providers					0	0
4. Capitation arrangement receivables					0	0
5. Risk sharing receivables	118,632			73,668	118,632	118,632
6. Other health care receivables.....					0	0
7. Totals (Lines 1 through 6)	1,377,606	757,665	0	209,295	1,377,606	1,377,605

Note that the accrued amounts in Columns 3, 4, and 6 are the total health care receivables, not just the admitted portion.

EXHIBIT 4 - CLAIMS UNPAID AND INCENTIVE POOL, WITHHOLD AND BONUS (Reported and Unreported)

[illegible]

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
EXHIBIT 7 PART 1- SUMMARY OF TRANSACTIONS WITH PROVIDERS

Payment Method	1 Direct Medical Expense Payment	2 Column 1 as a % of Total Payments	3 Total Members Covered	4 Column 3 as a % of Total Members	5 Column 1 Expenses Paid to Affiliated Providers	6 Column 1 Expenses Paid to Non-Affiliated Providers
Capitation Payments:						
1. Medical groups	14,908,103	5.8	103,318	100.0		14,908,103
2. Intermediaries .....	.0	0.0		0.0		
3. All other providers.....	15,686,305	6.1		0.0		15,686,305
4. Total capitation payments.....	30,594,408	11.9	103,318	100.0	0	30,594,408
Other Payments:						
5. Fee-for-service .....	.0	0.0	XXX	XXX		
6. Contractual fee payments	225,491,805	87.6	XXX	XXX		225,491,805
7. Bonus/withhold arrangements - fee-for-service .....	.0	0.0	XXX	XXX		
8. Bonus/withhold arrangements - contractual fee payments	1,212,558	0.5	XXX	XXX		1,212,558
9. Non-contingent salaries .....	.0	0.0	XXX	XXX		
10. Aggregate cost arrangements .....	.0	0.0	XXX	XXX		
11. All other payments .....	.0	0.0	XXX	XXX		
12. Total other payments	226,704,363	88.1	XXX	XXX	0	226,704,363
13. TOTAL (Line 4 plus Line 12)	257,298,771	100%	XXX	XXX	0	257,298,771

EXHIBIT 7 - PART 2 - SUMMARY OF TRANSACTIONS WITH INTERMEDIARIES

1 NAIC Code	2 Name of Intermediary	3 Capitation Paid	4 Average Monthly Capitation	5 Intermediary's Total Adjusted Capital	6 Intermediary's Authorized Control Level RBC
	NONE				
9999999 Totals			XXX	XXX	XXX

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

Exhibit 8 - Furniture and Equipment Owned

NONE

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies and Going Concern

A. Accounting Practices

The accompanying financial statements of Better Health, Inc. (the “Company”) have been prepared in conformity with the National Association of Insurance Commissioners’ (“NAIC”) *Annual Statement Instructions* and in accordance with accounting practices prescribed by the NAIC *Accounting Practices and Procedures Manual* (“NAIC SAP”), subject to any deviations prescribed or permitted by the Florida Office of Insurance Regulation (“Florida OIR”).

The Florida OIR state prescribed practice does not allow parent and affiliate receivables to be admitted assets. A reconciliation of the Company’s net income (loss) and capital and surplus between NAIC SAP and practices prescribed and permitted by the Florida OIR is shown below:

	SSAP #	F/S Page	F/S Line #	2016	2015
<u>Net Income</u>					
(1) Better Health, Inc. (Page 4, Line 32, Columns 2 & 3)		4	32	\$ 13,186,691	\$ (191,668)
(2) State Prescribed Practices that increase/(decrease) NAIC SAP:	Florida Statute 641.35 3(a)	4	9	\$ (43,233)	\$ (306,539)
(3) State Permitted Practices that increase/(decrease) NAIC SAP:					
(4) NAIC SAP (1-2-3=4)	XXX	XXX	XXX	\$ 13,229,924	\$ 114,871
<u>Surplus</u>					
(5) Better Health, Inc. (Page 3, Line 33, Columns 3 & 4)		3	33	\$ 30,914,747	\$ 15,213,932
(6) State Prescribed Practices that increase/(decrease) NAIC SAP:	Florida Statute 641.35 3(a)	4	9	(349,772)	\$ (306,539)
(7) State Permitted Practices that increase/(decrease) NAIC SAP:	Florida Statute 641.35 (2)(i)	2	23	\$ (5,364)	\$ (131,531)
(8) NAIC SAP (5-6-7=8)	XXX	XXX	XXX	\$ 31,269,883	\$ 15,652,002

B. Use of Estimates in the Preparation of the Financial Statements

Preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

C. Accounting Policies

Health premiums are recognized as income over the premium paying period of the related policies. Deposits on deposit-type contracts are recorded directly as a liability when received. Health premiums are earned over the term of the related insurance policies and reinsurance contracts. Premiums written are reported net of excess loss reinsurance ceded and experience rating refunds. Unearned premium reserves are established to cover the

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

NOTES TO FINANCIAL STATEMENTS

unexpired portion of premiums written, and are computed by pro rata methods for direct business and based on reports received from ceding companies for reinsurance. Premiums paid by subscribers prior to the effective date are recorded on the balance sheet as premiums received in advance and are subsequently credited to income as earned during the coverage period. Premium rates for certain lines of business are subject to approval by the Florida OIR. Expenses incurred in connection with acquiring new insurance business, including acquisition costs such as sales commissions, are charged to operations as incurred. All other costs, such as premium taxes and other underwriting expenses, are charged to operations as incurred.

In addition, the Company uses the following accounting policies:

- (1) Short-term investments include investments with maturities of less than one year at the date of acquisition and are reported at amortized cost, which approximates fair value. Non-investment grade short-term investments are stated at the lower of amortized cost or fair value.
- (2) Investment grade bonds not backed by other loans are stated at amortized cost, with amortization calculated based on the modified scientific method, using lower of yield to call or yield to maturity. Non-investment grade bonds are stated at the lower of amortized cost or fair value as determined by various third-party pricing sources.
- (3) The Company has no investments in common stocks of unaffiliated companies.
- (4) The Company has no investments in preferred stocks.
- (5) The Company has no mortgage loans - real estate.
- (6) The Company has no loan-backed securities.
- (7) The Company has no investments in subsidiaries, controlled and affiliated companies.
- (8) The Company has no investments in joint ventures, partnerships or limited liability companies.
- (9) The Company has no derivative instruments.
- (10) The Company does not anticipate investment income as a factor in premium deficiency calculations.
- (11) Unpaid claims and claims adjustment expenses include management's best estimate of amounts based on historical claim development patterns and certain individual case estimates. The established liability considers health benefit provisions, business practices, economic conditions and other factors that may materially affect the cost, frequency and severity of claims. Liabilities for unpaid claims and claim adjustment expenses are based on assumptions and estimates, and while management believes such estimates are reasonable, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed and changes in estimates are incorporated into current period estimates.
- (12) The Company has not modified its capitalization policy from the prior period.
- (13) Pharmacy rebate receivables are recorded when earned based upon actual rebate receivables billed and an estimate of receivables based upon current utilization of specific pharmaceuticals and provider contract terms.

D. Going Concern

Not applicable.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
ANNUAL STATEMENT FOR THE YEAR 2016 OF THE BETTER HEALTH, INC.

NOTES TO FINANCIAL STATEMENTS

2. Accounting Changes and Corrections of Errors

There were no accounting changes or corrections of errors during the years ended December 31, 2016 and 2015.

3. Business Combinations and Goodwill

A. Statutory Purchase Method	Not applicable.
B. Statutory Merger	Not applicable.
C. Assumption Reinsurance	Not applicable.
D. Impairment Loss	Not applicable.

4. Discontinued Operations

The Company had no operations that were discontinued during 2016 or 2015.

5. Investments

A. Mortgage Loans, including Mezzanine Real Estate Loans

The Company did not have investments in mortgage loans at December 31, 2016 or 2015.

B. Debt Restructuring

The Company did not have invested assets that were restructured debt at December 31, 2016 or 2015.

C. Reverse Mortgages

The Company did not have investments in reverse mortgages at December 31, 2016 or 2015.

D. Loan-Backed Securities

The Company did not have loan-backed securities at December 31, 2016 or 2015.

E. Repurchase Agreements and/or Securities Lending Transactions

The Company did not enter into repurchase agreements or securities lending transactions at December 31, 2016 or 2015.

F. Real Estate

The Company did not have investments in real estate and did not engage in retail land sales operations during 2016 or 2015.

G. Investments in Low-Income Housing Tax Credits

The Company did not invest in properties generating low-income housing tax credits during 2016 or 2015.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Legal Entity Name

NOTES TO FINANCIAL STATEMENTS

H. Restricted Assets

(1) Restricted assets (including pledged)

Restricted Asset Category	1	2	3	4	5	6	7
	Total Gross (Admitted & Nonadmitted) Restricted from Current Year	Total Gross (Admitted & Nonadmitted) Restricted from Current Year	Increase / (Decrease) (1 minus 2)	Total Current Year Nonadmitted Restricted	Total Current Year Admitted Restricted (1 minus 4)	Gross Admitted and Nonadmitted Restricted to Total Assets (a)	Admitted Restricted Total Admitted Assets (b)
a. Subject to contractual obligation for which liability is not shown	\$ -	\$ -	\$ -	\$ -	\$ -	0.00%	0.00%
b. Collateral held under security lending agreements	-	-	-	-	-	0.00%	0.00%
c. Subject to repurchase agreements	-	-	-	-	-	0.00%	0.00%
d. Subject to reverse repurchase agreements	-	-	-	-	-	0.00%	0.00%
e. Subject to dollar repurchase agreements	-	-	-	-	-	0.00%	0.00%
f. Subject to dollar reverse repurchase agreements	-	-	-	-	-	0.00%	0.00%
g. Placed under option contracts	-	-	-	-	-	0.00%	0.00%
h. Letter stock or securities restricted as to sale-excluding FHLB capital stock	-	-	-	-	-	0.00%	0.00%
i. FHLB capital stock	-	-	-	-	-	0.00%	0.00%
j. On deposit with states	300,000	300,000	-	-	300,000	0.58%	0.00%
k. On deposit with other regulatory bodies	9,409,284	9,409,284	-	-	9,409,284	1.05%	0.00%
l. Pledged as collateral to FHLB (including assets backing funding agreements)	-	-	-	-	-	0.00%	0.00%
m. Pledged as collateral not captured in other categories	-	-	-	-	-	0.00%	0.00%
n. Other restricted assets	-	-	-	-	-	0.00%	0.00%
o. Total Restricted Assets	\$ 9,709,284	\$ 9,709,284	\$ -	\$ -	\$ 9,709,284	1.63%	0.00%

(a) Column 1 divided by Asset Page, Column 1, Line 28

(b) Column 5 divided by Asset Page, Column 3, Line 28

(2) Details of Assets Pledged as Collateral Not Captured in Other Categories

Not applicable.

(3) Detail of Other Restricted Assets (Contracts that Share Similar Characteristics, Such as Reinsurance and Derivatives, Are Reported in the Aggregate.

Not applicable.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Legal Entity Name
NOTES TO FINANCIAL STATEMENTS

(4) Collateral Received and Reflected as Assets Within the Reporting Entity's Financial Statements.

Not applicable.

I. Working Capital Finance Investments

The Company did not have any working capital finance investments at December 31, 2016 and 2015.

J. Offsetting and Netting of Assets and Liabilities

The Company did not have any offsetting or netting of assets and liabilities at December 31, 2016 and 2015.

K. Structured Notes

The Company did not have any structured notes at December 31, 2016 and 2015.

L. 5* Securities

The Company has no 5* Securities as of December 31, 2016 and 2015.

6. Joint Ventures, Partnerships and Limited Liability Companies

A. The Company has no investments in joint ventures, partnerships or limited liability companies that exceeded 10% of its admitted assets at December 31, 2016 or 2015.

B. The Company did not recognize any impairment write downs for its investments in joint ventures, partnerships, or limited liability companies during 2016 or 2015.

7. Investment Income

A. All investment income due and accrued with amounts that are over 90 days past due is non-admitted.

B. At December 31, 2016 and 2015 there was no nonadmitted accrued investment interest income.

8. Derivative Instruments

The Company has no derivative instruments.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
NOTES TO FINANCIAL STATEMENTS

9. Income Taxes

A. The components of net deferred tax assets (liabilities):

(1) The components of net deferred tax asset (liabilities) at December 31 are as follows:

	12/31/2016		
	(1)	(2)	(3)
	Ordinary	Capital	(Col 1+2) Total
(a) Gross deferred tax assets	\$ 2,667,592	\$ -	\$ 2,667,592
(b) Statutory valuation allowance adjustments	-	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	2,667,592	-	2,667,592
(d) Deferred tax assets nonadmitted	73,531	-	73,531
(e) Subtotal net admitted deferred tax asset (1c - 1d)	2,594,061	-	2,594,061
(f) Deferred tax liabilities	550,143	-	550,143
(g) Net admitted deferred tax asset/(net deferred tax liability)	\$ 2,043,918	\$ -	\$ 2,043,918

	12/31/2015		
	(4)	(5)	(6)
	Ordinary	Capital	(Col 4+5) Total
(a) Gross deferred tax assets	\$ 3,263,929	\$ -	\$ 3,263,929
(b) Statutory valuation allowance adjustments	2,969,929	-	2,969,929
(c) Adjusted gross deferred tax assets (1a - 1b)	294,000	-	294,000
(d) Deferred tax assets nonadmitted	-	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	294,000	-	294,000
(f) Deferred tax liabilities	294,000	-	294,000
(g) Net admitted deferred tax asset/(net deferred tax liability)	\$ -	\$ -	\$ -

	Change		
	(7)	(8)	(9)
	(Col 1-4) Ordinary	(Col 2-5) Capital	(Col 7+8) Total
(a) Gross deferred tax assets	\$ (596,337)	\$ -	\$ (596,337)
(b) Statutory valuation allowance adjustments	(2,969,929)	-	(2,969,929)
(c) Adjusted gross deferred tax assets (1a - 1b)	2,373,592	-	2,373,592
(d) Deferred tax assets nonadmitted	73,531	-	73,531
(e) Subtotal net admitted deferred tax asset (1c - 1d)	2,300,061	-	2,300,061
(f) Deferred tax liabilities	256,143	-	256,143
(g) Net admitted deferred tax asset/(net deferred tax liability)	\$ 2,043,918	\$ -	\$ 2,043,918

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
NOTES TO FINANCIAL STATEMENTS

(2) The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101, *Income Taxes - A Replacement of SSAP No. 10R and SSAP 10* ("SSAP No. 101") as of December 31 is as follows:

12/31/2016			
(1)	(2)	(3)	
Ordinary	Capital	(Col 1+2)	Total
Admission Calculation Components SSAP No. 101			
(a) Federal income taxes paid in prior years recoverable through	\$ 770,631	\$ -	\$ 770,631
(b) Adjusted gross deferred tax assets expected to be realized	1,273,287	-	1,273,287
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	1,273,287	-	1,273,287
Adjusted gross deferred tax assets allowed per limitation			
2. threshold	XXX	XXX	4,330,624
(c) Adjusted gross deferred tax assets (excluding the amount of	550,143	-	550,143
(d) Deferred tax assets admitted as the result of application of	\$ 2,594,061	\$ -	\$ 2,594,061

12/31/2015			
(4)	(5)	(6)	
Ordinary	Capital	(Col 4+5)	Total
Admission Calculation Components SSAP No. 101			
(a) Federal income taxes paid in prior years recoverable through	\$ -	\$ -	\$ -
(b) Adjusted gross deferred tax assets expected to be realized	-	-	-
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	-	-	-
Adjusted gross deferred tax assets allowed per limitation			
2. threshold	XXX	XXX	2,754,206
(c) Adjusted gross deferred tax assets (excluding the amount of	294,000	-	294,000
(d) Deferred tax assets admitted as the result of application of	\$ 294,000	\$ -	\$ 294,000

Change			
(7)	(8)	(9)	
(Col 1-4)	(Col 2-5)	(Col 7+8)	Total
Admission Calculation Components SSAP No. 101			
(a) Federal income taxes paid in prior years recoverable through	\$ 770,631	\$ -	\$ 770,631
(b) Adjusted gross deferred tax assets expected to be realized	1,273,287	-	1,273,287
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	1,273,287	-	1,273,287
Adjusted gross deferred tax assets allowed per limitation			
2. threshold	XXX	XXX	1,576,418
(c) Adjusted gross deferred tax assets (excluding the amount of	256,143	-	256,143
(d) Deferred tax assets admitted as the result of application of	\$ 2,300,061	\$ -	\$ 2,300,061

(3)	2016	2015
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)2 above	\$ 28,870,830	\$ 15,213,932

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
NOTES TO FINANCIAL STATEMENTS

(4)	12/31/2016		12/31/2015		Change	
	(1)	(2)	(3)	(4)	(5)	(6)
	Ordinary	Capital	Ordinary	Capital	(Col 1-3) Ordinary	(Col 2-4) Capital
(a) Determination of adjusted gross deferred tax assets and net admitted deferred tax assets by tax character as a percentage						
1 Adjusted gross DTAs amount from Note 9A1(c)	\$ 2,667,592	\$ -	\$ 294,000	\$ -	\$ 2,373,592	\$ -
2 Percentage of adjusted gross DTAs by tax character attributable to the impact of tax	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
3 Net admitted adjusted gross DTAs amount from Note 9A1(e)	\$ 2,594,061	\$ -	\$ 294,000	\$ -	\$ 2,300,061	\$ -
4 Percentage of net admitted adjusted gross DTAs by tax character admitted because of the impact of tax planning strategies	20.77%	0.00%	0.00%	0.00%	20.77%	0.00%
(b) Does the Company's tax-planning strategies include the use of reinsurance?	Yes _____		No <u>X</u>			

B. The Company has no unrecognized deferred tax liabilities at December 31, 2016 and 2015.

C. Current income taxes incurred consist of the following major components:

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
NOTES TO FINANCIAL STATEMENTS

	(1)	(2)	(3)
	12/31/2016	12/31/2015	(Col 1-2) Change
(1) Current Income Tax			
(a) Federal	\$ 9,355,964	\$ (770,105)	\$ 10,126,069
(b) Foreign	-	-	-
(c) Subtotal	9,355,964	(770,105)	10,126,069
(d) Federal income tax expense on net capital gains	-	-	-
(e) Utilization of capital loss carry-forwards	(450,247)	(64,370)	(385,877)
(f) Other	-	-	-
(g) Federal and foreign income taxes incurred	\$ 8,905,717	\$ (834,475)	\$ 9,740,192
(2) Deferred Tax Assets:			
(a) Ordinary			
(1) Discounting of unpaid losses	\$ 96,974	\$ 101,270	\$ (4,296)
(2) Unearned premium reserve	-	-	-
(3) Policyholder reserves	455,000	-	455,000
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	-	-	-
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables - nonadmitted	75,131	235,976	(160,845)
(11) Net operating loss carryforward	1,205,250	1,923,152	(717,902)
(12) Tax credit carry-forward	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	-	-	-
(14) Accrued future expenses	-	34,999	(34,999)
(15) Amortization	827,785	895,822	(68,037)
(16) Partnership income	-	-	-
(17) Premium deficiency reserves	-	-	-
(18) Prepaid expenses	7,452	11,179	(3,727)
(99) Subtotal	2,667,592	3,202,398	(534,806)
(b) Statutory valuation allowance adjustment	-	2,908,398	(2,908,398)
(c) Nonadmitted	73,531	-	73,531
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	\$ 2,594,061	\$ 294,000	\$ 2,300,061
(e) Capital:			
(1) Investments	\$ -	\$ -	\$ -
(2) Net capital loss carry forward	-	-	-
(3) Real estate	-	-	-
(4) Other (including items <5% of total capital tax assets)	-	-	-
(5) Investment Partnership	-	-	-
(99) Subtotal	-	-	-
(f) Statutory valuation allowance adjustment	-	-	-
(g) Nonadmitted	-	-	-
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	-	-	-
(i) Admitted deferred tax assets (2d + 2h)	\$ 2,594,061	\$ 294,000	\$ 2,300,061
(3) Deferred Tax Liabilities:			
(a) Ordinary:			
(1) Investments	\$ -	\$ -	\$ -
(2) Fixed assets	-	-	-
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities)	-	-	-
(6) Amortization	-	-	-
(7) Discount of coordination of benefits	-	-	-
(8) Write-ins	550,143	294,000	256,143
(9) Write-ins	-	-	-
(99) Subtotal	550,143	294,000	256,143
(b) Capital:			
(1) Investments	-	-	-
(2) Real estate	-	-	-
(3) Other (including items <5% of total capital tax liabilities)	-	-	-
(99) Subtotal	-	-	-
(c) Deferred tax liabilities (3a99 + 3b99)	550,143	294,000	256,143
(4) Net deferred tax assets/liabilities (2i - 3C)	\$ 2,043,918	\$ (0)	\$ 2,043,919

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
NOTES TO FINANCIAL STATEMENTS

- D. The Company's income tax expense and change in deferred income taxes differs from the amount obtained by applying the federal statutory income tax rate of 35% for the year ended December 31 as follows:

	2016	2015
Tax expense computed using federal statutory rate	\$ 7,732,343	\$ (359,150)
ACA health insurer fee	1,851,061	896,872
Change in nonadmitted assets	164,572	(247,155)
Prior year true-ups and adjustments	1,749	(183,469)
Valuation allowance	(2,969,929)	(871,262)
Other	8,472	(70,311)
Total	<u>\$ 6,788,268</u>	<u>\$ (834,475)</u>
Federal income taxes incurred	\$ 8,905,717	\$ (834,475)
Change in net deferred income taxes	<u>(2,117,449)</u>	<u>-</u>
Total statutory income taxes	<u>\$ 6,788,268</u>	<u>\$ (834,475)</u>

E. Operating loss carryforwards:

- (1) At December 31, 2016, the Company had the following unused net operating loss or tax credit carryforwards available to offset future taxable income. The losses or credits will begin to expire as noted.

Unused NOL Carryforwards	Will Begin to Expire	Unused Tax Credit Carryforwards	Will Begin to Expire
\$ 3,443,572	2033	-	-

- (2) The following are income taxes incurred in the current and prior year(s) that will be available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2016	\$ 8,677,572	\$ -	\$ 8,677,572
2015	-	-	-
2014	N/A	-	-

- (3) The Company has no protective tax deposits reported as admitted assets under Section 6603 of the Internal Revenue Service Code as of December 31, 2016 and 2015.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
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- F. The following companies will be included in the consolidated federal income tax return with their parent Anthem, Inc. as of December 31, 2016 and either are current members of the consolidated tax sharing agreement or are in the process of being added to the consolidated tax sharing agreement. Allocation of federal income taxes with affiliates subject to the tax sharing agreement is based upon separate income tax return calculations with credit for net losses that can be used on a consolidated basis. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
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American Imaging Management, Inc.	DeCare Dental Health International, LLC
AMERIGROUP Community Care of New Mexico, Inc.	DeCare Dental Networks, LLC
AMERIGROUP Corporation	DeCare Dental, LLC
AMERIGROUP District of Columbia, Inc.	Designated Agent Company, Inc.
AMERIGROUP Florida, Inc.	EHC Benefits Agency, Inc.
Amerigroup Insurance Company	Empire HealthChoice Assurance, Inc.
AMERIGROUP Iowa, Inc.	Empire HealthChoice HMO, Inc.
Amerigroup Kansas, Inc.	Federal Government Solutions, LLC (fka
AMERIGROUP Maryland, Inc.	Government Health Services, LLC)
AMERIGROUP Mississippi, Inc.	Forty-Four Forty-Four Forest Park Redevelopment Corp
AMERIGROUP Nevada, Inc.	Golden West Health Plan, Inc.
AMERIGROUP New Jersey, Inc.	Greater Georgia Life Insurance Company
AMERIGROUP Ohio, Inc.	Health Core, Inc.
AMERIGROUP Oklahoma, Inc.	Health Management Corporation
Amerigroup Services, Inc.	HealthKeepers, Inc.
AMERIGROUP Tennessee, Inc.	HealthLink HMO, Inc.
AMERIGROUP Texas, Inc.	HealthLink, Inc.
AMERIGROUP Washington, Inc.	HealthPlus HP, LLC
AMGP Georgia Managed Care Company, Inc.	Healthy Alliance Life Insurance Company
Anthem Blue Cross Life and Health Insurance Company	HMO Colorado, Inc.
Anthem Financial, Inc.	HMO Missouri, Inc.
Anthem Health Insurance Company of Nevada	Imaging Management Holdings, LLC
Anthem Health Plans of Kentucky, Inc.	Imaging Providers of Texas
Anthem Health Plans of Maine, Inc.	Living Complete Technologies, Inc. (fka
Anthem Health Plans of New Hampshire, Inc.	Tidgewell Associates, Inc.)
Anthem Health Plans of Virginia, Inc.	Matthew Thornton Health Plan, Inc.
Anthem Health Plans, Inc.	National Government Services, Inc.
Anthem Holding Corp.	Park Square Holdings, Inc.
Anthem Insurance Companies, Inc.	Park Square I, Inc.
Anthem Kentucky Managed Care Plan, Inc.	Park Square II, Inc.
Anthem Life & Disability Insurance Company	PHP Holdings, Inc.
Anthem Southeast, Inc.	R&P Realty, Inc.
Anthem UM Services, Inc.	Resolution Health, Inc.
Anthem, Inc.	RightCHOICE Managed Care, Inc.
Arcus Enterprises, Inc.	Rocky Mountain Hospital and Medical Service, Inc.
ARCUS HealthyLiving Services, Inc.	SellCore, Inc.
Associated Group, Inc.	Simply Healthcare Holdings, Inc.
Better Health, Inc.	Simply Healthcare Plans, Inc.
Blue Cross and Blue Shield of Georgia, Inc.	Southeast Services, Inc.
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	State Sponsored Business UM Services, Inc.
Blue Cross Blue Shield of Wisconsin	The Anthem Companies of California, Inc.
Blue Cross of California	The Anthem Companies, Inc.
Blue Cross of California Partnership Plan, Inc.	TrustSolutions, LLC
CareMore Health Group, Inc.	UNICARE Health Plan of West Virginia, Inc.
CareMore Health Plan	UNICARE Health Plans of Texas, Inc.
CareMore Health Plan of Arizona, Inc.	UNICARE Illinois Services, Inc.
CareMore Health Plan of Georgia, Inc.	UNICARE Life & Health Insurance Company
CareMore Health Plan of Nevada	UNICARE National Services, Inc.
CareMore Health Plan of Texas, Inc.	UNICARE Specialty Services, Inc.
CareMore Health System	UtiliMed IPA, Inc.
CareMore Holdings, Inc.	WellPoint Behavioral Health, Inc.
Cerulean Companies, Inc.	WellPoint California Services, Inc.
Claim Management Services, Inc.	WellPoint Dental Services, Inc.
Community Care Health Plan of Louisiana, Inc. (fka	WellPoint Health Solutions, Inc.
AMERIGROUP Louisiana, Inc.)	WellPoint Holding Corporation
Community Insurance Company	WellPoint Information Technology Services, Inc.
Compcare Health Services Insurance Corporation	WellPoint Insurance Services, Inc.
Crossroads Acquisition Corp	WellPoint Military Care Corporation
DeCare Analytics, LLC	

G. Not applicable.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
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10. Information Concerning Parent, Subsidiaries, Affiliates and Other Related Parties

A. Nature of the Relationship

The Company is a Florida domiciled stock insurance company and is a wholly-owned subsidiary of Simply Healthcare Holdings, Inc., which is an indirect wholly-owned subsidiary of Anthem, Inc. (“Anthem”), a publicly traded company.

During 2015, Simply Healthcare Holdings, Inc. (parent company of Better Health, Inc.) (the “Parent”) entered into a merger agreement with Anthem, Inc. As a result of this merger, Anthem, Inc. acquired 100% of the stock of the Parent. During 2015 and prior to the merger, Parent acquired the 51% interest of Barbara R. Cowley, MD in Better Health, Inc. and as a result Parent wholly-owned Better Health, Inc. prior to the merger with Anthem, Inc. Based on receipt of all federal and state regulatory approvals, the acquisition was finalized and closed on February 17, 2015.

On July 24, 2015, the Company’s ultimate parent company, Anthem, and Cigna Corporation (“Cigna”) entered into an Agreement and Plan of Merger dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and a direct wholly-owned subsidiary of Anthem, pursuant to which Anthem will acquire all outstanding shares of Cigna, or the Acquisition. On July 21, 2016, the U.S. Department of Justice, or DOJ, along with certain state attorneys general, filed a civil antitrust lawsuit in the U.S. District Court for the District of Columbia seeking to block the Acquisition. On January 18, 2017, Anthem provided notice to Cigna that Anthem had elected to extend the termination date under the Merger Agreement from January 31, 2017 until April 30, 2017. On January 18, 2017, Anthem provided notice to Cigna that Anthem had elected to extend the termination date under the Merger Agreement from January 31, 2017 until April 30, 2017. Following the conclusion of the trial, the Court ruled in favor of the DOJ, on February 8, 2017, and Anthem promptly filed notice that Anthem would appeal the Court’s ruling. On February 14, 2017, Cigna purported to terminate the Merger Agreement and commenced litigation against Anthem in the Delaware Court of Chancery, or Delaware Court, seeking damages and a declaratory judgment that its purported termination of the Merger Agreement was lawful, among other claims. Anthem believes Cigna’s allegations are without merit. Also on February 14, 2017, Anthem initiated its own litigation against Cigna in the Delaware Court seeking a temporary restraining order to enjoin Cigna from terminating the Merger Agreement, specific performance compelling Cigna to comply with the Merger Agreement and damages. On February 15, 2017, the Delaware Court granted Anthem’s motion for a temporary restraining order and issued an order enjoining Cigna from terminating the Merger Agreement. The temporary restraining order became effective immediately and will remain in place pending any further order from the Delaware Court. Anthem intends to vigorously defend the Acquisition in both the Circuit Court and the Delaware Court and remains committed to completing the Acquisition as soon as practicable.

B. Significant Transactions for Each Period

The Company received no capital contributions from its parent for the year ended December 31, 2016 and December 31, 2015. The Company paid no dividends to its Parent in 2016 and 2015.

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C. Intercompany Management and Service Arrangements

There were no changes to the intercompany management and service arrangements, and there were no additional arrangements entered into during 2015. Effective January 1, 2016, the Company entered into the Anthem, Inc. Master Services agreement. The amounts of transactions under such agreements are presented in Schedule Y, Part 2.

D. Amounts Due to or from Related Parties

At December 31, 2016 and 2015, the Company reported \$909,401 and \$55,827 due to affiliates, and \$5,364 and \$131,531 due from affiliates, respectively. The payable and receivable balances represent intercompany transactions that will be settled in accordance with the settlement terms of the intercompany agreement.

E. Guarantees or Contingencies for Related Parties

The Company did not enter into guarantees or undertakings for the benefit of an affiliate which would result in a material contingent exposure of the Company's or any affiliated insurer's assets or liabilities.

F. Management and Service Contracts and Cost Sharing Arrangements

The Company has entered into administrative services agreements with its affiliated companies. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The costs and expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Costs include expenses such as salaries, employee benefits, communications, advertising, consulting services, rent, utilities, billing, accounting, underwriting, and product development, which support the Company's operations. These costs are allocated based on various utilization statistics.

The Company is party to a cash concentration agreement with its affiliated companies. Under this agreement, any of the Company's affiliates may be designated as a cash manager to handle the collection and/or payment of funds on behalf of the Company. Conversely, the Company may be designated as a cash manager to handle the collection and/or payment of funds on behalf of its affiliates. Cash services covered under this agreement include the collection of premiums and other revenue, the collection of benefit and administrative expense reimbursements, the payment of policy benefits, payroll expense, general and administrative expense, and accounts payable disbursements.

G. Nature of Control Relationships that Could Affect Operations or Financial Position

The Company's ultimate parent is Anthem, Inc.

H. Amount Deducted for Investment in Upstream Company

The Company does not own shares of upstream intermediate entities or Anthem.

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I. Detail of Investments in Affiliates Greater than 10% of Admitted Assets

The Company does not have investments in affiliates greater than 10% of admitted assets.

J. Write-down for Impairments of Investments in Subsidiaries, Controlled or Affiliated ("SCA") Companies

The Company did not write-down any investments in subsidiaries, controlled or affiliated SCA companies as of December 31, 2016 and 2015.

K. Investment in a Foreign Insurance Subsidiary

The Company does not have investments in foreign insurance subsidiaries.

L. Investment in Downstream Non-insurance Holding Companies

The Company does not have investments in downstream non-insurance holding companies.

M. All SCA Investments

The Company has no SCA Investments.

N. Investment in Insurance SCAs

The Company does not have investments in Insurance SCAs.

11. Debt

A. Capital Notes

The Company had no capital notes outstanding at December 31, 2016 and 2015.

B. All Other Debt

The Company had no other debt outstanding at December 31, 2016 and 2015.

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefit Plans

A. Defined Benefit Plan

Not applicable - See Note 12G.

B. Not applicable - See Note 12G.

C. Not applicable - See Note 12G.

D. Not applicable - See Note 12G.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
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E. Defined Contribution Plans

Not applicable - See Note 12G.

F. Multiemployer Plans

The Company does not participate in a multiemployer plan.

G. Consolidated/Holding Company Plans

The Company participates in the Anthem 401(k) Retirement Savings Plan, a defined contribution plan, sponsored by ATH Holding and covering substantially all employees. Voluntary employee contributions are matched by ATH Holding subject to certain limitations. ATH Holding allocates a share of the total accumulated costs of this plan to the Company based on the number of allocated employees. The Company has no legal obligation for benefits under this plan.

During 2016 and 2015, the Company was allocated the following costs or (credits) for these retirement benefits:

	2016	2015
Defined contribution plan	\$ 372,937	\$ -

During 2015, the Company participated in a defined contribution plan created prior to the February 17, 2015 acquisition of Better Healthcare by Anthem. No Company-matched amounts were contributed to the plan. Beginning on January 1, 2016, that defined contribution plan merged into the Anthem 401(k) Retirement Savings Plan, a defined contribution plan sponsored by ATH Holding Company, LLC ("ATH Holding") and covering substantially all employees. Voluntary employee contributions are matched by ATH Holding subject to certain limitations. ATH Holding allocates a share of the total accumulated costs of this plan to the Company based on the number of allocated employees. The Company has no legal obligation for benefits under this plan.

H. Post Employment Benefits and Compensated Absences

Not applicable.

I. Impact of Medicare Modernization Act on Postretirement Benefits (INT 04-17)

Not applicable.

13. Capital and Surplus, Shareholders' Dividend Restrictions and Quasi-Reorganizations

(1) Outstanding Shares

As of December 31, 2016, the Company has 1,000 shares of \$.01 par value common stock authorized, issued and outstanding.

(2) Preferred Stock

The Company has no preferred stock outstanding.

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(3) Dividend Restrictions

Per the Florida Statute 641.365, there are certain limitations exist on the Company's ability to pay dividends to its parent. The Company may pay funds only from accumulated surplus funds that were derived from realized net operating profits on its business and net realized capital gains. Prior written approval by the Florida DFS is required for payment of any dividend which would result in these accumulated surplus funds being less than zero. Florida DFS approval is not required if the dividend to be paid is less than the greater of 1) ten percent of the Company's accumulated surplus or 2) the Company's entire net operating profit, including realized capital gains, for the immediately preceding calendar year.

(4) Dividends Paid

No ordinary dividends were paid by the Company as of December 31, 2016.

(5) Maximum Ordinary Dividend During 2017

Within the limitations of (3) above, the Company may pay \$0 in dividends during 2017 without prior approval.

(6) Unassigned Surplus Restrictions

Unassigned surplus funds are not restricted at December 31, 2016.

(7) Mutual Surplus Advances

Not applicable.

(8) Company Stock Held for Special Purpose

There are no shares of stock held for special purposes at December 31, 2016.

(9) Changes in Special Surplus Funds

The change in balances of special surplus funds from the prior year is due to changes in the amounts segregated for the estimated Affordable Care Act ("ACA") health insurer fee. The annual fee under section 9010 of the ACA has been suspended for 2017; therefore no surplus has been segregated as of December 31, 2016.

(10) Changes in Unassigned Funds

There was no portion of unassigned funds represented by cumulative unrealized gains and losses at December 31, 2016.

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11) Surplus Notes

The Company has surplus note principal outstanding at December 31, 2016 and 2015 in the amount of \$10,500,000 and \$10,500,000, respectively. A summary is as follows:

Date Issued	Interest Rate	Par Value	Carrying Value of Note	Interest Paid Current Year	Total Interest Paid	Unapproved Interest Expense	Accrued Interest	Date of Maturity
12/20/2012	8%	\$ 2,500,000	\$ 2,500,000	\$ -	\$ -	\$ 806,575	\$ -	-
12/31/2012	8%	2,500,000	2,500,000	-	-	800,548	-	-
12/25/2013	8%	5,500,000	5,500,000	-	-	1,693,699	-	-
Total		\$10,500,000	\$10,500,000	\$ -	\$ -	\$3,300,822	\$ -	

As of December 3, 2016, the Company had entered into promissory surplus notes to related parties totaling \$10,500,000. The notes bear interest at the rate of 8% per annum, however, in accordance with statutory accounting principles set forth in SSAP No. 41 interest shall not be recorded as a liability or an expense until such interest has been approved by the Florida OIR.

Any payment of interest and repayment of surplus note principal may be paid only out of the Company's earnings, subject to approval by the Florida OIR. Interest expense on surplus notes not yet approved by the Florida OIR and thus not recorded was \$3,300,822 and \$2,248,520 at both December 31, 2016 and 2015. Surplus note interest expense is reported within net investment income in the Company's statements of income.

(12) Restatement due to Prior Quasi-reorganizations

The Company had no restatements due to prior quasi-reorganizations.

(13) Quasi-reorganizations over Prior 10 Years

The Company has not been involved in a quasi-reorganization during the past 10 years.

14. Liabilities, Contingencies and Assessments

A. Contingent Commitments

The Company had no contingent commitments at December 31, 2016.

B. Assessments

(1) The Company is subject to guaranty fund and other assessments by the state(s) in which it writes business. Guaranty fund assessments are accrued at the time of insolvencies. Other assessments are accrued either at the time of the assessment or at the time the losses are incurred.

The State of Florida has not issued a guaranty fund assessment, and the Company has not recorded a liability for an assessment as of December 31, 2016 or 2015.

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(2) Not applicable.

C. Gain Contingencies

The Company has no gain contingencies at December 31, 2016.

D. Claims-Related Extra Contractual Obligation and the Bad Faith Losses Stemming From Lawsuits

Not applicable.

E. Joint and Several Liabilities

Not applicable.

F. All Other Contingencies

In February 2015, Anthem reported that it was the target of a sophisticated external cyber-attack. The attackers gained unauthorized access to certain of Anthem's information technology systems and obtained personal information related to many individuals and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that Anthem will not identify additional information that was accessed or obtained.

Anthem has continued to implement security enhancements since this incident and is supporting federal law enforcement efforts to identify the responsible parties. Upon discovery of the cyber-attack, Anthem took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate its systems and identify solutions based on the evolving landscape. Anthem is providing credit monitoring and identity protection services to those who have been affected by this cyber-attack. Anthem has incurred expenses subsequent to the cyber-attack to investigate and remediate this matter and expects to continue to incur expenses of this nature in the foreseeable future. Anthem will recognize these expenses in the periods in which they are incurred.

Actions have been filed in various federal and state courts, and other claims have been or may be asserted against Anthem on behalf of current or former members, current or former employees, other individuals, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber-attack. State and federal agencies, including state insurance regulators, state attorneys general, the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigation, are investigating events related to the cyber-attack, including how it occurred, its consequences and Anthem's responses. Although Anthem is cooperating in these investigations, Anthem may be subject to fines or other obligations, which may have an adverse effect on how Anthem operates its business and results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation in February 2015 and was subsequently heard by the Panel in May 2015. In June 2015, the Panel entered its order transferring the consolidated matter to the U.S. District Court for the

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
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Northern District of California. The U.S. District Court entered its Case Management Order in September 2015. Anthem has filed a Motion to Dismiss several of the counts that are before the U.S. District Court. There remain a few state court cases that are presently proceeding outside of the Multidistrict Litigation.

Anthem has contingency plans and insurance coverage for certain expenses and potential liabilities of this nature. The coverage has been sufficient to cover the majority of claims and liabilities incurred to date. While a loss from these matters is reasonably possible, Anthem cannot reasonably estimate a range of possible losses because the investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

The Company is involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental and administrative proceedings. These investigations, audits and reviews include routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and Federal Agencies. Such investigations could result in the imposition of civil or criminal fines, penalties and other sanctions. The Company believes that any liability that may result from any one of these actions is unlikely to have a material adverse effect on the Company's financial position or results of operations.

At December 31, 2016 and 2015, the Company reported admitted assets of \$3,167,576 and \$4,017,140, respectively, in premium receivables due from policyholders and agents and receivables due from uninsured plans. Based upon Company experience, any uncollectible receivables are not expected to exceed \$0 that was nonadmitted at December 31, 2016; therefore, no additional provision for uncollectible amounts has been recorded. The potential for any additional loss is not believed to be material to the Company's financial condition.

15. Leases

A. Lessee Operating Lease

The Company has no lessee leasing arrangements.

B. Lessor Leases

(1) The Company has not entered into any operating leases.

(2) The Company has not entered into any leveraged leases.

16. Information About Financial Instruments With Off-Balance Sheet Risk and Financial Instruments With Concentrations of Credit Risk

The Company has no significant financial instruments with off-balance sheet risk.

Financial instruments that potentially subject the Company to concentrations of credit risk consist primarily of investment securities. All investment securities are managed by

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
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professional investment managers within policies authorized by the board of directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. As of December 31, 2016, there were no significant concentrations.

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. Transfers of Receivables Reported as Sales

Not applicable at December 31, 2016 and 2015.

B. Transfer and Servicing of Financial Assets

Not applicable at December 31, 2016 and 2015.

C. Wash Sales

(1) In the course of the Company's asset management, securities may be sold and reacquired within 30 days of the sale date to enhance the yield on the investments.

(2) At December 31, 2016 and 2015, there were no wash sales involving securities with an NAIC designation of 3 or below or unrated.

18. Gain or Loss to the Reporting Entity from Uninsured Plans and the Uninsured Portion of Partially Insured Plans

A. Administrative Services Only ("ASO") Plans

The gain from operations from ASO uninsured plans and the uninsured portion of partially insured plans during 2016 were:

	ASO Uninsured Plans	Uninsured Portion of Partially Insured Plans	Total ASO
a. Net reimbursement for administrative expenses (including administrative fees) in excess of actual expenses	\$ (6,546)	\$ -	\$ (6,546)
b. Total net other income or expenses (including interest paid to or received from plans)			
c. Net gain or (loss) from operations	\$ (6,546)	\$ -	\$ (6,546)
d. Total claim payment volume	\$ 201,403	\$ -	\$ 201,403

B. Administrative Services Contract ("ASC") Plans

Not applicable at December 31, 2016 and 2015.

C. Medicare or Other Similarly Structured Cost-Based Reimbursement Contract

Not applicable at December 31, 2016 and 2015.

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19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

No premiums were written by managing general agents or third party administrators during the years ended December 31, 2016 and 2015.

20. Fair Value Measurements

A.

(1) Fair Value Measurements at Reporting Date

There are no assets or liabilities measures at fair value as of December 31, 2016 and 2015.

(2) Fair Value Measurements in (Level 3) of the Fair Value Hierarchy

There are no investments in Level 3 as of December 31, 2016 and 2015.

(3) The Company's policy is to recognize transfers between Levels, if any, as of the beginning of the reporting period.

(4) Fair values of fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level 1 or Level 2 inputs, for the determination of fair value to facilitate fair value measurements and disclosures. United States government securities represent Level 1 securities, while Level 2 securities primarily include corporate securities, securities from states, municipalities and political subdivisions and residential mortgage-backed securities. For Securities not actively traded, the third party pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds.

Fair values of equity securities are generally designated as Level 1 and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level 2. The Company has certain equity securities, including private equity securities, for which the fair value is estimated based on each security's current condition and the future cash flow projections. Such securities are designated Level 3. The fair values of these private equity securities are generally based on either broker quotes or discounted cash flow projections using assumptions for inputs such as the weighted-average cost of capital, long-term revenue growth rates and earnings before interest, taxes, depreciation and amortization, or revenue multiples that are not observable in the markets.

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Certain financial assets are measured at fair value using Level 3 inputs, such as certain non-investment grade bonds and loan-backed securities or investments that are impaired during the year and recorded at fair value.

There have been no significant changes in the valuation techniques during the current period.

B. Fair Value Measurements Under Other Accounting Pronouncements

Not applicable at December 31, 2016 and 2015.

C. Financial Instruments

Type of Financial Instrument	Aggregate Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practicable (Carrying Value)
Bonds	\$ —	\$ —	\$ —	\$ —	\$ —	\$ —
Perpetual preferred stock	—	—	—	—	—	—
Common stock	—	—	—	—	—	—
Derivative assets - futures	—	—	—	—	—	—
Derivative assets - swaps	—	—	—	—	—	—
Derivative liabilities - futures	—	—	—	—	—	—
Derivative liabilities - swaps	—	—	—	—	—	—
Short-term investments	—	—	—	—	—	—
Securities lending collateral asset	—	—	—	—	—	—
Low income housing tax credit investments	—	—	—	—	—	—

D. Not Practicable to Estimate Fair Value

There are no financial instruments that were not practicable to estimate fair value.

21. Other Items

A. Unusual or Infrequent Items

The State of Florida, Agency for Health Care Administration (“AHCA”), informed the Company on June 7, 2016 of a pricing error related to the State Fiscal Year 2015-2016 contract. AHCA indicated it underpaid the Company due to a mismatch of rates. Related to this, the Company received and recognized cash and premiums of \$3,685,868 from AHCA during 2016 related to 2015. Not applicable at December 31, 2015.

B. Troubled Debt Restructuring; Debtors

Not applicable at December 31, 2016 and 2015.

C. Other Disclosures

Not applicable at December 31, 2016 and 2015.

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D. Business Interruption Insurance Recoveries

The Company has reported no recoveries for business interruption for the years ended December 31, 2016 and 2015.

E. State Transferable and Non-Transferable Tax Credits

The Company did not have state transferable tax credits at December 31, 2016 and 2015.

F. Subprime Mortgage-Related Risk Exposure

(1) The Company's investment strategy of providing safety and preservation of capital, sufficient liquidity to meet cash flow requirements and the attainment of a competitive after-tax investment return is supported by a well diversified portfolio consisting of many different types of investments. The portion of the Company's investment portfolio with subprime mortgage-related risk exposure is relatively small in comparison to the overall investment portfolio, and consists mainly of investment grade securities with no exposure to collateralized debt obligations. All mortgage related investments are monitored closely as part of the quarterly investment review performed by the Anthem Investment Impairment Review Committee.

(2) The Company did not carry investments in subprime mortgage loans in its portfolio at December 31, 2016 or 2015.

(3) The Company did not have subprime mortgage-related risk exposure at December 31, 2016 or 2015.

(4) The Company did not underwrite Mortgage Guaranty or Financial Guaranty insurance coverage at December 31, 2016 or 2015.

G. Retained Assets

The Company does not have retained assets at December 31, 2016 and 2015.

22. Events Subsequent

ACA entities with assessable premium:

The Company is subject to an annual fee under section 9010 of the ACA. A health insurance company's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. The annual fee under section 9010 of the ACA has been suspended for 2017 and will resume for 2018 and beyond.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
NOTES TO FINANCIAL STATEMENTS

	Current Year	Prior Year
A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the Federal Affordable Care Act (YES/NO)?	YES	
B. ACA fee assessment payable for the upcoming year	\$ -	\$ 4,874,590
C. ACA fee assessment paid	\$ 4,874,590	\$ 2,562,490
D. Premium written subject to ACA 9010 assessment	\$ 319,584,798	\$ 263,262,026
E. Total Adjusted Capital before surplus adjustment (Five-Year Historical Line 14)	\$ 30,914,747	
F. Total Adjusted Capital after surplus adjustment (Five-Year Historical Line 14 minus Line 22B above)	\$ 30,914,747	
G. Authorized Control Level (Five-Year Historical Line 15)	\$ 9,941,452	
H. Would reporting the ACA assessment as of Dec. 31, 2015 have triggered an RBC action level (YES/NO)?	NO	

Subsequent events have been considered through March 31, 2017 for the statutory statement issued on March 31, 2017. There were no other events occurring subsequent to December 31, 2016 requiring recognition or disclosure.

23. Reinsurance

A. Ceded Reinsurance Report

Section 1 - General Interrogatories

- (1) Are any of the reinsurers that are listed in Schedule S as non-affiliated owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?

Yes () No (X)

If yes, give full details.

- (2) Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled, directly or indirectly, by an insured, a beneficiary, a creditor or an insured or any other person not primarily engaged in the insurance business?

Yes () No (X)

If yes, give full details.

Section 2 - Ceded Reinsurance Report - Part A

- (1) Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credits?

Yes () No (X)

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
NOTES TO FINANCIAL STATEMENTS

If yes, give full details.

- (2) Does the reporting entity have any reinsurance agreements in effect such that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same reinsurer, exceed the total direct premium collected under the reinsured policies?

Yes () No (X)

If yes, give full details.

Section 3 - Ceded Reinsurance Report - Part B

- (1) What is the estimated amount of the aggregate reduction in surplus, (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of ALL reinsurance agreements, by either party, as of the date of this statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

\$0

- (2) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes () No (X)

B. Uncollectible Reinsurance

The Company has no uncollectible reinsurance at December 31, 2016 and 2015.

C. Commutation of Ceded Reinsurance

The Company has not commuted ceded reinsurance during 2016 and 2015.

D. Certified Reinsurer Rating Downgraded or Status Subject Revocation

The Company has no downgraded certified reinsurer ratings or status subject to revocations during 2016 and 2015.

24. Retrospectively Rated Contracts & Contracts Subject to Redetermination

- A. The Company sells accident and health policies for which the premiums vary based on loss experience. The Company estimates retrospective premium adjustments through the review of each retrospectively rated account, comparing the claim development with that anticipated in the policy contracts.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
NOTES TO FINANCIAL STATEMENTS

- B. The Company records accrued retrospective premium as an adjustment to earned premium.
- C. 100% of the Company's net premiums written are subject to retrospective rating features at December 31, 2016 and 2015.
- D. Not applicable.
- E. Risk-Sharing Provisions of the Affordable Care Act ("ACA")
- (1) Did the reporting entity write accident and health insurance premium that is subject to the Affordable Care Act risk-sharing provisions (YES/NO)? No
- (2) Impact of Risk-Sharing Provisions of the Affordable Care Act on Admitted Assets, Liabilities and Revenue for the Current Year
- Not applicable.
- (3) Roll-forward of prior year ACA risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balance.
- Not applicable.
- (4) Roll-forward of Risk Corridors Asset and Liability Balances by Program Benefit Year.
- Not applicable.
- (5) ACA Risk Corridors Receivable as of Reporting Date.
- Not applicable.

25. Change in Incurred Claims and Claim Adjustment Expenses

The estimated cost of claims and claim adjustment expense attributable to insured events of prior years decreased by \$5,738,930 during 2016. This is approximately 16.5% of unpaid claims and claim adjustment expenses of \$34,877,404 as of December 31, 2015. The redundancy reflects the decreases in estimated claims and claims adjustment expenses as a result of claims payment during the year, and as additional information is received regarding claims incurred prior to 2016. Recent claim development trends are also taken into account in evaluating the overall adequacy of unpaid claims and unpaid claim adjustment expense.

26. Intercompany Pooling Arrangements

Not applicable at December 31, 2016 and 2015.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Legal Entity Name
NOTES TO FINANCIAL STATEMENTS

27. Structured Settlements

Not applicable at December 31, 2016 and 2015.

28. Health Care Receivables

A. Pharmaceutical Rebate Receivables

Not applicable at December 31, 2016 and 2015.

B. Risk Sharing Receivables

Not applicable at December 31, 2016 and 2015.

29. Participating Policies

Not applicable at December 31, 2016 and 2015.

30. Premium Deficiency Reserves

The Company had no liabilities related to premium deficiency reserves as of December 31, 2016 and 2015.

31. Anticipated Salvage and Subrogation

Not applicable at December 31, 2016 and 2015.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

GENERAL INTERROGATORIES

**PART 1 - COMMON INTERROGATORIES
GENERAL**

- 1.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? Yes [☒] No [☐]
If yes, complete Schedule Y, Parts 1, 1A and 2
- 1.2 If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent, or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations? Yes [☒] No [☐] N/A [☐]
- 1.3 State Regulating? Florida
- 2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? Yes [☐] No [☒]
- 2.2 If yes, date of change:
- 3.1 State as of what date the latest financial examination of the reporting entity was made or is being made. 12/31/2015
- 3.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released.
- 3.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date).
- 3.4 By what department or departments?
Florida Office of Insurance Regulation
- 3.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments? Yes [☐] No [☐] N/A [☒]
- 3.6 Have all of the recommendations within the latest financial examination report been complied with? Yes [☐] No [☐] N/A [☒]
- 4.1 During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity), receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.11 sales of new business? Yes [☐] No [☒]
4.12 renewals? Yes [☐] No [☒]
- 4.2 During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.21 sales of new business? Yes [☐] No [☒]
4.22 renewals? Yes [☐] No [☒]
- 5.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? Yes [☐] No [☒]
- 5.2 If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.
- | 1
Name of Entity | 2
NAIC Company Code | 3
State of Domicile |
|---------------------|------------------------|------------------------|
| | | |
- 6.1 Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? Yes [☐] No [☒]
- 6.2 If yes, give full information:
- 7.1 Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity? Yes [☐] No [☒]
- 7.2 If yes,
7.21 State the percentage of foreign control: %
7.22 State the nationality(s) of the foreign person(s) or entity(s) or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact; and identify the type of entity(s) (e.g., individual, corporation or government, manager or attorney in fact).

1 Nationality	2 Type of Entity

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

GENERAL INTERROGATORIES

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? Yes [] No [X]

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? Yes [] No [X]

8.4 If response to 8.3 is yes, please provide below the names and location (city and state of the main office) of any affiliates regulated by a federal regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC

9. What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?
Ernst & Young LLP, 111 Monument Circle Suite 2600, Indianapolis, IN 46204

10.1 Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation? Yes [] No [X]

10.2 If the response to 10.1 is yes, provide information related to this exemption:

10.3 Has the insurer been granted any exemptions related to the other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 18A of the Model Regulation, or substantially similar state law or regulation? Yes [] No [X]

10.4 If the response to 10.3 is yes, provide information related to this exemption:

10.5 Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws? Yes [X] No [] N/A []

10.6 If the response to 10.5 is no or n/a, please explain

11. What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?
Sean Chou, FSA, MAAA, Associate Actuary (employee); 21555 Oxnard St., Woodland Hills, CA 91367

12.1 Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly? Yes [] No [X]

12.11 Name of real estate holding company

12.12 Number of parcels involved

12.13 Total book/adjusted carrying value\$

12.2 If, yes provide explanation:

13. **FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:**

13.1 What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?

13.2 Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located? Yes [] No []

13.3 Have there been any changes made to any of the trust indentures during the year? Yes [] No []

13.4 If answer to (13.3) is yes, has the domiciliary or entry state approved the changes? Yes [] No [] N/A [X]

14.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? Yes [X] No []

(a) Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;

(b) Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;

(c) Compliance with applicable governmental laws, rules and regulations;

(d) The prompt internal reporting of violations to an appropriate person or persons identified in the code; and

(e) Accountability for adherence to the code.

14.11 If the response to 14.1 is No, please explain:

14.2 Has the code of ethics for senior managers been amended? Yes [X] No []

14.21 If the response to 14.2 is yes, provide information related to amendment(s).
The Anthem Standards of Ethical Business Conduct applies to all associates, management, officers and directors of Anthem. In June 2016 the code of conduct was revised for the following: a) updated Gift policy (offering) to address new Finance policy prohibiting offering gift cards, unless an approved wellness program; b) added a new section on Telephone Consumer Protection Act; c) added a new section on Non-discrimination under the Affordable Care Act (ACA) since we had a section on non-discrimination for government business. In July 2016 the code of conduct was revised for minor administrative changes regarding definitions of confidential information pertaining to associates' information as well as the certification at the end of the code.

14.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes [] No [X]

14.31 If the response to 14.3 is yes, provide the nature of any waiver(s).

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

GENERAL INTERROGATORIES

- 15.1 Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List? Yes [] No [X]
- 15.2 If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.

1 American Bankers Association (ABA) Routing Number	2 Issuing or Confirming Bank Name	3 Circumstances That Can Trigger the Letter of Credit	4 Amount

BOARD OF DIRECTORS

16. Is the purchase or sale of all investments of the reporting entity passed upon either by the board of directors or a subordinate committee thereof? Yes [X] No []
17. Does the reporting entity keep a complete permanent record of the proceedings of its board of directors and all subordinate committees thereof? Yes [X] No []
18. Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict with the official duties of such person? Yes [X] No []

FINANCIAL

19. Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)? Yes [] No [X]
- 20.1 Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):
- 20.11 To directors or other officers.....\$
- 20.12 To stockholders not officers.....\$
- 20.13 Trustees, supreme or grand (Fraternal Only)\$
- 20.2 Total amount of loans outstanding at the end of year (inclusive of Separate Accounts, exclusive of policy loans):
- 20.21 To directors or other officers.....\$
- 20.22 To stockholders not officers.....\$
- 20.23 Trustees, supreme or grand (Fraternal Only)\$
- 21.1 Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reported in the statement? Yes [] No [X]
- 21.2 If yes, state the amount thereof at December 31 of the current year:
- 21.21 Rented from others.....\$
- 21.22 Borrowed from others.....\$
- 21.23 Leased from others.....\$
- 21.24 Other\$
- 22.1 Does this statement include payments for assessments as described in the Annual Statement Instructions other than guaranty fund or guaranty association assessments? Yes [] No [X]
- 22.2 If answer is yes:
- 22.21 Amount paid as losses or risk adjustment \$
- 22.22 Amount paid as expenses.....\$
- 22.23 Other amounts paid\$
- 23.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? Yes [] No [X]
- 23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount:\$

INVESTMENT

- 24.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date? (other than securities lending programs addressed in 24.03)..... Yes [X] No []
- 24.02 If no, give full and complete information relating thereto
- 24.03 For security lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet. (an alternative is to reference Note 17 where this information is also provided)
- 24.04 Does the Company's security lending program meet the requirements for a conforming program as outlined in the Risk-Based Capital Instructions? Yes [] No [] N/A [X]
- 24.05 If answer to 24.04 is yes, report amount of collateral for conforming programs.\$
- 24.06 If answer to 24.04 is no, report amount of collateral for other programs.\$
- 24.07 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract? Yes [] No [] N/A [X]
- 24.08 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%? Yes [] No [] N/A [X]
- 24.09 Does the reporting entity or the reporting entity's securities lending agent utilize the Master Securities lending Agreement (MSLA) to conduct securities lending? Yes [] No [] N/A [X]

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

GENERAL INTERROGATORIES

24.10 For the reporting entity's security lending program state the amount of the following as December 31 of the current year:

24.101	Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2	\$	0
24.102	Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2	\$	0
24.103	Total payable for securities lending reported on the liability page	\$	0

25.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity, or has the reporting entity sold or transferred any assets subject to a put option contract that is currently in force? (Exclude securities subject to Interrogatory 21.1 and 24.03) Yes [X] No []

25.2 If yes, state the amount thereof at December 31 of the current year:

25.21	Subject to repurchase agreements	\$
25.22	Subject to reverse repurchase agreements	\$
25.23	Subject to dollar repurchase agreements	\$
25.24	Subject to reverse dollar repurchase agreements	\$
25.25	Placed under option agreements	\$
25.26	Letter stock or securities restricted as to sale - excluding FHLB Capital Stock	\$
25.27	FHLB Capital Stock	\$
25.28	On deposit with states	\$ 300,000
25.29	On deposit with other regulatory bodies	\$ 9,409,284
25.30	Pledged as collateral - excluding collateral pledged to an FHLB	\$
25.31	Pledged as collateral to FHLB - including assets backing funding agreements	\$
25.32	Other	\$

25.3 For category (25.26) provide the following:

1 Nature of Restriction	2 Description	3 Amount

26.1 Does the reporting entity have any hedging transactions reported on Schedule DB? Yes [] No [X]

26.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes [] No [] N/A [X]
If no, attach a description with this statement.

27.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity? Yes [] No [X]

27.2 If yes, state the amount thereof at December 31 of the current year. \$

28. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? Yes [X] No []

28.01 For agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian's Address
N/A	The Company has not invested in Securities.

28.02 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

28.03 Have there been any changes, including name changes, in the custodian(s) identified in 28.01 during the current year? Yes [] No [X]

28.04 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

GENERAL INTERROGATORIES

28.05 Investment management – Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. ["...that have access to the investment accounts"; "...handle securities"]

1	2
Name of Firm or Individual	Affiliation

28.0597 For those firms/individuals listed in the table for Question 28.05, do any firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") manage more than 10% of the reporting entity's assets?..... Yes [] No []

28.0598 For firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") listed in the table for Question 28.05, does the total assets under management aggregate to more than 50% of the reporting entity's assets?..... Yes [] No []

28.06 For those firms or individuals listed in the table for 28.05 with an affiliation code of "A" (affiliated) or "U" (unaffiliated), provide the information for the table below.

1	2	3	4	5
Central Registration Depository Number	Name of Firm or Individual	Legal Entity Identifier (LEI)	Registered With	Investment Management Agreement (IMA) Filed

29.1 Does the reporting entity have any diversified mutual funds reported in Schedule D, Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5(b)(1)])? Yes [] No [X]

29.2 If yes, complete the following schedule:

1	2	3
CUSIP #	Name of Mutual Fund	Book/Adjusted Carrying Value
29.2999 - Total		0

29.3 For each mutual fund listed in the table above, complete the following schedule:

1	2	3	4
Name of Mutual Fund (from above table)	Name of Significant Holding of the Mutual Fund	Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	Date of Valuation

30. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

	1	2	3
	Statement (Admitted) Value	Fair Value	Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
30.1 Bonds			0
30.2 Preferred stocks	0		0
30.3 Totals	0	0	0

30.4 Describe the sources or methods utilized in determining the fair values:
Not applicable

31.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D? Yes [] No [X]

31.2 If the answer to 31.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source? Yes [] No [X]

31.3 If the answer to 31.2 is no, describe the reporting entity's process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D:
.....

32.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed? Yes [X] No []

32.2 If no, list exceptions:
.....

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

GENERAL INTERROGATORIES

OTHER

33.1 Amount of payments to trade associations, service organizations and statistical or rating bureaus, if any?\$

33.2 List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations and statistical or rating bureaus during the period covered by this statement.

1 Name	2 Amount Paid

34.1 Amount of payments for legal expenses, if any?\$23,287

34.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.

1 Name	2 Amount Paid
Littler Mendelson	15,151

35.1 Amount of payments for expenditures in connection with matters before legislative bodies, officers or departments of government, if any?\$34,845

35.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid
Larry J. Overton & Associates	15,487
Corcoran & Johnston	19,358
Lobbying expenses disclosed reflect amounts reported in the Lobbyist Disclosure Reports filed with the Secretary of State as well as the cost of external contractors who provided lobbying services to the Company. The amount may include expenses that may have been paid by an affiliate on behalf of the Company and, as a result, may not be included in the Underwriting Gain reported on page 4 of the 2016 Annual Statement	

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

GENERAL INTERROGATORIES

PART 2 - HEALTH INTERROGATORIES

1.1 Does the reporting entity have any direct Medicare Supplement Insurance in force? Yes [] No [X]

1.2 If yes, indicate premium earned on U.S. business only. \$ _____

1.3 What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit? \$ _____

1.31 Reason for excluding

1.4 Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above \$ _____

1.5 Indicate total incurred claims on all Medicare Supplement Insurance. \$ _____ 0

1.6 Individual policies:

Most current three years:

1.61 Total premium earned \$ 0

1.62 Total incurred claims \$ 0

1.63 Number of covered lives 0

All years prior to most current three years:

1.64 Total premium earned \$ 0

1.65 Total incurred claims \$ 0

1.66 Number of covered lives 0

1.7 Group policies:

Most current three years:

1.71 Total premium earned \$ 0

1.72 Total incurred claims \$ 0

1.73 Number of covered lives 0

All years prior to most current three years:

1.74 Total premium earned \$ 0

1.75 Total incurred claims \$ 0

1.76 Number of covered lives 0

2. Health Test:

	1 Current Year	2 Prior Year
2.1 Premium Numerator	321,690,311	267,338,684
2.2 Premium Denominator	321,690,311	267,338,684
2.3 Premium Ratio (2.1/2.2)	1.000	1.000
2.4 Reserve Numerator	38,992,200	34,203,293
2.5 Reserve Denominator	38,992,200	34,203,293
2.6 Reserve Ratio (2.4/2.5)	1.000	1.000

3.1 Has the reporting entity received any endowment or gift from contracting hospitals, physicians, dentists, or others that is agreed will be returned when, as and if the earnings of the reporting entity permits? Yes [] No [X]

3.2 If yes, give particulars:

4.1 Have copies of all agreements stating the period and nature of hospitals', physicians', and dentists' care offered to subscribers and dependents been filed with the appropriate regulatory agency? Yes [X] No []

4.2 If not previously filed, furnish herewith a copy(ies) of such agreement(s). Do these agreements include additional benefits offered? Yes [X] No []

5.1 Does the reporting entity have stop-loss reinsurance? Yes [] No [X]

5.2 If no, explain:
Became self insured in 2016

5.3 Maximum retained risk (see instructions)

5.31 Comprehensive Medical \$
5.32 Medical Only \$
5.33 Medicare Supplement \$
5.34 Dental & Vision \$
5.35 Other Limited Benefit Plan \$
5.36 Other \$

6. Describe arrangement which the reporting entity may have to protect subscribers and their dependents against the risk of insolvency including hold harmless provisions, conversion privileges with other carriers, agreements with providers to continue rendering services, and any other agreements:
.....

7.1 Does the reporting entity set up its claim liability for provider services on a service date basis? Yes [X] No []

7.2 If no, give details

8. Provide the following information regarding participating providers:

8.1 Number of providers at start of reporting year 5,126

8.2 Number of providers at end of reporting year 4,542

9.1 Does the reporting entity have business subject to premium rate guarantees? Yes [] No [X]

9.2 If yes, direct premium earned:

9.21 Business with rate guarantees between 15-36 months \$
9.22 Business with rate guarantees over 36 months \$

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

GENERAL INTERROGATORIES

- 10.1 Does the reporting entity have Incentive Pool, Withhold or Bonus Arrangements in its provider contracts? Yes [X] No []
- 10.2 If yes:
- 10.21 Maximum amount payable bonuses.....\$
- 10.22 Amount actually paid for year bonuses.....\$
- 10.23 Maximum amount payable withholds.....\$
- 10.24 Amount actually paid for year withholds.....\$
- 11.1 Is the reporting entity organized as:
- 11.12 A Medical Group/Staff Model, Yes [] No [X]
- 11.13 An Individual Practice Association (IPA), or, Yes [] No [X]
- 11.14 A Mixed Model (combination of above)? Yes [] No [X]
- 11.2 Is the reporting entity subject to Statutory Minimum Capital and Surplus Requirements? Yes [X] No []
- 11.3 If yes, show the name of the state requiring such minimum capital and surplus. Florida
- 11.4 If yes, show the amount required.\$ 6,433,806
- 11.5 Is this amount included as part of a contingency reserve in stockholder's equity? Yes [] No [X]
- 11.6 If the amount is calculated, show the calculation
The State of Florida requires Surplus to exceed a) 2% annualized revenues (\$321,690,311 x 0.2 = 6,433,806), b) 10% of liabilities (\$42,778,822 x .10 = 4,277,882), c) \$1,500,000 whichever is greater
12. List service areas in which reporting entity is licensed to operate:

1 Name of Service Area
Broward
Polk
Hillsborough
Manatee
Hardee
Highlands
.....

- 13.1 Do you act as a custodian for health savings accounts? Yes [] No [X]
- 13.2 If yes, please provide the amount of custodial funds held as of the reporting date.\$
- 13.3 Do you act as an administrator for health savings accounts? Yes [] No [X]
- 13.4 If yes, please provide the balance of funds administered as of the reporting date.\$
- 14.1 Are any of the captive affiliates reported on Schedule S, Part 3, authorized reinsurers? Yes [] No [X] N/A []
- 14.2 If the answer to 14.1 is yes, please provide the following:

1 Company Name	2 NAIC Company Code	3 Domiciliary Jurisdiction	4 Reserve Credit	Assets Supporting Reserve Credit		
				5 Letters of Credit	6 Trust Agreements	7 Other
.....

15. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded):

- 15.1 Direct Premium Written.....\$
- 15.2 Total Incurred Claims.....\$
- 15.3 Number of Covered Lives

*Ordinary Life Insurance Includes
Term (whether full underwriting, limited underwriting, jet issue, "short form app")
Whole Life (whether full underwriting, limited underwriting, jet issue, "short form app")
Variable Life (with or without secondary guarantee)
Universal Life (with or without secondary guarantee)
Variable Universal Life (with or without secondary guarantee)

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

FIVE-YEAR HISTORICAL DATA

	1 2016	2 2015	3 2014	4 2013	5 2012
Balance Sheet (Pages 2 and 3)					
1. Total admitted assets (Page 2, Line 28)	72,751,415	50,674,076	61,916,259	.0	.0
2. Total liabilities (Page 3, Line 24)	41,836,668	35,460,144	35,460,144	.0	.0
3. Statutory minimum capital and surplus requirement	6,433,806	5,346,774	4,609,837	.0	.0
4. Total capital and surplus (Page 3, Line 33)	30,914,747	15,213,932	15,817,890	.0	.0
Income Statement (Page 4)					
5. Total revenues (Line 8)	319,170,091	267,338,684	158,608,233	.0	.0
6. Total medical and hospital expenses (Line 18)	260,415,526	238,192,189	127,685,279	.0	.0
7. Claims adjustment expenses (Line 20)	16,235,723	6,341,286	3,875,346	.0	.0
8. Total administrative expenses (Line 21)	20,411,814	23,717,325	35,485,219	.0	.0
9. Net underwriting gain (loss) (Line 24)	22,107,028	(912,116)	(8,437,611)	.0	.0
10. Net investment gain (loss) (Line 27)	9,580	10,272	5,407	.0	.0
11. Total other income (Lines 28 plus 29)	(24,200)	(124,300)	(50,241)	.0	.0
12. Net income or (loss) (Line 32)	13,186,691	(191,668)	(8,482,445)	.0	.0
Cash Flow (Page 6)					
13. Net cash from operations (Line 11)	20,354,678	414,328	35,334,009	.0	.0
Risk-Based Capital Analysis					
14. Total adjusted capital	30,914,747	15,213,932	.0	.0	.0
15. Authorized control level risk-based capital	9,941,452	10,619,805	.0	.0	.0
Enrollment (Exhibit 1)					
16. Total members at end of period (Column 5, Line 7)	103,318	95,517	88,014	.0	.0
17. Total members months (Column 6, Line 7)	1,220,936	1,115,606	.0	.0	.0
Operating Percentage (Page 4) (Item divided by Page 4, sum of Lines 2, 3 and 5) x 100.0					
18. Premiums earned plus risk revenue (Line 2 plus Lines 3 and 5)	100.0	100.0	100.0	100.0	100.0
19. Total hospital and medical plus other non-health (Lines 18 plus Line 19)	81.6	89.1	80.5	.0.0	.0.0
20. Cost containment expenses	3.2	1.8	.0.0	.0.0	.0.0
21. Other claims adjustment expenses	1.9	0.7	2.4	.0.0	.0.0
22. Total underwriting deductions (Line 23)	93.1	100.3	105.3	.0.0	.0.0
23. Total underwriting gain (loss) (Line 24)	6.9	(0.3)	(5.3)	.0.0	.0.0
Unpaid Claims Analysis (U&I Exhibit, Part 2B)					
24. Total claims incurred for prior years (Line 13, Col. 5)	26,856,138	25,403,106	.0	.0	.0
25. Estimated liability of unpaid claims-[prior year (Line 13, Col. 6)]	33,896,754	25,832,966	.0	.0	.0
Investments in Parent, Subsidiaries and Affiliates					
26. Affiliated bonds (Sch. D Summary, Line 12, Col. 1) .....	.0	.0	.0	.0	.0
27. Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1) .....	.0	.0	.0	.0	.0
28. Affiliated common stocks (Sch. D Summary, Line 24, Col. 1) .....	.0	.0	.0	.0	.0
29. Affiliated short-term investments (subtotal included in Schedule DA Verification, Col. 5, Line 10) .....	.0	.0	.0	.0	.0
30. Affiliated mortgage loans on real estate					
31. All other affiliated					
32. Total of above Lines 26 to 31 .....	.0	.0	.0	.0	.0
33. Total investment in parent included in Lines 26 to 31 above					

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3, Accounting Changes and Correction of Errors? Yes [] No [X]
If no, please explain:



ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION

Better Health, Inc.

2. Miami, FL

NAIC Group Code	0000	BUSINESS IN THE STATE OF		Florida	DURING THE YEAR				2016	(LOCATION)	NAIC Company Code	15480
		1	Comprehensive (Hospital & Medical)		4	5	6	7		8	9	10
		Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan		Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:												
1. Prior Year		95,517	0	0	0	0	0	0	0	0	95,517	0
2. First Quarter		98,827									98,827	
3. Second Quarter		100,363									100,363	
4. Third Quarter		100,981									100,981	
5. Current Year		103,318									103,318	
6. Current Year Member Months		1,220,936									1,220,936	
Total Member Ambulatory Encounters for Year:												
7. Physician		892,692									892,692	
8. Non-Physician		111,001									111,001	
9. Total		1,003,693	0	0	0	0	0	0	0	0	1,003,693	0
10. Hospital Patient Days Incurred		38,470									38,470	
11. Number of Inpatient Admissions		8,218									8,218	
12. Health Premiums Written (b)		322,105,018									322,105,018	
13. Life Premiums Direct		0										
14. Property/Casualty Premiums Written		0										
15. Health Premiums Earned		319,584,798									319,584,798	
16. Property/Casualty Premiums Earned		0										
17. Amount Paid for Provision of Health Care Services		257,298,771									257,298,771	
18. Amount Incurred for Provision of Health Care Services		261,904,080									261,904,080	

(a) For health business: number of persons insured under PPO managed care products and number of persons insured under indemnity only products
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$



ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION

Better Health, Inc.

2. Miami, FL

NAIC Group Code	0000	BUSINESS IN THE STATE OF		Grand Total	DURING THE YEAR					2016	(LOCATION)	NAIC Company Code	15480
		1	2	3	4	5	6	7	8	9			10
		Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid			Other
Total Members at end of:													
1. Prior Year		95,517	0	0	0	0	0	0	0	95,517			0
2. First Quarter		98,827	0	0	0	0	0	0	0	98,827			0
3. Second Quarter		100,363	0	0	0	0	0	0	0	100,363			0
4. Third Quarter		100,981	0	0	0	0	0	0	0	100,981			0
5. Current Year		103,318	0	0	0	0	0	0	0	103,318			0
6. Current Year Member Months		1,220,936	0	0	0	0	0	0	0	1,220,936			0
Total Member Ambulatory Encounters for Year:													
7. Physician		892,692	0	0	0	0	0	0	0	892,692			0
8. Non-Physician		111,001	0	0	0	0	0	0	0	111,001			0
9. Total		1,003,693	0	0	0	0	0	0	0	1,003,693			0
10. Hospital Patient Days Incurred		38,470	0	0	0	0	0	0	0	38,470			0
11. Number of Inpatient Admissions		8,218	0	0	0	0	0	0	0	8,218			0
12. Health Premiums Written (b)		322,105,018	0	0	0	0	0	0	0	322,105,018			0
13. Life Premiums Direct		0	0	0	0	0	0	0	0	0			0
14. Property/Casualty Premiums Written		0	0	0	0	0	0	0	0	0			0
15. Health Premiums Earned		319,584,798	0	0	0	0	0	0	0	319,584,798			0
16. Property/Casualty Premiums Earned		0	0	0	0	0	0	0	0	0			0
17. Amount Paid for Provision of Health Care Services		257,298,771	0	0	0	0	0	0	0	257,298,771			0
18. Amount Incurred for Provision of Health Care Services		261,904,080	0	0	0	0	0	0	0	261,904,080			0

(a) For health business: number of persons insured under PPO managed care products0 and number of persons insured under indemnity only products0 .
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$0

30.GT

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

SCHEDULE S - PART 1 - SECTION 2

Reinsurance Assumed Accident and Health Insurance Listed by Reinsured Company as of December 31, Current Year

1 NAIC Company Code	2 ID Number	3 Effective Date	4 Name of Reinsured	5 Domiciliary Jurisdiction	6 Type of Reinsurance Assumed	7 Premiums	8 Unearned Premiums	9 Reserve Liability Other Than for Unearned Premiums	10 Reinsurance Payable on Paid and Unpaid Losses	11 Modified Coinsurance Reserve	12 Funds Withheld Under Coinsurance
NONE											
9999999 - Totals											

SCHEDULE S - PART 2

[illegible]

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

SCHEDULE S - PART 3 - SECTION 2

Reinsurance Ceded Accident and Health Insurance Listed by Reinsuring Company as of December 31, Current Year

1 NAIC Company Code	2 ID Number	3 Effective Date	4 Name of Company	5 Domi- ciliary Juris- diction	6 Type of Reinsurance Ceded	7 Type of Business Ceded	8 Premiums	9 Unearned Premiums (Estimated)	10 Reserve Credit Taken Other than for Unearned Premiums	Outstanding Surplus Relief		13 Modified Coinsurance Reserve	14 Funds Withheld Under Coinsurance
										11 Current Year	12 Prior Year		
0399999			Total General Account - Authorized U.S. Affiliates				0	0	0	0	0	0	0
0699999			Total General Account - Authorized Non-U.S. Affiliates				0	0	0	0	0	0	0
0799999			Total General Account - Authorized Affiliates				0	0	0	0	0	0	0
11835	04-160940	08/01/2015	Partner Re America Insurance Company	DE	SSL/L/I	MC	414,707						
0899999			General Account - Authorized U.S. Non-Affiliates				414,707	0	0	0	0	0	0
1099999			Total General Account - Authorized Non-Affiliates				414,707	0	0	0	0	0	0
1199999			Total General Account Authorized				414,707	0	0	0	0	0	0
1499999			Total General Account - Unauthorized U.S. Affiliates				0	0	0	0	0	0	0
1799999			Total General Account - Unauthorized Non-U.S. Affiliates				0	0	0	0	0	0	0
1899999			Total General Account - Unauthorized Affiliates				0	0	0	0	0	0	0
2199999			Total General Account - Unauthorized Non-Affiliates				0	0	0	0	0	0	0
2299999			Total General Account Unauthorized				0	0	0	0	0	0	0
2599999			Total General Account - Certified U.S. Affiliates				0	0	0	0	0	0	0
2899999			Total General Account - Certified Non-U.S. Affiliates				0	0	0	0	0	0	0
2999999			Total General Account - Certified Affiliates				0	0	0	0	0	0	0
3299999			Total General Account - Certified Non-Affiliates				0	0	0	0	0	0	0
3399999			Total General Account Certified				0	0	0	0	0	0	0
3499999			Total General Account Authorized, Unauthorized and Certified				414,707	0	0	0	0	0	0
3799999			Total Separate Accounts - Authorized U.S. Affiliates				0	0	0	0	0	0	0
4099999			Total Separate Accounts - Authorized Non-U.S. Affiliates				0	0	0	0	0	0	0
4199999			Total Separate Accounts - Authorized Affiliates				0	0	0	0	0	0	0
4499999			Total Separate Accounts - Authorized Non-Affiliates				0	0	0	0	0	0	0
4599999			Total Separate Accounts Authorized				0	0	0	0	0	0	0
4899999			Total Separate Accounts - Unauthorized U.S. Affiliates				0	0	0	0	0	0	0
5199999			Total Separate Accounts - Unauthorized Non-U.S. Affiliates				0	0	0	0	0	0	0
5299999			Total Separate Accounts - Unauthorized Affiliates				0	0	0	0	0	0	0
5599999			Total Separate Accounts - Unauthorized Non-Affiliates				0	0	0	0	0	0	0
5699999			Total Separate Accounts Unauthorized				0	0	0	0	0	0	0
5999999			Total Separate Accounts - Certified U.S. Affiliates				0	0	0	0	0	0	0
6299999			Total Separate Accounts - Certified Non-U.S. Affiliates				0	0	0	0	0	0	0
6399999			Total Separate Accounts - Certified Affiliates				0	0	0	0	0	0	0
6699999			Total Separate Accounts - Certified Non-Affiliates				0	0	0	0	0	0	0
6799999			Total Separate Accounts Certified				0	0	0	0	0	0	0
6899999			Total Separate Accounts Authorized, Unauthorized and Certified				0	0	0	0	0	0	0
6999999			Total U.S. (Sum of 0399999, 0899999, 1499999, 1999999, 2599999, 3099999, 3799999, 4299999, 4899999, 5399999, 5999999 and 6499999)				414,707	0	0	0	0	0	0
7099999			Total Non-U.S. (Sum of 0699999, 0999999, 1799999, 2099999, 2899999, 3199999, 4099999, 4399999, 5199999, 5499999, 6299999 and 6599999)				0	0	0	0	0	0	0
9999999			Totals				414,707	0	0	0	0	0	0

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

Schedule S - Part 4

NONE

Schedule S - Part 4 - Bank Footnote

NONE

Schedule S - Part 5

NONE

Schedule S - Part 5 - Bank Footnote

NONE

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

SCHEDULE S - PART 6

Five Year Exhibit of Reinsurance Ceded Business (000 Omitted)

	1 2016	2 2015	3 2014	4 2013	5 2012
A. OPERATIONS ITEMS					
1. Premiums0	.0	.0	.0	.0
2. Title XVIII - Medicare0	.0	.0	.0	.0
3. Title XIX - Medicaid .....	.415	.711	.0	.0	.0
4. Commissions and reinsurance expense allowance					
5. Total hospital and medical expenses					
B. BALANCE SHEET ITEMS					
6. Premiums receivable					
7. Claims payable .....	.0	.0	.0	.0	.0
8. Reinsurance recoverable on paid losses	1,262	.97	.0	.0	.0
9. Experience rating refunds due or unpaid					
10. Commissions and reinsurance expense allowances due					
11. Unauthorized reinsurance offset					
12. Offset for reinsurance with Certified Reinsurers					
C. UNAUTHORIZED REINSURANCE (DEPOSITS BY AND FUNDS WITHHELD FROM)					
13. Funds deposited by and withheld from (F) .....	.0	.0	.0	.0	.0
14. Letters of credit (L) .....	.0	.0	.0	.0	.0
15. Trust agreements (T) .....	.0	.0	.0	.0	.0
16. Other (O) .....	.0	.0	.0	.0	.0
D. REINSURANCE WITH CERTIFIED REINSURERS (DEPOSITS BY AND FUNDS WITHHELD FROM)					
17. Multiple Beneficiary Trust .....		.0	.0	.0	.0
18. Funds deposited by and withheld from (F) .....		.0	.0	.0	.0
19. Letters of credit (L) .....		.0	.0	.0	.0
20. Trust agreements (T) .....		.0	.0	.0	.0
21. Other (O) .....		.0	.0	.0	.0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

SCHEDULE S - PART 7

Restatement of Balance Sheet to Identify Net Credit For Ceded Reinsurance

	1 As Reported (net of ceded)	2 Restatement Adjustments	3 Restated (gross of ceded)
ASSETS (Page 2, Col. 3)			
1. Cash and invested assets (Line 12)	65,720,382		65,720,382
2. Accident and health premiums due and unpaid (Line 15)	3,167,576		3,167,576
3. Amounts recoverable from reinsurers (Line 16.1)	1,261,693		1,261,693
4. Net credit for ceded reinsurance	XXX	0	0
5. All other admitted assets (Balance)	2,601,764		2,601,764
6. Total assets (Line 28)	72,751,415	0	72,751,415
LIABILITIES, CAPITAL AND SURPLUS (Page 3)			
7. Claims unpaid (Line 1)	33,109,006		33,109,006
8. Accrued medical incentive pool and bonus payments (Line 2)	2,647,384		2,647,384
9. Premiums received in advance (Line 8)	0		0
10. Funds held under reinsurance treaties with authorized and unauthorized reinsurers (Line 19 first inset amount plus second inset amount)	0		0
11. Reinsurance in unauthorized companies (Line 20 minus inset amount)	0		0
12. Reinsurance with Certified Reinsurers (Line 20 inset amount)	0		0
13. Funds held under reinsurance treaties with Certified Reinsurers (Line 19 third inset amount)	0		0
14. All other liabilities (Balance)	6,080,278		6,080,278
15. Total liabilities (Line 24)	41,836,668	0	41,836,668
16. Total capital and surplus (Line 33)	30,914,747	XXX	30,914,747
17. Total liabilities, capital and surplus (Line 34)	72,751,415	0	72,751,415
NET CREDIT FOR CEDED REINSURANCE			
18. Claims unpaid	0		
19. Accrued medical incentive pool	0		
20. Premiums received in advance	0		
21. Reinsurance recoverable on paid losses	0		
22. Other ceded reinsurance recoverables	0		
23. Total ceded reinsurance recoverables	0		
24. Premiums receivable	0		
25. Funds held under reinsurance treaties with authorized and unauthorized reinsurers	0		
26. Unauthorized reinsurance	0		
27. Reinsurance with Certified Reinsurers	0		
28. Funds held under reinsurance treaties with Certified Reinsurers	0		
29. Other ceded reinsurance payables/offsets	0		
30. Total ceded reinsurance payables/offsets	0		
31. Total net credit for ceded reinsurance	0		

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

SCHEDULE T PREMIUMS AND OTHER CONSIDERATIONS

Allocated by States and Territories									
States, etc.	1 Active Status	Direct Business Only							
		2 Accident & Health Premiums	3 Medicare Title XVIII	4 Medicaid Title XIX	5 Federal Employees Health Benefits Plan Premiums	6 Life & Annuity Premiums & Other Considerations	7 Property/ Casualty Premiums	8 Total Columns 2 Through 7	9 Deposit-Type Contracts
1. Alabama AL	N							0	
2. Alaska AK	N							0	
3. Arizona AZ	N							0	
4. Arkansas AR	N							0	
5. California CA	N							0	
6. Colorado CO	N							0	
7. Connecticut CT	N							0	
8. Delaware DE	N							0	
9. District of Columbia DC	N							0	
10. Florida FL	L			322,105,018				322,105,018	
11. Georgia GA	N							0	
12. Hawaii HI	N							0	
13. Idaho ID	N							0	
14. Illinois IL	N							0	
15. Indiana IN	N							0	
16. Iowa IA	N							0	
17. Kansas KS	N							0	
18. Kentucky KY	N							0	
19. Louisiana LA	N							0	
20. Maine ME	N							0	
21. Maryland MD	N							0	
22. Massachusetts MA	N							0	
23. Michigan MI	N							0	
24. Minnesota MN	N							0	
25. Mississippi MS	N							0	
26. Missouri MO	N							0	
27. Montana MT	N							0	
28. Nebraska NE	N							0	
29. Nevada NV	N							0	
30. New Hampshire NH	N							0	
31. New Jersey NJ	N							0	
32. New Mexico NM	N							0	
33. New York NY	N							0	
34. North Carolina NC	N							0	
35. North Dakota ND	N							0	
36. Ohio OH	N							0	
37. Oklahoma OK	N							0	
38. Oregon OR	N							0	
39. Pennsylvania PA	N							0	
40. Rhode Island RI	N							0	
41. South Carolina SC	N							0	
42. South Dakota SD	N							0	
43. Tennessee TN	N							0	
44. Texas TX	N							0	
45. Utah UT	N							0	
46. Vermont VT	N							0	
47. Virginia VA	N							0	
48. Washington WA	N							0	
49. West Virginia WV	N							0	
50. Wisconsin WI	N							0	
51. Wyoming WY	N							0	
52. American Samoa AS	N							0	
53. Guam GU	N							0	
54. Puerto Rico PR	N							0	
55. U.S. Virgin Islands VI	N							0	
56. Northern Mariana Islands MP	N							0	
57. Canada CAN	N							0	
58. Aggregate other alien OT	XXX	0	0	0	0	0	0	0	0
59. Subtotal	XXX	0	0	322,105,018	0	0	0	322,105,018	0
60. Reporting entity contributions for Employee Benefit Plans	XXX							0	
61. Total (Direct Business) (a)	1	0	0	322,105,018	0	0	0	322,105,018	0
DETAILS OF WRITE-INS									
58001.	XXX								
58002.	XXX								
58003.	XXX								
58998. Summary of remaining write-ins for Line 58 from overflow page	XXX	0	0	0	0	0	0	0	0
58999. Totals (Lines 58001 through 58003 plus 58998)(Line 58 above)	XXX	0	0	0	0	0	0	0	0

(L) Licensed or Chartered - Licensed Insurance Carrier or Domiciled RRG; (R) Registered - Non-domiciled RRGs; (Q) Qualified - Qualified or Accredited Reinsurer; (E) Eligible - Reporting Entities eligible or approved to write Surplus Lines in the state; (N) None of the above - Not allowed to write business in the state.

Explanation of basis of allocation by states, premiums by state, etc.

The Company is licensed as an HMO only in the State of Florida.

(a) Insert the number of L responses except for Canada and Other Alien.

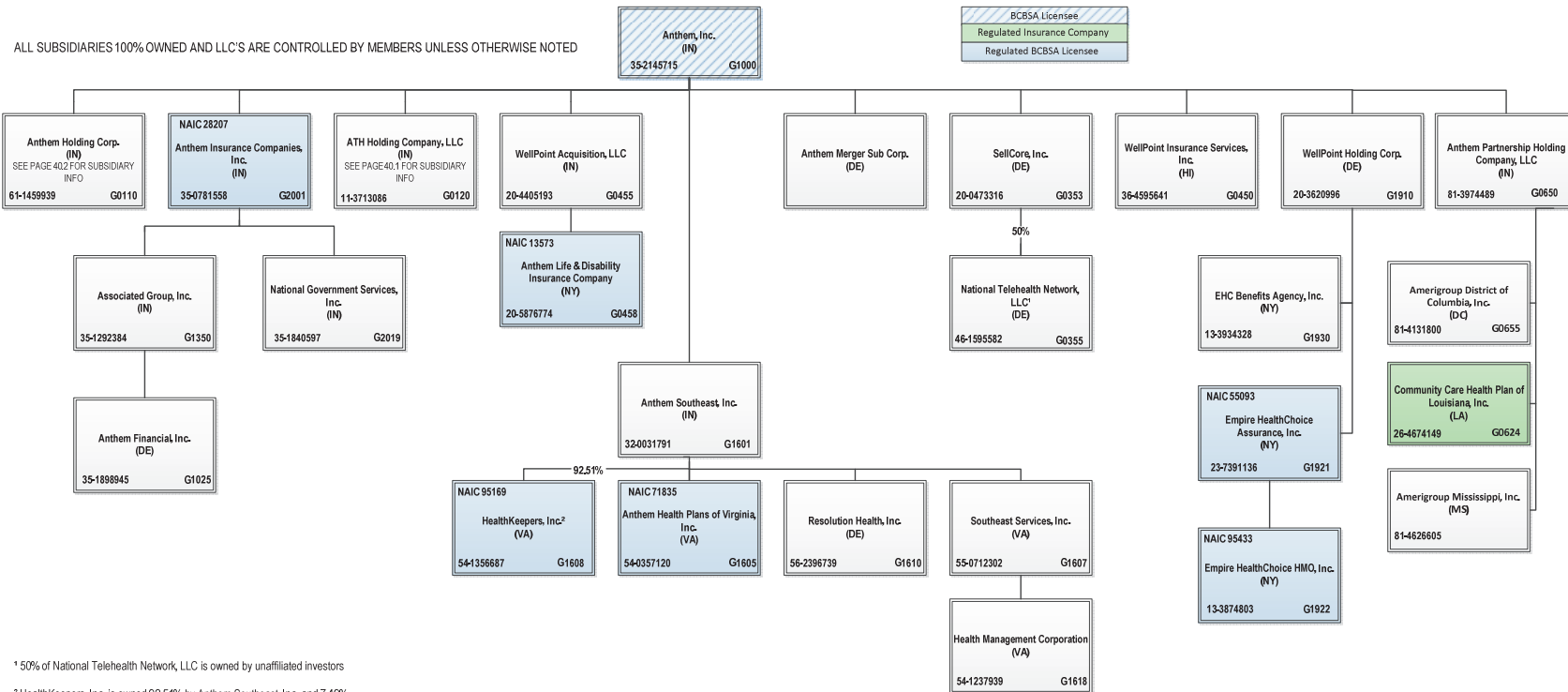
ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

SCHEDULE T - PART 2
INTERSTATE COMPACT - EXHIBIT OF PREMIUMS WRITTEN
Allocated by States and Territories

States, Etc.		Direct Business Only				
		1 Life (Group and Individual)	2 Annuities (Group and Individual)	3 Disability Income (Group and Individual)	4 Long-Term Care (Group and Individual)	5 Deposit-Type Contracts
						6 Totals
1. Alabama	AL					
2. Alaska	AK					
3. Arizona	AZ					
4. Arkansas	AR					
5. California	CA					
6. Colorado	CO					
7. Connecticut	CT					
8. Delaware	DE					
9. District of Columbia	DC					
10. Florida	FL					
11. Georgia	GA					
12. Hawaii	HI					
13. Idaho	ID					
14. Illinois	IL					
15. Indiana	IN					
16. Iowa	IA					
17. Kansas	KS					
18. Kentucky	KY					
19. Louisiana	LA					
20. Maine	ME					
21. Maryland	MD					
22. Massachusetts	MA					
23. Michigan	MI					
24. Minnesota	MN					
25. Mississippi	MS					
26. Missouri	MO					
27. Montana	MT					
28. Nebraska	NE					
29. Nevada	NV					
30. New Hampshire	NH					
31. New Jersey	NJ					
32. New Mexico	NM					
33. New York	NY					
34. North Carolina	NC					
35. North Dakota	ND					
36. Ohio	OH					
37. Oklahoma	OK					
38. Oregon	OR					
39. Pennsylvania	PA					
40. Rhode Island	RI					
41. South Carolina	SC					
42. South Dakota	SD					
43. Tennessee	TN					
44. Texas	TX					
45. Utah	UT					
46. Vermont	VT					
47. Virginia	VA					
48. Washington	WA					
49. West Virginia	WV					
50. Wisconsin	WI					
51. Wyoming	WY					
52. American Samoa	AS					
53. Guam	GU					
54. Puerto Rico	PR					
55. U.S. Virgin Islands	VI					
56. Northern Mariana Islands	MP					
57. Canada	CAN					
58. Aggregate Other Alien	OT					
59. Total						

NONE

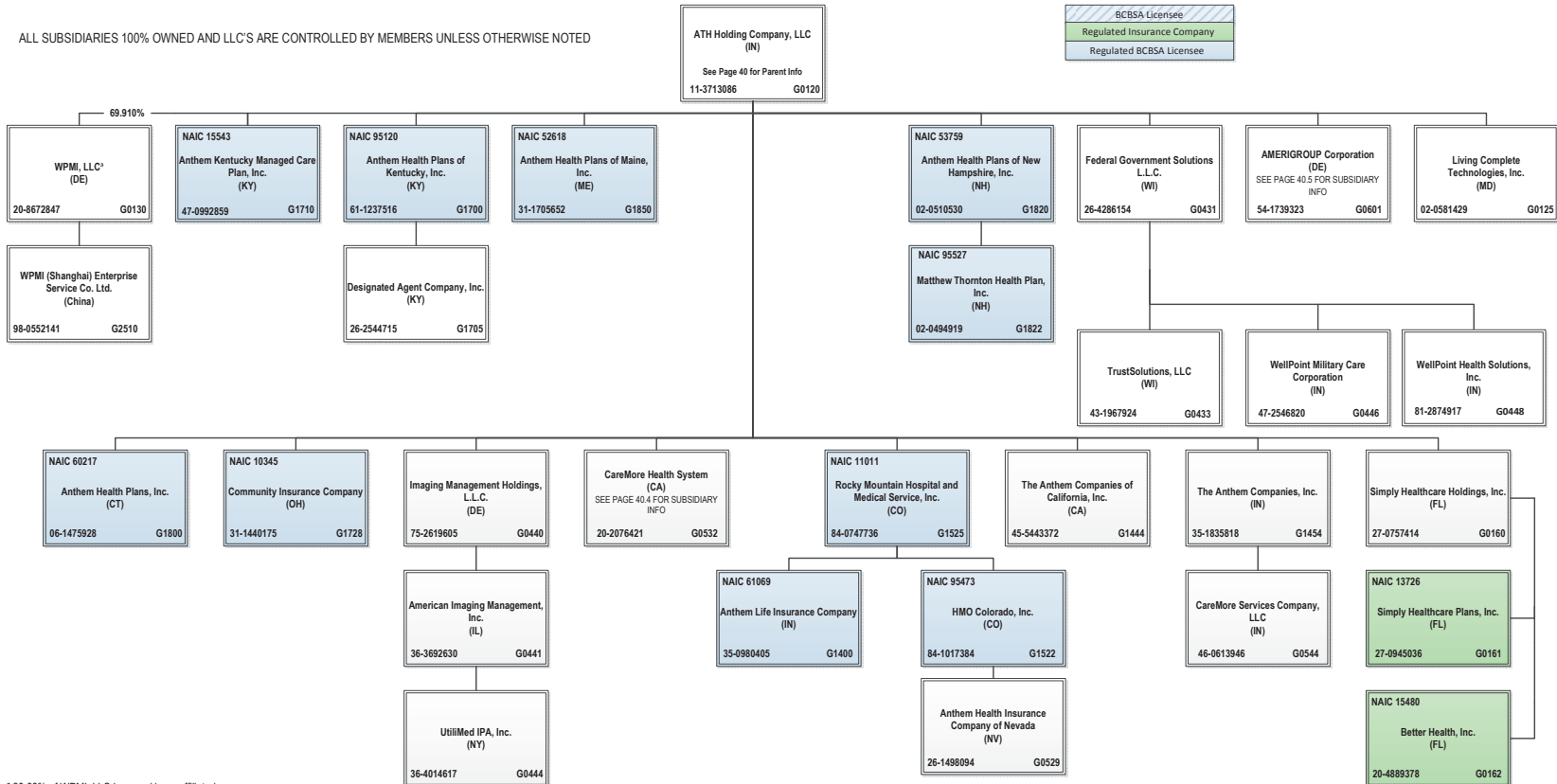
SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



¹ 50% of National Telehealth Network, LLC is owned by unaffiliated investors

² HealthKeepers, Inc. is owned 92.51% by Anthem Southeast, Inc. and 7.49% by UNICARE National Services, Inc.

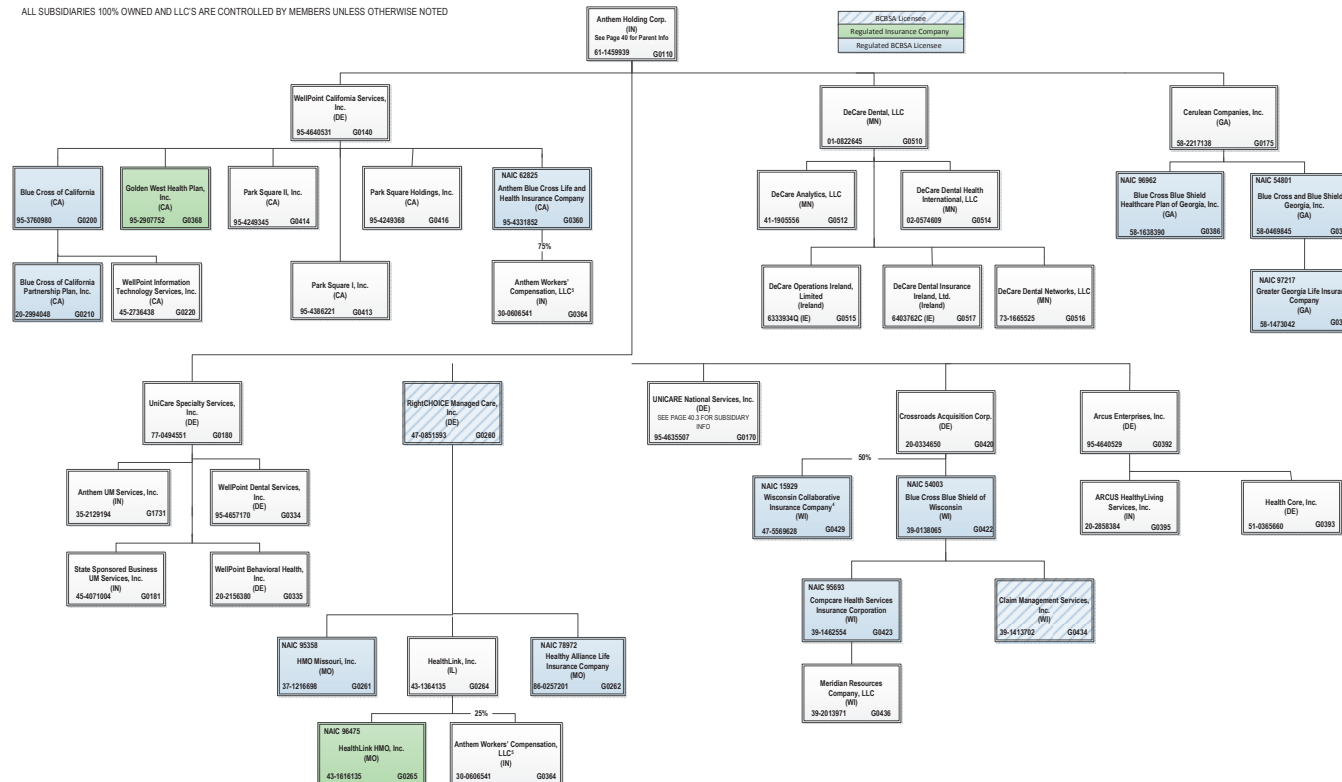
SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP PART 1 – ORGANIZATIONAL CHART



SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



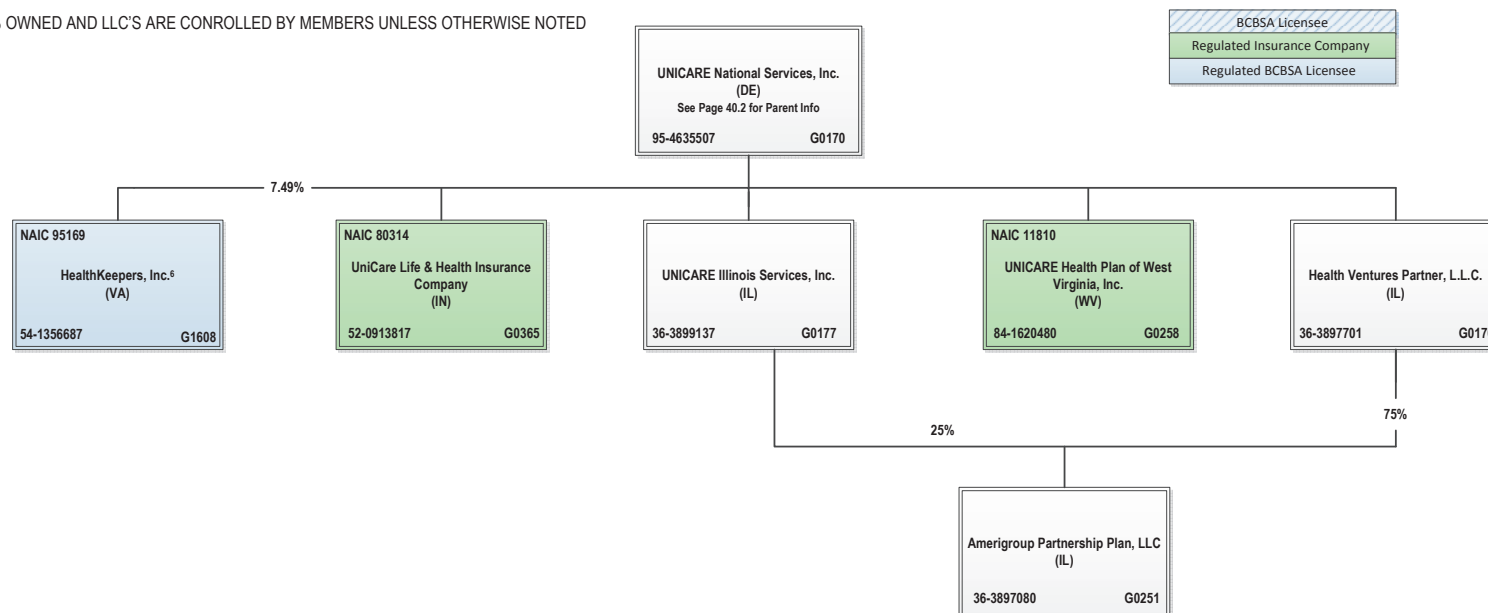
⁴ 50% of WIC is owned by an unaffiliated investor.

¹ Anthem Workers' Compensation LLC is owned 75% by Anthem Blue Cross Life and Health Insurance Company and 25% by HealthLink, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED

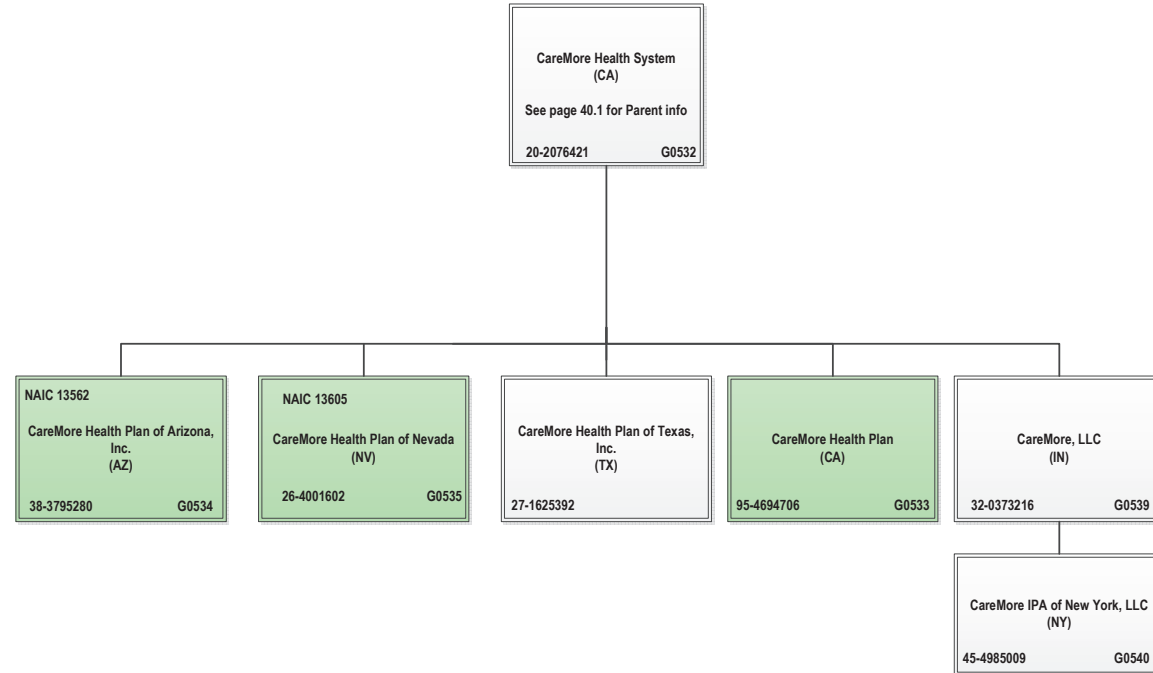


⁶ HealthKeepers, Inc. is owned 92.51% by Anthem Southeast, Inc. and 7.49% by UNICARE National Services, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP **PART 1 – ORGANIZATIONAL CHART**

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED

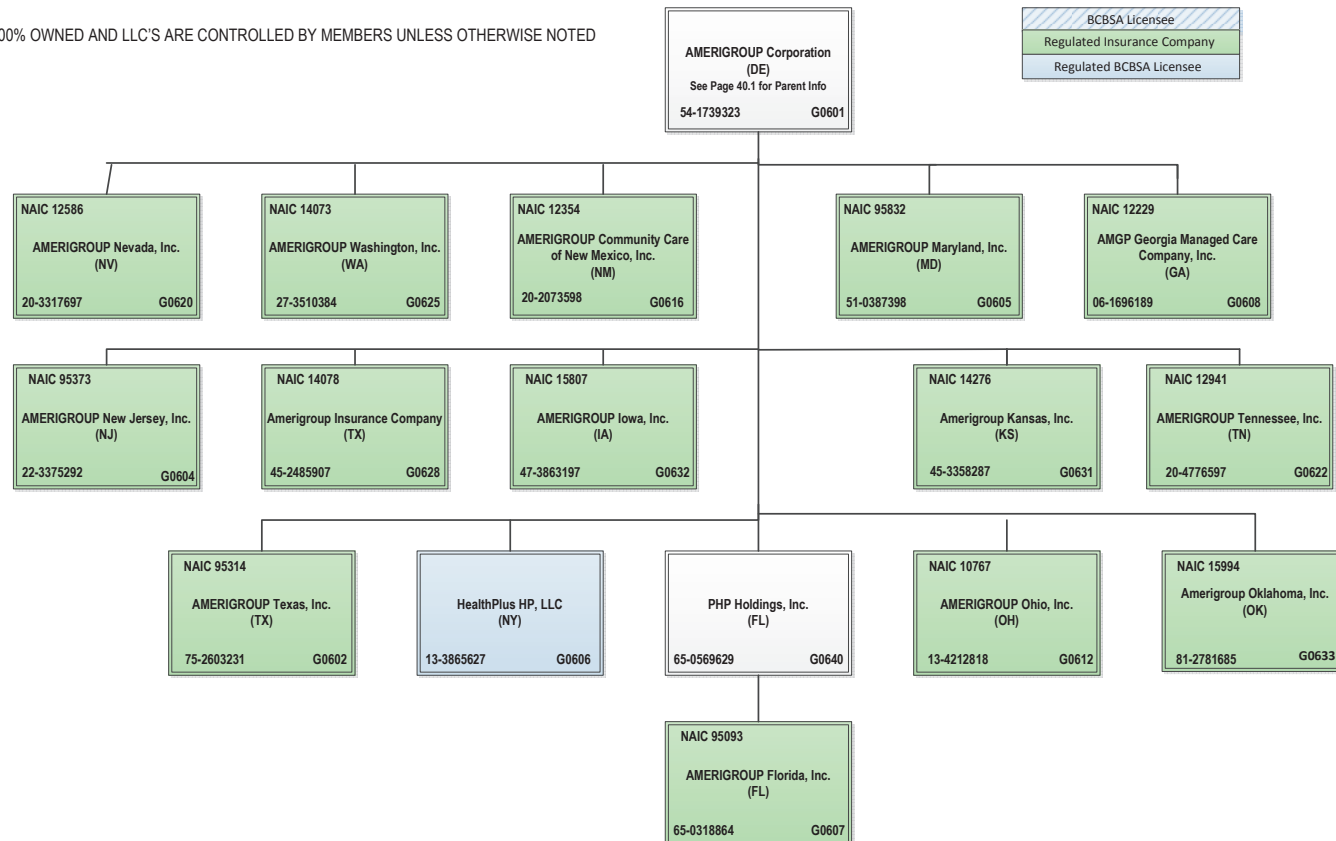
BCBSA Licensee
Regulated Insurance Company
Regulated BCBSA Licensee



SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP

PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Required? (Y/N)	*
.D671	Anthen, Inc.		36-3692630				American Imaging Management, Inc. AMERIGROUP Community Care of New Mexico, Inc.	IL	NIA	Imaging Management Holdings, L.L.C.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	12354	20-2073598				AMERIGROUP Corporation	IL	NIA	AMERIGROUP Corporation	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		54-1739323				Amerigroup District of Columbia, Inc.	DC	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		81-4131800				AMERIGROUP Florida, Inc.	FL	NIA	Anthen Partnership Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	95093	65-0318864				AMERIGROUP Insurance Company	TX	IA	PHP Holdings, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	14078	45-2486907				AMERIGROUP Iowa, Inc.	IA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	15807	47-3863197				Amerigroup Kansas, Inc.	KS	IA	AMERIGROUP Corporation	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	14276	45-3356287				AMERIGROUP Maryland, Inc.	MD	IA	AMERIGROUP Corporation	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	95632	51-0387398				Amerigroup Mississippi, Inc.	MS	NIA	Anthen Partnership Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		81-4626605				AMERIGROUP Nevada, Inc.	NV	IA	AMERIGROUP Corporation	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	12586	20-3317697				AMERIGROUP New Jersey, Inc.	NJ	IA	AMERIGROUP Corporation	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	95373	22-3375292				AMERIGROUP Ohio, Inc.	OH	IA	AMERIGROUP Corporation	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	10767	13-4212818				AMERIGROUP Oklahoma, Inc.	OK	IA	AMERIGROUP Corporation	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	15994	61-2781685				Amerigroup Partnership Plan, LLC	IL	NIA	Health Ventures Partner, L.L.C.	Ownership	75.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		36-3897080				Amerigroup Partnership Plan, LLC	IL	NIA	UNICARE Illinois Services, Inc.	Ownership	25.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	12941	20-4776597				AMERIGROUP Tennessee, Inc.	TN	IA	AMERIGROUP Corporation	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	95314	75-2603231				AMERIGROUP Texas, Inc.	TX	IA	AMERIGROUP Corporation	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	14073	27-3510384				AMERIGROUP Washington, Inc.	WA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	12229	06-1696189				AMP Georgia Managed Care Company, Inc.	GA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.						Anthen Blue Cross Life and Health Insurance Company	CA	IA	WellPoint California Services, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	62825	95-4331952				Anthen Financial, Inc.	DE	NIA	Associated Group, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		35-1898945				Anthen Health Insurance Company of Nevada	NV	NIA	HMO Colorado, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		26-1498094				Anthen Health Plans of Kentucky, Inc.	KY	IA	ATH Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	95120	61-1237516				Anthen Health Plans of Maine, Inc.	ME	IA	ATH Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	52618	31-1705652				Anthen Health Plans of New Hampshire, Inc.	NH	IA	ATH Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	53759	02-0510530				Anthen Health Plans of Virginia, Inc.	VA	IA	Anthen Southeast, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	71835	54-0357120	40003317			Anthen Health Plans, Inc.	CT	IA	ATH Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	60217	06-1475929				Anthen Holding Corp.	IN	NIA	Anthen, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		61-1459939				New York Stock Exchange (NYSE)								
.D671	Anthen, Inc.		35-2145715		6324		Anthen, Inc.	IN	UIP	Anthen, Inc.	Ownership		Anthen, Inc.	N	
.D671	Anthen, Inc.	28207	35-0781558				Anthen Insurance Companies, Inc.	IN	IA	Anthen, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	15543	47-0992859				Anthen Kentucky Managed Care Plan, Inc.	KY	IA	ATH Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	13573	20-5876774				Anthen Life & Disability Insurance Company	NY	IA	WellPoint Acquisition, LLC	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.						Anthen Life Insurance Company	IN	IA	Rocky Mountain Hospital and Medical Service, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	61069	35-0980405				Anthen Merger Sub Corp.	DE	NIA	Anthen, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.						Anthen Partnership Holding Company, LLC	DE	NIA	Anthen, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		81-3974489				Anthen Southeast, Inc.	IN	NIA	Anthen, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		32-0031791				Anthen UM Services, Inc.	IN	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		35-2129194				Anthen Workers' Compensation, LLC	IN	NIA	Anthen Blue Cross Life and Health Insurance Company	Ownership	75.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		30-0606541				Anthen Workers' Compensation, LLC	IN	NIA	HealthLink, Inc.	Ownership	25.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		95-4640529				Arcus Enterprises, Inc.	DE	NIA	Anthen Holding Corp.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		20-2858384				AROUS HealthLiving Services, Inc.	IN	NIA	Arcus Enterprises, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		35-1292384				Associated Group, Inc.	IN	NIA	Anthen Insurance Companies, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		11-3713086				ATH Holding Company, LLC	IN	UIP	Anthen, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	15480	20-4888378				Better Health, Inc.	FL	RE	Simply Healthcare Holdings, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	54801	58-0468945				Blue Cross and Blue Shield of Georgia, Inc.	GA	IA	Cerulean Companies, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.						Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	GA	IA	Cerulean Companies, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	96962	58-1638390				Blue Cross Blue Shield of Wisconsin	WI	IA	Crossroads Acquisition Corp.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	54003	39-0138065												

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Required? (Y/N)	*
.D671	Anthen, Inc.		95-3760980				Blue Cross of California Blue Cross of California Partnership Plan, Inc.	..CA	..IA	WellPoint California Services, Inc.	Ownership	100.000	Anthen, Inc.	N	..0101
.D671	Anthen, Inc.		20-2994048				Blue Cross of California	..CA	..IA	Blue Cross of California	Ownership	100.000	Anthen, Inc.	N	..0102
.D671	Anthen, Inc.		95-4694706				Carellore Health Plan	..CA	..IA	Carellore Health System	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.	13562	38-3795280				Carellore Health Plan of Arizona, Inc.	..AZ	..IA	Carellore Health System	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.	33605	26-4001602				Carellore Health Plan of Nevada	..NV	..IA	Carellore Health System	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		27-1625392				Carellore Health Plan of Texas, Inc.	..TX	..IA	Carellore Health System	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		45-4985009				Carellore IPA of New York, LLC	..NY	..NIA	Carellore, LLC	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		32-0373216				Carellore, LLC	..IN	..NIA	Carellore Health System	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		20-2078421				Carellore Health System	..CA	..NIA	ATH Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		46-0913946				Carellore Services Company, LLC	..IN	..NIA	The Anthen Companies, Inc.	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		58-2217138				Cerulean Companies, Inc.	..GA	..NIA	Anthen Holding Corp.	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		39-1413702				Claim Management Services, Inc.	..WI	..NIA	Blue Cross Blue Shield of Wisconsin	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		14064	26-4674149			Community Care Health Plan of Louisiana, Inc.	..LA	..IA	Anthen Partnership Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		30345	31-1440175			Community Insurance Company	..OH	..IA	ATH Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.	95693	39-1462554				Comcare Health Services Insurance Corporation	..WI	..IA	Blue Cross Blue Shield of Wisconsin	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		20-0334650				Crossroads Acquisition Corp.	..DE	..NIA	Anthen Holding Corp.	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		41-1905556				DeCare Analytics, LLC	..MN	..NIA	DeCare Dental, LLC	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		02-0574609				DeCare Dental Health International, LLC	..MN	..NIA	DeCare Dental, LLC	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.						DeCare Dental Insurance Ireland, Ltd.	..IRL	..NIA	DeCare Dental, LLC	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		73-1685529				DeCare Dental Networks, LLC	..MN	..NIA	DeCare Dental, LLC	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		01-0822645				DeCare Dental, LLC	..MN	..NIA	Anthen Holding Corp.	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.						DeCare Operations Ireland, Limited	..IRL	..NIA	DeCare Dental, LLC	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		26-2544715				Designated Agent Company, Inc.	..KY	..NIA	Anthen Health Plans of Kentucky, Inc.	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		13-3934328				BHC Benefits Agency, Inc.	..NY	..NIA	WellPoint Holding Corp.	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.	55093	23-7391136				Empire HealthChoice Assurance, Inc.	..NY	..IA	WellPoint Holding Corp.	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.	95433	13-3874803				Empire HealthChoice HMO, Inc.	..NY	..IA	Empire HealthChoice Assurance, Inc.	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		26-4286154				Federal Government Solutions, LLC	..WI	..NIA	ATH Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	..0103
.D671	Anthen, Inc.		95-2907732				Golden West Health Plan, Inc.	..CA	..IA	WellPoint California Services, Inc.	Ownership	100.000	Anthen, Inc.	N	..0104
.D671	Anthen, Inc.		97217				Greater Georgia Life Insurance Company	..GA	..IA	Blue Cross and Blue Shield of Georgia, Inc.	Ownership	100.000	Anthen, Inc.	N	..0104
.D671	Anthen, Inc.		51-036660				Health Core, Inc.	..DE	..NIA	Arcus Enterprises, Inc.	Ownership	100.000	Anthen, Inc.	N	..0104
.D671	Anthen, Inc.		54-1237939				Health Management Corporation	..VA	..NIA	Southeast Services, Inc.	Ownership	100.000	Anthen, Inc.	N	..0104
.D671	Anthen, Inc.		36-3897701				Health Ventures Partner, L.L.C.	..IL	..NIA	UNICARE National Services, Inc.	Ownership	100.000	Anthen, Inc.	N	..0104
.D671	Anthen, Inc.	95169	54-1356687				HealthKeepers, Inc.	..VA	..IA	Anthen Southeast, Inc.	Ownership	92.510	Anthen, Inc.	N	..0104
.D671	Anthen, Inc.	95169	54-1356687				HealthKeepers, Inc.	..VA	..IA	UNICARE National Services, Inc.	Ownership	7.490	Anthen, Inc.	N	..0104
.D671	Anthen, Inc.	96475	43-1616135				HealthLink HMO, Inc.	..MD	..IA	HealthLink, Inc.	Ownership	100.000	Anthen, Inc.	N	..0104
.D671	Anthen, Inc.		43-1364135				HealthLink, Inc.	..IL	..NIA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthen, Inc.	N	..0104
.D671	Anthen, Inc.		13-3865627				HealthPlus HP, LLC	..NY	..IA	AMERIGROUP Corporation	Ownership	100.000	Anthen, Inc.	N	..0100
.D671	Anthen, Inc.		86-0257201				Healthy Alliance Life Insurance Company	..MD	..IA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthen, Inc.	N	..0100
.D671	Anthen, Inc.	95473	84-1017384				HMO Colorado, Inc.	..CO	..IA	Rocky Mountain Hospital and Medical Services, Inc.	Ownership	100.000	Anthen, Inc.	N	..0108
.D671	Anthen, Inc.	95358	37-1216698				HMO Missouri, Inc.	..MO	..IA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthen, Inc.	N	..0108
.D671	Anthen, Inc.		75-2619605				Imaging Management Holdings, L.L.C.	..DE	..NIA	ATH Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	..0108
.D671	Anthen, Inc.		02-0581429				Living Complete Technologies, Inc.	..MD	..NIA	ATH Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	..0108
.D671	Anthen, Inc.	95527	02-0494919				Matthew Thornton Health Plan, Inc.	..NH	..IA	Anthen Health Plans of New Hampshire, Inc.	Ownership	100.000	Anthen, Inc.	N	..0108
.D671	Anthen, Inc.						Meridian Resource Company, LLC	..WI	..NIA	Comcare Health Services Insurance Corporation	Ownership	100.000	Anthen, Inc.	N	..0108
.D671	Anthen, Inc.		39-2013971				National Government Services, Inc.	..IN	..NIA	Anthen Insurance Companies, Inc.	Ownership	100.000	Anthen, Inc.	N	..0108
.D671	Anthen, Inc.		46-1595582				National Telehealth Network, LLC	..DE	..NIA	Sellcore, Inc.	Ownership	50.000	Anthen, Inc.	N	..0105
.D671	Anthen, Inc.		95-4248368				Park Square Holdings, Inc.	..CA	..NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthen, Inc.	N	..0105

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

SCHEDULE Y
PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

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Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Required? (Y/N)	*
.D671	Anthen, Inc.		95-4386221				Park Square I, Inc.	..CA	..NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		95-4249345				Park Square II, Inc.	..CA	..NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		65-0569629				PHP Holdings, Inc.	..FL	..NIA	AMBIGROUP Corporation	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		56-2396739				Resolution Health, Inc.	..DE	..NIA	Anthen Southeast, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		47-0851593				RightCHOICE Managed Care, Inc.	..DE	..NIA	Anthen Holding Corp.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	11011	84-0747736				Rocky Mountain Hospital and Medical Service, Inc.	..CO	..IA	ATH Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		20-0473316				SellCore, Inc.	..DE	..NIA	Anthen, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		27-0757414				Simply Healthcare Holdings, Inc.	..FL	..LDP	ATH Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	35726	27-0945036				Simply Healthcare Plans, Inc.	..FL	..IA	Simply Healthcare Holdings, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		55-0712302				Southeast Services, Inc.	..VA	..NIA	Anthen Southeast, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		45-4071004				State Sponsored Business UI Services, Inc.	..IN	..NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		35-1835818				The Anthen Companies, Inc.	..IN	..NIA	ATH Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		45-5443372				The Anthen Companies of California, Inc.	..CA	..NIA	ATH Holding Company, LLC	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		43-1967924				TrustSolutions, LLC	..WI	..NIA	Government Health Services, LLC	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	11810	84-1620480				UNICARE Health Plan of West Virginia, Inc.	..WV	..IA	UNICARE National Services, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		36-3999137				UNICARE Illinois Services, Inc.	..IL	..NIA	UNICARE National Services, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	80314	52-0913817				UNICARE Life & Health Insurance Company	..IN	..IA	UNICARE National Services, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		95-4635507				UNICARE National Services, Inc.	..DE	..NIA	Anthen Holding Corp.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		77-0494551				UNICARE Specialty Services, Inc.	..DE	..NIA	Anthen Holding Corp.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		36-4014617				Utilimed IPA, Inc.	..NY	..NIA	American Imaging Management, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		20-4405193				WellPoint Acquisition, LLC	..IN	..NIA	Anthen, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		20-2156380				WellPoint Behavioral Health, Inc.	..DE	..NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		95-4840531				WellPoint California Services, Inc.	..DE	..NIA	Anthen Holding Corp.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		95-4657170				WellPoint Dental Services, Inc.	..DE	..NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		81-2874917				WellPoint Health Solutions, Inc.	..DE	..NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		20-3620996				WellPoint Holding Corp.	..DE	..NIA	Anthen, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		45-2736438				WellPoint Information Technology Services, Inc.	..CA	..NIA	Blue Cross of California	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		96-495641				WellPoint Insurance Services, Inc.	..HI	..NIA	Anthen, Inc.	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		47-2546620				WellPoint Military Care Corporation	..IL	..NIA	Government Health Services, LLC	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.	35929	47-5569628				Wisconsin Collaborative Insurance Company	..WI	..IA	Crossroads Acquisition Corp.	Ownership	50.000	Anthen, Inc.	N	0107
.D671	Anthen, Inc.		98-0552141				WPMI (Shanghai) Enterprise Service Co. Ltd.	..DNL	..NIA	WPMI, LLC	Ownership	100.000	Anthen, Inc.	N	
.D671	Anthen, Inc.		20-8672847				WPMI, LLC	..DE	..NIA	ATH Holding Company, LLC	Ownership	69.910	Anthen, Inc.	N	0106

Asterisk	Explanation
0100	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the New York State Department of Health.
0101	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0102	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0103	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0104	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0105	50% owned by unaffiliated investors
0106	30.09% owned by unaffiliated investors
0107	50% owned by an unaffiliated investor
0108	Received exemption from domestic regulator

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

SCHEDULE Y
PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1	2	3	4	5	6	7	8	9	10	11	12	13
NAIC Company Code	ID Number	Names of Insurers and Parent, Subsidiaries or Affiliates	Shareholder Dividends	Capital Contributions	Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	Management Agreements and Service Contracts	Income/ (Disbursements) Incurred Under Reinsurance Agreements	*	Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	Totals	Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
12354	36-3692630	American Imaging Management, Inc.					(45,143,273)				(45,143,273)	
	20-2073598	AMERIGROUP Community Care of New Mexico, Inc.					(2,376,606)				(2,376,606)	
	54-1739323	AMERIGROUP Corporation					(23,463,877)				(23,463,877)	
95093	65-0318864	AMERIGROUP Florida, Inc.		10,000,000			(138,420,433)				(128,420,433)	
14078	45-2485907	AMERIGROUP Insurance Company					(46,993,561)				(46,993,561)	
15807	47-3863197	AMERIGROUP Iowa, Inc.		250,000,000			(78,378,221)				(78,378,221)	
14276	45-3358287	AMERIGROUP Kansas, Inc.					(74,340,938)				(74,340,938)	
95832	51-0387398	AMERIGROUP Maryland, Inc.	(20,000,000)				(121,837,959)				(141,837,959)	
12586	20-3317697	AMERIGROUP Nevada, Inc.					(61,302,699)				(61,302,699)	
95373	22-3375292	AMERIGROUP New Jersey, Inc.	(50,000,000)				(145,692,060)				(195,692,060)	
10767	13-4212818	AMERIGROUP Ohio Inc					(469,933)				(469,933)	
	36-3897080	AMERIGROUP Partnership Plan, LLC					(26,852,245)				(26,852,245)	
12941	20-4776597	AMERIGROUP Tennessee, Inc.					(190,076,813)				(190,076,813)	
95314	75-2603231	AMERIGROUP Texas, Inc.	(30,000,000)				(404,082,715)				(434,082,715)	
14073	27-3510384	AMERIGROUP Washington, Inc.	(12,000,000)				(68,215,341)				(80,215,341)	
12229	06-1696189	AMGP Georgia Managed Care Company, Inc.	(15,000,000)				(142,727,809)				(157,727,809)	
62825	95-4331852	Anthem Blue Cross Life and Health Insurance Company, Inc.	(235,600,000)				(941,956,611)	(983,470)			(1,178,540,081)	1,511,335
95120	61-1237516	Anthem Health Plans of Kentucky, Inc.	(95,000,000)				(391,288,399)				(486,288,399)	
52618	31-1705652	Anthem Health Plans of Maine, Inc.	(22,100,000)				(111,362,268)				(133,462,268)	
53759	02-0510530	Anthem Health Plans of New Hampshire, Inc.	(10,000,000)				(50,981,912)				(60,981,912)	
71835	54-0357120	Anthem Health Plans of Virginia, Inc.	(216,100,000)				(614,651,485)	10,369,959			(820,381,526)	(4,585,268)
60217	06-1475928	Anthem Health Plans, Inc.	(91,800,000)				(304,498,539)				(396,298,539)	
28207	35-0781558	Anthem Insurance Companies, Inc.	(325,000,000)				(1,254,634,382)	11,067,248			(1,568,567,134)	(1,644,166)
15543	47-0992859	Anthem Kentucky Managed Care Plan, Inc.					(64,835,810)				(64,835,810)	
13573	20-5876774	Anthem Life and Disability Insurance Company					(1,071,963)				(1,071,963)	
61069	35-0980405	Anthem Life Insurance Company	(18,900,000)				(35,571,292)	17,800,662			(36,670,630)	(23,079,605)
	35-2145715	Anthem, Inc.	2,611,100,000	(300,000,000)			6,354,566,658				8,665,666,658	
	11-3713086	ATH Holding Company, LLC					(41,675,909)				(41,675,909)	
15480	20-4889378	Better Health, Inc.					(40,459,168)				(40,459,168)	
54801	58-0469845	Blue Cross and Blue Shield of Georgia, Inc.	(73,600,000)				(352,736,642)				(426,336,642)	
96962	58-1638390	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	(25,700,000)				(401,841,849)				(427,541,849)	
54003	39-0138065	Blue Cross Blue Shield of Wisconsin	(60,000,000)				(137,431,914)				(197,431,914)	
	95-3760980	Blue Cross of California	(425,000,000)				(1,318,129,334)				(1,743,129,334)	
	20-2994048	Blue Cross of California Partnership Plan, Inc.					(332,338,749)				(332,338,749)	
	95-4694706	Caremore Health Plan	(50,000,000)				(187,480,869)				(237,480,869)	
13562	38-3975280	Caremore Health Plan of Arizona, Inc.					(36,300,363)				(36,300,363)	
13605	26-4001602	Caremore Health Plan of Nevada					(21,134,855)				(21,134,855)	

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

SCHEDULE Y
PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1	2	3	4	5	6	7	8	9	10	11	12	13
NAIC Company Code	ID Number	Names of Insurers and Parent, Subsidiaries or Affiliates	Shareholder Dividends	Capital Contributions	Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	Management Agreements and Service Contracts	Income/ (Disbursements) Incurred Under Reinsurance Agreements	*	Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	Totals	Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
	32-0373216	Caremore, LLC					(11,857,052)				(11,857,052)	
14064	26-4674149	Community Care Health Plan of Louisiana, Inc.		20,000,000			(69,006,060)				(49,006,060)	
10345	31-1440175	Community Insurance Company	(266,200,000)				(911,412,383)				(1,177,612,383)	
95693	39-1462554	Compcare Health Services Insurance Corporation	(10,000,000)				(92,054,648)				(102,054,648)	
	01-0822645	DeCare Dental, LLC					(45,567,014)				(45,567,014)	
55093	23-7391136	Empire HealthChoice Assurance, Inc.	(250,000,000)				(528,256,823)				(778,256,823)	
95433	13-3874903	Empire HealthChoice HMO, Inc.					(122,558,319)				(122,558,319)	
	95-2907752	Golden West Health Plan, Inc.					(790,279)				(790,279)	
97217	58-1473042	Greater Georgia Life Insurance Company					(7,681,353)				(7,681,353)	
	51-0365660	Health Core, Inc.					(21,346,159)				(21,346,159)	
95169	54-1356687	HealthKeepers, Inc.	(35,000,000)	15,000,000			(388,403,745)	(10,369,959)			(418,773,704)	4,585,268
96475	43-1616135	HealthLink HMO, Inc.	(10,000,000)				5,219,475				(4,780,525)	
	43-1364135	HealthLink, Inc.					(60,489,216)				(60,489,216)	
	13-3865627	HealthPlus LLC					(300,587,736)				(300,587,736)	
78972	86-0257201	Healthy Alliance Life Insurance Company	(105,200,000)				(294,007,288)				(399,207,288)	
95473	84-1017384	HMO Colorado, Inc.		15,000,000			(40,662,843)				(25,662,843)	
95358	37-1216698	HMO Missouri, Inc.	(800,000)				(18,848,458)				(19,648,458)	
	98-0408753	HTH Re, LTD						983,470			983,470	(1,511,335)
95527	02-0494919	Matthew Thornton Health Plan, Inc.	(30,000,000)				(75,499,873)				(105,499,873)	
	35-1840597	National Government Services, Inc.					(20,169,845)				(20,169,845)	
	47-0851593	RightCHOICE Managed Care, Inc.					(22,510,682)				(22,510,682)	
11011	84-0747736	Rocky Mountain Hospital and Medical Service, Inc.	(78,100,000)	(15,000,000)			(257,720,740)				(350,820,740)	
13726	27-0945036	Simply Healthcare Plans, Inc.					(140,514,747)				(140,514,747)	
	45-5443372	The Anthem Companies of California, Inc.					146,341,009				146,341,009	
	35-1835818	The Anthem Companies, Inc.					4,887,345,537				4,887,345,537	
11810	84-1620480	UNICARE Health Plan of West Virginia, Inc.					(43,128,585)				(43,128,585)	
80314	52-0913817	UNICARE Life & Health Insurance Company	(50,000,000)				(48,109,062)	(28,867,910)			(126,976,972)	24,723,771
	45-2736438	WellPoint Information Technology Services										
	47-2546820	WellPoint Military Care Corporation					349,756,226				349,756,226	
15929	47-5569628	Wisconsin Collaborative Insurance Company					(7,365,246)				(7,365,246)	
				5,000,000			(3,923,953)				1,076,047	
9999999	Control Totals		0	0	0	0	0	0	XXX	0	0	0









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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

	Responses
MARCH FILING	
1. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?	SEE EXPLANATION
2. Will an actuarial opinion be filed by March 1?	YES
3. Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?.....	YES
4. Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1?.....	YES
APRIL FILING	
5. Will Management's Discussion and Analysis be filed by April 1?	YES
6. Will the Supplemental Investment Risks Interrogatories be filed by April 1?	YES
7. Will the Accident and Health Policy Experience Exhibit be filed by April 1?	YES
JUNE FILING	
8. Will an audited financial report be filed by June 1?	YES
9. Will Accountant's Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?	YES
AUGUST FILING	
10. Will the regulator-only (non-public) Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile and electronically with the NAIC (as a regulator-only non-public document) by August 1?	YES
The following supplemental reports are required to be filed as part of your annual statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.	
MARCH FILING	
11. Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?	NO
12. Will the Supplemental Life data due March 1 be filed with the state of domicile and the NAIC?	NO
13. Will the Supplemental Property/Casualty data due March 1 be filed with the state of domicile and the NAIC?.....	NO
14. Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1?.....	NO
15. Will the actuarial opinion on participating and non-participating policies as required in Interrogatories 1 and 2 on Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?.....	NO
16. Will the actuarial opinion on non-guaranteed elements as required in Interrogatory 3 to Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?.....	NO
17. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?.....	NO
18. Will an approval from the reporting entity's state of domicile for relief related to the five-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1?	NO
19. Will an approval from the reporting entity's state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1?	NO
20. Will an approval from the reporting entity's state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?.....	NO
APRIL FILING	
21. Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?	NO
22. Will the Supplemental Life data due April 1 be filed with the state of domicile and the NAIC?	NO
23. Will the Supplemental Property/Casualty Insurance Expense Exhibit due April 1 be filed with any state that requires it, and, if so, the NAIC?	NO
24. Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?	YES
25. Will the regulator only (non-public) Supplemental Health Care Exhibit's Expense Allocation Report be filed with the state of domicile and the NAIC by April 1?	YES
AUGUST FILING	
26. Will Management's Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?	YES
Explanations:	
1. The annual filing for Florida isn't due until April 1, 2017.	
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Bar Codes:

11. Medicare Supplement Insurance Experience Exhibit [Document Identifier 360]	
12. Life Supplement [Document Identifier 205]	
13. Property/Casualty Supplement [Document Identifier 207]	
14. SIS Stockholder Information Supplement [Document Identifier 420]	
15. Participating Opinion for Exhibit 5 [Document Identifier 371]	
16. Non-Guaranteed Opinion for Exhibit 5 [Document Identifier 370]	
17. Medicare Part D Coverage Supplement [Document Identifier 365]	
18. Relief from the five-year rotation requirement for lead audit partner [Document Identifier 224]	

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

19. Relief from the one-year cooling off period for independent CPA
[Document Identifier 225]



20. Relief from the Requirements for Audit Committees [Document Identifier 226]



21. Long-Term Care Experience Reporting Forms [Document Identifier 306]



22. Life Supplement [Document Identifier 211]



23. Property/Casualty Supplement Insurance Expense Exhibit
[Document Identifier 213]



ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

OVERFLOW PAGE FOR WRITE-INS

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

SUMMARY INVESTMENT SCHEDULE

Investment Categories	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
	1 Amount	2 Percentage	3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage
1. Bonds:						
1.1 U.S. treasury securities		0.000			0	0.000
1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
1.21 Issued by U.S. government agencies		0.000			0	0.000
1.22 Issued by U.S. government sponsored agencies		0.000			0	0.000
1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)		0.000			0	0.000
1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S. :						
1.41 States, territories and possessions general obligations		0.000			0	0.000
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations		0.000			0	0.000
1.43 Revenue and assessment obligations		0.000			0	0.000
1.44 Industrial development and similar obligations		0.000			0	0.000
1.5 Mortgage-backed securities (includes residential and commercial MBS):						
1.51 Pass-through securities:						
1.511 Issued or guaranteed by GNMA		0.000			0	0.000
1.512 Issued or guaranteed by FNMA and FHLMC		0.000			0	0.000
1.513 All other		0.000			0	0.000
1.52 CMOs and REMICs:						
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA		0.000			0	0.000
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521		0.000			0	0.000
1.523 All other		0.000			0	0.000
2. Other debt and other fixed income securities (excluding short-term):						
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)		0.000			0	0.000
2.2 Unaffiliated non-U.S. securities (including Canada)		0.000			0	0.000
2.3 Affiliated securities		0.000			0	0.000
3. Equity interests:						
3.1 Investments in mutual funds		0.000			0	0.000
3.2 Preferred stocks:						
3.21 Affiliated		0.000			0	0.000
3.22 Unaffiliated		0.000			0	0.000
3.3 Publicly traded equity securities (excluding preferred stocks):						
3.31 Affiliated		0.000			0	0.000
3.32 Unaffiliated		0.000			0	0.000
3.4 Other equity securities:						
3.41 Affiliated		0.000			0	0.000
3.42 Unaffiliated		0.000			0	0.000
3.5 Other equity interests including tangible personal property under lease:						
3.51 Affiliated		0.000			0	0.000
3.52 Unaffiliated		0.000			0	0.000
4. Mortgage loans:						
4.1 Construction and land development		0.000			0	0.000
4.2 Agricultural		0.000			0	0.000
4.3 Single family residential properties		0.000			0	0.000
4.4 Multifamily residential properties		0.000			0	0.000
4.5 Commercial loans		0.000			0	0.000
4.6 Mezzanine real estate loans		0.000			0	0.000
5. Real estate investments:						
5.1 Property occupied by company		0.000	0		0	0.000
5.2 Property held for production of income (including \$ of property acquired in satisfaction of debt)		0.000	0		0	0.000
5.3 Property held for sale (including \$ property acquired in satisfaction of debt)		0.000	0		0	0.000
6. Contract loans		0.000	0		0	0.000
7. Derivatives		0.000	0		0	0.000
8. Receivables for securities		0.000	0		0	0.000
9. Securities Lending (Line 10, Asset Page reinvested collateral)		0.000	0	XXX	XXX	XXX
10. Cash, cash equivalents and short-term investments	65,720,382	100.000	65,720,382		65,720,382	100.000
11. Other invested assets	0.000				0	0.000
12. Total invested assets	65,720,382	100.000	65,720,382	0	65,720,382	100.000

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

Schedule A - Verification - Real Estate

NONE

Schedule B - Verification - Mortgage Loans

NONE

Schedule BA - Verification - Other Long-Term Invested Assets

NONE

Schedule D - Verification - Bonds and Stock

NONE

Schedule D - Summary By Country

NONE

Schedule D - Part 1A - Section 1 - Quality and Maturity Distribution of All Bonds Owned by Major Type
and NAIC Designation

NONE

Schedule D - Part 1A - Section 2 - Quality and Maturity Distribution of All Bonds Owned by Major Type
and Subtype

NONE

Schedule DA - Verification - Short-Term Investments

NONE

Schedule DB - Part A - Verification - Options, Caps, Floors, Collars, Swaps and Forwards

NONE

Schedule DB - Part B - Verification - Futures Contracts

NONE

Schedule DB - Part C - Section 1 - Replication (Synthetic Asset) Transactions (RSATs) Open

NONE

Schedule DB-Part C-Section 2-Reconciliation of Replication (Synthetic Asset) Transactions Open

NONE

Schedule DB - Verification - Book/Adjusted Carrying Value, Fair Value and Potential Exposure of
Derivatives

NONE

Schedule E - Verification - Cash Equivalents

NONE

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

Schedule A - Part 1 - Real Estate Owned

NONE

Schedule A - Part 2 - Real Estate Acquired and Additions Made

NONE

Schedule A - Part 3 - Real Estate Disposed

NONE

Schedule B - Part 1 - Mortgage Loans Owned

NONE

Schedule B - Part 2 - Mortgage Loans Acquired and Additions Made

NONE

Schedule B - Part 3 - Mortgage Loans Disposed, Transferred or Repaid

NONE

Schedule BA - Part 1 - Other Long-Term Invested Assets Owned

NONE

Schedule BA - Part 2 - Other Long-Term Invested Assets Acquired and Additions Made

NONE

Schedule BA - Part 3 - Other Long-Term Invested Assets Disposed, Transferred or Repaid

NONE

Schedule D - Part 1 - Long Term Bonds Owned

NONE

Schedule D - Part 2 - Section 1 - Preferred Stocks Owned

NONE

Schedule D - Part 2 - Section 2 - Common Stocks Owned

NONE

Schedule D - Part 3 - Long-Term Bonds and Stocks Acquired

NONE

Schedule D - Part 4 - Long-Term Bonds and Stocks Sold, Redeemed or Otherwise Disposed Of

NONE

E01, E02, E03, E04, E05, E06, E07, E08, E09, E10, E11, E12, E13, E14

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

Schedule D - Part 5 - Long Term Bonds and Stocks Acquired and Fully Disposed Of

NONE

Schedule D-Part 6-Section 1-Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

NONE

Schedule D - Part 6 - Section 2

NONE

Schedule DA - Part 1 - Short-Term Investments Owned

NONE

Schedule DB - Part A - Section 1 - Options, Caps, Floors, Collars, Swaps and Forwards Open

NONE

Schedule DB - Part A - Section 2 - Options, Caps, Floors, Collars, Swaps and Forwards Terminated

NONE

Schedule DB - Part B - Section 1 - Futures Contracts Open

NONE

Schedule DB - Part B - Section 1B - Brokers with whom cash deposits have been made

NONE

Schedule DB - Part B - Section 2 - Futures Contracts Terminated

NONE

Schedule DB - Part D - Section 1 - Counterparty Exposure for Derivative Instruments Open

NONE

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged By

NONE

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged To

NONE

Schedule DL - Part 1 - Reinvested Collateral Assets Owned

NONE

Schedule DL - Part 2 - Reinvested Collateral Assets Owned

NONE

E15, E16, E17, E18, E19, E20, E21, E22, E23, E24, E25

SCHEDULE E - PART 1 - CASH

TOTALS OF DEPOSITORY BALANCES ON THE LAST DAY OF EACH MONTH DURING THE CURRENT YEAR											
1.	January.	48,884,959	4.	April.	43,984,851	7.	July.	49,395,393	10.	October.	50,613,101
2.	February.	44,584,470	5.	May.	45,795,691	8.	August.	57,169,652	11.	November.	56,104,560
3.	March.	45,451,037	6.	June.	48,268,180	9.	September.	51,361,009	12.	December.	65,720,382

Show Investments Owned December 31 of Current Year

NONE

Attachment 2016 Better Health Inc.
Annual Health Statement — Page 94

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

SCHEDULE E - PART 3 - SPECIAL DEPOSITS

States, Etc.	1 Type of Deposit	2 Purpose of Deposit	Deposits For the Benefit of All Policyholders		All Other Special Deposits	
			3 Book/Adjusted Carrying Value	4 Fair Value	5 Book/Adjusted Carrying Value	6 Fair Value
1. Alabama .....AL						
2. Alaska .....AK						
3. Arizona .....AZ						
4. Arkansas .....AR						
5. California .....CA						
6. Colorado .....CO						
7. Connecticut .....CT						
8. Delaware .....DE						
9. District of Columbia .....DC						
10. Florida .....FL	ST	Insolvency	9,709,284	9,709,284		
11. Georgia .....GA						
12. Hawaii .....HI						
13. Idaho .....ID						
14. Illinois .....IL						
15. Indiana .....IN						
16. Iowa .....IA						
17. Kansas .....KS						
18. Kentucky .....KY						
19. Louisiana .....LA						
20. Maine .....ME						
21. Maryland .....MD						
22. Massachusetts .....MA						
23. Michigan .....MI						
24. Minnesota .....MN						
25. Mississippi .....MS						
26. Missouri .....MO						
27. Montana .....MT						
28. Nebraska .....NE						
29. Nevada .....NV						
30. New Hampshire .....NH						
31. New Jersey .....NJ						
32. New Mexico .....NM						
33. New York .....NY						
34. North Carolina .....NC						
35. North Dakota .....ND						
36. Ohio .....OH						
37. Oklahoma .....OK						
38. Oregon .....OR						
39. Pennsylvania .....PA						
40. Rhode Island .....RI						
41. South Carolina .....SC						
42. South Dakota .....SD						
43. Tennessee .....TN						
44. Texas .....TX						
45. Utah .....UT						
46. Vermont .....VT						
47. Virginia .....VA						
48. Washington .....WA						
49. West Virginia .....WV						
50. Wisconsin .....WI						
51. Wyoming .....WY						
52. American Samoa .....AS						
53. Guam .....GU						
54. Puerto Rico .....PR						
55. U.S. Virgin Islands .....VI						
56. Northern Mariana Islands .....MP						
57. Canada .....CAN						
58. Aggregate Alien and Other .....OT	XXX	XXX	0	0	0	0
59. Subtotal	XXX	XXX	9,709,284	9,709,284	0	0
DETAILS OF WRITE-INS						
5801.						
5802.						
5803.						
5898. Summary of remaining write-ins for Line 58 from overflow page	XXX	XXX	0	0	0	0
5899. Totals (Lines 5801 thru 5803 plus 5898)(Line 58 above)	XXX	XXX	0	0	0	0



Relief from the five-year rotation requirement for lead audit partner



Relief from the one-year cooling off period for independent CPA



Relief from the Requirements for Audit Committees



FOR THE STATE OF _____
 NAIC Group Code _____ NAIC Company Code _____
 ADDRESS (City, State and Zip Code) _____
 Person Completing This Form _____
 Title _____ Telephone Number _____

[illegible]

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details: _____
2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395u(h)(3)(B) for this date: _____
- 2.1 Address: _____
- 2.2 Contact Person and Phone Number: _____
3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B): _____
- 3.1 Address: _____
- 3.2 Contact Person and Phone Number: _____
4. Explain any policies identified above as policy type "O": _____



SUPPLEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
MEDICARE PART D COVERAGE SUPPLEMENT
(Net of Reinsurance)

NAIC Group Code 0000		(To Be Filed by March 1)		NAIC Company Code 15480	
	Individual Coverage		Group Coverage		5 Total Cash
	1 Insured	2 Uninsured	3 Insured	4 Uninsured	
1. Premiums Collected					
1.1 Standard Coverage					
1.11 With Reinsurance Coverage		XXX		XXX	
1.12 Without Reinsurance Coverage		XXX		XXX	
1.13 Risk-Corridor Payment Adjustments		XXX		XXX	
1.2 Supplemental Benefits		XXX		XXX	
2. Premiums Due and Uncollected-change					
2.1 Standard Coverage					
2.11 With Reinsurance Coverage		XXX		XXX	XXX
2.12 Without Reinsurance Coverage		XXX		XXX	XXX
2.2 Supplemental Benefits		XXX		XXX	XXX
3. Unearned Premium and Advance Premium-change					
3.1 Standard Coverage					
3.11 With Reinsurance Coverage		XXX		XXX	XXX
3.12 Without Reinsurance Coverage		XXX		XXX	XXX
3.2 Supplemental Benefits		XXX		XXX	XXX
4. Risk-Corridor Payment Adjustments-change					
4.1 Receivable		XXX		XXX	XXX
4.2 Payable		XXX		XXX	XXX
5. Earned Premiums					
5.1 Standard Coverage					
5.11 With Reinsurance Coverage		XXX		XXX	XXX
5.12 Without Reinsurance Coverage		XXX		XXX	XXX
5.13 Risk-Corridor Payment Adjustments		XXX		XXX	XXX
5.2 Supplemental Benefits		XXX		XXX	XXX
6. Total Premiums		XXX		XXX	
7. Claims Paid					
7.1 Standard Coverage					
7.11 With Reinsurance Coverage				XXX	
7.12 Without Reinsurance Coverage				XXX	
7.2 Supplemental Benefits				XXX	
8. Claim Reserves and Liabilities-change					
8.1 Standard Coverage					
8.11 With Reinsurance Coverage		XXX		XXX	XXX
8.12 Without Reinsurance Coverage		XXX		XXX	XXX
8.2 Supplemental Benefits		XXX		XXX	XXX
9. Health Care Receivables-change					
9.1 Standard Coverage					
9.11 With Reinsurance Coverage		XXX		XXX	XXX
9.12 Without Reinsurance Coverage		XXX		XXX	XXX
9.2 Supplemental Benefits		XXX		XXX	XXX
10. Claims Incurred					
10.1 Standard Coverage					
10.11 With Reinsurance Coverage		XXX		XXX	XXX
10.12 Without Reinsurance Coverage		XXX		XXX	XXX
10.2 Supplemental Benefits		XXX		XXX	XXX
11. Total Claims		XXX		XXX	
12. Reinsurance Coverage and Low Income Cost Sharing					
12.1 Claims Paid - Net of Reimbursements Applied	XXX		XXX		
12.2 Reimbursements Received but Not Applied-change	XXX		XXX		
12.3 Reimbursements Receivable-change	XXX		XXX		XXX
12.4 Health Care Receivables-change	XXX		XXX		XXX
13. Aggregate Policy Reserves-change					XXX
14. Expenses Paid		XXX		XXX	
15. Expenses Incurred		XXX		XXX	XXX
16. Underwriting Gain/Loss		XXX		XXX	XXX
17. Cash Flow Results	XXX	XXX	XXX	XXX	

NONE



Non-Guaranteed Opinion for Exhibit 5



Participating Opinion for Exhibit 5

SUPPLEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

Schedule SIS

NONE

Schedule SIS II

NONE

Schedule SIS III

NONE

Schedule SIS IV

NONE

SUPPLEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

Life Supplement Cover

NONE

Life Supplement - Exhibit 5 - Aggregate Reserve for Life Contracts

NONE

Life Supplement - Exhibit 5 - Interrogatories

NONE

Life Supplement - Exhibit 7 - Deposit-Type Contracts

NONE

Life Supplement - Schedule S - Part 1 - Section 1

NONE

Life Supplement - Schedule S - Part 3 - Section 1

NONE

LS01, LS02, LS03, LS04, LS05, LS06



SUPPLEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

DIRECT BUSINESS IN THE STATE OF

NAIC Group Code 0000

LIFE INSURANCE

DURING THE YEAR 2016

NAIC Company Code 15480

	1 Ordinary	2 Credit Life (Group and Individual)	3 Group	4 Industrial	5 Total
DIRECT PREMIUMS AND ANNUITY CONSIDERATIONS					
1. Life insurance					
2. Annuity considerations					
3. Deposit-type contract funds		XXX		XXX	
4. Other considerations					
5. Totals (Sum of Lines 1 to 4)					
DIRECT DIVIDENDS TO POLICYHOLDERS					
Life insurance:					
6.1 Paid in cash or left on deposit					
6.2 Applied to pay renewal premiums					
6.3 Applied to provide paid-up additions or shorten the endowment or premium-paying period					
6.4 Other					
6.5 Totals (sum of Line 6.1 to 6.4)					
Annuities:					
7.1 Paid in cash or left on deposit					
7.2 Applied to provide paid-up annuities					
7.3 Other					
7.4 Totals (sum of Lines 7.1 to 7.3)					
8. Grand Totals (Lines 6.5 plus 7.4)					
DIRECT CLAIMS AND BENEFITS PAID					
9. Death benefits					
10. Matured endowments					
11. Annuity benefits					
12. Surrender values and withdrawals for life contracts					
13. Aggregate write-ins for miscellaneous direct claims and benefits paid					
14. All other benefits, except accident and health					
15. Totals					
DETAILS OF WRITE-INS					
1301.					
1302.					
1303.					
1398. Summary of Line 13 from overflow page					
1399. Totals (Lines 1301 thru 1303 plus 1398) (Line 13 above)					

NONE

DIRECT DEATH BENEFITS AND MATURED ENDOWMENTS INCURRED	Ordinary		Credit Life (Group and Individual)		Group		Industrial		Total	
	1	2	3	4	5	6	7	8	9	10
	No.	Amount	No. of Ind. Pol. & Gr. Certifs.	Amount	No. of Certifs.	Amount	No.	Amount	No.	Amount
16. Unpaid December 31, prior year										
17. Incurred during current year										
Settled during current year:										
18.1 By payment in full										
18.2 By payment on compromised claims										
18.3 Totals paid										
18.4 Reduction by compromise										
18.5 Amount rejected										
18.6 Total settlements										
19. Unpaid Dec. 31, current year (16+17-18.6)										
POLICY EXHIBIT										
20. In force December 31, prior year					No. of Policies					
21. Issued during year			(a)							
22. Other changes to in force (Net)										
23. In force December 31 of current year			(a)							

(a) Includes Individual Credit Life Insurance prior year \$, current year \$
Includes Group Credit Life Insurance Loans less than or equal to 60 months at issue, prior year \$, current year \$
Loans greater than 60 months at issue BUT NOT GREATER THAN 120 MONTHS, prior year \$, current year \$

ACCIDENT AND HEALTH INSURANCE

	1 Direct Premiums	2 Direct Premiums Earned	3 Dividends Paid Or Credited On Direct Business	4 Direct Losses Paid	5 Direct Losses Incurred
24. Group Policies (b)					
24.1 Federal Employees Health Benefits Plan premium (b)					
24.2 Credit (Group and Individual)					
24.3 Collectively renewable policies (b)					
24.4 Medicare Title XVIII exempt from state taxes or fees Other Individual Policies:					
25.1 Non-cancelable (b)					
25.2 Guaranteed renewable (b)					
25.3 Non-renewable for stated reasons only (b)					
25.4 Other accident only					
25.5 All other (b)					
25.6 Totals (sum of Lines 25.1 to 25.5)					
26. Totals (Lines 24 + 24.1 + 24.2 + 24.3 + 24.4 + 25.6)					

(b) For health business on indicated lines report: Number of persons insured under PPO managed care products0 and number of persons
insured under indemnity only products

LS206

SUPPLEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

P&C Supplement Cover

NONE

P&C Supplement - Schedule F - Part 1

NONE

P&C Supplement - Schedule F - Part 3

NONE

P&C Supplement - Schedule P - Part 1 - Summary

NONE

P&C Supplement - Schedule P - Part 1A - Homeowners/Farmowners

NONE

P&C Supplement - Schedule P - Part 1B - Private Passenger Auto Liability/Medical

NONE

P&C Supplement - Schedule P - Part 1C - Commercial Auto/Truck Liability/Medical

NONE

P&C Supplement - Schedule P - Part 1D - Workers' Compensation (Excluding Excess Workers' Compensation)

NONE

P&C Supplement - Schedule P - Part 1E - Commercial Multiple Peril

NONE

P&C Supplement - Schedule P - Part 1F - Section 1 - Medical Professional Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 1F - Section 2 - Medical Professional Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 1G - Special Liability (Ocean Marine, Aircraft (all perils), Boiler and Machinery)

NONE

P&C Supplement - Schedule P - Part 1H - Section 1 - Other Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 1H - Section 2 - Other Liability - Claims-Made

NONE

PS01, PS02, PS03, PS04, PS05, PS06, PS07, PS08, PS09, PS10, PS11, PS12, PS13, PS14

SUPPLEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

P&C Supplement - Schedule P - Part 1I - Special Property (Fire, Allied Lines...)

NONE

P&C Supplement - Schedule P - Part 1J - Auto Physical Damage

NONE

P&C Supplement - Schedule P - Part 1K - Fidelity/Surety

NONE

P&C Supplement - Schedule P - Part 1L - Other (Including Credit, Accident and Health)

NONE

P&C Supplement - Schedule P - Part 1M - International

NONE

P&C Supplement - Schedule P - Part 1N - Reinsurance - Nonproportional Assumed Property

NONE

P&C Supplement - Schedule P - Part 1O - Reinsurance - Nonproportional Assumed Liability

NONE

P&C Supplement - Schedule P - Part 1P - Reinsurance - Nonproportional Assumed Financial Lines

NONE

P&C Supplement - Schedule P - Part 1R - Section 1 - Products Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 1R - Section 2 - Products Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 1S - Financial Guaranty/Mortgage Guaranty

NONE

P&C Supplement - Schedule P - Part 1T - Warranty

NONE

P&C Supplement - Schedule P - Part 2 - Summary

NONE

P&C Supplement - Schedule P - Part 2A - Homeowners/Farmowners

NONE

PS15, PS16, PS17, PS18, PS19, PS20, PS21, PS22, PS23, PS24, PS25, PS26, PS27, PS28

SUPPLEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

P&C Supplement - Schedule P - Part 2B - Private Passenger Auto Liability/Medical

NONE

P&C Supplement - Schedule P - Part 2C - Commercial Auto/Truck Liability/Medical

NONE

P&C Supplement - Schedule P - Part 2D - Workers' Compensation (Excluding Excess Workers' Compensation)

NONE

P&C Supplement - Schedule P - Part 2E - Commercial Multiple Peril

NONE

P&C Supplement - Schedule P - Part 2F - Section 1 - Medical Professional Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 2F - Section 2 - Medical Professional Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 2G - Special Liability (Ocean Marine, Aircraft (all perils), Boiler and Machinery)

NONE

P&C Supplement - Schedule P - Part 2H - Section 1 - Other Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 2H - Section 2- Other Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 2I - Special Property

NONE

P&C Supplement - Schedule P - Part 2J - Auto Physical Damage

NONE

P&C Supplement - Schedule P - Part 2K - Fidelity/Surety

NONE

P&C Supplement - Schedule P - Part 2L - Other (Including Credit, Accident and Health)

NONE

P&C Supplement - Schedule P - Part 2M - International

NONE

SUPPLEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

P&C Supplement - Schedule P - Part 2N - Reinsurance - Nonproportional Assumed Property

NONE

P&C Supplement - Schedule P - Part 2O - Reinsurance - Nonproportional Assumed Liability

NONE

P&C Supplement - Schedule P - Part 2P - Reinsurance - Nonproportional Assumed Financial Lines

NONE

P&C Supplement - Schedule P - Part 2R - Section 1 - Products Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 2R - Section 2 - Products Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 2S - Financial Guaranty/Mortgage Guaranty

NONE

P&C Supplement - Schedule P - Part 2T - Warranty

NONE



SUPPLEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
EXHIBIT OF PREMIUMS AND LOSSES (Statutory Page 14)

NAIC Group Code 0000

BUSINESS IN THE STATE OF

DURING THE YEAR 2016

NAIC Company Code 15480

Line of Business	Gross Premiums, Including Policy and Membership Fees, Less Return Premiums and Premiums on Policies not Taken		3	4	5	6	7	8	9	10	11	12
	1	2										
	Direct Premiums Written	Direct Premiums Earned	Dividends Paid or Credited to Policyholders on Direct Business	Direct Unearned Premium Reserves	Direct Losses Paid (deducting salvage)	Direct Losses Incurred	Direct Losses Unpaid	Direct Defense and Cost Containment Expense Paid	Direct Defense and Cost Containment Expense Incurred	Direct Defense and Cost Containment Expense Unpaid	Commissions and Brokerage Expenses	Taxes, Licenses and Fees
1. Fire												
2.1 Allied lines												
2.2 Multiple peril crop												
2.3 Federal flood												
2.4 Private crop												
2.5 Private flood												
3. Farmowners multiple peril												
4. Homeowners multiple peril												
5.1 Commercial multiple peril (non-liability portion)												
5.2 Commercial multiple peril (liability portion)												
6. Mortgage guaranty												
8. Ocean marine												
9. Inland marine												
10. Financial guaranty												
11. Medical professional liability												
12. Earthquake												
13. Group accident and health (b)												
14. Credit accident and health (group and individual)												
15.1 Collectively renewable accident and health (b)												
15.2 Non-cancelable accident and health(b)												
15.3 Guaranteed renewable accident and health(b)												
15.4 Non-renewable for stated reasons only (b)												
15.5 Other accident only												
15.6 Medicare Title XVIII exempt from state taxes or fees												
15.7 All other accident and health (b)												
15.8 Federal employees health benefits plan premium (b)												
16. Workers' compensation												
17.1 Other Liability - occurrence												
17.2 Other Liability - claims made												
17.3 Excess workers' compensation												
18. Products liability												
19.1 Private passenger auto no-fault (personal injury protection)												
19.2 Other private passenger auto liability												
19.3 Commercial auto no-fault (personal injury protection)												
19.4 Other commercial auto liability												
21.1 Private passenger auto physical damage												
21.2 Commercial auto physical damage												
22. Aircraft (all perils)												
23. Fidelity												
24. Surety												
26. Burglary and theft												
27. Boiler and machinery												
28. Credit												
30. Warranty												
34. Aggregate write-ins for other lines of business												
35. TOTALS (a)												
DETAILS OF WRITE-INS												
3401.												
3402.												
3403.												
3498. Summary of remaining write-ins for Line 34 from overflow page												
3499. Totals (Lines 3401 thru 3403 plus 3498)(Line 34 above)												

NONE

(a) Finance and service charges not included in Lines 1 to 35 \$
(b) For health business on indicated lines report: Number of persons insured under PPO managed care products and number of persons insured under indemnity only products

ALPHABETICAL INDEX

ANNUAL STATEMENT BLANK

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Underwriting and Investment Exhibit - Part 3	14

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.

Prior Year Validation Data

1.	XXASU900029	PYPAGE ASSETS L28C3 = ASSETS L28C4.....	50,674,076
2.	XXASN000272	PYPAGE REVEX2 L49C1 = REVEX2 L33C1.....	15,213,932
3.	XXASU900102	PYPAGE ASSETS L05 C1 = CASH L19.1C1.....	43,761,382
4.	XXASU900066	PYPAGE SCAVER L09C2 = SCAVER L01C2.....	0
5.	XXASU900067	PYPAGE SCBAVER L11C2 = SCBAVER L01C2.....	0
6.	XXASU900068	PYPAGE SCBAVER L11C2 = SCBAVER L01C2.....	0
7.	XXASU090298	PYPAGE SCDVER L10C2 = SCDVER L01C2.....	0
8.	XXASU090582	PYPAGE SCDAPT1 L919999C8 = SCDAVER L01C1.....	0
9.	XXASU099985	PYPAGE SCDBPTCSN2 L07C9 = SCDBPTCSN2 L01C1.....	0
10.	XXASU099986	PYPAGE SCDBPTCSN2 L07C10 = SCDBPTCSN2 L01C2.....	0
11.	XXASU900058	PYPAGE SCEPT2 L869999C6 = SCEVER L01C1.....	0
12.	XXASN000339	PYPAGE REVEX1 L02C2 = GENINTPT2 L02.2C5.....	267,338,684
13.	XXASN000341	PYPAGE LIAB L01C3 + L02C3 + L04C3 + L07C3 = GENINTPT2 L02.5C5.....	34,203,293
14.	XXAAU900307	PYPAGE SHCEPT1 - GT L05.5C15 = SHCEPT1 - GT L05.4C15.....	0
15.	PXASU900138	PYPAGE SCDBPTAVER L09C2 = SCDBPTAVER L09C1.....	0
16.	PXASU900140	PYPAGE SCDBPTBVER L06C4 = SCDBPTBVER L01C4.....	0
17.	PXASU900141	PYPAGE SCDBPTBSN1 L1449999C15 = SCDBPTBVER L03.12C1.....	0
18.	PXASU900142	PYPAGE SCDBPTBSN1 L1449999C18 = SCDBPTBVER L03.14C1.....	0
19.	PXASU900143	PYPAGE SCDBPTBSN1 L1449999C17 = SCDBPTBVER L03.22C1.....	0
20.	PXASU900144	PYPAGE SCDBPTBSN1 L1449999C19 = SCDBPTBVER L03.24C1.....	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Better Health, Inc.
ANNUAL DISKETTE TRANSMITTAL FORM AND CERTIFICATION (HEALTH)

Name of Insurer Better Health, Inc.
Date _____ FEIN 20-4889378
NAIC Group # 0671 NAIC Company # 15480

THIS FORM IS REQUIRED FOR ALL DISKETTE TRANSMITTALS. PLEASE PROVIDE ANY ADDITIONAL COMMENTS THAT MAY HELP TO IDENTIFY DISKETTE CONTENT.

A.		MARCH	APRIL	JUNE
1.	Is this the first time you've submitted this filing? (Y/N)			
2.	Is this being re-filed at the request of the NAIC or a state insurance department? (Y/N)			
3.	Is this being re-filed due to changes to the data originally filed? (Y/N) (IF "YES", ENCLOSE HARD COPY PAGES FOR THE CHANGES.)			
4.	Other? (Y/N) (If "yes", attach an explanation.)			

B. Additional comments if necessary for clarification:

C. Diskette Contact Person:

Holly Jean Prince

Phone: 305-921-2610

Address:: 9250 W Flagler Street, Suite 600 Miami FL 33174

D. Software Vendor: Eagle Technology Management

Version: 2016

E. Have material validation failures been addressed in the explanation file?

Yes _____ No _____

The undersigned hereby certifies, according to the best of his/her knowledge and belief: that the diskettes submitted with this form were prepared in compliance with the NAIC specifications, that the diskettes have been tested against the validations included with these specifications, and that annual statement information required to be contained on diskette is identical to the information in the 2016 Annual Statement blank filed with the insurer's domiciliary state insurance department. In addition, the diskettes submitted have been scanned through a virus detection software package, and no viruses are present on the diskettes. The virus detection software used was (name)

_____ (version number) _____

Signed

Type Name and Title:

Schedule Qtr - G

[illegible]

AUTH - F.A.C. RULE 69O-191.075(6)

Attachment 2016 Better Health Inc.
Annual Health Statement — Page 115

Schedule Qtr - D

Individually list prepaid expenses with account balances greater than 10% of Total Prepaid Expenses

AUTH - F.A.C. RULE 69O-191.075(6)

Attachment 2016 Better Health Inc.
Annual Health Statement — Page 116

ANNUAL STATEMENT

OF THE

AMERIGROUP Florida, Inc.

of

Tampa

in the state of

Florida

TO THE

Insurance Department

OF THE STATE OF

Florida

FOR THE YEAR ENDED
DECEMBER 31, 2016

2016

HEALTH

2016



HEALTH ANNUAL STATEMENT

FOR THE YEAR ENDED DECEMBER 31, 2016
OF THE CONDITION AND AFFAIRS OF THE

AMERIGROUP Florida, Inc.

NAIC Group Code 0671 0671 NAIC Company Code 95093 Employer's ID Number 65-0318864
(Current) (Prior)

Organized under the Laws of Florida State of Domicile or Port of Entry FL

Country of Domicile United States of America

Licensed as business type: Health Maintenance Organization

Is HMO Federally Qualified? Yes ☐ No ☒ [X]

Incorporated/Organized 02/01/1992 Commenced Business 10/01/1993

Statutory Home Office 4200 West Cypress Street, Suite 900 Tampa, FL, US 33607
(Street and Number) (City or Town, State, Country and Zip Code)

Main Administrative Office 4425 Corporation Lane
(Street and Number)
Virginia Beach, VA, US 23462 757-490-6900
(City or Town, State, Country and Zip Code) (Area Code) (Telephone Number)

Mail Address 4425 Corporation Lane Virginia Beach, VA, US 23462
(Street and Number or P.O. Box) (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 4425 Corporation Lane
(Street and Number)
Virginia Beach, VA, US 23462 757-490-6900
(City or Town, State, Country and Zip Code) (Area Code) (Telephone Number)

Internet Website Address www.amerigroup.com

Statutory Statement Contact Bette Lou Gronseth 757-518-3638
(Name) (Area Code) (Telephone Number)
Bette.Gronseth@amerigroup.com 757-557-6742
(E-mail Address) (FAX Number)

OFFICERS

Chairperson Charles Brian Shipp Vice President/COO Judith Lynn Peterson
President/CEO Maria Lourdes Rivas Vice President/Assistant Secretary Jack Louis Young

OTHER

Kathleen Susan Kiefer, Secretary Robert David Kretschmer, Treasurer Eric (Rick) Kenneth Noble, Assistant Treasurer
Sean Tzer Chou #, Valuation Actuary

DIRECTORS OR TRUSTEES

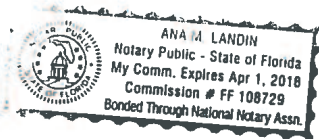
Carter Allen Beck Maria Lourdes Rivas Catherine Irene Kelaghan
Judith Lynn Peterson Charles Brian Shipp

State of Florida SS:
County of Tampa

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Maria Lourdes Rivas Robert David Kretschmer Kathleen Susan Kiefer
President/CEO Treasurer Secretary

Subscribed and sworn to before me this 23rd day of March 2017
[Signature]
a. Is this an original filing? Yes ☒ No ☐ [X]
b. If no,
1. State the amendment number
2. Date filed
3. Number of pages attached



ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

ASSETS

	Current Year			Prior Year
	1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 Net Admitted Assets
1. Bonds (Schedule D)	147,034,570		147,034,570	110,896,532
2. Stocks (Schedule D):				
2.1 Preferred stocks			0	0
2.2 Common stocks			0	13,826,041
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens			0	0
3.2 Other than first liens			0	0
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less \$			0	0
encumbrances)				
4.2 Properties held for the production of income (less				
\$			0	0
encumbrances)				
4.3 Properties held for sale (less \$			0	0
encumbrances)				
5. Cash (\$13,838,742 , Schedule E - Part 1), cash equivalents				
(\$, Schedule E - Part 2) and short-term				
investments (\$36,287,609 , Schedule DA)	50,126,351		50,126,351	62,452,557
6. Contract loans, (including \$ premium notes)			0	0
7. Derivatives (Schedule DB)			0	0
8. Other invested assets (Schedule BA)			0	0
9. Receivables for securities			0	5,836
10. Securities lending reinvested collateral assets (Schedule DL)	948,299		948,299	6,809,150
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	198,109,220	0	198,109,220	193,990,116
13. Title plants less \$ charged off (for Title insurers				
only)			0	0
14. Investment income due and accrued	857,642	0	857,642	800,456
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	19,174,192	0	19,174,192	6,042,339
15.2 Deferred premiums and agents' balances and installments booked but				
deferred and not yet due (including \$				
earned but unbilled premiums)			0	0
15.3 Accrued retrospective premiums (\$922,215) and				
contracts subject to redetermination (\$)	922,215	0	922,215	880,739
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers			0	0
16.2 Funds held by or deposited with reinsured companies			0	0
16.3 Other amounts receivable under reinsurance contracts			0	0
17. Amounts receivable relating to uninsured plans	835,435	0	835,435	329,726
18.1 Current federal and foreign income tax recoverable and interest thereon			0	0
18.2 Net deferred tax asset	9,648,988	503,521	9,145,467	5,576,211
19. Guaranty funds receivable or on deposit			0	0
20. Electronic data processing equipment and software			0	12,618
21. Furniture and equipment, including health care delivery assets				
(\$)	1,931,273	1,931,273	0	0
22. Net adjustment in assets and liabilities due to foreign exchange rates			0	0
23. Receivables from parent, subsidiaries and affiliates	1,957,553	1,957,553	0	0
24. Health care (\$0) and other amounts receivable	5,168,720	5,168,720	0	460,893
25. Aggregate write-ins for other than invested assets	8,750,378	8,750,378	0	299,822
26. Total assets excluding Separate Accounts, Segregated Accounts and				
Protected Cell Accounts (Lines 12 to 25)	247,355,615	18,311,445	229,044,170	208,392,920
27. From Separate Accounts, Segregated Accounts and Protected Cell				
Accounts			0	0
28. Total (Lines 26 and 27)	247,355,615	18,311,445	229,044,170	208,392,920
DETAILS OF WRITE-INS				
1101.			0	
1102.			0	
1103.			0	
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	0	0	0	0
2501. Goodwill, Intangibles, and Covenant not to Compete	8,069,210	8,069,210	0	0
2502. Prepaids	525,948	525,948	0	0
2503. State Income Taxes Receivable	0	0	0	299,822
2598. Summary of remaining write-ins for Line 25 from overflow page	155,220	155,220	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	8,750,378	8,750,378	0	299,822

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

LIABILITIES, CAPITAL AND SURPLUS

	Current Year			Prior Year
	1 Covered	2 Uncovered	3 Total	4 Total
1. Claims unpaid (less \$0 reinsurance ceded)	103,405,613		103,405,613	96,061,391
2. Accrued medical incentive pool and bonus amounts	4,184,830		4,184,830	3,497,761
3. Unpaid claims adjustment expenses.....	3,184,297		3,184,297	3,280,587
4. Aggregate health policy reserves, including the liability of \$0 for medical loss ratio rebate per the Public Health Service Act	480,354		480,354	333,978
5. Aggregate life policy reserves.....			0	0
6. Property/casualty unearned premium reserves.....			0	0
7. Aggregate health claim reserves.....	11,450,968		11,450,968	227,821
8. Premiums received in advance.....			0	0
9. General expenses due or accrued.....	2,202,465		2,202,465	889,919
10.1 Current federal and foreign income tax payable and interest thereon (including \$ on realized capital gains (losses))	2,351,202		2,351,202	368,772
10.2 Net deferred tax liability.....			0	0
11. Ceded reinsurance premiums payable.....			0	0
12. Amounts withheld or retained for the account of others.....			0	0
13. Remittances and items not allocated.....	4,926,093		4,926,093	8,257,157
14. Borrowed money (including \$ current) and interest thereon \$ (including \$ current).....			0	0
15. Amounts due to parent, subsidiaries and affiliates.....	3,235,127		3,235,127	9,876,638
16. Derivatives.....			0	0
17. Payable for securities.....			0	0
18. Payable for securities lending.....	948,299		948,299	6,809,150
19. Funds held under reinsurance treaties (with \$ authorized reinsurers, \$0 unauthorized reinsurers and \$0 certified reinsurers).....			0	0
20. Reinsurance in unauthorized and certified (\$) companies			0	0
21. Net adjustments in assets and liabilities due to foreign exchange rates			0	0
22. Liability for amounts held under uninsured plans.....	558,747		558,747	402,654
23. Aggregate write-ins for other liabilities (including \$243,955 current).....	5,986,512	0	5,986,512	2,702,621
24. Total liabilities (Lines 1 to 23).....	142,914,507	0	142,914,507	132,708,449
25. Aggregate write-ins for special surplus funds.....	XXX	XXX	0	20,965,043
26. Common capital stock.....	XXX	XXX	100	100
27. Preferred capital stock.....	XXX	XXX		
28. Gross paid in and contributed surplus.....	XXX	XXX	80,184,970	70,184,970
29. Surplus notes.....	XXX	XXX	0	
30. Aggregate write-ins for other than special surplus funds.....	XXX	XXX	0	0
31. Unassigned funds (surplus).....	XXX	XXX	5,944,593	(15,465,642)
32. Less treasury stock, at cost:				
32.1 shares common (value included in Line 26 \$).....	XXX	XXX		
32.2 shares preferred (value included in Line 27 \$).....	XXX	XXX		
33. Total capital and surplus (Lines 25 to 31 minus Line 32).....	XXX	XXX	86,129,663	75,684,471
34. Total liabilities, capital and surplus (Lines 24 and 33).....	XXX	XXX	229,044,170	208,392,920
DETAILS OF WRITE-INS				
2301. Escheat Liability	978,070		978,070	875,238
2302. Other Premium Liability	4,152,656		4,152,656	0
2303. ACA PCP Fee	855,786		855,786	1,827,383
2398. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0
2399. Totals (Lines 2301 thru 2303 plus 2398)(Line 23 above)	5,986,512	0	5,986,512	2,702,621
2501. Estimated ACA Health Insurer Fee	XXX	XXX	0	20,965,043
2502.	XXX	XXX		
2503.	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page	XXX	XXX	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	XXX	XXX	0	20,965,043
3001.	XXX	XXX		
3002.	XXX	XXX		
3003.	XXX	XXX		
3098. Summary of remaining write-ins for Line 30 from overflow page	XXX	XXX	0	0
3099. Totals (Lines 3001 thru 3003 plus 3098)(Line 30 above)	XXX	XXX	0	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

STATEMENT OF REVENUE AND EXPENSES

	Current Year		Prior Year
	1 Uncovered	2 Total	3 Total
1. Member Months.....	XXX	4,854,650	4,608,418
2. Net premium income (including \$ non-health premium income)	XXX	1,431,822,517	1,309,626,197
3. Change in unearned premium reserves and reserve for rate credits	XXX	768,311	199,969
4. Fee-for-service (net of \$ medical expenses).....	XXX		
5. Risk revenue	XXX		
6. Aggregate write-ins for other health care related revenues	XXX	.0	.0
7. Aggregate write-ins for other non-health revenues	XXX	.0	.0
8. Total revenues (Lines 2 to 7)	XXX	1,432,590,828	1,309,826,166
Hospital and Medical:			
9. Hospital/medical benefits		740,917,240	683,640,899
10. Other professional services		75,918,573	66,537,302
11. Outside referrals			
12. Emergency room and out-of-area		120,539,039	119,317,809
13. Prescription drugs		256,710,435	210,136,548
14. Aggregate write-ins for other hospital and medical.....	.0	83,914,654	79,384,877
15. Incentive pool, withhold adjustments and bonus amounts		5,105,917	3,882,263
16. Subtotal (Lines 9 to 15) .....	.0	1,283,105,858	1,162,899,698
Less:			
17. Net reinsurance recoveries			
18. Total hospital and medical (Lines 16 minus 17) .....	.0	1,283,105,858	1,162,899,698
19. Non-health claims (net)			
20. Claims adjustment expenses, including \$53,628,463 cost containment expenses		75,928,230	79,803,226
21. General administrative expenses		67,937,647	65,958,505
22. Increase in reserves for life and accident and health contracts (including \$ increase in reserves for life only) .....		.0	(1,535,613)
23. Total underwriting deductions (Lines 18 through 22).....	.0	1,426,971,735	1,307,125,816
24. Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	5,619,093	2,700,350
25. Net investment income earned (Exhibit of Net Investment Income, Line 17)		3,065,243	3,474,158
26. Net realized capital gains (losses) less capital gains tax of \$1,729,786		3,217,916	(412,408)
27. Net investment gains (losses) (Lines 25 plus 26) .....	.0	6,283,159	3,061,750
28. Net gain or (loss) from agents' or premium balances charged off [(amount recovered \$) (amount charged off \$)]			
29. Aggregate write-ins for other income or expenses .....	.0	.0	.0
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	11,902,252	5,762,100
31. Federal and foreign income taxes incurred	XXX	13,870,421	7,697,859
32. Net income (loss) (Lines 30 minus 31)	XXX	(1,968,169)	(1,935,759)
DETAILS OF WRITE-INS			
0601.	XXX		
0602.	XXX		
0603.	XXX		
0698. Summary of remaining write-ins for Line 6 from overflow page	XXX	.0	.0
0699. Totals (Lines 0601 thru 0603 plus 0698)(Line 6 above)	XXX	0	0
0701.	XXX		
0702.	XXX		
0703.	XXX		
0798. Summary of remaining write-ins for Line 7 from overflow page	XXX	.0	.0
0799. Totals (Lines 0701 thru 0703 plus 0798)(Line 7 above)	XXX	0	0
1401. Ambulance, DME, Home Health Care, Other LTSS		83,914,654	79,384,877
1402.			
1403.			
1498. Summary of remaining write-ins for Line 14 from overflow page .....	.0	.0	.0
1499. Totals (Lines 1401 thru 1403 plus 1498)(Line 14 above)	0	83,914,654	79,384,877
2901.			
2902.			
2903.			
2998. Summary of remaining write-ins for Line 29 from overflow page .....	.0	.0	.0
2999. Totals (Lines 2901 thru 2903 plus 2998)(Line 29 above)	0	0	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

STATEMENT OF REVENUE AND EXPENSES (Continued)

	1 Current Year	2 Prior Year
CAPITAL AND SURPLUS ACCOUNT		
33. Capital and surplus prior reporting year.....	75,684,471	83,605,928
34. Net income or (loss) from Line 32	(1,968,169)	(1,935,759)
35. Change in valuation basis of aggregate policy and claim reserves		
36. Change in net unrealized capital gains (losses) less capital gains tax of \$ (1,496,810)	(2,779,788)	(271,018)
37. Change in net unrealized foreign exchange capital gain or (loss)		
38. Change in net deferred income tax	2,575,967	528,475
39. Change in nonadmitted assets	2,617,182	(6,243,155)
40. Change in unauthorized and certified reinsurance	0	0
41. Change in treasury stock	0	0
42. Change in surplus notes	0	0
43. Cumulative effect of changes in accounting principles.....		
44. Capital Changes:		
44.1 Paid in	0	0
44.2 Transferred from surplus (Stock Dividend).....	0	0
44.3 Transferred to surplus.....		
45. Surplus adjustments:		
45.1 Paid in	10,000,000	0
45.2 Transferred to capital (Stock Dividend)		
45.3 Transferred from capital		
46. Dividends to stockholders		
47. Aggregate write-ins for gains or (losses) in surplus	0	0
48. Net change in capital and surplus (Lines 34 to 47)	10,445,192	(7,921,457)
49. Capital and surplus end of reporting period (Line 33 plus 48)	86,129,663	75,684,471
DETAILS OF WRITE-INS		
4701.		
4702.		
4703.		
4798. Summary of remaining write-ins for Line 47 from overflow page	0	0
4799. Totals (Lines 4701 thru 4703 plus 4798)(Line 47 above)	0	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

CASH FLOW

	1	2
	Current Year	Prior Year
Cash from Operations		
1. Premiums collected net of reinsurance	1,419,563,875	1,285,808,972
2. Net investment income	4,290,546	4,745,195
3. Miscellaneous income	0	0
4. Total (Lines 1 through 3)	1,423,854,422	1,290,554,167
5. Benefit and loss related payments	1,258,437,888	1,151,307,850
6. Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts		
7. Commissions, expenses paid and aggregate write-ins for deductions	142,423,117	142,883,953
8. Dividends paid to policyholders		
9. Federal and foreign income taxes paid (recovered) net of \$0 tax on capital gains (losses)	13,617,777	(226,983)
10. Total (Lines 5 through 9)	1,414,478,782	1,293,964,820
11. Net cash from operations (Line 4 minus Line 10)	9,375,640	(3,410,653)
Cash from Investments		
12. Proceeds from investments sold, matured or repaid:		
12.1 Bonds	40,218,428	46,456,084
12.2 Stocks	14,394,209	0
12.3 Mortgage loans	0	0
12.4 Real estate	0	0
12.5 Other invested assets	0	0
12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	6,823	0
12.7 Miscellaneous proceeds	5,866,687	0
12.8 Total investment proceeds (Lines 12.1 to 12.7)	60,486,147	46,456,084
13. Cost of investments acquired (long-term only):		
13.1 Bonds	77,536,736	43,243,560
13.2 Stocks	0	496,365
13.3 Mortgage loans	0	0
13.4 Real estate	0	0
13.5 Other invested assets	0	0
13.6 Miscellaneous applications	0	1,317,007
13.7 Total investments acquired (Lines 13.1 to 13.6)	77,536,736	45,056,932
14. Net increase (decrease) in contract loans and premium notes	0	0
15. Net cash from investments (Line 12.8 minus Line 13.7 minus Line 14)	(17,050,589)	1,399,152
Cash from Financing and Miscellaneous Sources		
16. Cash provided (applied):		
16.1 Surplus notes, capital notes	0	0
16.2 Capital and paid in surplus, less treasury stock	10,000,000	0
16.3 Borrowed funds	0	0
16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	0
16.5 Dividends to stockholders	0	0
16.6 Other cash provided (applied)	(14,651,257)	4,972,970
17. Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6)	(4,651,257)	4,972,970
RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS		
18. Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	(12,326,206)	2,961,469
19. Cash, cash equivalents and short-term investments:		
19.1 Beginning of year	62,452,557	59,491,088
19.2 End of year (Line 18 plus Line 19.1)	50,126,351	62,452,557
Note: Supplemental disclosures of cash flow information for non-cash transactions:		
20.0001. Depreciation	582,226	461,133

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.
ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Net premium income	1,431,822,517	67,599,027					(1,280,225)	1,208,465,775	157,037,940	
2. Change in unearned premium reserves and reserve for rate credit	768,311						768,311			
3. Fee-for-service (net of \$0 medical expenses) .....	.0									XXX
4. Risk revenue .....	.0									XXX
5. Aggregate write-ins for other health care related revenues .....	.0	.0	.0	.0	.0	.0	.0	.0	.0	XXX
6. Aggregate write-ins for other non-health care related revenues .....	.0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.0
7. Total revenues (Lines 1 to 6)	1,432,590,828	67,599,027	.0	.0	.0	.0	(511,914)	1,208,465,775	157,037,940	.0
8. Hospital/medical benefits	740,917,240	33,677,860					(560,239)	591,613,737	116,185,882	XXX
9. Other professional services	75,918,573	2,918,266					(68,798)	75,984,284	(2,914,179)	XXX
10. Outside referrals .....	.0									XXX
11. Emergency room and out-of-area	120,539,039	8,101,441					(100,320)	111,015,013	1,522,905	XXX
12. Prescription drugs	256,710,435	16,364,744					(383,199)	237,278,216	3,450,674	XXX
13. Aggregate write-ins for other hospital and medical	83,914,654	2,102,671	.0	.0	.0	.0	216,987	49,414,996	32,180,000	XXX
14. Incentive pool, withhold adjustments and bonus amounts	5,105,917						(9,683)	4,673,846	441,754	XXX
15. Subtotal (Lines 8 to 14)	1,283,105,858	63,164,982	.0	.0	.0	.0	(906,252)	1,089,980,092	150,867,036	XXX
16. Net reinsurance recoveries .....	.0									XXX
17. Total medical and hospital (Lines 15 minus 16)	1,283,105,858	63,164,982	.0	.0	.0	.0	(906,252)	1,089,980,092	150,867,036	XXX
18. Non-health claims (net) .....	.0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
19. Claims adjustment expenses including \$53,628,463 cost containment expenses	75,928,230	5,853,246					94,503	64,429,170	5,551,311	
20. General administrative expenses	67,937,647	5,237,259					(274,903)	58,008,192	4,967,099	
21. Increase in reserves for accident and health contracts .....	.0									XXX
22. Increase in reserves for life contracts .....	.0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
23. Total underwriting deductions (Lines 17 to 22)	1,426,971,735	74,255,487	.0	.0	.0	.0	(1,086,652)	1,192,417,454	161,385,446	.0
24. Total underwriting gain or (loss) (Line 7 minus Line 23)	5,619,093	(6,656,460)	0	0	0	0	574,738	16,048,321	(4,347,506)	0
DETAILS OF WRITE-INS										
0501. ....	.0									XXX
0502. ....	.0									XXX
0503. ....	.0									XXX
0598. Summary of remaining write-ins for Line 5 from overflow page .....	.0	.0	.0	.0	.0	.0	.0	.0	.0	XXX
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above) .....	.0	0	0	0	0	0	0	0	0	XXX
0601. ....	.0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0602. ....	.0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0603. ....	.0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0698. Summary of remaining write-ins for Line 6 from overflow page .....	.0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	.0
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
1301. Ambulance, DME, Home Health Care, Other LTSS	83,914,654	2,102,671					216,987	49,414,996	32,180,000	XXX
1302. ....	.0									XXX
1303. ....	.0									XXX
1398. Summary of remaining write-ins for Line 13 from overflow page .....	.0	.0	.0	.0	.0	.0	.0	.0	.0	XXX
1399. Totals (Lines 1301 thru 1303 plus 1398) (Line 13 above)	83,914,654	2,102,671	0	0	0	0	216,987	49,414,996	32,180,000	XXX

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.
UNDERWRITING AND INVESTMENT EXHIBIT
PART 1 - PREMIUMS

	1	2	3	4
Line of Business	Direct Business	Reinsurance Assumed	Reinsurance Ceded	Net Premium Income (Cols. 1 + 2 - 3)
1. Comprehensive (hospital and medical)	67,599,027			67,599,027
2. Medicare Supplement				0
3. Dental only				0
4. Vision only				0
5. Federal Employees Health Benefits Plan	0			0
6. Title XVIII - Medicare	(1,280,225)			(1,280,225)
7. Title XIX - Medicaid	1,365,503,715			1,365,503,715
8. Other health				0
9. Health subtotal (Lines 1 through 8)	1,431,822,517	0	0	1,431,822,517
10. Life	0			0
11. Property/casualty	0			0
12. Totals (Lines 9 to 11)	1,431,822,517	0	0	1,431,822,517

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2 - CLAIMS INCURRED DURING THE YEAR

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Payments during the year:										
1.1 Direct	1,254,019,040	60,988,078					1,175,016	1,040,111,161	151,744,785	
1.2 Reinsurance assumed .....	.0									
1.3 Reinsurance ceded .....	.0									
1.4 Net	1,254,019,040	60,988,078	.0	.0	.0	.0	1,175,016	1,040,111,161	151,744,785	.0
2. Paid medical incentive pools and bonuses	4,418,848						47,308	1,956,591	2,414,949	
3. Claim liability December 31, current year from Part 2A:										
3.1 Direct	103,405,613	4,117,409	.0	.0	.0	.0	(391,367)	87,593,147	12,086,424	.0
3.2 Reinsurance assumed .....	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
3.3 Reinsurance ceded .....	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
3.4 Net	103,405,613	4,117,409	.0	.0	.0	.0	(391,367)	87,593,147	12,086,424	.0
4. Claim reserve December 31, current year from Part 2D:										
4.1 Direct	11,450,968	781,323						10,471,974	197,671	
4.2 Reinsurance assumed .....	.0									
4.3 Reinsurance ceded .....	.0									
4.4 Net	11,450,968	781,323	.0	.0	.0	.0	.0	10,471,974	197,671	.0
5. Accrued medical incentive pools and bonuses, current year	4,184,830							4,184,830		
6. Net healthcare receivables (a)	(5,413,532)	(911,235)					(1,699,523)	(2,847,021)	44,247	
7. Amounts recoverable from reinsurers December 31, current year .....	.0									
8. Claim liability December 31, prior year from Part 2A:										
8.1 Direct	96,061,391	3,633,063	.0	.0	.0	.0	3,379,741	75,489,236	13,559,351	.0
8.2 Reinsurance assumed .....	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
8.3 Reinsurance ceded .....	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
8.4 Net	96,061,391	3,633,063	.0	.0	.0	.0	3,379,741	75,489,236	13,559,351	.0
9. Claim reserve December 31, prior year from Part 2D:										
9.1 Direct	227,821							227,821		
9.2 Reinsurance assumed .....	.0									
9.3 Reinsurance ceded .....	.0									
9.4 Net	227,821	.0	.0	.0	.0	.0	.0	227,821	.0	.0
10. Accrued medical incentive pools and bonuses, prior year	3,497,761						56,991	1,467,575	1,973,195	
11. Amounts recoverable from reinsurers December 31, prior year .....	.0									
12. Incurred Benefits:										
12.1 Direct	1,277,999,941	63,164,982	.0	.0	.0	.0	(896,569)	1,065,306,246	150,425,282	.0
12.2 Reinsurance assumed .....	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
12.3 Reinsurance ceded .....	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
12.4 Net	1,277,999,941	63,164,982	.0	.0	.0	.0	(896,569)	1,065,306,246	150,425,282	.0
13. Incurred medical incentive pools and bonuses	5,105,917	.0	.0	.0	.0	.0	(9,683)	4,673,846	441,754	.0

(a) Excludes \$ loans or advances to providers not yet expensed.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2A - CLAIMS LIABILITY END OF CURRENT YEAR

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Reported in Process of Adjustment:										
1.1 Direct	34,845,951	1,590,709					85,904	26,313,343	6,855,995	
1.2 Reinsurance assumed .....	.0									
1.3 Reinsurance ceded .....	.0									
1.4 Net	34,845,951	1,590,709	.0	.0	.0	.0	85,904	26,313,343	6,855,995	.0
2. Incurred but Unreported:										
2.1 Direct	68,559,662	2,526,700					(477,271)	61,279,804	5,230,429	
2.2 Reinsurance assumed .....	.0									
2.3 Reinsurance ceded .....	.0									
2.4 Net	68,559,662	2,526,700	.0	.0	.0	.0	(477,271)	61,279,804	5,230,429	.0
3. Amounts Withheld from Paid Claims and Capitulations:										
3.1 Direct .....	.0									
3.2 Reinsurance assumed .....	.0									
3.3 Reinsurance ceded .....	.0									
3.4 Net .....	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
4. TOTALS:										
4.1 Direct	103,405,613	4,117,409	.0	.0	.0	.0	(391,367)	87,593,147	12,086,424	.0
4.2 Reinsurance assumed .....	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
4.3 Reinsurance ceded0	.0	.0	.0	.0	.0	.0	.0	.0	.0
4.4 Net	103,405,613	4,117,409	.0	.0	.0	.0	(391,367)	87,593,147	12,086,424	.0

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2B - ANALYSIS OF CLAIMS UNPAID - PRIOR YEAR - NET OF REINSURANCE

Line of Business	Claims Paid During the Year		Claim Reserve and Claim Liability December 31 of Current Year		5	6
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid December 31 of Prior Year	4 On Claims Incurred During the Year	Claims Incurred In Prior Years (Columns 1 + 3)	Estimated Claim Reserve and Claim Liability December 31 of Prior Year
1. Comprehensive (hospital and medical)	4,072,465	57,818,169	(115,629)	5,014,361	3,956,836	3,633,063
2. Medicare Supplement					0	0
3. Dental Only					0	0
4. Vision Only					0	0
5. Federal Employees Health Benefits Plan					0	0
6. Title XVIII - Medicare	3,697,148		(391,367)		3,305,781	3,379,741
7. Title XIX - Medicaid	79,482,557	967,254,636	451,535	97,613,586	79,934,092	75,717,057
8. Other health	11,013,670	140,965,116	55,306	12,228,789	11,068,976	13,559,351
9. Health subtotal (Lines 1 to 8)	98,265,840	1,166,037,921	(155)	114,856,736	98,265,685	96,289,212
10. Healthcare receivables (a)	1,643,057	3,228,132			1,643,057	0
11. Other non-health					0	0
12. Medical incentive pools and bonus amounts	4,418,848		485,600	3,699,230	4,904,448	3,497,761
13. Totals (Lines 9 - 10 + 11 + 12)	101,041,631	1,162,809,789	485,445	118,555,966	101,527,076	99,786,973

(a) Excludes \$ 297,531 loans or advances to providers not yet expensed.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Comprehensive (Hospital & Medical)

Year in Which Losses Were Incurred		Cumulative Net Amounts Paid				
		1 2012	2 2013	3 2014	4 2015	5 2016
1. Prior	.....	6,998	7,237	7,199	7,162	7,148
2. 2012	.....	77,150	79,931	79,812	79,569	79,620
3. 2013	.....	XXX	61,962	71,529	71,474	71,462
4. 2014	.....	XXX	XXX	59,040	66,035	66,048
5. 2015	.....	XXX	XXX	XXX	51,032	55,379
6. 2016	.....	XXX	XXX	XXX	XXX	57,514

Section B - Incurred Health Claims - Comprehensive (Hospital & Medical)

Year in Which Losses Were Incurred		Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
		1 2012	2 2013	3 2014	4 2015	5 2016
1. Prior	.....	7,443	7,268	7,200	7,162	7,148
2. 2012	.....	80,905	80,104	79,799	79,564	79,620
3. 2013	.....	XXX	72,755	71,681	71,438	71,462
4. 2014	.....	XXX	XXX	67,079	66,066	66,028
5. 2015	.....	XXX	XXX	XXX	54,674	55,283
6. 2016	.....	XXX	XXX	XXX	XXX	62,529

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Comprehensive (Hospital & Medical)

Years in which Premiums were Earned and Claims were Incurred		1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2012	.....	87,705	79,620	2,725	3.4	82,345	93.9	0	0	82,345	93.9
2. 2013	.....	80,098	71,462	6,521	9.1	77,983	97.4	0	0	77,983	97.4
3. 2014	.....	73,418	66,048	7,220	10.9	73,268	99.8	(20)	(1)	73,247	99.8
4. 2015	60,587	55,378	6,319	11.4	61,697	101.8	(96)	(2)	61,599	101.7
5. 2016	67,599	57,514	5,112	8.9	62,626	92.6	5,015	128	67,769	100.3

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Title XVIII

Year in Which Losses Were Incurred		Cumulative Net Amounts Paid				
		1 2012	2 2013	3 2014	4 2015	5 2016
1.	Prior	1,769	1,666	1,639	1,638	1,415
2.	2012	20,682	23,901	23,871	23,777	23,717
3.	2013	XXX	21,838	24,489	24,348	24,289
4.	2014	XXX	XXX	26,994	29,712	29,705
5.	2015	XXX	XXX	XXX	30,665	33,936
6.	2016	XXX	XXX	XXX	XXX	0

Section B - Incurred Health Claims - Title XVIII

Year in Which Losses Were Incurred		Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
		1 2012	2 2013	3 2014	4 2015	5 2016
1.	Prior	1,671	1,646	1,637	1,638	1,415
2.	2012	23,887	23,860	23,859	23,778	23,717
3.	2013	XXX	24,888	24,519	24,355	24,289
4.	2014	XXX	XXX	31,069	29,762	29,638
5.	2015	XXX	XXX	XXX	34,044	33,612
6.	2016	XXX	XXX	XXX	XXX	0

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Title XVIII

Years in which Premiums were Earned and Claims were Incurred		1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1.	2012	25,029	23,717	585	2.5	24,302	97.1	0	0	24,302	97.1
2.	2013	29,447	24,289	1,621	6.7	25,910	88.0	0	0	25,910	88.0
3.	2014	31,601	29,705	2,365	8.0	32,070	101.5	(67)	(3)	32,000	101.3
4.	2015	44,136	33,936	2,855	8.4	36,791	83.4	(324)	(12)	36,455	82.6
5.	2016	(512)	0	113	0.0	113	(22.1)	0	0	113	(22.1)

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Title XIX

Year in Which Losses Were Incurred		Cumulative Net Amounts Paid				
		1 2012	2 2013	3 2014	4 2015	5 2016
1. Prior	.....	17,456	21,582	21,897	21,678	21,582
2. 2012	.....	366,536	386,081	386,555	386,378	386,393
3. 2013	.....	XXX	357,222	382,849	384,432	384,314
4. 2014	.....	XXX	XXX	576,925	631,772	629,606
5. 2015	.....	XXX	XXX	XXX	859,093	941,864
6. 2016	.....	XXX	XXX	XXX	XXX	964,509

Section B - Incurred Health Claims - Title XIX

Year in Which Losses Were Incurred		Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
		1 2012	2 2013	3 2014	4 2015	5 2016
1. Prior	.....	20,084	21,530	21,901	21,678	21,582
2. 2012	.....	388,916	385,361	386,491	386,354	386,393
3. 2013	.....	XXX	382,420	383,101	384,195	384,314
4. 2014	.....	XXX	XXX	635,326	631,733	629,348
5. 2015	.....	XXX	XXX	XXX	936,578	943,059
6. 2016	.....	XXX	XXX	XXX	XXX	1,065,821

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Title XIX

Years in which Premiums were Earned and Claims were Incurred		1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2012	.....	440,991	386,393	13,853	3.6	400,246	90.8	0	0	400,246	90.8
2. 2013	.....	436,265	384,314	29,352	7.6	413,666	94.8	0	0	413,666	94.8
3. 2014	.....	697,605	629,606	40,929	6.5	670,535	96.1	(258)	(7)	670,270	96.1
4. 2015	1,051,493	941,864	65,383	6.9	1,007,247	95.8	1,195	19	1,008,461	95.9
5. 2016	1,208,466	964,509	55,922	5.8	1,020,431	84.4	101,312	2,680	1,124,423	93.0

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Other

Year in Which Losses Were Incurred		Cumulative Net Amounts Paid				
		1 2012	2 2013	3 2014	4 2015	5 2016
1. Prior	.....	1,356	1,348	1,345	1,345	1,340
2. 2012	.....	34,955	36,506	36,516	36,517	36,488
3. 2013	.....	XXX	33,773	44,415	44,406	44,413
4. 2014	.....	XXX	XXX	119,664	134,941	135,803
5. 2015	.....	XXX	XXX	XXX	126,160	138,654
6. 2016	.....	XXX	XXX	XXX	XXX	140,787

Section B - Incurred Health Claims - Other

Year in Which Losses Were Incurred		Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
		1 2012	2 2013	3 2014	4 2015	5 2016
1. Prior	.....	1,503	1,318	1,346	1,345	1,340
2. 2012	.....	36,767	36,408	36,515	36,517	36,488
3. 2013	.....	XXX	46,990	44,403	44,406	44,413
4. 2014	.....	XXX	XXX	133,095	135,910	135,800
5. 2015	.....	XXX	XXX	XXX	140,724	138,712
6. 2016	.....	XXX	XXX	XXX	XXX	153,016

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Other

Years in which Premiums were Earned and Claims were Incurred		1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2012	.....	47,955	36,488	1,587	4.3	38,075	79.4	0	0	38,075	79.4
2. 2013	.....	53,653	44,413	3,515	7.9	47,928	89.3	0	0	47,928	89.3
3. 2014	.....	135,631	135,803	1,050	0.8	136,853	100.9	(3)	0	136,850	100.9
4. 2015	.....	153,610	138,654	4,571	3.3	143,225	93.2	58	2	143,285	93.3
5. 2016	.....	157,038	140,787	4,915	3.5	145,702	92.8	12,229	380	158,311	100.8

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Grand Total

Year in Which Losses Were Incurred		Cumulative Net Amounts Paid				
		1 2012	2 2013	3 2014	4 2015	5 2016
1.	Prior	27,579	31,833	32,080	31,823	31,485
2.	2012	499,323	526,419	526,754	526,241	526,218
3.	2013	XXX	474,795	523,282	524,660	524,478
4.	2014	XXX	XXX	782,623	862,460	861,162
5.	2015	XXX	XXX	XXX	1,066,950	1,169,833
6.	2016	XXX	XXX	XXX	XXX	1,162,810

Section B - Incurred Health Claims - Grand Total

Year in Which Losses Were Incurred		Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
		1 2012	2 2013	3 2014	4 2015	5 2016
1.	Prior	30,701	31,762	32,084	31,823	31,485
2.	2012	530,475	525,733	526,664	526,213	526,218
3.	2013	XXX	527,053	523,704	524,394	524,478
4.	2014	XXX	XXX	866,569	863,471	860,814
5.	2015	XXX	XXX	XXX	1,166,020	1,170,666
6.	2016	XXX	XXX	XXX	XXX	1,281,366

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Grand Total

Years in which Premiums were Earned and Claims were Incurred		1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1.	2012	601,680	526,218	18,750	3.6	544,968	90.6	0	0	544,968	90.6
2.	2013	599,463	524,478	41,009	7.8	565,487	94.3	0	0	565,487	94.3
3.	2014	938,255	861,162	51,564	6.0	912,726	97.3	(348)	(11)	912,367	97.2
4.	2015	1,309,826	1,169,832	79,128	6.8	1,248,960	95.4	833	7	1,249,800	95.4
5.	2016	1,432,591	1,162,810	66,062	5.7	1,228,872	85.8	118,556	3,188	1,350,616	94.3

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2D - AGGREGATE RESERVE FOR ACCIDENT AND HEALTH CONTRACTS ONLY

	1	2	3	4	5	6	7	8	9
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
1. Unearned premium reserves	0								
2. Additional policy reserves (a)	0								
3. Reserve for future contingent benefits	0								
4. Reserve for rate credits or experience rating refunds (including \$) for investment income	480,354						480,354		
5. Aggregate write-ins for other policy reserves	0	0	0	0	0	0	0	0	0
6. Totals (gross)	480,354	0	0	0	0	0	480,354	0	0
7. Reinsurance ceded	0								
8. Totals (Net)(Page 3, Line 4)	480,354	0	0	0	0	0	480,354	0	0
9. Present value of amounts not yet due on claims	0								
10. Reserve for future contingent benefits	11,450,968	781,323						10,471,973	197,672
11. Aggregate write-ins for other claim reserves	0	0	0	0	0	0	0	0	0
12. Totals (gross)	11,450,968	781,323	0	0	0	0	0	10,471,973	197,672
13. Reinsurance ceded	0								
14. Totals (Net)(Page 3, Line 7)	11,450,968	781,323	0	0	0	0	0	10,471,973	197,672
DETAILS OF WRITE-INS									
0501.									
0502.									
0503.									
0598. Summary of remaining write-ins for Line 5 from overflow page.....	0	0	0	0	0	0	0	0	0
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above)	0	0	0	0	0	0	0	0	0
1101.									
1102.									
1103.									
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0	0	0	0	0	0
1199. Totals (Lines 1101 thru 1103 plus 1198) (Line 11 above)	0	0	0	0	0	0	0	0	0

(a) Includes \$ premium deficiency reserve.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 3 - ANALYSIS OF EXPENSES

	Claim Adjustment Expenses		3 General Administrative Expenses	4 Investment Expenses	5 Total
	1 Cost Containment Expenses	2 Other Claim Adjustment Expenses			
1. Rent (\$ for occupancy of own building)	1,568,330	772,942	(470,032)	(1,255)	1,869,985
2. Salary, wages and other benefits	40,196,710	11,830,498	20,047,143	53,514	72,127,865
3. Commissions (less \$ ceded plus \$ assumed)					0
4. Legal fees and expenses	2,989	6,385	574,896	1,534	585,804
5. Certifications and accreditation fees					0
6. Auditing, actuarial and other consulting services	3,094,630	191,526	5,599,033	14,946	8,900,135
7. Traveling expenses	437,566	43,379	467,425	1,248	949,618
8. Marketing and advertising	849,138	24,411	826,645	2,207	1,702,401
9. Postage, express and telephone	1,334,867	330,237	1,337,345	3,570	3,006,019
10. Printing and office supplies	89,384	11,183	124,795	333	225,695
11. Occupancy, depreciation and amortization					0
12. Equipment	13,899	4,021	573,734	1,532	593,186
13. Cost or depreciation of EDP equipment and software	1,176,316	134,028	3,709,533	9,902	5,029,779
14. Outsourced services including EDP, claims, and other services	2,348,878	4,697,611	1,513,592	4,040	8,564,121
15. Boards, bureaus and association fees	13,763	0	219,507	586	233,856
16. Insurance, except on real estate	0	0	507,041	1,354	508,395
17. Collection and bank service charges	0	0	135,532	362	135,894
18. Group service and administration fees	2,433	0	10,866	29	13,328
19. Reimbursements by uninsured plans					0
20. Reimbursements from fiscal intermediaries					0
21. Real estate expenses	9,955	292	1,624,163	4,336	1,638,746
22. Real estate taxes	0	0	71,900	0	71,900
23. Taxes, licenses and fees:					
23.1 State and local insurance taxes	122	0	1,816,435	0	1,816,557
23.2 State premium taxes					0
23.3 Regulatory authority licenses and fees	8,412	115	56,600	0	65,127
23.4 Payroll taxes	2,474,678	733,283	1,287,076	0	4,495,037
23.5 Other (excluding federal income and real estate taxes)	0	0	21,148,836	0	21,148,836
24. Investment expenses not included elsewhere				128,488	128,488
25. Aggregate write-ins for expenses	6,393	3,519,856	6,755,582	18,033	10,299,864
26. Total expenses incurred (Lines 1 to 25)	53,628,463	22,299,767	67,937,647	244,759	(a) 144,110,636
27. Less expenses unpaid December 31, current year		3,184,297	2,202,465		5,386,762
28. Add expenses unpaid December 31, prior year	3,280,587		889,919		4,170,506
29. Amounts receivable relating to uninsured plans, prior year			329,726		329,726
30. Amounts receivable relating to uninsured plans, current year			835,435		835,435
31. Total expenses paid (Lines 26 minus 27 plus 28 minus 29 plus 30)	56,909,050	19,115,470	67,130,810	244,759	143,400,089
DETAILS OF WRITE-INS					
2501. Capitation Administrative Fee			6,047,683		6,047,683
2502. Pharmacy Administrative Fee		2,171,288			2,171,288
2503. Claims Related Fees		1,348,568			1,348,568
2598. Summary of remaining write-ins for Line 25 from overflow page	6,393	0	707,899	18,033	732,325
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	6,393	3,519,856	6,755,582	18,033	10,299,864

(a) Includes management fees of \$ 124,802,658 to affiliates and \$ to non-affiliates.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

EXHIBIT OF NET INVESTMENT INCOME

	1 Collected During Year	2 Earned During Year
1. U.S. government bonds	(a) 172,829	256,960
1.1 Bonds exempt from U.S. tax	(a)	
1.2 Other bonds (unaffiliated)	(a) 2,740,404	2,715,319
1.3 Bonds of affiliates	(a) 0	0
2.1 Preferred stocks (unaffiliated)	(b) 0	0
2.11 Preferred stocks of affiliates	(b) 0	0
2.2 Common stocks (unaffiliated)	191,561	191,561
2.21 Common stocks of affiliates	0	0
3. Mortgage loans	(c) 0	0
4. Real estate	(d) 0	0
5. Contract Loans	0	0
6. Cash, cash equivalents and short-term investments	(e) 128,434	127,567
7. Derivative instruments	(f)	
8. Other invested assets		
9. Aggregate write-ins for investment income	19,589	18,595
10. Total gross investment income	3,252,817	3,310,002
11. Investment expenses		(g) 244,759
12. Investment taxes, licenses and fees, excluding federal income taxes		(g) 0
13. Interest expense		(h) 0
14. Depreciation on real estate and other invested assets		(i) 0
15. Aggregate write-ins for deductions from investment income		0
16. Total deductions (Lines 11 through 15)		244,759
17. Net investment income (Line 10 minus Line 16)		3,065,243
DETAILS OF WRITE-INS		
0901.	5	5
0902.	19,584	18,590
0903.	0	0
0998. Summary of remaining write-ins for Line 9 from overflow page	0	0
0999. Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)	19,589	18,595
1501.		
1502.		
1503.		
1598. Summary of remaining write-ins for Line 15 from overflow page		0
1599. Totals (Lines 1501 thru 1503 plus 1598) (Line 15, above)		0

- (a) Includes \$ 14,654 accrual of discount less \$ 1,291,037 amortization of premium and less \$ 59,703 paid for accrued interest on purchases.
- (b) Includes \$ accrual of discount less \$ amortization of premium and less \$ paid for accrued dividends on purchases.
- (c) Includes \$ accrual of discount less \$ amortization of premium and less \$ paid for accrued interest on purchases.
- (d) Includes \$ for company's occupancy of its own buildings; and excludes \$ interest on encumbrances.
- (e) Includes \$ accrual of discount less \$ amortization of premium and less \$ paid for accrued interest on purchases.
- (f) Includes \$ accrual of discount less \$ amortization of premium.
- (g) Includes \$. investment expenses and \$ investment taxes, licenses and fees, excluding federal income taxes, attributable to segregated and Separate Accounts.
- (h) Includes \$ interest on surplus notes and \$ interest on capital notes.
- (i) Includes \$ depreciation on real estate and \$ depreciation on other invested assets.

EXHIBIT OF CAPITAL GAINS (LOSSES)

	1 Realized Gain (Loss) On Sales or Maturity	2 Other Realized Adjustments	3 Total Realized Capital Gain (Loss) (Columns 1 + 2)	4 Change in Unrealized Capital Gain (Loss)	5 Change in Unrealized Foreign Exchange Capital Gain (Loss)
1. U.S. Government bonds	0	0	0	0	0
1.1 Bonds exempt from U.S. tax					
1.2 Other bonds (unaffiliated)	136,535	0	136,535	(40,423)	0
1.3 Bonds of affiliates	0	0	0	0	0
2.1 Preferred stocks (unaffiliated)	0	0	0	0	0
2.11 Preferred stocks of affiliates	0	0	0	0	0
2.2 Common stocks (unaffiliated)	4,804,344	0	4,804,344	(4,236,175)	0
2.21 Common stocks of affiliates	0	0	0	0	0
3. Mortgage loans	0	0	0	0	0
4. Real estate	0	0	0	0	0
5. Contract loans	0	0	0	0	0
6. Cash, cash equivalents and short-term investments	6,823	0	6,823	0	0
7. Derivative instruments	0	0	0	0	0
8. Other invested assets	0	0	0	0	0
9. Aggregate write-ins for capital gains (losses)	0	0	0	0	0
10. Total capital gains (losses)	4,947,702	0	4,947,702	(4,276,598)	0
DETAILS OF WRITE-INS					
0901.					
0902.					
0903.					
0998. Summary of remaining write-ins for Line 9 from overflow page	0	0	0	0	0
0999. Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)	0	0	0	0	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

EXHIBIT OF NON-ADMITTED ASSETS

	1 Current Year Total Nonadmitted Assets	2 Prior Year Total Nonadmitted Assets	3 Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
1. Bonds (Schedule D)			0
2. Stocks (Schedule D):			
2.1 Preferred stocks			0
2.2 Common stocks			0
3. Mortgage loans on real estate (Schedule B):			
3.1 First liens			0
3.2 Other than first liens.....			0
4. Real estate (Schedule A):			
4.1 Properties occupied by the company			0
4.2 Properties held for the production of income.....			0
4.3 Properties held for sale			0
5. Cash (Schedule E - Part 1), cash equivalents (Schedule E - Part 2) and short-term investments (Schedule DA)			0
6. Contract loans			0
7. Derivatives (Schedule DB)			0
8. Other invested assets (Schedule BA)			0
9. Receivables for securities			0
10. Securities lending reinvested collateral assets (Schedule DL)			0
11. Aggregate write-ins for invested assets	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	0	0	0
13. Title plants (for Title insurers only)			0
14. Investment income due and accrued	0		0
15. Premiums and considerations:			
15.1 Uncollected premiums and agents' balances in the course of collection	0		0
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due			0
15.3 Accrued retrospective premiums and contracts subject to redetermination	0		0
16. Reinsurance:			
16.1 Amounts recoverable from reinsurers			0
16.2 Funds held by or deposited with reinsured companies			0
16.3 Other amounts receivable under reinsurance contracts			0
17. Amounts receivable relating to uninsured plans	0		0
18.1 Current federal and foreign income tax recoverable and interest thereon			0
18.2 Net deferred tax asset	503,521		(503,521)
19. Guaranty funds receivable or on deposit			0
20. Electronic data processing equipment and software			0
21. Furniture and equipment, including health care delivery assets	1,931,273	2,494,874	563,601
22. Net adjustment in assets and liabilities due to foreign exchange rates			0
23. Receivable from parent, subsidiaries and affiliates	1,957,553	189,499	(1,768,054)
24. Health care and other amounts receivable	5,168,720	10,121,359	4,952,639
25. Aggregate write-ins for other than invested assets	8,750,378	8,122,895	(627,483)
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	18,311,445	20,928,627	2,617,182
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0
28. Total (Lines 26 and 27)	18,311,445	20,928,627	2,617,182
DETAILS OF WRITE-INS			
1101.			
1102.			
1103.			
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0
1199. Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	0	0	0
2501. Goodwill, Intangibles, and Covenant not to Compete	8,069,210	8,069,210	0
2502. Prepaids	525,948	53,685	(472,263)
2503. Tenant Improvement Allowance	155,220		(155,220)
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	8,750,378	8,122,895	(627,483)

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

EXHIBIT 1 - ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS ONLY

Source of Enrollment	Total Members at End of					6 Current Year Member Months
	1 Prior Year	2 First Quarter	3 Second Quarter	4 Third Quarter	5 Current Year	
1. Health Maintenance Organizations	392,725	407,974	411,295	407,350	404,090	4,854,650
2. Provider Service Organizations						
3. Preferred Provider Organizations						
4. Point of Service						
5. Indemnity Only						
6. Aggregate write-ins for other lines of business.....	0	0	0	0	0	0
7. Total	392,725	407,974	411,295	407,350	404,090	4,854,650
DETAILS OF WRITE-INS						
0601.						
0602.						
0603.						
0698. Summary of remaining write-ins for Line 6 from overflow page	0	0	0	0	0	0
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	0	0	0	0	0

EXHIBIT 2 - ACCIDENT AND HEALTH PREMIUMS DUE AND UNPAID

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

EXHIBIT 3 - HEALTH CARE RECEIVABLES

1 Name of Debtor	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 Over 90 Days	6 Nonadmitted	7 Admitted
Express Scripts, Inc.	(905,582)	154,571	153,213	646,569	48,771	
CVS Caremark	1,448			5,480	6,928	
0199998. Aggregate Pharmaceutical Rebate Receivables Not Individually Listed						0
0199999. Total Pharmaceutical Rebate Receivables	(904,134)	154,571	153,213	652,049	55,699	0
0299998. Aggregate Claim Overpayment Receivables Not Individually Listed	797,595	129,064	395,987	1,726,101	3,048,747	
0299999. Total Claim Overpayment Receivables	797,595	129,064	395,987	1,726,101	3,048,747	0
0399998. Aggregate Loans and Advances to Providers Not Individually Listed		302,996		(5,465)	297,531	
0399999. Total Loans and Advances to Providers	0	302,996	0	(5,465)	297,531	0
0499998. Aggregate Capitation Arrangement Receivables Not Individually Listed				1,331,852	1,331,852	
0499999. Total Capitation Arrangement Receivables	0	0	0	1,331,852	1,331,852	0
0599998. Aggregate Risk Sharing Receivables Not Individually Listed						
0599999. Total Risk Sharing Receivables	0	0	0	0	0	0
0699998. Aggregate Other Receivables Not Individually Listed		434,427		464	434,891	
0699999. Total Other Receivables	0	434,427	0	464	434,891	0
0799999 Gross health care receivables	(106,539)	1,021,058	549,200	3,705,001	5,168,720	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

EXHIBIT 3A - ANALYSIS OF HEALTH CARE RECEIVABLES COLLECTED AND ACCRUED

Type of Health Care Receivable	Health Care Receivables Collected During the Year		Health Care Receivables Accrued as of December 31 of Current Year		5	6
	1 On Amounts Accrued Prior to January 1 of Current Year	2 On Amounts Accrued During the Year	3 On Amounts Accrued December 31 of Prior Year	4 On Amounts Accrued During the Year	Health Care Receivables in Prior Years (Columns 1 + 3)	Estimated Health Care Receivables Accrued as of December 31 of Prior Year
1. Pharmaceutical rebate receivables	3,165,854	700,067	(428,689)	484,388	2,737,165	2,284,987
2. Claim overpayment receivables	3,368,407	3,525,965	1,517,871	1,530,876	4,886,278	4,406,536
3. Loans and advances to providers		3,153,547	297,531		297,531	297,531
4. Capitation arrangement receivables			553,874	777,978	553,874	2,684,535
5. Risk sharing receivables					0	0
6. Other health care receivables.....	1,950,463	45,514		434,891	1,950,463	908,663
7. Totals (Lines 1 through 6)	8,484,724	7,425,093	1,940,587	3,228,133	10,425,311	10,582,252

Note that the accrued amounts in Columns 3, 4, and 6 are the total health care receivables, not just the admitted portion.

EXHIBIT 4 - CLAIMS UNPAID AND INCENTIVE POOL, WITHHOLD AND BONUS (Reported and Unreported)

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

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EXHIBIT 6 - AMOUNTS DUE TO PARENT, SUBSIDIARIES AND AFFILIATES

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

EXHIBIT 7 PART 1- SUMMARY OF TRANSACTIONS WITH PROVIDERS

Payment Method	1 Direct Medical Expense Payment	2 Column 1 as a % of Total Payments	3 Total Members Covered	4 Column 3 as a % of Total Members	5 Column 1 Expenses Paid to Affiliated Providers	6 Column 1 Expenses Paid to Non-Affiliated Providers
Capitation Payments:						
1. Medical groups	30,749,584	2.4	404,090	100.0		30,749,584
2. Intermediaries.....	0	0.0		0.0		
3. All other providers.....	14,008,862	1.1	404,090	100.0		14,008,862
4. Total capitation payments.....	44,758,446	3.5	808,180	200.0	0	44,758,446
Other Payments:						
5. Fee-for-service	20,401,252	1.6	XXX	XXX		20,401,252
6. Contractual fee payments	1,194,272,874	94.5	XXX	XXX		1,194,272,874
7. Bonus/withhold arrangements - fee-for-service	0	0.0	XXX	XXX		
8. Bonus/withhold arrangements - contractual fee payments	4,418,848	0.3	XXX	XXX		4,418,848
9. Non-contingent salaries	0	0.0	XXX	XXX		
10. Aggregate cost arrangements	0	0.0	XXX	XXX		
11. All other payments	0	0.0	XXX	XXX		
12. Total other payments	1,219,092,974	96.5	XXX	XXX	0	1,219,092,974
13. TOTAL (Line 4 plus Line 12)	1,263,851,420	100%	XXX	XXX	0	1,263,851,420

EXHIBIT 7 - PART 2 - SUMMARY OF TRANSACTIONS WITH INTERMEDIARIES

1 NAIC Code	2 Name of Intermediary	3 Capitation Paid	4 Average Monthly Capitation	5 Intermediary's Total Adjusted Capital	6 Intermediary's Authorized Control Level RBC
	NONE				
9999999 Totals			XXX	XXX	XXX

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

EXHIBIT 8 - FURNITURE, EQUIPMENT AND SUPPLIES OWNED

		1	2	3	4	5	6
Description		Cost	Improvements	Accumulated Depreciation	Book Value Less Encumbrances	Assets Not Admitted	Net Admitted Assets
1.	Administrative furniture and equipment	6,012,297		(4,081,024)	1,931,273	1,931,273	
2.	Medical furniture, equipment and fixtures						
3.	Pharmaceuticals and surgical supplies						
4.	Durable medical equipment						
5.	Other property and equipment						
6.	Total	6,012,297	0	(4,081,024)	1,931,273	1,931,273	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies and Going Concern

A. Accounting Practices

The accompanying financial statements of AMERIGROUP Florida, Inc. (the "Company") have been prepared in conformity with the National Association of Insurance Commissioners' ("NAIC") *Annual Statement Instructions* and in accordance with accounting practices prescribed by the NAIC *Accounting Practice and Procedures Manual* ("NAIC SAP"), subject to any deviations prescribed or permitted by the Florida Office of Insurance Regulation ("Florida OIR").

The Florida OIR state prescribed practice does not allow parent and affiliate receivables to be admitted assets. A reconciliation of the Company's net loss and capital and surplus between NAIC SAP and practices prescribed and permitted by the Florida OIR is shown below:

	SSAP #	F/S Page	F/S Line #	2016	2015
Net Loss					
(1) AMERIGROUP Florida, Inc. state basis (Page 4, Line 32, Columns 2 & 3)	XXX	XXX	XXX	\$ (1,968,169)	\$ (1,935,759)
(2) States Prescribed Practices that increase(decrease) NAIC SAP:	Florida statute 641.35 (3)(a)	4	13	(11,218,436)	-
(3) State Permitted Practices that increase(decrease) NAIC SAP:				-	-
(4) NAIC SAP (1 - 2 - 3 = 4)	XXX	XXX	XXX	\$ 9,250,267	\$ (1,935,759)
Surplus					
(5) AMERIGROUP Florida, Inc. state basis (Page 3, Line 33, Columns 3 & 4)	XXX	XXX	XXX	\$ 86,129,663	\$ 75,684,471
(6) States Prescribed Practices that increase(decrease) NAIC SAP:	Florida statute 641.35 (2)(i)	2	23	(1,957,553)	(189,499)
(7) State Permitted Practices that increase(decrease) NAIC SAP:	Florida statute 641.35 (3)(a)	4	13	(11,218,436)	-
(8) NAIC SAP (5 - 6 - 7 = 8)	XXX	XXX	XXX	\$ 99,305,652	\$ 75,873,970

B. Use of Estimates in the Preparation of the Financial Statements

Preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

C. Accounting Policies

Health premium revenues, based on membership records and premiums rates for each membership category within each county, are recognized as revenue during the period in which the Company is obligated to provide service to members. Premiums are reported net of excess loss reinsurance ceded and experience rating refunds. Premiums paid before the effective service month are recorded on the balance sheet as premiums received in advance and are subsequently credited to income as earned during the coverage period. Premium rates are subject to approval by State Medicaid agencies and the Centers for Medicare and Medicaid Services ("CMS"). Costs, such as premium taxes and other underwriting expenses are charged to operations as incurred.

In addition, the Company uses the following accounting policies:

- (1) Short-term investments include investments with maturities of less than one year at the date of acquisition and are reported at amortized cost, which approximates fair value. Non-investment grade short-term investments are stated at the lower of amortized cost or fair value.
- (2) Investment grade bonds not backed by other loans are stated at amortized cost, with amortization calculated based on the modified scientific method, using lower of yield to call or yield to maturity. Non-investment grade bonds are stated at the lower of amortized cost or fair value as determined by various third-party pricing sources.
- (3) The Company has no investments in common stocks of unaffiliated companies.
- (4) The Company has no investments in preferred stock.
- (5) The Company has no mortgage loans - real estate.
- (6) Loan-backed securities are stated at amortized cost. Pre-payment assumptions for loan-backed securities and structured securities are obtained from broker-dealer survey values or internal estimates. These assumptions are consistent with the current interest rate and economic environment. The retrospective adjustment method is used to value all loan-backed securities. Non-investment grade loan-backed securities are stated at the lower of amortized cost or fair value.
- (7) The Company has no investments in subsidiaries, controlled and affiliated companies.
- (8) The Company has no investments in joint ventures, partnerships and limited liability companies.
- (9) The Company has no derivatives instruments.

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- (10) The Company does not anticipate investment income as a factor in premium deficiency calculation.
- (11) Unpaid claims and claims adjustment expenses include management's best estimate of amounts based on historical claim development patterns and certain individual case estimates. The established liability considers health benefit provisions, business practices, economic conditions and other factors that may materially affect the cost, frequency and severity of claims. Liabilities for unpaid claims and claim adjustment expenses are based on assumptions and estimates, and while management believes such estimates are reasonable, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed and changes in estimates are incorporated into current period estimates.
- (12) The Company has not modified its capitalization policy from the prior period.
- (13) Pharmacy rebate receivables are recorded when earned based upon actual rebate receivables billed and an estimate of receivables based upon current utilization of specific pharmaceuticals and provider contract terms.

D. Going Concern

Not applicable.

2. Accounting Changes and Corrections of Errors

There were no accounting changes or corrections of errors during the years ended December 31, 2016 and 2015.

3. Business Combinations and Goodwill

- | | |
|-------------------------------------|-----------------|
| A. Statutory Purchase Method | Not applicable. |
| B. Statutory Merger | Not applicable. |
| C. Assumption Reinsurance | Not applicable. |
| D. Impairment Loss | Not applicable. |

4. Discontinued Operations

The Company had no operations that were discontinued during 2016 or 2015.

5. Investments

A. Mortgage Loans, including Mezzanine Real Estate Loans

The Company did not have investments in mortgage loans at December 31, 2016 or 2015.

B. Debt Restructuring

The Company did not have invested assets that were restructured debt at December 31, 2016 or 2015.

C. Reverse Mortgages

The Company did not have investments in reverse mortgages at December 31, 2016 or 2015.

D. Loan-Backed Securities

- (1) Prepayment assumptions for single-class and multi-class mortgage-backed and asset-backed securities were obtained from broker-dealer survey values or internal estimates. The Company used various third-party pricing sources in determining the market value of its loan-back securities.
- (2) The Company did not recognize other-than-temporary impairments on its loan-backed securities during December 31, 2016 and 2015.
- (3) The Company did not recognize other-than-temporarily impairments on its loan-backed securities at December 31, 2016 and 2015.
- (4) The Company had no impaired securities for which an other-than-temporary impairment had not been recognized in earnings as a realized loss at December 31, 2016 and 2015.
- (5) The Company had no impaired loan-backed securities at December 31, 2016 and 2015.

E. Repurchase Agreements and/or Securities Lending Transactions

- (1) The Company did not enter into repurchase agreements at December 31, 2016 or 2015.
- (2) The Company participates in a securities lending program whereby marketable securities in its investment portfolio are transferred to independent brokers or dealers based on, among other things,

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their creditworthiness in exchange for collateral initially equal to at least 102% of the market value of the loaned securities. The Company receives the collateral in cash or securities, and if cash is received the cash collateral is thereafter invested according to guidelines of the Company's Investment Policy.

(3) Collateral Received

a. Aggregate amount collateral received

1. Repurchase agreement – Not applicable.

	Fair Value
2. Securities Lending	
a. Open	948,951
b. 30 days or less	-
c. 31 to 60 days	-
d. 61 to 90 days	-
e. Greater than 90 days	-
f. Subtotal	948,951
g. Securities received	-
h. Total collateral received	948,951

3. Dollar repurchase agreement – Not applicable.

b. The fair value of that collateral and of the portion of that collateral that it has sold or repledged \$ 948,951

c. The Company receives cash collateral in an amount in excess of the fair value of the securities lent. The Company reinvests the cash collateral according to guidelines of the Company's Investment Policy.

(4) Not applicable.

(5) Collateral Reinvestment

a. Aggregate amount collateral reinvested

(1) Repurchase agreement – Not applicable.

	Amortized Cost	Fair Value
2. Securities Lending		
a. Open	\$ -	\$ -
b. 30 days or less	948,299	948,951
c. 31 to 60 days	-	-
d. 61 to 90 days	-	-
e. 91 to 120 days	-	-
f. 121 to 180 days	-	-
g. 181 to 365 days	-	-
h. 1 to 2 years	-	-
i. 2 to 3 years	-	-
j. Greater than 3 years	-	-
k. Subtotal	\$ 948,299	\$ 948,951
l. Securities received	-	-
m. Total collateral reinvested	\$ 948,299	\$ 948,951

3. Dollar repurchase agreement – Not applicable.

b. Not applicable.

(6) Not applicable.

(7) Not applicable.

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F. Real Estate

The Company did not have investments in real estate and did not engage in retail land sales operations during 2016 or 2015.

G. Investments in Low-Income Housing Tax Credits

The Company did not invest in properties generating low-income housing tax credits during 2016 or 2015.

H. Restricted Assets

(1) Restricted assets (including pledged)

	1	2	3	4	5	6	7
Restricted Asset Category	Total Gross (Admitted & Nonadmitted) Restricted From Current Year	Total Gross (Admitted & Nonadmitted) Restricted From Prior Year	Increase/ (Decrease) (1 minus 2)	Total Current Year Nonadmitted Restricted	Total Current Year Admitted Restricted (1 minus 4)	Gross Admitted and Nonadmitted Restricted to Total Assets (a)	Admitted Restricted to Total Admitted Assets (b)
a. Subject to contractual obligation for which liability is not shown	\$ -	\$ -	\$ -	\$ -	-	-	-
b. Collateral held under security lending agreements	948,299	6,809,150	(5,860,851)	-	948,299	0.40%	0.43%
c. Subject to repurchase agreements	-	-	-	-	-	-	-
d. Subject to reverse repurchase agreements	-	-	-	-	-	-	-
e. Subject to dollar repurchase agreements	-	-	-	-	-	-	-
f. Subject to dollar reverse repurchase agreements	-	-	-	-	-	-	-
g. Placed under option contracts	-	-	-	-	-	-	-
h. Letter stock or securities restricted as to sale - excluding FHLB capital stock	-	-	-	-	-	-	-
i. FHLB capital stock	-	-	-	-	-	-	-
j. On deposit with states	39,081,653	38,846,192	235,461	-	39,081,653	16.44%	17.77%
k. On deposit with other regulatory bodies	-	-	-	-	-	-	-
l. Pledged collateral to FHLB (including assets backing funding agreements)	-	-	-	-	-	-	-
m. Pledged as collateral not captured in other categories	-	-	-	-	-	-	-
n. Other restricted assets	-	-	-	-	-	-	-
o. Total Restricted Assets	\$ 40,029,952	\$ 45,655,342	\$ (5,625,390)	\$ -	\$ 40,029,952	16.84%	18.20%

(a) Column 1 divided by Asset Page, Column 1, Line 28

(b) Column 5 divided by Asset Page, Column 3, Line 28

(2) Not applicable.

(3) Not applicable.

(4) Collateral Received and Reflected as Assets Within the Reporting Entity's Financial Statements

	1	2	3	4
Collateral Assets	Book/Adjusted Carrying Value (BACV)	Fair Value	% of BACV to Total Assets (Admitted & Nonadmitted) *	% of BACV to Total Admitted Assets **
a. Cash	\$ -	\$ -	0.00%	0.00%
b. Schedule D, Part 1	-	-	0.00%	0.00%
c. Schedule D, Part 2, Section 1	-	-	0.00%	0.00%
d. Schedule D, Part 2, Section 2	-	-	0.00%	0.00%
e. Schedule B	-	-	0.00%	0.00%
f. Schedule A	-	-	0.00%	0.00%
g. Schedule BA, Part 1	-	-	0.00%	0.00%
h. Schedule DL, Part 1	948,299	948,951	0.40%	0.43%
i. Other	-	-	0.00%	0.00%
j. Total Collateral Assets (a+b+c+d+e+f+g+h+i)	\$ 948,299	\$ 948,951	0.40%	0.43%

* Column 1 divided by Asset Page, Line 26 (Column 1)

** Column 1 divided by Asset Page, Line 26 (Column 3)

	1	2
	Amount	% of Liability to Total Liabilities *
k. Recognized Obligation to Return Collateral Asset	\$ 948,299	0%

* Column 1 divided by Liability Page, Line 24 (Column 3)

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I. Working Capital Finance Investments

The Company did not have any working capital finance investments as December 31, 2016 and 2015.

J. Offsetting and Netting of Assets and Liabilities

The Company did not have any offsetting and netting of assets and liabilities at December 31, 2016 and 2015.

K. Structured Notes

The Company did not have any structured notes at December 31, 2016 and 2015.

L. 5*Securities

The Company has no 5* Securities as of December 31, 2016 and 2015.

6. Joint Ventures, Partnerships and Limited Liability Companies

A. The Company has no investments in joint ventures, partnerships, or limited liability companies that exceeded 10% of its admitted assets at December 31, 2016 or 2015.

B. The Company did not recognize impairment write downs for its investments in joint ventures, partnerships or limited liability companies during 2016 or 2015.

7. Investment Income

A. All investment income due and accrued with amounts that are over 90 days past due is non-admitted.

B. At December 31, 2016 and 2015, there was no non-admitted accrued investment interest income.

8. Derivative Instruments

The Company has no derivative instruments.

9. Income Taxes

A. The components of net deferred tax assets (liabilities):

(1) The components of net deferred tax asset (liabilities) at December 31 are as follows:

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12/31/2016		
(1)	(2)	(3)
Ordinary	Capital	(Col 1+2) Total
(a) Gross deferred tax assets	\$ 9,661,835	\$ - \$ 9,661,835
(b) Statutory valuation allowance adjustments	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	9,661,835	9,661,835
(d) Deferred tax assets nonadmitted	503,521	503,521
(e) Subtotal net admitted deferred tax asset (1c - 1d)	9,158,314	9,158,314
(f) Deferred tax liabilities	3,122	9,725 12,847
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	\$ 9,155,192	\$ (9,725) \$ 9,145,467

12/31/2015		
(4)	(5)	(6)
Ordinary	Capital	(Col 4+5) Total
(a) Gross deferred tax assets	\$ 7,069,987	\$ - \$ 7,069,987
(b) Statutory valuation allowance adjustments	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	7,069,987	7,069,987
(d) Deferred tax assets nonadmitted	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	7,069,987	7,069,987
(f) Deferred tax liabilities	1,609	1,492,167 1,493,776
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	\$ 7,068,378	\$ (1,492,167) \$ 5,576,211

Change		
(7)	(8)	(9)
(Col 1-4) Ordinary	(Col 2-5) Capital	(Col 7+8) Total
(a) Gross deferred tax assets	\$ 2,591,848	\$ - \$ 2,591,848
(b) Statutory valuation allowance adjustments	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	2,591,848	2,591,848
(d) Deferred tax assets nonadmitted	503,521	503,521
(e) Subtotal net admitted deferred tax asset (1c - 1d)	2,088,327	2,088,327
(f) Deferred tax liabilities	1,513	(1,482,442) (1,480,929)
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	\$ 2,086,814	\$ 1,482,442 \$ 3,569,256

- (2) The amount of admitted adjusted gross deferred tax assets under each component of SSAP No. 101, *Income Taxes - A Replacement of SSAP No. 10R and SSAP 10* ("SSAP No. 101") as of December 31 is as follows:

12/31/2016		
(1)	(2)	(3)
Ordinary	Capital	(Col 1+2) Total
Admission Calculation Components SSAP No. 101		
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	\$ 8,641,274	\$ - \$ 8,641,274
(b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation (the lesser of 2(b)1 and 2(b)2 below)	504,193	504,193
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	504,193	504,193
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	11,547,629
(c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	12,847	12,847
(d) Deferred tax assets admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	\$ 9,158,314	\$ - \$ 9,158,314

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12/31/2015		
(4)	(5)	(6)
Ordinary	Capital	(Col 4+5) Total

Admission Calculation Components SSAP No. 101

(a) Federal income taxes paid in prior years recoverable through loss carrybacks	\$ 6,214,537	\$ -	\$ 6,214,537
(b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation (the lesser of 2(b)1 and 2(b)2 below)	163,960	-	163,960
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	163,960	-	163,960
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	10,514,346
(c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	691,490	-	691,490
(d) Deferred tax assets admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	\$ 7,069,987	\$ -	\$ 7,069,987

Change		
(7)	(8)	(9)
(Col 1-4) Ordinary	(Col 2-5) Capital	(Col 7+8) Total

Admission Calculation Components SSAP No. 101

(a) Federal income taxes paid in prior years recoverable through loss carrybacks	\$ 2,426,737	\$ -	\$ 2,426,737
(b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation (the lesser of 2(b)1 and 2(b)2 below)	340,233	-	340,233
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	340,233	-	340,233
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	1,033,283
(c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	(678,643)	-	(678,643)
(d) Deferred tax assets admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	\$ 2,088,327	\$ -	\$ 2,088,327

(3)	2016	2015
(a) Ratio percentage used to determine recovery period and threshold limitation amount	69.13%	68.95%
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)2 above	\$ 76,984,195	\$ 70,095,642

(4) Impact of tax planning strategies

12/31/2016		12/31/2015		Change	
(1)	(2)	(3)	(4)	(5)	(6)
Ordinary	Capital	Ordinary	Capital	(Col 1-3) Ordinary	(Col 2-4) Capital

(a) Determination of adjusted gross deferred tax assets and net admitted deferred tax assets by tax character as a percentage					
1 Adjusted gross DTAs amount from Note 9A1(c)	\$ 9,661,835	\$ -	\$ 7,069,987	\$ -	\$ 2,591,848
2 Percentage of adjusted gross DTAs by tax character attributable to the impact of tax planning strategies	0.00%	0.00%	0.00%	0.00%	0.00%
3 Net admitted adjusted gross DTAs amount from Note 9A1(e)	\$ 9,158,314	\$ -	\$ 7,069,987	\$ -	\$ 2,088,327
4 Percentage of net admitted adjusted gross DTAs by tax character admitted because of the impact of tax planning strategies	0.00%	0.00%	0.00%	0.00%	0.00%
(b) Does the Company's tax-planning strategies include the use of reinsurance?	Yes		No X		

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B. The Company has no unrecognized deferred tax liabilities at December 31, 2016 and 2015.

C. Current income taxes incurred consist of the following major components:

	(1) 12/31/2016	(2) 12/31/2015	(3) (Col 1-2) Change
(1) Current Income Tax			
(a) Federal	\$ 13,870,421	\$ 7,697,859	\$ 6,172,562
(b) Foreign	-	-	-
(c) Subtotal	13,870,421	7,697,859	6,172,562
(d) Federal income tax expense on net capital gains	1,729,786	(222,491)	1,952,277
(e) Utilization of capital loss carry-forwards	-	-	-
(f) Other	-	-	-
(g) Federal and foreign income taxes incurred	\$ 15,600,207	\$ 7,475,368	\$ 8,124,839
(2) Deferred Tax Assets:			
(a) Ordinary			
(1) Discounting of unpaid losses	\$ 288,009	\$ 278,869	\$ 9,140
(2) Unearned premium reserve	-	-	-
(3) Policyholder reserves	5,362,584	1,713,126	3,649,458
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	791,128	877,514	(86,386)
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables - nonadmitted	2,795,683	3,609,954	(814,271)
(11) Net operating loss carryforward	-	-	-
(12) Tax credit carry-forward	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	87,029	9,087	77,942
(14) Accrued future expenses	7,712	47,529	(39,817)
(15) Amortization	308,111	516,271	(208,160)
(16) Partnership income	-	-	-
(17) Premium deficiency reserves	-	-	-
(18) Prepaid expenses	21,579	17,637	3,942
(99) Subtotal	9,661,835	7,069,987	2,591,848
(b) Statutory valuation allowance adjustment	-	-	-
(c) Nonadmitted	503,521	0	503,521
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	\$ 9,158,314	\$ 7,069,987	\$ 2,088,327
(e) Capital:			
(1) Investments	\$ -	\$ -	\$ -
(2) Net capital loss carryforward	-	-	-
(3) Real estate	-	-	-
(4) Other (including items <5% of total capital tax assets)	-	-	-
(5) Investment Partnership	-	-	-
(99) Subtotal	-	-	-
(f) Statutory valuation allowance adjustment	-	-	-
(g) Nonadmitted	-	-	-
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	-	-	-
(i) Admitted deferred tax assets (2d + 2h)	\$ 9,158,314	\$ 7,069,987	\$ 2,088,327
(3) Deferred Tax Liabilities:			
(a) Ordinary:			
(1) Investments	\$ -	\$ -	\$ -
(2) Fixed assets	-	-	-
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities)	-	-	-
(6) Amortization	-	-	-
(7) Discount of coordination of benefits	3,122	1,609	1,513
(99) Subtotal	3,122	1,609	1,513
(b) Capital:			
(1) Investments	9,725	1,492,167	(1,482,442)
(2) Real estate	-	-	-
(3) Other (including items <5% of total capital tax liabilities)	-	-	-
(99) Subtotal	9,725	1,492,167	(1,482,442)
(c) Deferred tax liabilities (3a99 + 3b99)	12,847	1,493,776	(1,480,928)
(4) Net deferred tax assets/liabilities (2i - 3C)	\$ 9,145,467	\$ 5,576,211	\$ 3,569,255

D. The Company's income tax expense and change in deferred income taxes differs from the amount obtained by applying the federal statutory income tax rate of 35% for the year ended December 31 as follows:

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	2016	2015
Tax expense computed using federal statutory rate	\$ 4,771,213	\$ 1,938,863
ACA health insurer fee	7,394,439	7,440,707
Change in nonadmitted assets	1,092,246	(2,185,104)
Tax exempt income and dividend received	(304,115)	(389,430)
Prior year true-ups and adjustments	(36,116)	(1,657)
Other	106,573	143,514
Total	<u>\$ 13,024,240</u>	<u>\$ 6,946,893</u>
Federal income taxes incurred	\$ 15,600,207	\$ 7,475,368
Change in net deferred income taxes	(2,575,967)	(528,475)
Total statutory income taxes	<u>\$ 13,024,240</u>	<u>\$ 6,946,893</u>

E. Operating loss carryforwards:

- (1) The Company has no operating loss carryforwards and no tax credit carryforwards as of December 31, 2016 or 2015.
- (2) The following are income taxes incurred in the current and prior year(s) that will be available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2016	\$ 13,815,034	\$ 1,729,784	\$ 15,544,818
2015	6,942,672	-	6,942,672
2014	-	-	-

- (3) The Company has no protective tax deposits reported as admitted assets under Section 6603 of the Internal Revenue Code as of December 31, 2016 and 2015.

- F.** The following companies will be included in the consolidated federal income tax return with their parent Anthem, Inc. as of December 31, 2016, and either are current members of the consolidated tax sharing agreement or are in the process of being added to the consolidated tax sharing agreement. Allocation of federal income taxes with affiliates subject to the tax sharing agreement is based upon separate income tax return calculations with credit for net losses that can be used on a consolidated basis. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

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American Imaging Management, Inc.	DeCare Dental Health International, LLC
AMERIGROUP Community Care of New Mexico, Inc.	DeCare Dental Networks, LLC
AMERIGROUP Corporation	DeCare Dental, LLC
AMERIGROUP District of Columbia, Inc.	Designated Agent Company, Inc.
AMERIGROUP Florida, Inc.	EHC Benefits Agency, Inc.
Amerigroup Insurance Company	Empire HealthChoice Assurance, Inc.
AMERIGROUP Iowa, Inc.	Empire HealthChoice HMO, Inc.
Amerigroup Kansas, Inc.	Federal Government Solutions, LLC (fka
AMERIGROUP Maryland, Inc.	Government Health Services, LLC)
AMERIGROUP Mississippi, Inc.	Forty-Four Forty-Four Forest Park Redevelopment Corp
AMERIGROUP Nevada, Inc.	Golden West Health Plan, Inc.
AMERIGROUP New Jersey, Inc.	Greater Georgia Life Insurance Company
AMERIGROUP Ohio, Inc.	Health Core, Inc.
AMERIGROUP Oklahoma, Inc.	Health Management Corporation
Amerigroup Services, Inc.	HealthKeepers, Inc.
AMERIGROUP Tennessee, Inc.	HealthLink HMO, Inc.
AMERIGROUP Texas, Inc.	HealthLink, Inc.
AMERIGROUP Washington, Inc.	HealthPlus HP, LLC
AMGP Georgia Managed Care Company, Inc.	Healthy Alliance Life Insurance Company
Anthem Blue Cross Life and Health Insurance Company	HMO Colorado, Inc.
Anthem Financial, Inc.	HMO Missouri, Inc.
Anthem Health Insurance Company of Nevada	Imaging Management Holdings, LLC
Anthem Health Plans of Kentucky, Inc.	Imaging Providers of Texas
Anthem Health Plans of Maine, Inc.	Living Complete Technologies, Inc. (fka
Anthem Health Plans of New Hampshire, Inc.	Tidgewell Associates, Inc.)
Anthem Health Plans of Virginia, Inc.	Matthew Thornton Health Plan, Inc.
Anthem Health Plans, Inc.	National Government Services, Inc.
Anthem Holding Corp.	Park Square Holdings, Inc.
Anthem Insurance Companies, Inc.	Park Square I, Inc.
Anthem Kentucky Managed Care Plan, Inc.	Park Square II, Inc.
Anthem Life & Disability Insurance Company	PHP Holdings, Inc.
Anthem Southeast, Inc.	R&P Realty, Inc.
Anthem UM Services, Inc.	Resolution Health, Inc.
Anthem, Inc.	RightCHOICE Managed Care, Inc.
Arcus Enterprises, Inc.	Rocky Mountain Hospital and Medical Service, Inc.
ARCUS HealthyLiving Services, Inc.	SellCore, Inc.
Associated Group, Inc.	Simply Healthcare Holdings, Inc.
Better Health, Inc.	Simply Healthcare Plans, Inc.
Blue Cross and Blue Shield of Georgia, Inc.	Southeast Services, Inc.
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	State Sponsored Business UM Services, Inc.
Blue Cross Blue Shield of Wisconsin	The Anthem Companies of California, Inc.
Blue Cross of California	The Anthem Companies, Inc.
Blue Cross of California Partnership Plan, Inc.	TrustSolutions, LLC
CareMore Health Group, Inc.	UNICARE Health Plan of West Virginia, Inc.
CareMore Health Plan	UNICARE Health Plans of Texas, Inc.
CareMore Health Plan of Arizona, Inc.	UNICARE Illinois Services, Inc.
CareMore Health Plan of Georgia, Inc.	UNICARE Life & Health Insurance Company
CareMore Health Plan of Nevada	UNICARE National Services, Inc.
CareMore Health Plan of Texas, Inc.	UNICARE Specialty Services, Inc.
CareMore Health System	UtiliMed IPA, Inc.
CareMore Holdings, Inc.	WellPoint Behavioral Health, Inc.
Cerulean Companies, Inc.	WellPoint California Services, Inc.
Claim Management Services, Inc.	WellPoint Dental Services, Inc.
Community Care Health Plan of Louisiana, Inc. (fka	WellPoint Health Solutions, Inc.
AMERIGROUP Louisiana, Inc.)	WellPoint Holding Corporation
Community Insurance Company	WellPoint Information Technology Services, Inc.
Compcare Health Services Insurance Corporation	WellPoint Insurance Services, Inc.
Crossroads Acquisition Corp	WellPoint Military Care Corporation
DeCare Analytics, LLC	

G. Not applicable.

10. Information Concerning Parent, Subsidiaries, Affiliates, and Other Related Parties

A. Nature of the Relationship

The Company is a Florida owned domiciled stock insurance company and is a wholly-owned subsidiary of PHP Holding, Inc, which is own by AMERIGROUP Corporation (“AGP”). AGP is a wholly-own subsidiary of ATH Holding Company, LLC (“ATH Holding”), which is an indirect wholly-owned subsidiary of Anthem, Inc. (“Anthem”), a publicly traded company owning 100% of the outstanding shares of the Physicians Healthcare Plan Holding, Inc. (PHP Holdings, Inc.).

On July 24, 2015, the Company’s ultimate parent company, Anthem, and Cigna Corporation (“Cigna”) entered into an Agreement and Plan of Merger dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and a direct wholly-owned subsidiary of Anthem, pursuant to which Anthem will acquire all outstanding shares of Cigna, or the Acquisition. On

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July 21, 2016, the U.S. Department of Justice, or DOJ, along with certain state attorneys general, filed a civil antitrust lawsuit in the U.S. District Court for the District of Columbia seeking to block the Acquisition. On January 18, 2017, Anthem provided notice to Cigna that Anthem had elected to extend the termination date under the Merger Agreement from January 31, 2017 until April 30, 2017. On January 18, 2017, Anthem provided notice to Cigna that Anthem had elected to extend the termination date under the Merger Agreement from January 31, 2017 until April 30, 2017. Following the conclusion of the trial, the Court ruled in favor of the DOJ, on February 8, 2017, and Anthem promptly filed notice that Anthem would appeal the Court's ruling. On February 14, 2017, Cigna purported to terminate the Merger Agreement and commenced litigation against Anthem in the Delaware Court of Chancery, or Delaware Court, seeking damages and a declaratory judgment that its purported termination of the Merger Agreement was lawful, among other claims. Anthem believes Cigna's allegations are without merit. Also on February 14, 2017, Anthem initiated its own litigation against Cigna in the Delaware Court seeking a temporary restraining order to enjoin Cigna from terminating the Merger Agreement, specific performance compelling Cigna to comply with the Merger Agreement and damages. On February 15, 2017, the Delaware Court granted Anthem's motion for a temporary restraining order and issued an order enjoining Cigna from terminating the Merger Agreement. The temporary restraining order became effective immediately and will remain in place pending any further order from the Delaware Court. Anthem intends to vigorously defend the Acquisition in both the Circuit Court and the Delaware Court and remains committed to completing the Acquisition as soon as practicable.

B. Significant Transactions for Each Period

The following significant transactions took place between the Company and its affiliates:

The Company received a \$10,000,000 on September 30, 2016 of capital contributions from its parent. The Company received no capital contributions from its parent for the year ended December 31, 2015.

The Company paid no dividends for the years ended December 31, 2016 and 2015.

C. Intercompany Management and Service Arrangements

There were no changes to the intercompany management and service arrangements, and there were no additional arrangements entered into during 2016 or 2015. The amounts of transactions under such agreements are presented in Schedule Y, Part 2.

D. Amounts Due to or from Related Parties

At December 31, 2016 and 2015, the Company reported \$1,957,553 and \$189,499 due from affiliates, which were nonadmitted per Florida OIR. The Company reported \$3,235,127 and \$9,876,638 due to affiliates. The receivable and payable balances represent intercompany transactions that will be settled in accordance with the settlement terms of the intercompany agreement.

E. Guarantees or Contingencies for Related Parties

The Company did not enter into guarantees or undertakings for the benefit of an affiliate which would result in a material contingent exposure of the Company's or any affiliated insurer's assets or liabilities.

F. Management and Service Contracts and Cost Sharing Arrangements

The Company entered into an administrative services agreement with its affiliated companies. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The costs and expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Costs include expenses such as salaries, employee benefits, communications, advertising, consulting services, billing, accounting, underwriting, and product development, which support the Company's operations. These costs are allocated based on various utilization statistics.

G. Nature of Control Relationships that Could Affect Operations or Financial Position

AGP owns all the outstanding shares of the Company. The Company's ultimate parent is Anthem, Inc.

H. Amount deducted for Investment in Upstream Company

The Company does not own shares of upstream intermediate entities or Anthem.

I. Detail of Investments in Affiliates Greater than 10% of Admitted Assets

The Company does not have investment in affiliates greater than 10% of admitted assets.

J. Write-down for Impairments of Investments in Subsidiaries, Controlled or Affiliated Companies

The Company did not write-down any investments in subsidiaries, controlled or affiliated SCA companies as of December 31, 2016 and 2015.

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K. Investment in a Foreign Insurance Subsidiary

The Company does not have investments in foreign insurance subsidiaries.

L. Investment in Downstream Non-insurance Holding Companies

The Company does not have investments in downstream non-insurance holding companies.

M. All SCA Investments

The Company has no SCA Investments.

N. Investment in Insurance SCAs

The Company does not have investments in Insurance SCAs.

11. Debt

A. Capital Notes

The Company had no capital notes outstanding at December 31, 2016 and 2015.

B. All Other Debt

The Company had no other debt outstanding at December 31, 2016 and 2015.

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefits Plans

A. Defined Benefit Plan

Not applicable – See Note 12G.

B. Not applicable – See Note 12G.

C. Not applicable – See Note 12G.

D. Not applicable – See Note 12G.

E. Defined Contribution Plans

Not applicable – See Note 12G.

F. Multiemployer Plan

The Company does not participate in a multiemployer plan.

G. Consolidated/Holding Company Plans

The Company participates in a deferred compensation plan sponsored by Anthem which covers certain employees. The deferred amounts are payable according to the terms and subject to the conditions of said deferred compensation agreements. Anthem allocates a share of the total accumulated costs of this plan to the Company based on the number of allocated employees subject to the deferred compensation agreements. The Company has no legal obligation for benefits under this plan.

The Company participates in the Anthem 401(k) Retirement Savings Plan, a defined contribution plan, sponsored by ATH Holding and covering substantially all employees. Voluntary employee contributions are matched by ATH Holding subject to certain limitations. ATH Holding allocates a share of the total accumulated costs of this plan to the Company based on the number of allocated employees. The Company has no legal obligation for benefits under this plan.

During 2016 and 2015, the Company was allocated the following costs or (credits) for these retirement benefits:

		2016		2015
Deferred compensation plans	\$	50,688	\$	51,071
Defined contribution plan		1,747,274		1,714,522

H. Post Employment Benefits and Compensated Absences

Not applicable.

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I. Impact of Medicare Modernization Act on Postretirement Benefits (INT 04-17)

Not applicable.

13. Capital and Surplus, Shareholder's Dividend Restrictions and Quasi-Reorganizations

(1) Outstanding Shares

As of December 31, 2016, the Company has 1,000 shares of \$1 par value common stock authorized. The number of shares issued and outstanding is 100.

(2) Preferred Stock

The Company has no preferred stock outstanding.

(3) Dividend Restrictions

Per the *Florida Statute 641.365*, there are certain limitations exist on the Company's ability to pay dividends to its parent. The Company may pay funds only from accumulated surplus funds that were derived from realized net operating profits on its business and net realized capital gains. Prior written approval by the Florida DFS is required for payment of any dividend which would result in these accumulated surplus funds being less than zero. Florida DFS approval is not required if the dividend to be paid is less than the greater of 1) ten percent of the Company's accumulated surplus or 2) the Company's entire net operating profit, including realized capital gains, for the immediately preceding calendar year.

(4) Dividends Paid

See Footnote 10B.

(5) Maximum Ordinary Dividends During 2017

Within the limitations of (3) above, the Company may pay \$594,459 in dividends during 2017 without prior approval.

(6) Unassigned Surplus Restrictions

Unassigned surplus funds are not restricted at December 31, 2016.

(7) Mutual Surplus Advances

Not applicable.

(8) Company Stock Held for Special Purpose

There are no shares of stock held for special purposes at December 31, 2016.

(9) Changes in Special Surplus Funds

The changes in balances of special surplus funds from the prior year are due to changes in the amounts segregated for the estimated Affordable Care Act ("ACA") health insurer fee. The annual fee under section 9010 of the ACA has been suspended for 2017, therefore no surplus has been segregated as of December 31, 2016.

(10) Changes in Unassigned Funds

The portion of unassigned funds represented by cumulative unrealized gains and losses was (\$41,424) at December 31, 2016.

(11) Surplus Notes

The Company has not issued any surplus notes or debentures of similar obligations.

(12) Restatement due to Prior Quasi-reorganization

The Company has no restatements due to prior quasi-reorganizations.

(13) Quasi-reorganization over Prior 10 years

The Company has not been involved in a quasi-reorganization during the past 10 years.

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14. Liabilities, Contingencies and Assessments

A. Contingent Commitments

The Company has no contingent commitments at December 31, 2016.

B. Assessments

1. The Company is subject to guaranty fund and other assessments by the state(s) in which it writes business. Guaranty fund assessments are accrued at the time of insolvencies. Other assessments are accrued either at the time of the assessment or at the time the losses are incurred.

The State of Florida has not issued a guaranty fund assessment, and the Company has not recorded a liability for an assessment as of December 31, 2016 or 2015.

2. Not applicable.

C. Gain Contingencies

The Company has no gain contingencies at December 31, 2016.

D. Claims-Related Extra Contractual Obligations and Bad Faith Losses Stemming from Lawsuits

Not applicable.

E. Joint and Several Liabilities

Not applicable.

F. All Other Contingencies

In March 2016, Anthem filed a lawsuit against its vendor for pharmacy benefit management ("PBM") services, captioned Anthem, Inc. v. Express Scripts, Inc., in the U.S. District Court for the Southern District of New York. The lawsuit seeks to recover damages for pharmacy pricing that is higher than competitive benchmark pricing, damages related to operational breaches and seeks various declarations under the PBM agreement between the parties. Anthem's suit asserts that Express Scripts, Inc.'s ("Express Scripts") current pricing exceeds the competitive benchmark pricing required by the PBM agreement over the remaining term of the PBM agreement and through the post-termination transition period. Further, Anthem believes that Express Scripts' excessive pricing has caused Anthem to lose existing customers and prevented the Company from gaining new business. In addition to the amounts associated with competitive benchmark pricing, Anthem is seeking damages associated with operational breaches incurred to date, together with a declaratory judgment that Express Scripts: (1) breached its obligation to negotiate in good faith and to agree in writing to new pricing terms; (2) is required to provide competitive benchmark pricing to Anthem through the term of the PBM agreement; (3) has breached the PBM agreement, and that Anthem can terminate the PBM agreement either due to Express Scripts' breaches or because Anthem has determined that Express Scripts' performance with respect to the delegated Medicare Part D functions has been unsatisfactory; and (4) is required under the PBM agreement to provide post-termination services, at competitive benchmark pricing, for one year following any termination. In April 2016, Express Scripts filed an answer to the lawsuit disputing Anthem's contractual claims and alleging various defenses and counterclaims. Express Scripts contends that Anthem breached the PBM agreement by failing to negotiate proposed new pricing terms in good faith and that Anthem breached the implied covenant of good faith and fair dealing by disregarding the terms of the transaction. In addition, Express Scripts is seeking declaratory judgments: (1) regarding the timing of the periodic pricing review under the PBM agreement; (2) that it has no obligation to ensure that Anthem receives any specific level of pricing, that Anthem has no contractual right to any change in pricing under the PBM agreement and that its sole obligation is to negotiate proposed pricing terms in good faith; and (3) that Anthem does not have the right to terminate the PBM agreement. In the alternative, Express Scripts claims that Anthem has been unjustly enriched by its payment of \$4.675 billion at the time of the PBM agreement. Anthem believes that Express Scripts' defenses and counterclaims are without merit. Anthem filed a motion to dismiss Express Script's counterclaims, which is pending. Anthem intends to vigorously pursue these claims and defend against any counterclaims; however, the ultimate outcome cannot be presently determined.

Anthem and Express Scripts were also named as defendants in a purported class action lawsuit filed in June 2016 in the Southern District of New York by three members of ERISA plans alleging ERISA violations captioned Karen Burnett, Brendan Farrell, and Robert Shullich, individually and on behalf of all others similarly situated vs. Express Scripts, Inc. and Anthem, Inc. The lawsuit was then consolidated with a similar lawsuit that was previously filed against Express Scripts. A first amended consolidated complaint was filed in the consolidated lawsuit, which is captioned In Re Express Scripts/Anthem ERISA Litigation. The first amended consolidated complaint was filed by six individual plaintiffs against Anthem and Express Scripts on behalf of all persons who are participants in or beneficiaries of any ERISA or non-ERISA health care plan from December 1, 2009 to the present in which Anthem provided prescription drug benefits through a PBM agreement with Express Scripts and who paid a

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percentage bases on co-insurance payment in the course of using that prescription drug benefit. As to the ERISA members, the plaintiffs allege that Anthem breached its duties under ERISA (i) by failing to adequately monitor Express Scripts' pricing under the PBM agreement and (ii) by trading off the best interests of Anthem insureds for its own pecuniary interest by allegedly agreeing to higher pricing in the PBM agreement in exchange for the \$4.675 billion purchase price for Anthem's NextRX PBM business. As to the non-ERISA members, the plaintiffs assert that Anthem breached the implied covenant of good faith and fair dealing implied in the health plans under which the non-ERISA members are covered by (i) negotiating and entering into the PBM agreement with Express Scripts that was detrimental to the interests of the such non-ERISA members, (ii) failing to adequately monitor the activities of Express Scripts, including failing to timely monitor and correct the prices charged by Express Scripts for prescription medications, and (iii) acting in Anthem's self-interests instead of the interests of the non-ERISA members when it accepted the \$4.675 billion purchase price for NextRx. Plaintiffs seek to hold Anthem and Express Scripts jointly and severally liable and to recover all losses suffered by the proposed class, equitable relief, disgorgement of alleged ill-gotten gains, injunctive relief, attorney's fees and costs and interest. Anthem filed a motion to dismiss all of the claims brought against Anthem, which is pending. Express Scripts filed a motion to transfer the case to a federal court in Missouri and Anthem intends to oppose this transfer. Anthem intends to vigorously defend this suit; however, its ultimate outcome cannot be presently determined.

In February 2015, Anthem reported that it was the target of a sophisticated external cyber-attack. The attackers gained unauthorized access to certain of Anthem's information technology systems and obtained personal information related to many individuals and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that Anthem will not identify additional information that was accessed or obtained.

Upon discovery of the cyber-attack, Anthem took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate its systems and identify solutions based on the evolving landscape. Anthem is providing credit monitoring and identity protection services to those who have been affected by this cyber-attack. Anthem has continued to implement security enhancements since this incident. Anthem has incurred expenses subsequent to the cyber-attack to investigate and remediate this matter and expects to continue to incur expenses of this nature in the foreseeable future. Anthem will recognize these expenses in the periods in which they are incurred.

Actions have been filed in various federal and state courts and other claims have been or may be asserted against Anthem on behalf of current or former members, current or former employees, other individuals, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber-attack. Federal and state agencies, including state insurance regulators, state attorneys general, the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigation, are investigating events related to the cyber-attack, including how it occurred, its consequences and Anthem's responses. The NAIC's multistate targeted market conduct and financial exam was concluded in December 2016. As part of the resolution, the NAIC asked and Anthem has agreed to provide a customized credit protection program functionally equivalent to a credit freeze for minors who were under the age of 18 on January 27, 2015. No fines or penalties were issued. Although Anthem is cooperating in these investigations, Anthem may be subject to fines or other obligations, which may have an adverse effect on how Anthem operates its business and on its results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation in February 2015 and was subsequently heard by the Panel in May 2015. In June 2015, the Panel entered its order transferring the consolidated matter to the U.S. District Court for the Northern District of California. The U.S. District Court entered its case management order in September 2015. Anthem filed a motion to dismiss ten of the counts that are before the U.S. District Court. In February 2016, the court issued an order granting in part and denying in part our motion, dismissing three counts with prejudice, four counts without prejudice and allowing three counts to proceed. Plaintiffs filed a second amended complaint in March 2016, and Anthem subsequently filed a second motion to dismiss. In May 2016, the court issued an order granting in part and denying in part our motion, dismissing one count with prejudice, dismissing certain counts asserted by specific named plaintiffs with or without prejudice depending on their individualized facts, and allowing the remaining counts to proceed. In July 2016, plaintiffs filed a third amended complaint, which Anthem answered in August 2016. Fact discovery was completed in December 2016. There remain two state court cases that are presently proceeding outside of the Multidistrict Litigation.

Anthem has contingency plans and insurance coverage for certain expenses and potential liabilities of this nature. While a loss from these matters is reasonably possible, Anthem cannot reasonably estimate a range of possible losses because the investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

The Company is involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits and reviews and administrative proceedings include routine and special investigations by state

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insurance departments, state attorneys general, the U.S. Attorney General and Federal Agencies. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on The Company's business operations. The Company believes that any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on the Company's financial position or results of operations.

At December 31, 2016 and 2015, the Company reported admitted assets of \$20,931,842 and \$7,252,804, respectively, in premium receivables due from policyholders and agents and receivables due from uninsured plans. Based upon Company experience, any uncollectible premium receivables and uncollectible receivables are not expected to exceed \$0 that was nonadmitted at December 31, 2016; therefore, no additional provision for uncollectible amounts has been recorded. The potential for any additional loss is not believed to be material to the Company's financial operations.

15. Leases

A. Lessee Operating Lease

- (1) The Company leases office space, office equipment, EDP equipment, software under various noncancelable operating leases. Related lease expense for 2016 and 2015 was \$3,115,343 and \$2,564,331, respectively.
- (2) At January 1, 2017, the minimum aggregate rental commitments are as follows:

Year Ending December 31	Operating Leases
2017	\$ 1,138,909
2018	1,149,022
2019	485,575
2020	145,084
2021	-
Total	<u>\$ 2,918,590</u>

- (3) The Company has not entered into any material sale-leaseback transactions.

B. Lessor Leases

- (1) The Company has not entered into any operating leases.
- (2) The Company has not entered into any leverage leases.

16. Information about Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk

The Company has no significant financial instruments with off-balance sheet risk.

Financial instruments that potentially subject the Company to concentrations of credit risk consist primarily of investment securities. All investment securities are managed by professional investment managers within policies authorized by the board of directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. As of December 31, 2016, there were no significant concentrations.

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. Transfers of Receivables Reported as Sales

Not applicable at December 31, 2016 and 2015.

B. Transfer and Servicing of Financial Assets

- (1) The Company participates in a securities lending program whereby marketable securities in its investment portfolio are transferred to independent brokers or dealers. At December 31, 2016, the fair value of securities loaned was \$928,082 and the carrying value of securities loaned was \$915,535.
- (2) – (7). Not applicable.

C. Wash Sales

1. In the course of the Company's asset management, securities may be sold and reacquired within 30 days of the sale date to enhance the yield on the investments.

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2. At December 31, 2016 and 2015, there were no wash sales involving securities with an NAIC designation of 3 or below or unrated.

18. Gain or Loss to the Reporting Entity from Uninsured A&H Plans and the Uninsured Portion of Partially Insured Plans

A. Administrative Services Only (“ASO”) Plans

The gain from operations from ASO uninsured plans and the uninsured portion of partially insured plans during 2016 was:

	ASO Uninsured Plans	Uninsured Portion of Partially Insured Plans	Total ASO
a. Net reimbursement for administrative expenses (including administrative fees) in excess of actual expenses	\$ (111,538)	\$ -	\$ (111,538)
b. Total net other income or expenses (including interest paid to or received from plans)	-	-	-
c. Net gain or (loss) from operations	\$ (111,538)	\$ -	\$ (111,538)
d. Total claim payment volume	\$ 3,431,950	\$ -	\$ 3,431,950

B. Administrative Services Contract (“ASC”) Plans

Not applicable in December 31, 2016 and 2015.

C. Medicare or Other Similarly Structured Cost-Based Reimbursement Contract

- The Company does not record revenue explicitly attributable to the cost share and reinsurance components of administered Medicare products.
- As of December 31, 2016 and 2015, the Company recorded a receivable from CMS of \$835,435 and \$329,726, respectively, related to the cost share and reinsurance components of administered Medicare products.
- As no revenue is recorded in connection with the cost share and reinsurance components of the Company’s reinsurance contracts, the Company has recorded no allowances and reserves for the adjustment of recorded revenues and receivables.
- The Company has made no adjustment to revenue resulting from audit of receivables related to revenues recorded in the prior period.

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

No premiums were written by managing general agents or third party administrators during the years ended December 31, 2016 and 2015.

20. Fair Value

A. Fair Value Measurements

(1) Fair Value Measurements at Reporting Date

Description for each class of asset or liability	(Level 1)	(Level 2)	(Level 3)	Total
a. Assets at fair value				
Bonds				
Industrial and Misc	\$ -	\$ 915,536	\$ -	\$ 915,536
Total bonds	\$ -	\$ 915,536	\$ -	\$ 915,536
Total assets at fair value	\$ -	\$ 915,536	\$ -	\$ 915,536

There are no investments in Level 3 as of December 31, 2016 and 2015.

- The Company’s policy is to recognize transfers between Levels, if any, as of the beginning of the reporting period.
- Fair values of fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level 1 or Level 2 inputs, for the determination of fair value to facilitate fair value measurements and disclosures. United States government securities represent Level 1 securities, while Level 2 securities primarily include corporate securities, securities from states, municipalities and political subdivisions and residential mortgage-backed securities. For Securities not actively traded, the third

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party pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds.

Fair values of equity securities are generally designated as Level 1 and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level 2. The Company has certain equity securities, including private equity securities, for which the fair value is estimated based on each security's current condition and the future cash flow projections. Such securities are designated Level 3. The fair values of these private equity securities are generally based on either broker quotes or discounted cash flow projections using assumptions for inputs such as the weighted-average cost of capital, long-term revenue growth rates and earnings before interest, taxes, depreciation and amortization, or revenue multiples that are not observable in the markets.

Certain financial assets are measured at fair value using Level 3 inputs, such as certain non-investment grade bonds and loan-backed securities or investments that are impaired during the year and recorded at fair value.

There have been no significant changes in the valuation techniques during the current period.

B. Fair Value Measurements Under Other Accounting Pronouncements

Not applicable at December 31, 2016 and 2015.

C. Financial Instruments

Type of Financial Instrument	Aggregated Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practicable (Carrying Value)
Bonds	\$ 147,613,049	\$ 147,034,570	\$ 30,234,300	\$ 117,378,736	\$ -	\$ -
Short Term Inv & MMFs	36,287,609	36,287,609	36,287,609	-	-	-
Securities Lending Collateral	948,951	948,299	948,951	-	-	-
	<u>\$ 184,849,609</u>	<u>\$ 184,270,478</u>	<u>\$ 67,470,860</u>	<u>\$ 117,378,736</u>	<u>\$ -</u>	<u>\$ -</u>

D. Not Practicable to Estimate Fair Value

There are no financial instruments that were not practicable to estimate fair value.

21. Other Items

A. Unusual or Infrequent Items

Pursuant to Section 641.35(3)(a), Florida Statutes, if an HMO, through a health risk contract, transfers to any entity the obligation to pay providers for subscriber claims, the liability for any such payment remains with the HMO until the payment is received by the provider and should be reflected in loss reserves. Although the Company's pharmacy benefit manager was paid for materially all December 2016 expenses, their contract allows 30 days for these payments to be made to providers. The Company reported \$11,218,436 and \$0 as a liability included on page 3, line 7 at December 31, 2016 and 2015. The additional expense is also included on page 4, line 13 for the year ending December 31, 2016. The Company evaluated the impact of this liability on our December 31, 2015 surplus and determined it would not have impacted our compliance with the OIR's capital requirements.

B. Troubled Debt Restructuring: Debtors

Not applicable at December 31, 2016 and 2015.

C. Other Disclosures

Pursuant to Section 641.35(3)(a), Florida Statutes, if an HMO, through a health risk contract, transfers to any entity the obligation to pay providers for subscriber claims, the liability for any such payment remains with the HMO until the payment is received by the provider and should be reflected in loss reserves. The Company reported \$11,218,436 and \$0 at December 31, 2016 and 2015. The Company evaluated the impact of this liability on our December 31, 2015 surplus and determined it would not have impacted our compliance with the OIR's capital requirements.

D. Business Interruption Insurance Recoveries

The Company has reported no recoveries for business interruption for the years ended December 31, 2016 and 2015.

E. State Transferable and Non-Transferable Tax Credits

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The Company did not have state transferable tax credits at December 31, 2016 and 2015.

F. Subprime Mortgage-Related Risk Exposure

- (1) The Company's investment strategy of providing safety and preservation of capital, sufficient liquidity to meet cash flow requirements and the attainment of a competitive after-tax investment return is supported by a well diversified portfolio consisting of many different types of investments. The portion of the Company's investment portfolio with subprime mortgage-related risk exposure is relatively small in comparison to the overall investment portfolio, and consists of investment grade securities with no exposure to collateralized debt obligations. All mortgage related investments are monitored closely as part of the quarterly investment review performed by the Anthem Investment Impairment Review Committee.
- (2) The Company did not carry investments in subprime mortgage loans in its portfolio at December 31, 2016 or 2015.
- (3) The Company did not have subprime mortgage-related risk exposure at December 31, 2016 or 2015.
- (4) The Company did not underwrite Mortgage Guaranty or Financial Guaranty insurance coverage at December 31, 2016 or 2015.

G. Retained Assets

The Company did not have any retained assets at December 31, 2016 and 2015.

H. Insurance-Linked Securities Contracts

Not applicable.

22. Events Subsequent

The Company is subject to an annual fee under section 9010 of the ACA. A health insurance company's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. The annual fee under section 9010 of the ACA has been suspended for 2017 and will resume for 2018 and beyond.

	Current Year	Prior Year
A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the Federal Affordable Care Act (YES/NO)?	YES	
B. ACA fee assessment payable for the upcoming year	\$ -	\$ 20,965,043
C. ACA fee assessment paid	\$ 20,112,463	\$ 21,259,163
D. Premium written subject to ACA 9010 assessment	\$ 1,275,615,764	\$ 1,156,733,460
E. Total Adjusted Capital before surplus adjustment (Five-Year Historical Line 14)	\$ 86,129,663	
F. Total Adjusted Capital after surplus adjustment (Five-Year Historical Line 14 minus Line 22B above)	\$ 86,129,663	
G. Authorized Control Level (Five-Year Historical Line 15)	\$ 53,222,110	
H. Would reporting the ACA assessment as of December 31, 2016 have triggered an RBC action level (YES/NO)?	NO	

Subsequent events have been considered through March 31, 2017 for the statutory statement issued on March 31, 2017. There were no other events occurring subsequent to December 31, 2016 requiring recognition or disclosure.

23. Reinsurance

A. Ceded Reinsurance Report

Section 1 – General Interrogatories

- (1) Are any of the reinsurers that are listed in Schedule S as non-affiliated owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?

Yes () No (X)

If yes, give full details.

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- (2) Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled, directly or indirectly, by an insured, a beneficiary, a creditor or an insured or any other person not primarily engaged in the insurance business?

Yes () No (X)

If yes, give full details.

Section 2 – Ceded Reinsurance Report – Part A

- (1) Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credits?

Yes () No (X)

If yes, give full details.

- (2) Does the reporting entity have any reinsurance agreements in effect such that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same insurer, exceed the total direct premium collected under reinsured policies?

Yes () No (X)

If yes, give full details.

Section 3 – Ceded Reinsurance Report – Part B

- (1) What is the estimated amount of the aggregate reduction in surplus, (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2 above) of termination of ALL reinsurance agreements, by either party, as of the date of this statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

Not Applicable.

- (2) Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement, to include policies or contracts that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes () No (X)

If yes, give full details.

B. Uncollectible Reinsurance

The Company has no uncollectible reinsurance at December 31, 2016 and 2015.

C. Commutation of Ceded Reinsurance

The Company has not commuted ceded reinsurance during 2016 and 2015.

D. Certified Reinsurer Rating Downgraded or Status Subject Revocation

The Company has no downgraded certified reinsurer ratings or status subject revocations during 2016 and 2015.

24. Retrospectively Rated Contracts and Contracts Subject to Redetermination

- A. The Company's contracts with the State Medicaid agency and CMS includes provisions for which the premiums vary based on loss experience. The Company estimates retrospective premium adjustments through the review of each retrospectively rated account, comparing the claim development with that anticipated in the policy contracts.
- B. The Company records accrued retrospective premium as an adjustment to earned premium.
- C. 100% of the net premiums written are subject to retrospective rating features.
- D. In accordance with the NAIC Accounting Practices and Procedures Manual, medical loss ratio rebates in accordance with the Federal 2010 Patient Protection and Affordable Care Act and Public Health Service Act, are to be reported in accordance with SSAP No. 66 - *Retrospectively Rated Contracts* ("SSAP No.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

66"). A retrospectively rated contract is one that has the final policy premium calculated based on the loss experience of the insured during the term of the policy (including loss development after the term of the policy) and the stipulated formula set forth in the policy, or in the case of medical loss ratio rebates, a formula required by law. The Company based the incurred and unpaid liability amounts reported below based on its underwriting experience; actuarial, tax, and accounting estimates and assumptions at the financial statement date; as well as regulations and guidance available that is not final and subject to change prior to settlement. Accordingly, the Company's use of estimates and assumptions in the preparation of the statutory based financial statements and related footnote disclosures may differ from actual results. Hence, the amounts reported herein are for financial reporting purposes solely and not intended to be used for settlement purposes.

Medical loss ratio rebates accrued pursuant to the Public Health Service Act are as follows:

	Individual	Small Group Employer	Large Group Employer	Other Categories with Rebates	Total
Prior Reporting Year					
(1) Medical loss ratio rebates incurred	\$ -	\$ -	\$ -	\$ -	\$ -
(2) Medical loss ratio rebates paid	-	-	-	-	-
(3) Medical loss ratio rebates unpaid	-	-	-	-	-
(4) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(5) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(6) Rebate unpaid net of reinsurance	XXX	XXX	XXX	XXX	\$ -
Current Reporting Year-to-Date					
(7) Medical loss ratio rebates incurred	\$ -	\$ -	\$ -	\$ -	\$ -
(8) Medical loss ratio rebates paid	-	-	-	-	-
(9) Medical loss ratio rebates unpaid	-	-	-	-	-
(10) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(11) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(12) Rebate unpaid net of reinsurance	XXX	XXX	XXX	XXX	\$ -

E. Risk-Sharing Provisions of the Affordable Care Act ("ACA")

(1) Did the reporting entity write accident and health insurance premium which is subject to the Affordable Care Act risk sharing provisions (YES/NO)? No

(2) Impact of Risk-Sharing Provisions of the Affordable Care Act on Admitted Assets, Liabilities and Revenue for the Current Year

Not applicable.

(3) Roll-forward of prior year ACA risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balance.

Not applicable.

(4) Roll-Forward of Risk Corridors Asset and Liability Balances by Program Benefit Year

Not applicable.

(5) ACA Risk Corridors Receivable as of Reporting Date

Not applicable.

25. Change in Incurred Claims and Claim Adjustment Expenses

The estimated cost of claims and claim adjustment expense attributable to insured events of prior years increased by \$8,419,159 during 2016. This is approximately 8.2% of unpaid claims and claim adjustment expense of \$103,067,560 as of December 31, 2015. The deficiency reflects the decreases in estimated claims and claims adjustment expenses as a result of claims payment during the year, and as additional information is received regarding claims incurred prior to 2016. Recent claim development trends are also taken into account in evaluating the overall adequacy of unpaid claims and unpaid claim adjustment expense

26. Intercompany Pooling Arrangements

Not applicable at December 31, 2016 and 2015.

27. Structured Settlements

Not applicable at December 31, 2016 and 2015.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

28. Health Care Receivables

A. Pharmaceutical Rebate Receivables

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More Than 180 Days After Billing
12/31/2016	\$ -	\$ 307,784	\$ -	\$ -	\$ -
9/30/2016	-	517,927	-	-	-
6/30/2016	-	421,060	162	400,870	-
3/31/2016	50,661	305,625	-	108,684	190,351
12/31/2015	1,265,695	901,031	-	720,501	178,788
9/30/2015	991,277	1,312,992	-	1,170,761	162,098
6/30/2015	955,886	1,149,693	-	702,211	388,923
3/31/2015	992,693	955,072	-	551,528	343,985
12/31/2014	1,455,611	666,929	-	359,128	480,422
9/30/2014	1,264,332	756,189	-	395,594	360,851
6/30/2014	1,455,624	875,627	-	606,291	268,582
3/31/2014	1,235,399	980,145	-	732,360	247,784

B. Risk Sharing Receivables

Not applicable at December 31, 2016 and 2015.

29. Participating Policies

Not applicable at December 31, 2016 and 2015.

30. Premium Deficiency Reserves

1. Liability carried for premium deficiency reserves \$ 0
2. Date of the most recent evaluation of this liability December 31, 2016
3. Was anticipated investment income utilized in the calculation? Yes [] No [X]

The Company had no liabilities related to premium deficiency reserves as of December 31, 2016 and 2015.

31. Anticipated Salvage and Subrogation

The Company took into account estimated anticipated subrogation and other recoveries in its determination of the liability for unpaid claims and reduced the liability by \$1,339,000 and \$1,157,000 at December 31, 2016 and 2015, respectively.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

**PART 1 - COMMON INTERROGATORIES
GENERAL**

- 1.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? Yes [X] No []
If yes, complete Schedule Y, Parts 1, 1A and 2
- 1.2 If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent, or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations? Yes [X] No [] N/A []
- 1.3 State Regulating? Florida
- 2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? Yes [] No [X]
- 2.2 If yes, date of change:
- 3.1 State as of what date the latest financial examination of the reporting entity was made or is being made. 12/31/2014
- 3.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released. 12/31/2014
- 3.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date). 06/14/2016
- 3.4 By what department or departments?
Florida Office of Insurance Regulation
- 3.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments? Yes [X] No [] N/A []
- 3.6 Have all of the recommendations within the latest financial examination report been complied with? Yes [X] No [] N/A []
- 4.1 During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity), receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.11 sales of new business? Yes [] No [X]
4.12 renewals? Yes [] No [X]
- 4.2 During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.21 sales of new business? Yes [] No [X]
4.22 renewals? Yes [] No [X]
- 5.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? Yes [] No [X]
- 5.2 If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.
- | 1
Name of Entity | 2
NAIC Company Code | 3
State of Domicile |
|---------------------|------------------------|------------------------|
| | | |
- 6.1 Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? Yes [] No [X]
- 6.2 If yes, give full information:
- 7.1 Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity? Yes [] No [X]
- 7.2 If yes,
7.21 State the percentage of foreign control; %
7.22 State the nationality(s) of the foreign person(s) or entity(s) or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact; and identify the type of entity(s) (e.g., individual, corporation or government, manager or attorney in fact).

1 Nationality	2 Type of Entity

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GENERAL INTERROGATORIES

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? Yes [] No [X]
8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? Yes [] No [X]

8.4 If response to 8.3 is yes, please provide below the names and location (city and state of the main office) of any affiliates regulated by a federal regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC

9. What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?
Ernst & Young LLP, 111 Monument Circle, Suite 2600, Indianapolis, IN 46204

10.1 Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation? Yes [] No [X]
10.2 If the response to 10.1 is yes, provide information related to this exemption:

10.3 Has the insurer been granted any exemptions related to the other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 18A of the Model Regulation, or substantially similar state law or regulation? Yes [] No [X]
10.4 If the response to 10.3 is yes, provide information related to this exemption:

10.5 Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws? Yes [X] No [] N/A []
10.6 If the response to 10.5 is no or n/a, please explain

11. What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?
Mark Blessinger, FSA, MAAA, Actuarial Director (employee); 4425 Corporation Lane, Virginia Beach, VA 23462

12.1 Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly? Yes [] No [X]
12.11 Name of real estate holding company
12.12 Number of parcels involved
12.13 Total book/adjusted carrying value\$

12.2 If, yes provide explanation:

13. FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:

13.1 What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?

13.2 Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located? Yes [] No []

13.3 Have there been any changes made to any of the trust indentures during the year? Yes [] No []

13.4 If answer to (13.3) is yes, has the domiciliary or entry state approved the changes? Yes [] No [] N/A []

14.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? Yes [X] No []

- (a) Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
(b) Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
(c) Compliance with applicable governmental laws, rules and regulations;
(d) The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
(e) Accountability for adherence to the code.

14.11 If the response to 14.1 is No, please explain:

14.2 Has the code of ethics for senior managers been amended? Yes [X] No []

14.21 If the response to 14.2 is yes, provide information related to amendment(s).

The Anthem Standards of Ethical Business Conduct applies to all associates, management, officers and directors of Anthem. In June 2016 the code of conduct was revised for the following: a) updated Gift policy (offering) to address new Finance policy prohibiting offering gift cards, unless an approved wellness program; b) added a new section on Telephone Consumer Protection Act; c) added a new section on Non-discrimination under the Affordable Care Act (ACA) since we had a section on non-discrimination for government business. In July 2016 the code of conduct was revised for minor administrative changes regarding definitions of confidential information pertaining to associates' information as well as the certification at the end of the code.

14.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes [] No [X]

14.31 If the response to 14.3 is yes, provide the nature of any waiver(s).

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

- 15.1 Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List? Yes [] No [X]
- 15.2 If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.

1 American Bankers Association (ABA) Routing Number	2 Issuing or Confirming Bank Name	3 Circumstances That Can Trigger the Letter of Credit	4 Amount

BOARD OF DIRECTORS

16. Is the purchase or sale of all investments of the reporting entity passed upon either by the board of directors or a subordinate committee thereof? Yes [X] No []
17. Does the reporting entity keep a complete permanent record of the proceedings of its board of directors and all subordinate committees thereof? Yes [X] No []
18. Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict with the official duties of such person? Yes [X] No []

FINANCIAL

19. Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)? Yes [] No [X]
- 20.1 Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):
- 20.11 To directors or other officers\$
- 20.12 To stockholders not officers\$
- 20.13 Trustees, supreme or grand (Fraternal Only)\$
- 20.2 Total amount of loans outstanding at the end of year (inclusive of Separate Accounts, exclusive of policy loans):
- 20.21 To directors or other officers\$
- 20.22 To stockholders not officers\$
- 20.23 Trustees, supreme or grand (Fraternal Only)\$
- 21.1 Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reported in the statement? Yes [] No [X]
- 21.2 If yes, state the amount thereof at December 31 of the current year:
- 21.21 Rented from others\$
- 21.22 Borrowed from others\$
- 21.23 Leased from others\$
- 21.24 Other\$
- 22.1 Does this statement include payments for assessments as described in the Annual Statement Instructions other than guaranty fund or guaranty association assessments? Yes [] No [X]
- 22.2 If answer is yes:
- 22.21 Amount paid as losses or risk adjustment\$
- 22.22 Amount paid as expenses\$
- 22.23 Other amounts paid\$
- 23.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? Yes [X] No []
- 23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount:\$ 0

INVESTMENT

- 24.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date? (other than securities lending programs addressed in 24.03)..... Yes [X] No []
- 24.02 If no, give full and complete information relating thereto
- 24.03 For security lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet. (an alternative is to reference Note 17 where this information is also provided) Please see Notes 5H and 17.
- 24.04 Does the Company's security lending program meet the requirements for a conforming program as outlined in the Risk-Based Capital Instructions? Yes [X] No [] N/A []
- 24.05 If answer to 24.04 is yes, report amount of collateral for conforming programs.\$ 948,299
- 24.06 If answer to 24.04 is no, report amount of collateral for other programs.\$
- 24.07 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract? Yes [X] No [] N/A []
- 24.08 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%? Yes [X] No [] N/A []
- 24.09 Does the reporting entity or the reporting entity's securities lending agent utilize the Master Securities lending Agreement (MSLA) to conduct securities lending? Yes [X] No [] N/A []

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

24.10 For the reporting entity's security lending program state the amount of the following as December 31 of the current year:

24.101	Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2	\$	948,951
24.102	Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2	\$	948,299
24.103	Total payable for securities lending reported on the liability page	\$	948,299

25.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity, or has the reporting entity sold or transferred any assets subject to a put option contract that is currently in force? (Exclude securities subject to Interrogatory 21.1 and 24.03). Yes [X] No []

25.2 If yes, state the amount thereof at December 31 of the current year:

25.21	Subject to repurchase agreements	\$	
25.22	Subject to reverse repurchase agreements	\$	
25.23	Subject to dollar repurchase agreements	\$	
25.24	Subject to reverse dollar repurchase agreements	\$	
25.25	Placed under option agreements	\$	
25.26	Letter stock or securities restricted as to sale - excluding FHLB Capital Stock	\$	
25.27	FHLB Capital Stock	\$	
25.28	On deposit with states	\$	39,081,653
25.29	On deposit with other regulatory bodies	\$	
25.30	Pledged as collateral - excluding collateral pledged to an FHLB	\$	
25.31	Pledged as collateral to FHLB - including assets backing funding agreements	\$	
25.32	Other	\$	

25.3 For category (25.26) provide the following:

1 Nature of Restriction	2 Description	3 Amount

26.1 Does the reporting entity have any hedging transactions reported on Schedule DB? Yes [] No [X]

26.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes [] No [] N/A [X]
If no, attach a description with this statement.

27.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity? Yes [] No [X]

27.2 If yes, state the amount thereof at December 31 of the current year. \$

28. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? Yes [X] No []

28.01 For agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian's Address
Bank of New York Mellon Corporation	One BNY Mellon Center Room 151-1035 Pittsburgh, PA 15258

28.02 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

28.03 Have there been any changes, including name changes, in the custodian(s) identified in 28.01 during the current year? Yes [] No [X]

28.04 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

- 28.05 Investment management – Identify all investment advisors, investment managers, broker/dealers, including individuals that have the authority to make investment decisions on behalf of the reporting entity. For assets that are managed internally by employees of the reporting entity, note as such. ["...that have access to the investment accounts"; "...handle securities"]

1 Name of Firm or Individual	2 Affiliation
Deutsche Asset Management	U.....
McDonnell Investment Management, LLC	U.....

28.0597 For those firms/individuals listed in the table for Question 28.05, do any firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") manage more than 10% of the reporting entity's assets?..... Yes [X] No []

28.0598 For firms/individuals unaffiliated with the reporting entity (i.e. designated with a "U") listed in the table for Question 28.05, does the total assets under management aggregate to more than 50% of the reporting entity's assets?..... Yes [X] No []

- 28.06 For those firms or individuals listed in the table for 28.05 with an affiliation code of "A" (affiliated) or "U" (unaffiliated), provide the information for the table below.

1 Central Registration Depository Number	2 Name of Firm or Individual	3 Legal Entity Identifier (LEI)	4 Registered With	5 Investment Management Agreement (IMA) Filed
105006	Deutsche Asset Management .....	.....	Securities Exchange Commission	NO.....
113878	McDonnell Investment Management, LLC .....	.....	Securities Exchange Commission	NO.....

- 29.1 Does the reporting entity have any diversified mutual funds reported in Schedule D, Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5(b)(1)])?..... Yes [] No [X]

- 29.2 If yes, complete the following schedule:

1 CUSIP #	2 Name of Mutual Fund	3 Book/Adjusted Carrying Value
29.2999 - Total		0

- 29.3 For each mutual fund listed in the table above, complete the following schedule:

1 Name of Mutual Fund (from above table)	2 Name of Significant Holding of the Mutual Fund	3 Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	4 Date of Valuation
.....

30. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

	1 Statement (Admitted) Value	2 Fair Value	3 Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
30.1 Bonds	183,322,180	183,900,658	578,478
30.2 Preferred stocks	0		0
30.3 Totals	183,322,180	183,900,658	578,478

- 30.4 Describe the sources or methods utilized in determining the fair values:

Fair values were obtained from third-party pricing sources. If a security was not priced by a third-party pricing source, internal analytical systems or broker quotes were utilized.

- 31.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D?..... Yes [] No [X]

- 31.2 If the answer to 31.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source?..... Yes [] No []

- 31.3 If the answer to 31.2 is no, describe the reporting entity's process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D:
N/A

- 32.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed?..... Yes [X] No []

- 32.2 If no, list exceptions:
N/A

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

OTHER

33.1 Amount of payments to trade associations, service organizations and statistical or rating bureaus, if any?\$

33.2 List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations and statistical or rating bureaus during the period covered by this statement.

1 Name	2 Amount Paid

34.1 Amount of payments for legal expenses, if any?\$577,830

34.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.

1 Name	2 Amount Paid
Hogan Lovells	152,759

35.1 Amount of payments for expenditures in connection with matters before legislative bodies, officers or departments of government, if any?\$136,282

35.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid
Larry J. Overton & Associates	60,570
Corcoran & Johnston	75,712
Lobbying expenses disclosed reflect amounts reported in the Lobbyist Disclosure Reports filed with the Secretary of State as well as the cost of external contractors who provided lobbying services to the Company. The amount may include expenses that may have been paid by an affiliate on behalf of the Company and, as a result, may not be included in the Underwriting Gain reported on page 4 of the 2016 Annual Statement	

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

PART 2 - HEALTH INTERROGATORIES

1.1 Does the reporting entity have any direct Medicare Supplement Insurance in force? Yes [] No [X]

1.2 If yes, indicate premium earned on U.S. business only.\$

1.3 What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit?\$

1.31 Reason for excluding

1.4 Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above\$

1.5 Indicate total incurred claims on all Medicare Supplement Insurance.\$ 0

1.6 Individual policies:

Most current three years:

1.61 Total premium earned\$ 0

1.62 Total incurred claims\$ 0

1.63 Number of covered lives 0

All years prior to most current three years:

1.64 Total premium earned\$ 0

1.65 Total incurred claims\$ 0

1.66 Number of covered lives 0

1.7 Group policies:

Most current three years:

1.71 Total premium earned\$ 0

1.72 Total incurred claims\$ 0

1.73 Number of covered lives 0

All years prior to most current three years:

1.74 Total premium earned\$ 0

1.75 Total incurred claims\$ 0

1.76 Number of covered lives 0

2. Health Test:

	1 Current Year	2 Prior Year
2.1 Premium Numerator	1,431,822,517	1,309,626,197
2.2 Premium Denominator	1,431,822,517	1,309,626,197
2.3 Premium Ratio (2.1/2.2)	1.000	1.000
2.4 Reserve Numerator	119,521,765	100,120,951
2.5 Reserve Denominator	119,521,765	100,120,951
2.6 Reserve Ratio (2.4/2.5)	1.000	1.000

3.1 Has the reporting entity received any endowment or gift from contracting hospitals, physicians, dentists, or others that is agreed will be returned when, as and if the earnings of the reporting entity permits? Yes [] No [X]

3.2 If yes, give particulars:

4.1 Have copies of all agreements stating the period and nature of hospitals', physicians', and dentists' care offered to subscribers and dependents been filed with the appropriate regulatory agency? Yes [X] No []

4.2 If not previously filed, furnish herewith a copy(ies) of such agreement(s). Do these agreements include additional benefits offered? Yes [] No []

5.1 Does the reporting entity have stop-loss reinsurance? Yes [] No [X]

5.2 If no, explain:
Self-insured

5.3 Maximum retained risk (see instructions)

5.31 Comprehensive Medical\$

5.32 Medical Only\$

5.33 Medicare Supplement\$

5.34 Dental & Vision\$

5.35 Other Limited Benefit Plan\$

5.36 Other\$

6. Describe arrangement which the reporting entity may have to protect subscribers and their dependents against the risk of insolvency including hold harmless provisions, conversion privileges with other carriers, agreements with providers to continue rendering services, and any other agreements:
Physician and hospital contracts contain provisions, including hold harmless agreements, to protect members and dependents against insolvency.

7.1 Does the reporting entity set up its claim liability for provider services on a service date basis? Yes [X] No []

7.2 If no, give details

8. Provide the following information regarding participating providers:

8.1 Number of providers at start of reporting year16,169

8.2 Number of providers at end of reporting year17,892

9.1 Does the reporting entity have business subject to premium rate guarantees? Yes [] No [X]

9.2 If yes, direct premium earned:

9.21 Business with rate guarantees between 15-36 months...\$

9.22 Business with rate guarantees over 36 months\$

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

- 10.1 Does the reporting entity have Incentive Pool, Withhold or Bonus Arrangements in its provider contracts? Yes [X] No []
- 10.2 If yes:
- 10.21 Maximum amount payable bonuses.....\$4,184,830
- 10.22 Amount actually paid for year bonuses.....\$4,418,848
- 10.23 Maximum amount payable withholds.....\$
- 10.24 Amount actually paid for year withholds.....\$
- 11.1 Is the reporting entity organized as:
- 11.12 A Medical Group/Staff Model, Yes [] No [X]
- 11.13 An Individual Practice Association (IPA), or, .. Yes [] No [X]
- 11.14 A Mixed Model (combination of above)? Yes [X] No []
- 11.2 Is the reporting entity subject to Statutory Minimum Capital and Surplus Requirements? Yes [X] No []
- 11.3 If yes, show the name of the state requiring such minimum capital and surplus. Florida
- 11.4 If yes, show the amount required.\$31,636,450
- 11.5 Is this amount included as part of a contingency reserve in stockholder's equity? Yes [] No [X]
- 11.6 If the amount is calculated, show the calculation
- 2% December 31, 2016 annualized premiums from Income Statement = 2% * \$1,431,822,517 + \$3,000,000 (PHP consent order) = 31,636,450
12. List service areas in which reporting entity is licensed to operate:

1 Name of Service Area
Brevard
Broward
Hardee
Highlands
Hillsborough
Manatee
Miami-Dade
Monroe
Pasco
Pinellas
Polk
Orange
Osceola
Seminole
.....

- 13.1 Do you act as a custodian for health savings accounts? Yes [] No [X]
- 13.2 If yes, please provide the amount of custodial funds held as of the reporting date.\$
- 13.3 Do you act as an administrator for health savings accounts? Yes [] No [X]
- 13.4 If yes, please provide the balance of funds administered as of the reporting date.\$
- 14.1 Are any of the captive affiliates reported on Schedule S, Part 3, authorized reinsurers? Yes [] No [] N/A [X]
- 14.2 If the answer to 14.1 is yes, please provide the following:

1 Company Name	2 NAIC Company Code	3 Domiciliary Jurisdiction	4 Reserve Credit	Assets Supporting Reserve Credit		
				5 Letters of Credit	6 Trust Agreements	7 Other
.....

15. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded):

- 15.1 Direct Premium Written\$
- 15.2 Total Incurred Claims\$
- 15.3 Number of Covered Lives

*Ordinary Life Insurance Includes
Term(whether full underwriting, limited underwriting, jet issue, "short form app")
Whole Life (whether full underwriting, limited underwriting, jet issue, "short form app")
Variable Life (with or without secondary guarantee)
Universal Life (with or without secondary guarantee)
Variable Universal Life (with or without secondary guarantee)

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

FIVE-YEAR HISTORICAL DATA

	1 2016	2 2015	3 2014	4 2013	5 2012
Balance Sheet (Pages 2 and 3)					
1. Total admitted assets (Page 2, Line 28)	229,044,170	208,392,920	219,433,430	155,734,148	118,391,216
2. Total liabilities (Page 3, Line 24)	142,914,507	132,708,449	135,827,502	82,312,994	40,871,014
3. Statutory minimum capital and surplus requirement	31,636,450	29,192,524	21,769,008	14,993,600	15,033,596
4. Total capital and surplus (Page 3, Line 33)	86,129,663	75,684,471	83,605,928	73,421,154	77,520,202
Income Statement (Page 4)					
5. Total revenues (Line 8)	1,432,590,828	1,309,826,166	938,255,404	599,462,959	601,679,818
6. Total medical and hospital expenses (Line 18)	1,283,105,858	1,162,899,698	864,473,296	523,370,721	520,920,122
7. Claims adjustment expenses (Line 20)	75,928,230	79,803,226	51,537,238	41,192,030	15,818,014
8. Total administrative expenses (Line 21)	67,937,647	65,958,505	56,823,350	25,603,756	49,470,432
9. Net underwriting gain (loss) (Line 24)	5,619,093	2,700,350	(36,114,093)	9,296,452	15,471,250
10. Net investment gain (loss) (Line 27)	6,283,159	3,061,750	3,183,244	1,770,216	991,278
11. Total other income (Lines 28 plus 29)	0	0	0	23,500	23,263
12. Net income or (loss) (Line 32)	(1,968,169)	(1,935,759)	(26,651,523)	6,759,103	11,541,636
Cash Flow (Page 6)					
13. Net cash from operations (Line 11)	9,375,640	(3,410,653)	16,513,999	24,936,007	6,930,116
Risk-Based Capital Analysis					
14. Total adjusted capital	86,129,663	75,684,471	83,605,928	73,421,154	77,520,202
15. Authorized control level risk-based capital	53,222,110	48,327,719	36,144,939	18,641,375	18,862,444
Enrollment (Exhibit 1)					
16. Total members at end of period (Column 5, Line 7)	404,090	392,725	364,108	239,177	256,002
17. Total members months (Column 6, Line 7)	4,854,650	4,608,418	3,613,410	2,947,017	3,146,682
Operating Percentage (Page 4) (Item divided by Page 4, sum of Lines 2, 3 and 5) x 100.0					
18. Premiums earned plus risk revenue (Line 2 plus Lines 3 and 5)	100.0	100.0	100.0	100.0	100.0
19. Total hospital and medical plus other non-health (Lines 18 plus Line 19)	89.6	88.8	92.1	87.3	86.6
20. Cost containment expenses	3.7	4.0	4.0	5.0	2.0
21. Other claims adjustment expenses	1.6	2.1	1.5	1.9	0.6
22. Total underwriting deductions (Line 23)	99.6	99.8	103.8	98.4	97.4
23. Total underwriting gain (loss) (Line 24)	0.4	0.2	(3.8)	1.6	2.6
Unpaid Claims Analysis (U&I Exhibit, Part 2B)					
24. Total claims incurred for prior years (Line 13, Col. 5)	101,527,076	81,161,234	49,404,878	30,593,009	30,287,092
25. Estimated liability of unpaid claims-[prior year (Line 13, Col. 6)]	99,786,973	84,281,824	51,501,048	34,275,305	38,174,388
Investments in Parent, Subsidiaries and Affiliates					
26. Affiliated bonds (Sch. D Summary, Line 12, Col. 1)			0	0	0
27. Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1)				0	0
28. Affiliated common stocks (Sch. D Summary, Line 24, Col. 1)			0	0	0
29. Affiliated short-term investments (subtotal included in Schedule DA Verification, Col. 5, Line 10)	0	0	0	0	0
30. Affiliated mortgage loans on real estate					
31. All other affiliated					
32. Total of above Lines 26 to 31	0	0	0	0	0
33. Total investment in parent included in Lines 26 to 31 above					

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3, Accounting Changes and Correction of Errors? Yes [] No []
If no, please explain:



ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION AMERIGROUP Florida, Inc.

2. Tampa, FL

NAIC Group Code		BUSINESS IN THE STATE OF		DURING THE YEAR							(LOCATION)
0671		Florida		2016							NAIC Company Code
		1	2	3	4	5	6	7	8	9	10
		Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:											
1. Prior Year		392,725	41,563						2,524	340,957	7,681
2. First Quarter		407,974	43,393							357,087	7,494
3. Second Quarter		411,295	46,309							357,168	7,818
4. Third Quarter		407,350	47,604							351,899	7,847
5. Current Year		404,090	47,658							348,561	7,871
6. Current Year Member Months		4,854,650	549,268							4,237,803	67,579
Total Member Ambulatory Encounters for Year:											
7. Physician		2,318,550	191,199							2,114,080	13,271
8. Non-Physician		2,679,406	77,663						1	1,679,074	922,668
9. Total		4,997,956	268,862	0	0	0	0	0	1	3,793,154	935,939
10. Hospital Patient Days Incurred		201,727	3,413							166,465	31,849
11. Number of Inpatient Admissions		39,196	856							38,119	221
12. Health Premiums Written (b)		1,431,822,517	67,599,027						(1,280,225)	1,208,465,775	157,037,940
13. Life Premiums Direct		0									
14. Property/Casualty Premiums Written		0									
15. Health Premiums Earned		1,432,590,828	67,599,027						(511,914)	1,208,465,775	157,037,940
16. Property/Casualty Premiums Earned		0									
17. Amount Paid for Provision of Health Care Services		1,263,851,420	61,899,313						2,921,847	1,044,914,773	154,115,487
18. Amount Incurred for Provision of Health Care Services		1,283,105,858	63,164,982						(906,252)	1,069,980,092	150,867,036

(a) For health business: number of persons insured under PPO managed care products and number of persons insured under indemnity only products

(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$ (1,280,225)



ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION AMERIGROUP Florida, Inc.

2. Tampa, FL

NAIC Group Code	0671	BUSINESS IN THE STATE OF	Grand Total		DURING THE YEAR					(LOCATION)	
			Comprehensive (Hospital & Medical)		2016					NAIC Company Code	
			2	3	4	5	6	7	8	9	10
			Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other
Total Members at end of:		Total									
1. Prior Year	392,725		41,563	0	0	0	0	0	2,524	340,957	7,681
2. First Quarter	407,974		43,393	0	0	0	0	0	0	357,087	7,494
3. Second Quarter	411,295		46,309	0	0	0	0	0	0	357,168	7,818
4. Third Quarter	407,350		47,604	0	0	0	0	0	0	351,899	7,847
5. Current Year	404,090		47,658	0	0	0	0	0	0	348,561	7,871
6. Current Year Member Months	4,854,650		549,268	0	0	0	0	0	0	4,237,803	67,579
Total Member Ambulatory Encounters for Year:											
7. Physician	2,318,550		191,199	0	0	0	0	0	0	2,114,080	13,271
8. Non-Physician	2,679,406		77,663	0	0	0	0	0	1	1,679,074	922,668
9. Total	4,997,956		268,862	0	0	0	0	0	1	3,793,154	935,939
10. Hospital Patient Days Incurred	201,727		3,413	0	0	0	0	0	0	166,465	31,849
11. Number of Inpatient Admissions	39,196		856	0	0	0	0	0	0	38,119	221
12. Health Premiums Written (b)	1,431,822,517		67,599,027	0	0	0	0	0	(1,280,225)	1,208,465,775	157,037,940
13. Life Premiums Direct	0		0	0	0	0	0	0	0	0	0
14. Property/Casualty Premiums Written	0		0	0	0	0	0	0	0	0	0
15. Health Premiums Earned	1,432,590,828		67,599,027	0	0	0	0	0	(511,914)	1,208,465,775	157,037,940
16. Property/Casualty Premiums Earned	0		0	0	0	0	0	0	0	0	0
17. Amount Paid for Provision of Health Care Services	1,263,851,420		61,899,313	0	0	0	0	0	2,921,847	1,044,914,773	154,115,487
18. Amount Incurred for Provision of Health Care Services	1,283,105,858		63,164,982	0	0	0	0	0	(906,252)	1,069,980,092	150,867,036

(a) For health business: number of persons insured under PPO managed care products0 and number of persons insured under indemnity only products0 .

(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$(1,280,225)

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

Schedule S - Part 1 - Section 2

NONE

Schedule S - Part 2

NONE

Schedule S - Part 3 - Section 2

NONE

Schedule S - Part 4

NONE

Schedule S - Part 4 - Bank Footnote

NONE

Schedule S - Part 5

NONE

Schedule S - Part 5 - Bank Footnote

NONE

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE S - PART 6

Five Year Exhibit of Reinsurance Ceded Business (000 Omitted)

	1 2016	2 2015	3 2014	4 2013	5 2012
A. OPERATIONS ITEMS					
1. Premiums	0	0	0	0	0
2. Title XVIII - Medicare	0	0	0	1	4
3. Title XIX - Medicaid	0	0	0	59	142
4. Commissions and reinsurance expense allowance					
5. Total hospital and medical expenses					
B. BALANCE SHEET ITEMS					
6. Premiums receivable					
7. Claims payable	0	0	0	0	0
8. Reinsurance recoverable on paid losses	0	0	0	0	0
9. Experience rating refunds due or unpaid					
10. Commissions and reinsurance expense allowances due					
11. Unauthorized reinsurance offset					
12. Offset for reinsurance with Certified Reinsurers					
C. UNAUTHORIZED REINSURANCE (DEPOSITS BY AND FUNDS WITHHELD FROM)					
13. Funds deposited by and withheld from (F)	0	0	0	0	0
14. Letters of credit (L)	0	0	0	0	0
15. Trust agreements (T)	0	0	0	0	0
16. Other (O)	0	0	0	0	0
D. REINSURANCE WITH CERTIFIED REINSURERS (DEPOSITS BY AND FUNDS WITHHELD FROM)					
17. Multiple Beneficiary Trust				0	0
18. Funds deposited by and withheld from (F)				0	0
19. Letters of credit (L)				0	0
20. Trust agreements (T)				0	0
21. Other (O)				0	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE S - PART 7

Restatement of Balance Sheet to Identify Net Credit For Ceded Reinsurance

	1 As Reported (net of ceded)	2 Restatement Adjustments	3 Restated (gross of ceded)
ASSETS (Page 2, Col. 3)			
1. Cash and invested assets (Line 12)	198,109,220		198,109,220
2. Accident and health premiums due and unpaid (Line 15)	20,096,407		20,096,407
3. Amounts recoverable from reinsurers (Line 16.1)			0
4. Net credit for ceded reinsurance	XXX	0	0
5. All other admitted assets (Balance)	10,838,543		10,838,543
6. Total assets (Line 28)	229,044,170	0	229,044,170
LIABILITIES, CAPITAL AND SURPLUS (Page 3)			
7. Claims unpaid (Line 1)	103,405,613		103,405,613
8. Accrued medical incentive pool and bonus payments (Line 2)	4,184,830		4,184,830
9. Premiums received in advance (Line 8)			0
10. Funds held under reinsurance treaties with authorized and unauthorized reinsurers (Line 19 first inset amount plus second inset amount)	0		0
11. Reinsurance in unauthorized companies (Line 20 minus inset amount)	0		0
12. Reinsurance with Certified Reinsurers (Line 20 inset amount)			0
13. Funds held under reinsurance treaties with Certified Reinsurers (Line 19 third inset amount)	0		0
14. All other liabilities (Balance)	35,324,064		35,324,064
15. Total liabilities (Line 24)	142,914,507	0	142,914,507
16. Total capital and surplus (Line 33)	86,129,663	XXX	86,129,663
17. Total liabilities, capital and surplus (Line 34)	229,044,170	0	229,044,170
NET CREDIT FOR CEDED REINSURANCE			
18. Claims unpaid	0		
19. Accrued medical incentive pool	0		
20. Premiums received in advance	0		
21. Reinsurance recoverable on paid losses	0		
22. Other ceded reinsurance recoverables	0		
23. Total ceded reinsurance recoverables	0		
24. Premiums receivable	0		
25. Funds held under reinsurance treaties with authorized and unauthorized reinsurers	0		
26. Unauthorized reinsurance	0		
27. Reinsurance with Certified Reinsurers	0		
28. Funds held under reinsurance treaties with Certified Reinsurers	0		
29. Other ceded reinsurance payables/offsets	0		
30. Total ceded reinsurance payables/offsets	0		
31. Total net credit for ceded reinsurance	0		

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE T PREMIUMS AND OTHER CONSIDERATIONS

Allocated by States and Territories									
States, etc.	1 Active Status	Direct Business Only							
		2 Accident & Health Premiums	3 Medicare Title XVIII	4 Medicaid Title XIX	5 Federal Employees Health Benefits Plan Premiums	6 Life & Annuity Premiums & Other Considerations	7 Property/Casualty Premiums	8 Total Columns 2 Through 7	9 Deposit-Type Contracts
1. Alabama	AL	N						.0	
2. Alaska	AK	N						.0	
3. Arizona	AZ	N						.0	
4. Arkansas	AR	N						.0	
5. California	CA	N						.0	
6. Colorado	CO	N						.0	
7. Connecticut	CT	N						.0	
8. Delaware	DE	N						.0	
9. District of Columbia	DC	N						.0	
10. Florida	FL	67,599,027	(1,280,225)	1,365,503,715				1,431,822,517	
11. Georgia	GA	N						.0	
12. Hawaii	HI	N						.0	
13. Idaho	ID	N						.0	
14. Illinois	IL	N						.0	
15. Indiana	IN	N						.0	
16. Iowa	IA	N						.0	
17. Kansas	KS	N						.0	
18. Kentucky	KY	N						.0	
19. Louisiana	LA	N						.0	
20. Maine	ME	N						.0	
21. Maryland	MD	N						.0	
22. Massachusetts	MA	N						.0	
23. Michigan	MI	N						.0	
24. Minnesota	MN	N						.0	
25. Mississippi	MS	N						.0	
26. Missouri	MO	N						.0	
27. Montana	MT	N						.0	
28. Nebraska	NE	N						.0	
29. Nevada	NV	N						.0	
30. New Hampshire	NH	N						.0	
31. New Jersey	NJ	N						.0	
32. New Mexico	NM	N						.0	
33. New York	NY	N						.0	
34. North Carolina	NC	N						.0	
35. North Dakota	ND	N						.0	
36. Ohio	OH	N						.0	
37. Oklahoma	OK	N						.0	
38. Oregon	OR	N						.0	
39. Pennsylvania	PA	N						.0	
40. Rhode Island	RI	N						.0	
41. South Carolina	SC	N						.0	
42. South Dakota	SD	N						.0	
43. Tennessee	TN	N						.0	
44. Texas	TX	N						.0	
45. Utah	UT	N						.0	
46. Vermont	VT	N						.0	
47. Virginia	VA	N						.0	
48. Washington	WA	N						.0	
49. West Virginia	WV	N						.0	
50. Wisconsin	WI	N						.0	
51. Wyoming	WY	N						.0	
52. American Samoa	AS	N						.0	
53. Guam	GU	N						.0	
54. Puerto Rico	PR	N						.0	
55. U.S. Virgin Islands	VI	N						.0	
56. Northern Mariana Islands	MP	N						.0	
57. Canada	CAN	N						.0	
58. Aggregate other alien	OT	XXX .0	.0	.0	.0	.0	.0	.0	.0
59. Subtotal	XXX	67,599,027	(1,280,225)	1,365,503,715	.0	.0	.0	1,431,822,517	.0
60. Reporting entity contributions for Employee Benefit Plans	XXX							.0	
61. Total (Direct Business)	(a) 1	67,599,027	(1,280,225)	1,365,503,715	0	0	0	1,431,822,517	0
DETAILS OF WRITE-INS									
58001.	XXX								
58002.	XXX								
58003.	XXX								
58998. Summary of remaining write-ins for Line 58 from overflow page	XXX	.0	.0	.0	.0	.0	.0	.0	.0
58999. Totals (Lines 58001 through 58003 plus 58998)(Line 58 above)	XXX	0	0	0	0	0	0	0	0

(L) Licensed or Chartered - Licensed Insurance Carrier or Domiciled RRG; (R) Registered - Non-domiciled RRGs; (Q) Qualified - Qualified or Accredited Reinsurer; (E) Eligible - Reporting Entities eligible or approved to write Surplus Lines in the state; (N) None of the above - Not allowed to write business in the state.

Explanation of basis of allocation by states, premiums by state, etc.

by states, premiums by state, etc.

(a) Insert the number of L responses except for Canada and Other Alien.

by states, premiums by state, etc.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

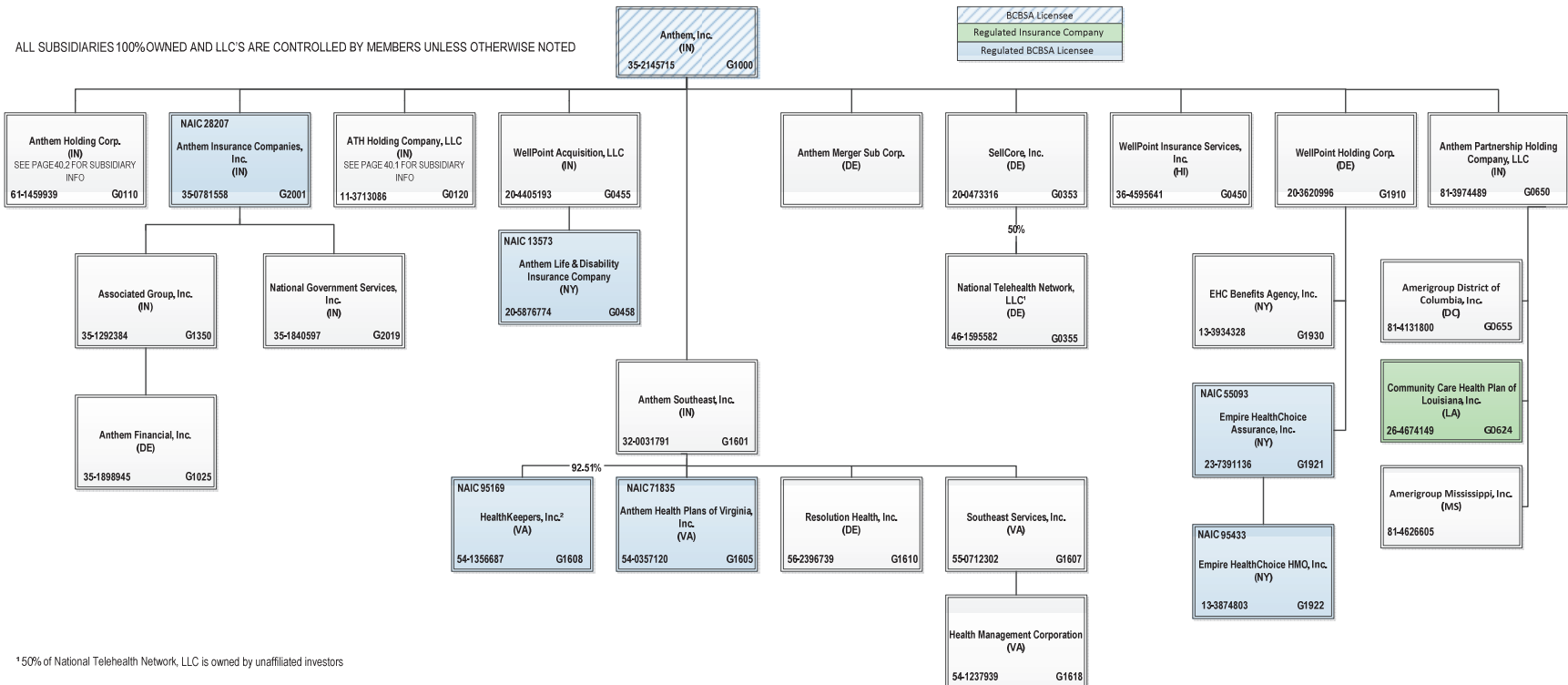
SCHEDULE T - PART 2
INTERSTATE COMPACT - EXHIBIT OF PREMIUMS WRITTEN

Allocated by States and Territories

States, Etc.	Direct Business Only					
	1 Life (Group and Individual)	2 Annuities (Group and Individual)	3 Disability Income (Group and Individual)	4 Long-Term Care (Group and Individual)	5 Deposit-Type Contracts	6 Totals
1. Alabama	AL					
2. Alaska	AK					
3. Arizona	AZ					
4. Arkansas	AR					
5. California	CA					
6. Colorado	CO					
7. Connecticut	CT					
8. Delaware	DE					
9. District of Columbia	DC					
10. Florida	FL					
11. Georgia	GA					
12. Hawaii	HI					
13. Idaho	ID					
14. Illinois	IL					
15. Indiana	IN					
16. Iowa	IA					
17. Kansas	KS					
18. Kentucky	KY					
19. Louisiana	LA					
20. Maine	ME					
21. Maryland	MD					
22. Massachusetts	MA					
23. Michigan	MI					
24. Minnesota	MN					
25. Mississippi	MS					
26. Missouri	MO					
27. Montana	MT					
28. Nebraska	NE					
29. Nevada	NV					
30. New Hampshire	NH					
31. New Jersey	NJ					
32. New Mexico	NM					
33. New York	NY					
34. North Carolina	NC					
35. North Dakota	ND					
36. Ohio	OH					
37. Oklahoma	OK					
38. Oregon	OR					
39. Pennsylvania	PA					
40. Rhode Island	RI					
41. South Carolina	SC					
42. South Dakota	SD					
43. Tennessee	TN					
44. Texas	TX					
45. Utah	UT					
46. Vermont	VT					
47. Virginia	VA					
48. Washington	WA					
49. West Virginia	WV					
50. Wisconsin	WI					
51. Wyoming	WY					
52. American Samoa	AS					
53. Guam	GU					
54. Puerto Rico	PR					
55. U.S. Virgin Islands	VI					
56. Northern Mariana Islands	MP					
57. Canada	CAN					
58. Aggregate Other Alien	OT					
59. Total						

NONE

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.
SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



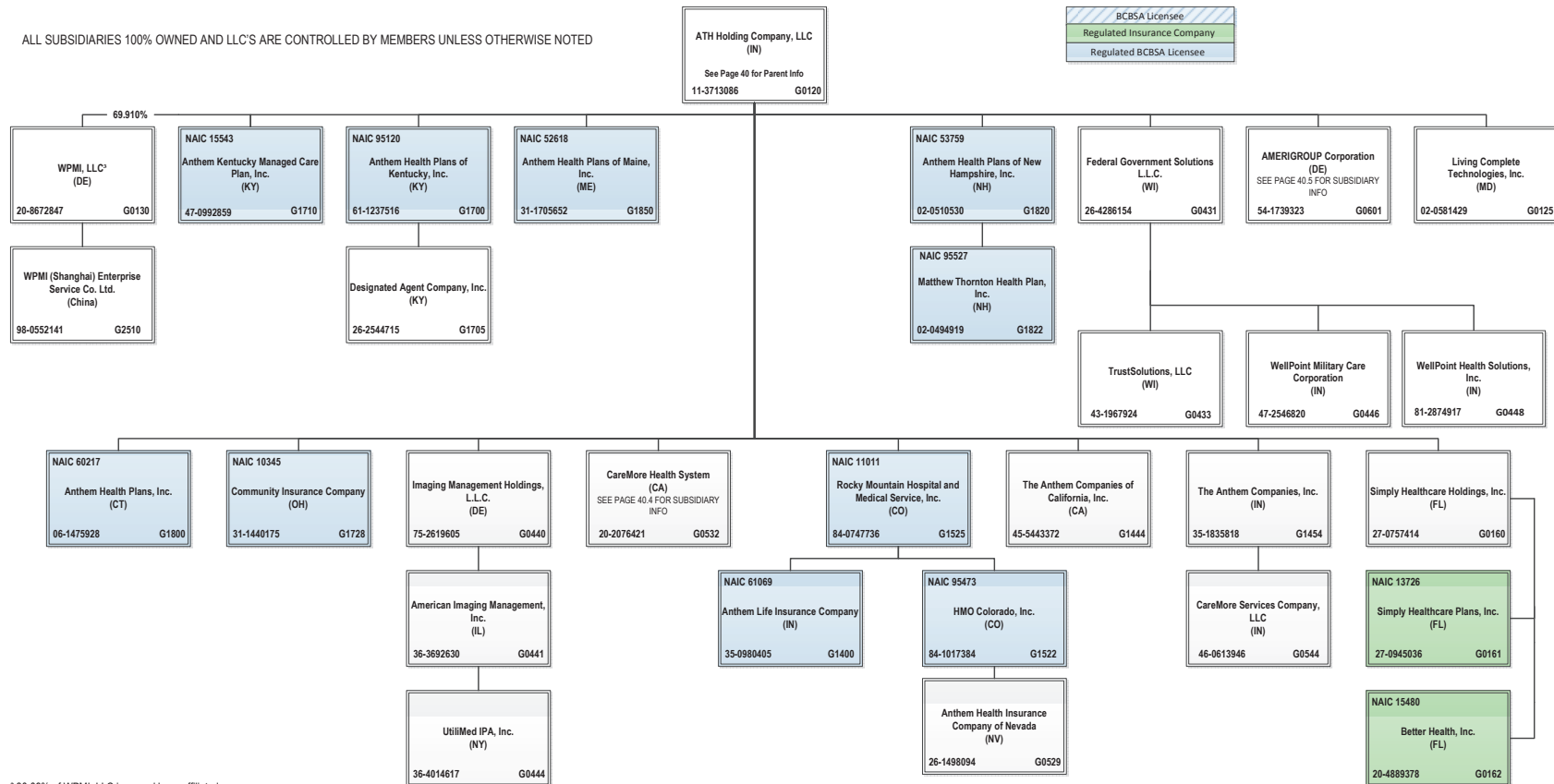
* 50% of National Telehealth Network, LLC is owned by unaffiliated investors

² HealthKeepers, Inc. is owned 92.51% by Anthem Southeast, Inc. and 7.49% by UNICARE National Services, Inc.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

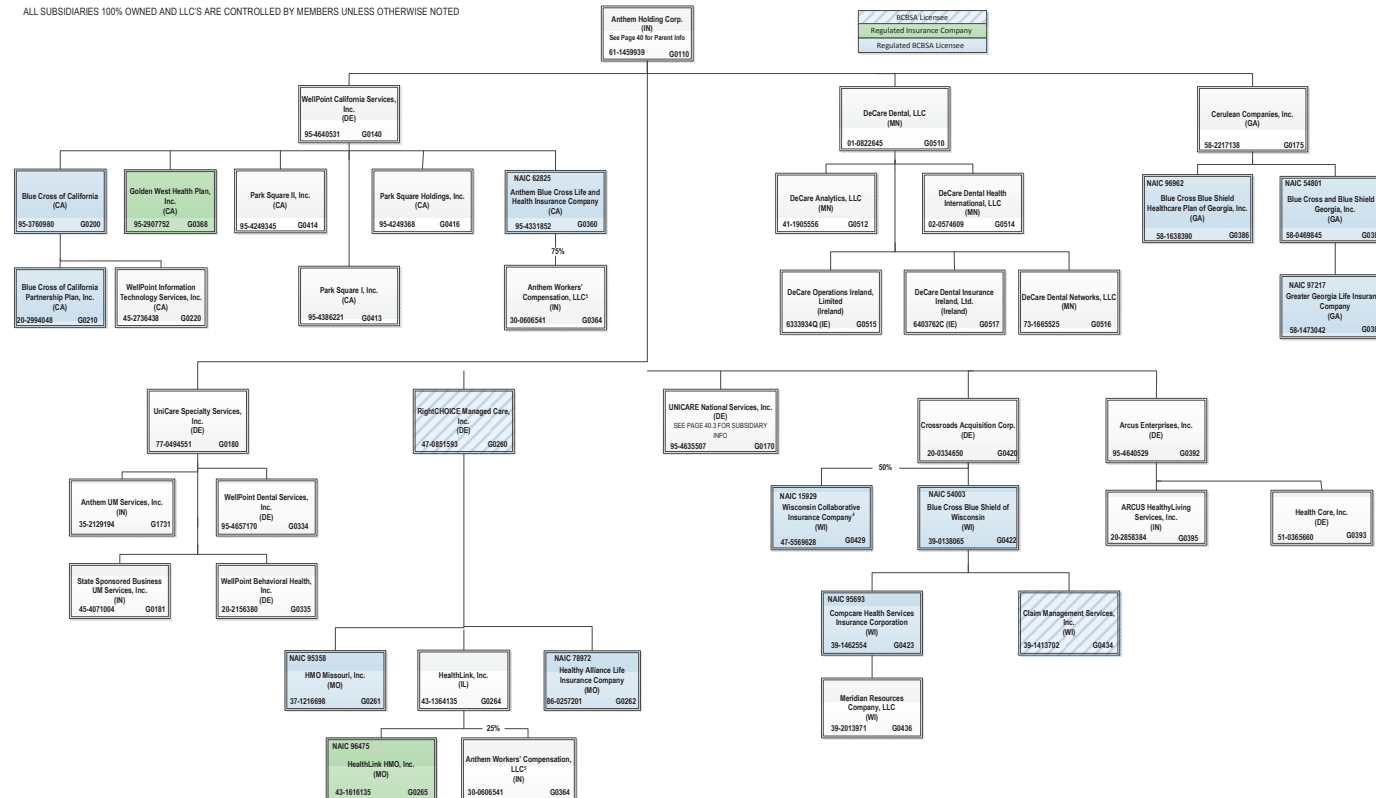
ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.
SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



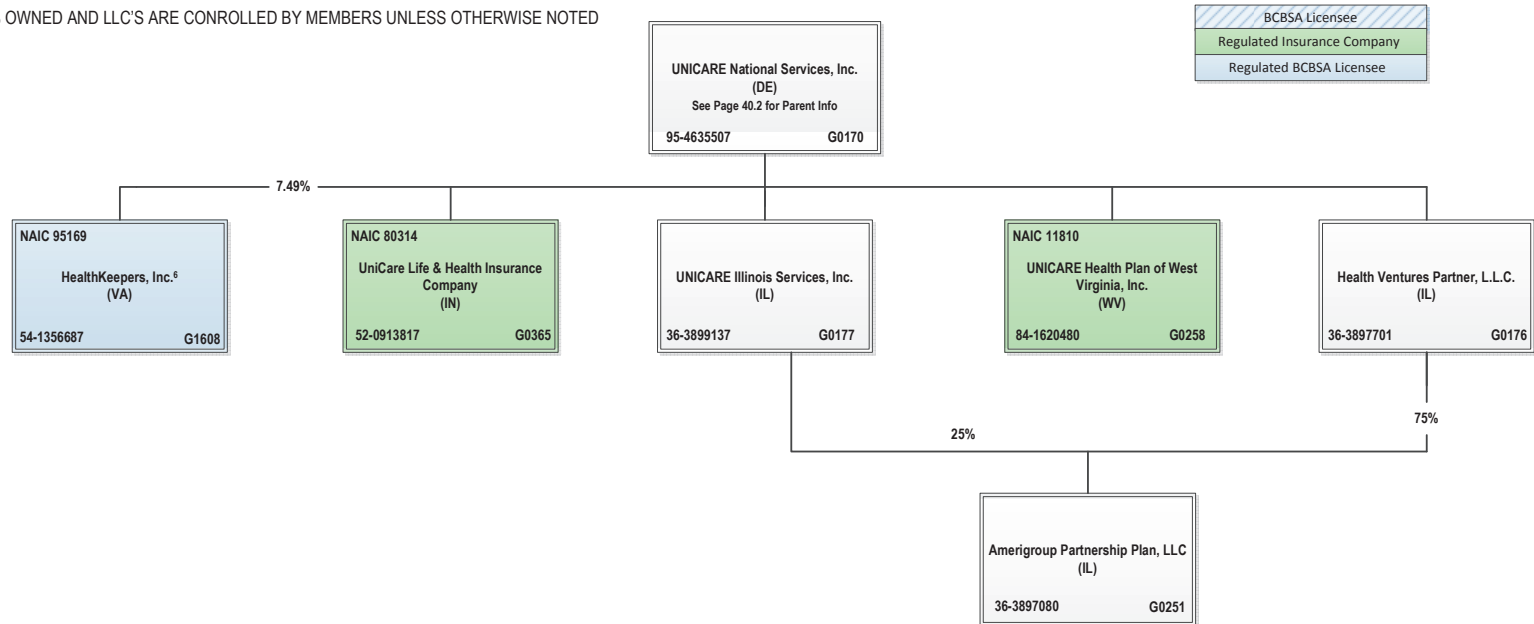
¹ 50% of WIOC is owned by an unaffiliated investor.

² Anthem Workers' Compensation LLC is owned 75% by Anthem Blue Cross Life and Health Insurance Company and 25% by HealthLink, Inc.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



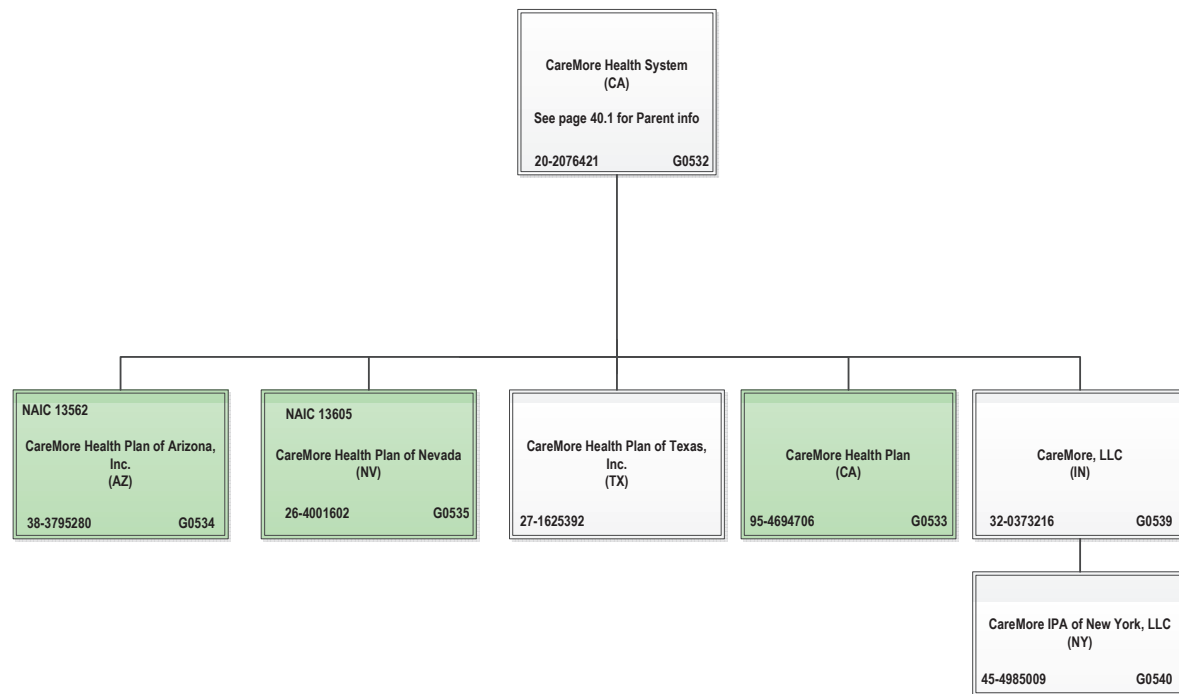
⁶ HealthKeepers, Inc. is owned 92.51% by Anthem Southeast, Inc. and 7.49% by UNICARE National Services, Inc.

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED

BCBSA Licensee
Regulated Insurance Company
Regulated BCBSA Licensee

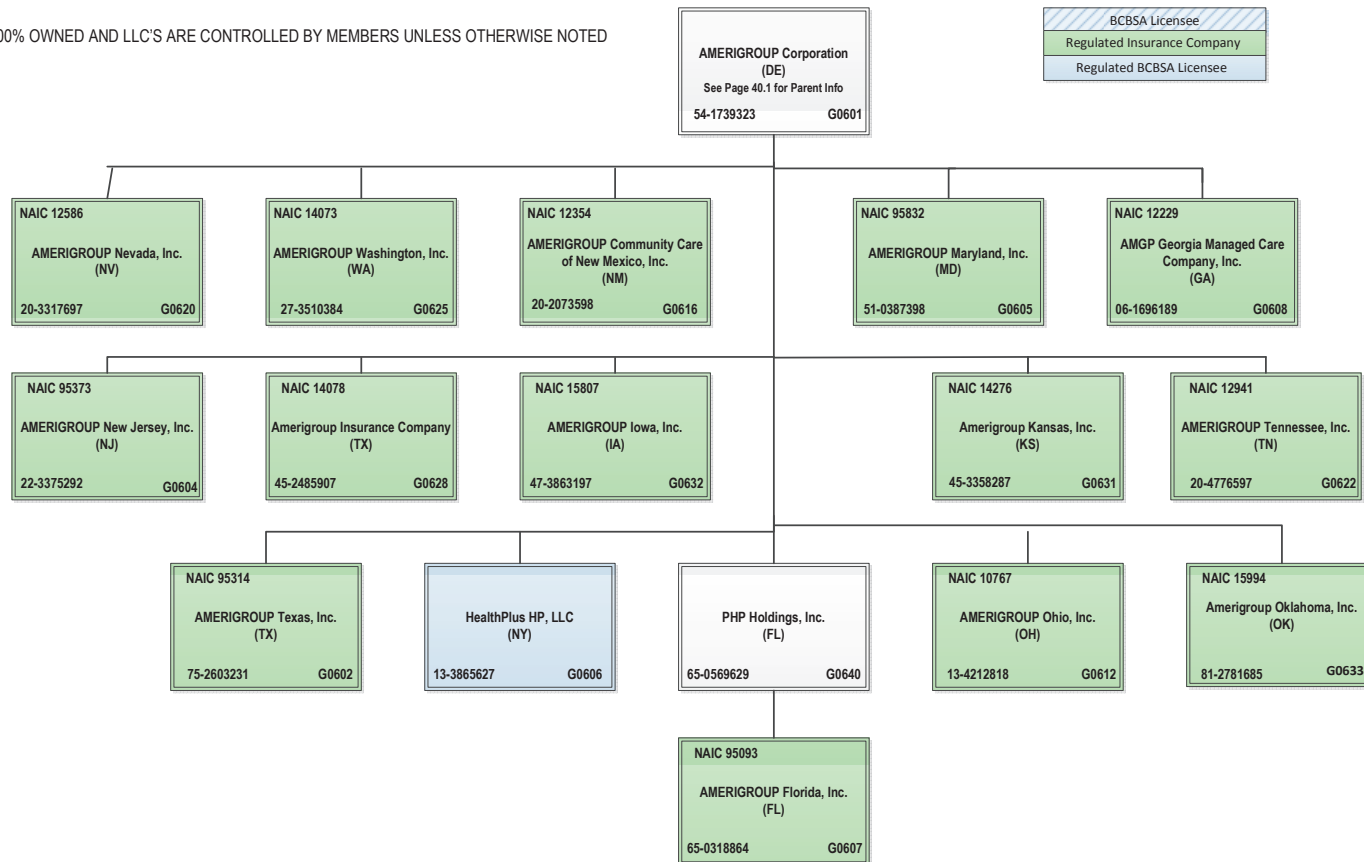


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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

ALL SUBSIDIARIES 100% OWNED AND LLC'S ARE CONTROLLED BY MEMBERS UNLESS OTHERWISE NOTED



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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Required? (Y/N)	*
.0671	Anthem, Inc.		36-3692630				American Imaging Management, Inc. AMERIGROUP Community Care of New Mexico, Inc.	IL	NIA	Imaging Management Holdings, L.L.C.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	12354	20-2073598				AMERIGROUP Corporation	MI	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		54-1739323				AMERIGROUP Corporation	DE	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		81-4131800				Amerigroup District of Columbia, Inc.	DC	NIA	Anthem Partnership Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	95093	65-0318864				AMERIGROUP Florida, Inc.	FL	IA	PHP Holdings, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	14078	45-2485907				Amerigroup Insurance Company	TX	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	15807	47-3863197				AMERIGROUP Iowa, Inc.	IA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	14276	45-3358287				Amerigroup Kansas, Inc.	KS	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	95832	51-0387388				AMERIGROUP Maryland, Inc.	MD	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		81-4626605				Amerigroup Mississippi, Inc.	MS	NIA	Anthem Partnership Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	12586	20-3317697				AMERIGROUP Nevada, Inc.	NV	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	95373	22-3375292				AMERIGROUP New Jersey, Inc.	NJ	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	10767	13-4212818				AMERIGROUP Ohio, Inc.	OH	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	15994	81-2781685				AMERIGROUP Oklahoma, Inc.	OK	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		36-3897080				Amerigroup Partnership Plan, LLC	IL	NIA	Health Ventures Partner, L.L.C.	Ownership	75.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		36-3897080				Amerigroup Partnership Plan, LLC	IL	NIA	UNICARE Illinois Services, Inc.	Ownership	25.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	12941	20-4776597				AMERIGROUP Tennessee, Inc.	TN	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	95314	75-2603231				AMERIGROUP Texas, Inc.	TX	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	14073	27-3510384				AMERIGROUP Washington, Inc.	WA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	12229	06-1696189				AMGP Georgia Managed Care Company, Inc. Anthem Blue Cross Life and Health Insurance Company	GA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	62825	95-4331852				Anthem Financial, Inc.	CA	IA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		35-1898945				Anthem Health Insurance Company of Nevada	DE	NIA	Associated Group, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		26-1498094				Anthem Health Plans of Kentucky, Inc.	NV	NIA	Hill Country, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	95120	61-1237516				Anthem Health Plans of Kentucky, Inc.	KY	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	0108
.0671	Anthem, Inc.	52618	31-1705652				Anthem Health Plans of Maine, Inc.	ME	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	53759	02-0510530				Anthem Health Plans of New Hampshire, Inc.	NH	RE	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	71835	54-0357120	40003317			Anthem Health Plans of Virginia, Inc.	VA	IA	Anthem Southeast, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	60217	06-1475928				Anthem Health Plans, Inc.	CT	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		61-1459939				Anthem Holding Corp.	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		35-2145715		6324	New York Stock Exchange (NYSE)	Anthem, Inc.	IN	UIP	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	28207	35-0781558				Anthem Insurance Companies, Inc.	IN	IA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	15543	47-0992859				Anthem Kentucky Managed Care Plan, Inc.	KY	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	13573	20-5876774				Anthem Life & Disability Insurance Company	NY	IA	WellPoint Acquisition, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	61069	35-0980405				Anthem Life Insurance Company	IN	IA	Service, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		81-3974489				Anthem Merger Sub Corp.	DE	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		32-0031791				Anthem Partnership Holding Company, LLC	DE	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		35-2129194				Anthem Southeast, Inc.	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.						Anthem UM Services, Inc.	IN	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		30-0606541				Anthem Workers' Compensation, LLC	IN	NIA	Anthem Blue Cross Life and Health Insurance Company	Ownership	75.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		30-0606541				Anthem Workers' Compensation, LLC	IN	NIA	HealthLink, Inc.	Ownership	25.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		95-4640529				Arcus Enterprises, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		20-2856384				ARCUS HealthLiving Services, Inc.	IN	NIA	Arcus Enterprises, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		35-1292384				Associated Group, Inc.	IN	NIA	Anthem Insurance Companies, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		11-3713086				ATH Holding Company, LLC	IN	UIP	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	15480	20-4889378				Better Health, Inc.	FL	IA	Simply Healthcare Holdings, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	54801	58-0469845				Blue Cross and Blue Shield of Georgia, Inc.	GA	IA	Cerulean Companies, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		96962	58-1638390			Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	GA	IA	Cerulean Companies, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	54003	39-0138065				Blue Cross Blue Shield of Wisconsin	WI	IA	Crossroads Acquisition Corp.	Ownership	100.000	Anthem, Inc.	N	0108

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE Y
PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	Is an SCA Filing Required? (Y/N)	*
.0671	Anthem, Inc.		95-3760980				Blue Cross of California	CA	IA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	.0101
.0671	Anthem, Inc.		20-2994048				Blue Cross of California Partnership Plan, Inc.	CA	IA	Blue Cross of California	Ownership	100.000	Anthem, Inc.	N	.0102
.0671	Anthem, Inc.		95-4694706				Caremore Health Plan	CA	IA	Caremore Health System	Ownership	100.000	Anthem, Inc.	N	.0103
.0671	Anthem, Inc.	13562	38-3795280				Caremore Health Plan of Arizona, Inc.	AZ	IA	Caremore Health System	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	13605	26-4001602				Caremore Health Plan of Nevada	NV	IA	Caremore Health System	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		27-1625392				Caremore Health Plan of Texas, Inc.	TX	NIA	Caremore Health System	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		45-4985009				Caremore IPA of New York, LLC	NY	NIA	Caremore, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		32-0373216				Caremore, LLC	IN	NIA	Caremore Health System	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		20-2078421				Caremore Health System	CA	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		46-0613946				Caremore Services Company, LLC	IN	NIA	The Anthem Companies, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		58-2217138				Cerulean Companies, Inc.	GA	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		39-1413702				Claim Management Services, Inc.	WI	NIA	Blue Cross Blue Shield of Wisconsin	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.						Community Care Health Plan of Louisiana, Inc.	LA	IA	Anthem Partnership Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	14084	26-4674149				Community Insurance Company	OH	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	10345	31-1440175				CompCare Health Services Insurance Corporation	WI	IA	Blue Cross Blue Shield of Wisconsin	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	95693	39-1462554				Crossroads Acquisition Corp.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		20-0334650				DeCare Analytics, LLC	MD	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		41-1905556				DeCare Dental Health International, LLC	MD	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		02-0574609				DeCare Dental Insurance Ireland, Ltd.	IRL	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		73-1665525				DeCare Dental Networks, LLC	MD	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		01-0822945				DeCare Dental, LLC	MD	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.						DeCare Operations Ireland, Limited	IRL	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		26-2544715				Designated Agent Company, Inc.	KY	NIA	Anthem Health Plans of Kentucky, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		13-3934328				EHC Benefits Agency, Inc.	NY	NIA	WellPoint Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	55093	23-7391136				Empire HealthChoice Assurance, Inc.	NY	IA	WellPoint Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	95433	13-3874803				Empire HealthChoice HMO, Inc.	NY	IA	Empire HealthChoice Assurance, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		26-4286154				Federal Government Solutions, LLC	WI	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		95-2907752				Golden West Health Plan, Inc.	CA	IA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	.0104
.0671	Anthem, Inc.						Greater Georgia Life Insurance Company	GA	IA	Blue Cross and Blue Shield of Georgia, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	97217	58-1473042				Health Core, Inc.	DE	NIA	Arcus Enterprises, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		51-0365660				Health Management Corporation	VA	NIA	Southeast Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		54-1237939				Health Ventures Partner, L.L.C.	IL	NIA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		36-3897701				HealthKeepers, Inc.	VA	IA	Anthem Southeast, Inc.	Ownership	92.510	Anthem, Inc.	N	
.0671	Anthem, Inc.	95169	54-1356687				HealthKeepers, Inc.	VA	IA	UNICARE National Services, Inc.	Ownership	7.490	Anthem, Inc.	N	
.0671	Anthem, Inc.	95169	43-1616135				HealthLink HMO, Inc.	MD	IA	HealthLink, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	96475	43-1361135				HealthLink, Inc.	IL	NIA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		13-3865627				HealthPlus HP, LLC	NY	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	.0100
.0671	Anthem, Inc.		78972				Healthy Alliance Life Insurance Company	MD	IA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.						HMO Colorado, Inc.	CO	IA	Rocky Mountain Hospital and Medical Service, Inc.	Ownership	100.000	Anthem, Inc.	N	.0108
.0671	Anthem, Inc.	95473	84-1017384				HMO Missouri, Inc.	MO	IA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	95358	37-1216698				Imaging Management Holdings, L.L.C.	DE	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		75-2619605				Living Complete Technologies, Inc.	MD	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		02-0581429				Matthew Thornton Health Plan, Inc.	NH	DS	Anthem Health Plans of New Hampshire, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	95527	02-0494919				Meridian Resource Company, LLC	WI	NIA	CompCare Health Services Insurance Corporation	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		39-2013971				National Government Services, Inc.	IN	NIA	Anthem Insurance Companies, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		35-1840597				National Telehealth Network, LLC	DE	NIA	Selloore, Inc.	Ownership	50.000	Anthem, Inc.	N	.0105
.0671	Anthem, Inc.		46-1595582				Park Square Holdings, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	

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SCHEDULE Y
PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

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.0671	Anthem, Inc.		95-4386221				Park Square I, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		95-4249345				Park Square II, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		65-0569629				PHP Holdings, Inc.	FL	NIA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		56-2396739				Resolution Health, Inc.	DE	NIA	Anthem Southeast, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		47-0851593				RightCHOICE Managed Care, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	11011	84-0747736				Rocky Mountain Hospital and Medical Service, Inc.	CO	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		20-0473316				SellCore, Inc.	DE	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		27-0757414				Simply Healthcare Holdings, Inc.	FL	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	13726	27-0945036				Simply Healthcare Plans, Inc.	FL	IA	Simply Healthcare Holdings, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		55-0712302				Southeast Services, Inc.	VA	NIA	Anthem Southeast, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		45-4071004				State Sponsored Business UM Services, Inc.	IN	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		35-1835818				The Anthem Companies, Inc.	IN	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		45-5443372				The Anthem Companies of California, Inc.	CA	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		43-1967924				TrustSolutions, LLC	WI	NIA	Government Health Services, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	11810	84-1620480				UNICARE Health Plan of West Virginia, Inc.	WV	IA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		96-3899137				UNICARE Illinois Services, Inc.	IL	NIA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	80314	52-0913817				UNICARE Life & Health Insurance Company	IN	IA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		95-4635507				UNICARE National Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		77-0494551				UNICARE Specialty Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		36-4014617				Utilimed IPA, Inc.	NY	NIA	American Imaging Management, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		20-4405193				WellPoint Acquisition, LLC	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		20-2156380				WellPoint Behavioral Health, Inc.	DE	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		95-4640331				WellPoint California Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		95-4657170				WellPoint Dental Services, Inc.	DE	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		81-2874917				WellPoint Health Solutions, Inc.	DE	NIA	Federal Government Solutions, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		20-3620996				WellPoint Holding Corp.	DE	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		45-2736438				WellPoint Information Technology Services, Inc.	CA	NIA	Blue Cross of California	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		36-4595641				WellPoint Insurance Services, Inc.	HI	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		47-2546820				WellPoint Military Care Corporation	IN	NIA	Government Health Services, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.	15929	47-5569628				Wisconsin Collaborative Insurance Company	WI	IA	Crossroads Acquisition Corp.	Ownership	50.000	Anthem, Inc.	N	.0107
.0671	Anthem, Inc.		98-0552141				WPMI (Shanghai) Enterprise Service Co. Ltd.	CHN	NIA	WPMI, LLC	Ownership	100.000	Anthem, Inc.	N	
.0671	Anthem, Inc.		20-8672847				WPMI, LLC	DE	NIA	ATH Holding Company, LLC	Ownership	69.910	Anthem, Inc.	N	.0106

Asterisk	Explanation
0100	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the New York State Department of Health.
0101	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0102	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0103	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0104	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0105	50% owned by unaffiliated investors
0106	30.08% owned by unaffiliated investors
0107	50% owned by an unaffiliated investor
0108	Received exemption from domestic regulator

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE Y
PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1	2	3	4	5	6	7	8	9	10	11	12	13
NAIC Company Code	ID Number	Names of Insurers and Parent, Subsidiaries or Affiliates	Shareholder Dividends	Capital Contributions	Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	Management Agreements and Service Contracts	Income/ (Disbursements) Incurred Under Reinsurance Agreements	*	Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	Totals	Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
12354	36-3692630	American Imaging Management, Inc.					(45,143,273)				(45,143,273)	
	20-2073598	AMERIGROUP Community Care of New Mexico, Inc.					(2,376,606)				(2,376,606)	
	54-1739323	AMERIGROUP Corporation					(23,463,877)				(23,463,877)	
95093	65-0318864	AMERIGROUP Florida, Inc.			10,000,000		(138,420,433)				(128,420,433)	
14078	45-2485907	AMERIGROUP Insurance Company					(46,993,561)				(46,993,561)	
15807	47-3863197	AMERIGROUP Iowa, Inc.			250,000,000		(78,378,221)				(71,621,779)	
14276	45-3358287	AMERIGROUP Kansas, Inc.					(74,340,938)				(74,340,938)	
95832	51-0387398	AMERIGROUP Maryland, Inc.		(20,000,000)			(121,837,959)				(141,837,959)	
12586	20-3317697	AMERIGROUP Nevada, Inc.					(61,302,699)				(61,302,699)	
95373	22-3375292	AMERIGROUP New Jersey, Inc.		(50,000,000)			(145,692,060)				(195,692,060)	
10767	13-4212818	AMERIGROUP Ohio Inc.					(469,933)				(469,933)	
	36-3897080	AMERIGROUP Partnership Plan, LLC					(26,852,245)				(26,852,245)	
12941	20-4776597	AMERIGROUP Tennessee, Inc.					(190,076,813)				(190,076,813)	
95314	75-2603231	AMERIGROUP Texas, Inc.		(30,000,000)			(404,082,715)				(434,082,715)	
14073	27-3510384	AMERIGROUP Washington, Inc.		(12,000,000)			(68,215,341)				(80,215,341)	
12229	06-1696189	AMGP Georgia Managed Care Company, Inc.		(15,000,000)			(142,727,809)				(157,727,809)	
62825	95-4331852	Anthem Blue Cross Life and Health Insurance Company, Inc.		(235,600,000)			(941,956,611)	(983,470)			(1,178,540,081)	1,511,335
95120	61-1237516	Anthem Health Plans of Kentucky, Inc.		(95,000,000)			(391,288,399)				(486,288,399)	
52618	31-1705652	Anthem Health Plans of Maine, Inc.		(22,100,000)			(111,362,268)				(133,462,268)	
53759	02-0510530	Anthem Health Plans of New Hampshire, Inc.		(10,000,000)			(50,981,912)				(60,981,912)	
71835	54-0357120	Anthem Health Plans of Virginia, Inc.		(216,100,000)			(614,651,485)	10,369,959			(820,381,526)	(4,585,268)
60217	06-1475928	Anthem Health Plans, Inc.		(91,800,000)			(304,498,539)				(396,298,539)	
28207	35-0781558	Anthem Insurance Companies, Inc.		(325,000,000)			(1,254,634,382)	11,067,248			(1,568,567,134)	(1,644,166)
15543	47-0992859	Anthem Kentucky Managed Care Plan, Inc.					(64,835,810)				(64,835,810)	
13573	20-5876774	Anthem Life and Disability Insurance Company		(18,900,000)			(1,071,963)				(1,071,963)	
61069	35-0980405	Anthem Life Insurance Company		(18,900,000)			(35,571,292)	17,800,662			(36,670,630)	(23,079,605)
	35-2145715	Anthem, Inc.		2,611,100,000	(300,000,000)		6,354,566,658				8,665,666,658	
	11-3713086	ATH Holding Company, LLC					(41,675,909)				(41,675,909)	
15480	20-4889378	Better Health, Inc.					(40,459,168)				(40,459,168)	
54801	58-0469845	Blue Cross and Blue Shield of Georgia, Inc.		(73,600,000)			(352,736,642)				(426,336,642)	
96962	58-1638390	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.		(25,700,000)			(401,841,849)				(427,541,849)	
54003	39-0138065	Blue Cross Blue Shield of Wisconsin		(60,000,000)			(137,431,914)				(197,431,914)	
	95-3760980	Blue Cross of California		(425,000,000)			(1,318,129,334)				(1,743,129,334)	
	20-2994048	Blue Cross of California Partnership Plan, Inc.					(332,338,749)				(332,338,749)	
	95-4694706	Caremore Health Plan		(50,000,000)			(187,480,869)				(237,480,869)	
13562	38-3975280	Caremore Health Plan of Arizona, Inc.					(36,300,363)				(36,300,363)	
13605	26-4001602	Caremore Health Plan of Nevada					(21,134,855)				(21,134,855)	

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE Y
PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES









1	2	3	4	5	6	7	8	9	10	11	12	13
NAIC Company Code	ID Number	Names of Insurers and Parent, Subsidiaries or Affiliates	Shareholder Dividends	Capital Contributions	Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	Management Agreements and Service Contracts	Income/ (Disbursements) Incurred Under Reinsurance Agreements	*	Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	Totals	Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
14064	32-0373216	Caremore, LLC					(11,857,052)				(11,857,052)	
10345	26-4674149	Community Care Health Plan of Louisiana, Inc.			20,000,000		(69,006,060)				(49,006,060)	
95693	31-1440175	Community Insurance Company		(266,200,000)			(911,412,383)				(1,177,612,383)	
	39-1462554	Compcare Health Services Insurance Corporation		(10,000,000)			(92,054,648)				(102,054,648)	
	01-0822645	DeCare Dental, LLC					(45,567,014)				(45,567,014)	
55093	23-7391136	Empire HealthChoice Assurance, Inc.		(250,000,000)			(528,256,823)				(778,256,823)	
95433	13-3874803	Empire HealthChoice HMO, Inc.					(122,558,319)				(122,558,319)	
	95-2907752	Golden West Health Plan, Inc.					(790,279)				(790,279)	
97217	58-1473042	Greater Georgia Life Insurance Company					(7,681,353)				(7,681,353)	
	51-0365660	Health Core, Inc.					(21,346,159)				(21,346,159)	
95169	54-1356687	HealthKeepers, Inc.		(35,000,000)	15,000,000		(388,403,745)	(10,369,959)			(418,773,704)	4,585,268
96475	43-1616135	HealthLink HMO, Inc.		(10,000,000)			5,219,475				(4,780,525)	
	43-1364135	HealthLink, Inc.					(60,489,216)				(60,489,216)	
	13-3865627	HealthPlus LLC					(300,587,736)				(300,587,736)	
78972	86-0257201	Healthy Alliance Life Insurance Company		(105,200,000)			(294,007,288)				(399,207,288)	
95473	84-1017384	HMO Colorado, Inc.			15,000,000		(40,662,843)				(25,662,843)	
95358	37-1216698	HMO Missouri, Inc.		(800,000)			(18,848,458)				(19,648,458)	
	98-0408753	HTH Re, LTD						983,470			983,470	(1,511,335)
95527	02-0494919	Matthew Thornton Health Plan, Inc.		(30,000,000)			(75,499,873)				(105,499,873)	
	35-1840597	National Government Services, Inc.					(20,169,845)				(20,169,845)	
	47-0851593	RightCHOICE Managed Care, Inc.					(22,510,682)				(22,510,682)	
11011	84-0747736	Rocky Mountain Hospital and Medical Service, Inc.		(78,100,000)	(15,000,000)		(257,720,740)				(350,820,740)	
13726	27-0945036	Simply Healthcare Plans, Inc.					(140,514,747)				(140,514,747)	
	45-5443372	The Anthem Companies of California, Inc.					146,341,009				146,341,009	
	35-1835818	The Anthem Companies, Inc.					4,887,345,537				4,887,345,537	
11810	84-1620480	UNICARE Health Plan of West Virginia, Inc.					(43,128,585)				(43,128,585)	
80314	52-0913817	UNICARE Life & Health Insurance Company		(50,000,000)			(48,109,062)	(28,867,910)			(126,976,972)	24,723,771
	45-2736438	WellPoint Information Technology Services					349,756,226				349,756,226	
	47-2546820	WellPoint Military Care Corporation					(7,365,246)				(7,365,246)	
15929	47-5569628	Wisconsin Collaborative Insurance Company			5,000,000		(3,923,953)				1,076,047	
9999999 Control Totals			0	0	0	0	0	0	XXX	0	0	0

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

	Responses
MARCH FILING	
1. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?	SEE EXPLANATION
2. Will an actuarial opinion be filed by March 1?	YES
3. Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?	YES
4. Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1?	YES
APRIL FILING	
5. Will Management's Discussion and Analysis be filed by April 1?	YES
6. Will the Supplemental Investment Risks Interrogatories be filed by April 1?	YES
7. Will the Accident and Health Policy Experience Exhibit be filed by April 1?	YES
JUNE FILING	
8. Will an audited financial report be filed by June 1?	YES
9. Will Accountant's Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?	YES
AUGUST FILING	
10. Will the regulator-only (non-public) Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile and electronically with the NAIC (as a regulator-only non-public document) by August 1?	YES
The following supplemental reports are required to be filed as part of your annual statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.	
MARCH FILING	
11. Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?	NO
12. Will the Supplemental Life data due March 1 be filed with the state of domicile and the NAIC?	NO
13. Will the Supplemental Property/Casualty data due March 1 be filed with the state of domicile and the NAIC?	NO
14. Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1?	NO
15. Will the actuarial opinion on participating and non-participating policies as required in Interrogatories 1 and 2 on Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
16. Will the actuarial opinion on non-guaranteed elements as required in Interrogatory 3 to Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
17. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?	NO
18. Will an approval from the reporting entity's state of domicile for relief related to the five-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1?	NO
19. Will an approval from the reporting entity's state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1?	NO
20. Will an approval from the reporting entity's state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?	NO
APRIL FILING	
21. Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?	NO
22. Will the Supplemental Life data due April 1 be filed with the state of domicile and the NAIC?	NO
23. Will the Supplemental Property/Casualty Insurance Expense Exhibit due April 1 be filed with any state that requires it, and, if so, the NAIC?	NO
24. Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?	NO
25. Will the regulator only (non-public) Supplemental Health Care Exhibit's Expense Allocation Report be filed with the state of domicile and the NAIC by April 1?	NO
AUGUST FILING	
26. Will Management's Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?	YES
Explanations:	
1. The annual filing for Florida isn't due until April 1, 2017.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	
21.	
22.	
23.	
24. No contract in 2016	
25. No contract in 2016	
Bar Codes:	
11. Medicare Supplement Insurance Experience Exhibit [Document Identifier 360]	
12. Life Supplement [Document Identifier 205]	
13. Property/Casualty Supplement [Document Identifier 207]	
14. SIS Stockholder Information Supplement [Document Identifier 420]	
15. Participating Opinion for Exhibit 5 [Document Identifier 371]	
16. Non-Guaranteed Opinion for Exhibit 5 [Document Identifier 370]	
17. Medicare Part D Coverage Supplement [Document Identifier 365]	
18. Relief from the five-year rotation requirement for lead audit partner [Document Identifier 224]	

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

19. Relief from the one-year cooling off period for independent CPA
[Document Identifier 225]



20. Relief from the Requirements for Audit Committees [Document Identifier 226]



21. Long-Term Care Experience Reporting Forms [Document Identifier 306]



22. Life Supplement [Document Identifier 211]



23. Property/Casualty Supplement Insurance Expense Exhibit
[Document Identifier 213]



24. Supplemental Health Care Exhibit (Parts 1, 2 and 3) [Document Identifier 216]



25. Supplemental Health Care Exhibit's Expense Allocation Report
[Document Identifier 217]



ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

OVERFLOW PAGE FOR WRITE-INS

Additional Write-ins for Assets Line 11

	Current Year			Prior Year
	1	2	3	4
	Assets	Nonadmitted Assets	Net Admitted Assets (Cols. 1 - 2)	Net Admitted Assets
1104.			0	
1197. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0

Additional Write-ins for Assets Line 25

	Current Year			Prior Year
	1	2	3	4
	Assets	Nonadmitted Assets	Net Admitted Assets (Cols. 1 - 2)	Net Admitted Assets
2504. Tenant Improvement Allowance	155,220	155,220	0	0
2505.	0	0	0	0
2597. Summary of remaining write-ins for Line 25 from overflow page	155,220	155,220	0	0

Additional Write-ins for Liabilities Line 23

	Current Year			Prior Year
	1	2	3	4
	Covered	Uncovered	Total	Total
2304.			0	0
2305.			0	0
2397. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	0

Additional Write-ins for Underwriting and Investment Exhibit Part 3 Line 25

	Claim Adjustment Expenses		3	4	5
	1	2			
	Cost Containment Expenses	Other Claim Adjustment Expenses	General Administrative Expenses	Investment Expenses	Total
2504. Miscellaneous	6,393	0	707,899	18,033	732,325
2597. Summary of remaining write-ins for Line 25 from overflow page	6,393	0	707,899	18,033	732,325

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

OVERFLOW PAGE FOR WRITE-INS

Additional Write-ins for Analysis of Operations Line 13

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1304.	0									XXX
1397. Summary of remaining write-ins for Line 13 from overflow page	0	0	0	0	0	0	0	0	0	XXX

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SUMMARY INVESTMENT SCHEDULE

Investment Categories	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
	1 Amount	2 Percentage	3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage
1. Bonds:						
1.1 U.S. treasury securities	30,460,374	15.376	30,460,374	0	30,460,374	15.376
1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
1.21 Issued by U.S. government agencies		0.000			0	0.000
1.22 Issued by U.S. government sponsored agencies		0.000			0	0.000
1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)		0.000			0	0.000
1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S. :						
1.41 States, territories and possessions general obligations	6,580,084	3.321	6,580,084	0	6,580,084	3.321
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	7,094,848	3.581	7,094,848	0	7,094,848	3.581
1.43 Revenue and assessment obligations	18,193,181	9.183	18,193,181	0	18,193,181	9.183
1.44 Industrial development and similar obligations		0.000			0	0.000
1.5 Mortgage-backed securities (includes residential and commercial MBS):						
1.51 Pass-through securities:						
1.511 Issued or guaranteed by GNMA	3,792,337	1.914	3,792,337	0	3,792,337	1.914
1.512 Issued or guaranteed by FNMA and FHLMC	21,599,323	10.903	21,599,323	0	21,599,323	10.903
1.513 All other		0.000		883,992	883,992	0.446
1.52 CMOs and REMICs:						
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	904,433	0.457	904,433	0	904,433	0.457
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521		0.000			0	0.000
1.523 All other	6,244,728	3.152	6,244,728	0	6,244,728	3.152
2. Other debt and other fixed income securities (excluding short-term):						
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	51,410,413	25.951	51,410,413	64,307	51,474,720	25.983
2.2 Unaffiliated non-U.S. securities (including Canada)	754,849	0.381	754,849	0	754,849	0.381
2.3 Affiliated securities		0.000			0	0.000
3. Equity interests:						
3.1 Investments in mutual funds		0.000			0	0.000
3.2 Preferred stocks:						
3.21 Affiliated		0.000			0	0.000
3.22 Unaffiliated		0.000			0	0.000
3.3 Publicly traded equity securities (excluding preferred stocks):						
3.31 Affiliated		0.000			0	0.000
3.32 Unaffiliated		0.000			0	0.000
3.4 Other equity securities:						
3.41 Affiliated		0.000			0	0.000
3.42 Unaffiliated		0.000			0	0.000
3.5 Other equity interests including tangible personal property under lease:						
3.51 Affiliated		0.000			0	0.000
3.52 Unaffiliated		0.000			0	0.000
4. Mortgage loans:						
4.1 Construction and land development		0.000			0	0.000
4.2 Agricultural		0.000			0	0.000
4.3 Single family residential properties		0.000			0	0.000
4.4 Multifamily residential properties		0.000			0	0.000
4.5 Commercial loans		0.000			0	0.000
4.6 Mezzanine real estate loans		0.000			0	0.000
5. Real estate investments:						
5.1 Property occupied by company		0.000	0		0	0.000
5.2 Property held for production of income (including \$ of property acquired in satisfaction of debt)		0.000	0		0	0.000
5.3 Property held for sale (including \$ of property acquired in satisfaction of debt)		0.000	0		0	0.000
6. Contract loans		0.000	0		0	0.000
7. Derivatives		0.000	0		0	0.000
8. Receivables for securities		0.000	0		0	0.000
9. Securities Lending (Line 10, Asset Page reinvested collateral)	948,299	0.479	948,299	XXX	XXX	XXX
10. Cash, cash equivalents and short-term investments	50,126,351	25.302	50,126,351	0	50,126,351	25.302
11. Other invested assets		0.000			0	0.000
12. Total invested assets	198,109,220	100.000	198,109,220	948,299	198,109,220	100.000

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

Schedule A - Verification - Real Estate

NONE

Schedule B - Verification - Mortgage Loans

NONE

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.
SCHEDULE BA - VERIFICATION BETWEEN YEARS
Other Long-Term Invested Assets

1.	Book/adjusted carrying value, December 31 of prior year	
2.	Cost of acquired:	
2.1	Actual cost at time of acquisition (Part 2, Column 8)	
2.2	Additional investment made after acquisition (Part 2, Column 9)	
3.	Capitalized deferred interest and other:	
3.1	Totals, Part 1, Column 16	
3.2	Totals, Part 3, Column 12	
4.	Accrual of discount	
5.	Unrealized valuation increase (decrease):	
5.1	Totals, Part 1, Column 13	
5.2	Totals, Part 3, Column 9	
6.	Total gain (loss) on disposals, Part 3, Column 19	
7.	Deduct amounts received on disposals, Part 3, Column 1	
8.	Deduct amortization of premium and depreciation	
9.	Total foreign exchange change in book/adjusted carrying value:	
9.1	Totals, Part 1, Column 17	
9.2	Totals, Part 3, Column 14	
10.	Deduct current year's other than temporary impairment recognized:	
10.1	Totals, Part 1, Column 15	
10.2	Totals, Part 3, Column 11	
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	
12.	Deduct total nonadmitted amounts	
13.	Statement value at end of current period (Line 11 minus Line 12)	

NONE

SCHEDULE D - VERIFICATION BETWEEN YEARS
Bonds and Stocks

1.	Book/adjusted carrying value, December 31 of prior year	124,722,573
2.	Cost of bonds and stocks acquired, Part 3, Column 7	77,536,736
3.	Accrual of discount	14,654
4.	Unrealized valuation increase (decrease):	
4.1.	Part 1, Column 12	(40,423)
4.2.	Part 2, Section 1, Column 15	
4.3.	Part 2, Section 2, Column 13	
4.4.	Part 4, Column 11	(4,236,175)
		(4,276,598)
5.	Total gain (loss) on disposals, Part 4, Column 19	4,940,879
6.	Deduction consideration for bonds and stocks disposed of, Part 4, Column 7	54,612,637
7.	Deduct amortization of premium	1,291,037
8.	Total foreign exchange change in book/adjusted carrying value:	
8.1.	Part 1, Column 15	0
8.2.	Part 2, Section 1, Column 19	
8.3.	Part 2, Section 2, Column 16	
8.4.	Part 4, Column 15	0
		0
9.	Deduct current year's other than temporary impairment recognized:	
9.1.	Part 1, Column 14	0
9.2.	Part 2, Section 1, Column 17	
9.3.	Part 2, Section 2, Column 14	
9.4.	Part 4, Column 13	0
		0
10.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	147,034,570
11.	Deduct total nonadmitted amounts	0
12.	Statement value at end of current period (Line 10 minus Line 11)	147,034,570

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE D - SUMMARY BY COUNTRY

Long-Term Bonds and Stocks OWNED December 31 of Current Year

Description		1 Book/Adjusted Carrying Value	2 Fair Value	3 Actual Cost	4 Par Value of Bonds
BONDS Governments (Including all obligations guaranteed by governments)	1. United States	34,252,711	33,992,659	34,378,790	33,656,072
	2. Canada				
	3. Other Countries				
	4. Totals	34,252,711	33,992,659	34,378,790	33,656,072
U.S. States, Territories and Possessions (Direct and guaranteed)	5. Totals	6,580,084	6,752,115	6,970,954	6,325,000
U.S. Political Subdivisions of States, Territories and Possessions (Direct and guaranteed)	6. Totals	7,094,848	7,314,652	7,683,485	6,645,000
U.S. Special Revenue and Special Assessment Obligations and all Non-Guaranteed Obligations of Agencies and Authorities of Governments and their Political Subdivisions	7. Totals	40,696,937	41,191,902	41,622,425	37,829,180
Industrial and Miscellaneous, SVO Identified Funds and Hybrid Securities (unaffiliated)	8. United States	57,655,141	57,602,357	58,314,427	57,568,565
	9. Canada				
	10. Other Countries	754,849	759,364	754,630	755,000
	11. Totals	58,409,990	58,361,721	59,069,057	58,323,565
Parent, Subsidiaries and Affiliates	12. Totals				
	13. Total Bonds	147,034,570	147,613,049	149,724,711	142,778,817
PREFERRED STOCKS Industrial and Miscellaneous (unaffiliated)	14. United States				
	15. Canada				
	16. Other Countries				
	17. Totals	0	0	0	
Parent, Subsidiaries and Affiliates	18. Totals				
	19. Total Preferred Stocks	0	0	0	
COMMON STOCKS Industrial and Miscellaneous (unaffiliated)	20. United States				
	21. Canada				
	22. Other Countries				
	23. Totals	0	0	0	
Parent, Subsidiaries and Affiliates	24. Totals				
	25. Total Common Stocks	0	0	0	
	26. Total Stocks	0	0	0	
	27. Total Bonds and Stocks	147,034,570	147,613,049	149,724,711	

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1A - SECTION 1

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

1 NAIC Designation	2 1 Year or Less	3 Over 1 Year Through 5 Years	4 Over 5 Years Through 10 Years	5 Over 10 Years Through 20 Years	6 Over 20 Years	7 No Maturity Date	8 Total Current Year	9 Col. 7 as a % of Line 10.7	10 Total from Col. 6 Prior Year	11 % From Col. 7 Prior Year	12 Total Publicly Traded	13 Total Privately Placed (a)
1. U.S. Governments												
1.1 NAIC 1	36,851,301	31,913,454	861,431	671,133	243,001	XXX	70,540,320	38.5	3,761,564	2.5	70,540,320	0
1.2 NAIC 2						XXX	0	0.0		0.0		0
1.3 NAIC 3						XXX	0	0.0		0.0		0
1.4 NAIC 4						XXX	0	0.0		0.0		0
1.5 NAIC 5						XXX	0	0.0		0.0		0
1.6 NAIC 6						XXX	0	0.0		0.0		0
1.7 Totals	36,851,301	31,913,454	861,431	671,133	243,001	XXX	70,540,320	38.5	3,761,564	2.5	70,540,320	0
2. All Other Governments												
2.1 NAIC 1						XXX	0	0.0		0.0		0
2.2 NAIC 2						XXX	0	0.0		0.0		0
2.3 NAIC 3						XXX	0	0.0		0.0		0
2.4 NAIC 4						XXX	0	0.0		0.0		0
2.5 NAIC 5						XXX	0	0.0		0.0		0
2.6 NAIC 6						XXX	0	0.0		0.0		0
2.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3. U.S. States, Territories and Possessions etc., Guaranteed												
3.1 NAIC 1	2,240,259	1,355,566	2,984,259	0	0	XXX	6,580,084	3.6	6,664,799	4.4	6,580,084	0
3.2 NAIC 2						XXX	0	0.0		0.0		0
3.3 NAIC 3						XXX	0	0.0		0.0		0
3.4 NAIC 4						XXX	0	0.0		0.0		0
3.5 NAIC 5						XXX	0	0.0		0.0		0
3.6 NAIC 6						XXX	0	0.0		0.0		0
3.7 Totals	2,240,259	1,355,566	2,984,259	0	0	XXX	6,580,084	3.6	6,664,799	4.4	6,580,084	0
4. U.S. Political Subdivisions of States, Territories and Possessions , Guaranteed												
4.1 NAIC 1	1,691,238	4,224,887	1,178,723	0	0	XXX	7,094,848	3.9	7,235,647	4.8	7,094,848	0
4.2 NAIC 2						XXX	0	0.0		0.0		0
4.3 NAIC 3						XXX	0	0.0		0.0		0
4.4 NAIC 4						XXX	0	0.0		0.0		0
4.5 NAIC 5						XXX	0	0.0		0.0		0
4.6 NAIC 6						XXX	0	0.0		0.0		0
4.7 Totals	1,691,238	4,224,887	1,178,723	0	0	XXX	7,094,848	3.9	7,235,647	4.8	7,094,848	0
5. U.S. Special Revenue & Special Assessment Obligations, etc., Non-Guaranteed												
5.1 NAIC 1	3,911,038	9,609,761	20,815,646	4,055,096	2,305,396	XXX	40,696,937	22.2	36,104,135	24.0	40,696,937	0
5.2 NAIC 2						XXX	0	0.0		0.0		0
5.3 NAIC 3						XXX	0	0.0		0.0		0
5.4 NAIC 4						XXX	0	0.0		0.0		0
5.5 NAIC 5						XXX	0	0.0		0.0		0
5.6 NAIC 6						XXX	0	0.0		0.0		0
5.7 Totals	3,911,038	9,609,761	20,815,646	4,055,096	2,305,396	XXX	40,696,937	22.2	36,104,135	24.0	40,696,937	0

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 10.7	9 Total from Col. 6 Prior Year	10 % From Col. 7 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
6. Industrial & Miscellaneous (Unaffiliated)												
6.1 NAIC 1	6,223,785	24,164,528	1,596,657	0	0	XXX	31,984,970	17.4	71,605,954	47.7	25,452,202	6,532,768
6.2 NAIC 2	4,340,268	15,752,959	4,829,859	0	0	XXX	24,923,086	13.6	24,761,320	16.5	22,580,783	2,342,303
6.3 NAIC 3	0	1,120,534	0	0	0	XXX	1,120,534	0.6	0	0.0	1,120,534	0
6.4 NAIC 4	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
6.5 NAIC 5	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
6.6 NAIC 6	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
6.7 Totals	10,564,053	41,038,021	6,426,516	0	0	XXX	58,028,590	31.7	96,367,274	64.2	49,153,519	8,875,071
7. Hybrid Securities												
7.1 NAIC 1	381,400	0	0	0	0	XXX	381,400	0.2	0	0.0	381,400	0
7.2 NAIC 2	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7.3 NAIC 3	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7.4 NAIC 4	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7.5 NAIC 5	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7.6 NAIC 6	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
7.7 Totals	381,400	0	0	0	0	XXX	381,400	0.2	0	0.0	381,400	0
8. Parent, Subsidiaries and Affiliates												
8.1 NAIC 1	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8.2 NAIC 2	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8.3 NAIC 3	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8.4 NAIC 4	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8.5 NAIC 5	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8.6 NAIC 6	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
8.7 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
9. SVO Identified Funds												
9.1 NAIC 1	XXX	XXX	XXX	XXX	XXX	XXX	0	0.0	XXX	XXX	0	0
9.2 NAIC 2	XXX	XXX	XXX	XXX	XXX	XXX	0	0.0	XXX	XXX	0	0
9.3 NAIC 3	XXX	XXX	XXX	XXX	XXX	XXX	0	0.0	XXX	XXX	0	0
9.4 NAIC 4	XXX	XXX	XXX	XXX	XXX	XXX	0	0.0	XXX	XXX	0	0
9.5 NAIC 5	XXX	XXX	XXX	XXX	XXX	XXX	0	0.0	XXX	XXX	0	0
9.6 NAIC 6	XXX	XXX	XXX	XXX	XXX	XXX	0	0.0	XXX	XXX	0	0
9.7 Totals	XXX	XXX	XXX	XXX	XXX	0	0	0.0	XXX	XXX	0	0

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 10.7	9 Total from Col. 6 Prior Year	10 % From Col. 7 Prior Year	11 Total Publicly Traded	12 Total Privately Placed (a)
10. Total Bonds Current Year												
10.1 NAIC 1	(d) 51,299,021	71,268,196	27,436,716	4,726,229	2,548,397	0	157,278,559	85.8	XXX	XXX	150,745,791	6,532,768
10.2 NAIC 2	(d) 4,340,268	15,752,959	4,829,859	0	0	0	24,923,086	13.6	XXX	XXX	22,580,783	2,342,303
10.3 NAIC 3	(d) 0	1,120,534	0	0	0	0	1,120,534	0.6	XXX	XXX	1,120,534	0
10.4 NAIC 4	(d) 0	0	0	0	0	0	0	0.0	XXX	XXX	0	0
10.5 NAIC 5	(d) 0	0	0	0	0	0	0	0.0	XXX	XXX	0	0
10.6 NAIC 6	(d) 0	0	0	0	0	0	0	0.0	XXX	XXX	0	0
10.7 Totals	55,639,289	88,141,689	32,266,575	4,726,229	2,548,397	0	183,322,179	100.0	XXX	XXX	174,447,108	8,875,071
10.8 Line 10.7 as a % of Col. 7	30.4	48.1	17.6	2.6	1.4	0.0	100.0	XXX	XXX	XXX	95.2	4.8
11. Total Bonds Prior Year												
11.1 NAIC 1	53,186,244	36,809,860	30,194,830	3,803,684	1,377,481	XXX	XXX	XXX	125,372,099	83.5	124,532,198	839,901
11.2 NAIC 2	1,515,838	19,289,201	3,956,281	0	0	XXX	XXX	XXX	24,761,320	16.5	21,722,582	3,038,738
11.3 NAIC 3						XXX	XXX	XXX	0	0.0	0	0
11.4 NAIC 4						XXX	XXX	XXX	0	0.0	0	0
11.5 NAIC 5						XXX	XXX	XXX	0	0.0	0	0
11.6 NAIC 6						XXX	XXX	XXX	0	0.0	0	0
11.7 Totals	54,702,082	56,099,061	34,151,111	3,803,684	1,377,481	XXX	XXX	XXX	150,133,419	100.0	146,254,780	3,878,639
11.8 Line 11.7 as a % of Col. 9	36.4	37.4	22.7	2.5	0.9	XXX	XXX	XXX	100.0	XXX	97.4	2.6
12. Total Publicly Traded Bonds												
12.1 NAIC 1	51,299,021	64,735,428	27,436,716	4,726,229	2,548,397	0	150,745,791	82.2	124,532,198	82.9	150,745,791	XXX
12.2 NAIC 2	4,327,456	14,173,466	4,079,861	0	0	0	22,580,783	12.3	21,722,582	14.5	22,580,783	XXX
12.3 NAIC 3	0	1,120,534	0	0	0	0	1,120,534	0.6	0	0.0	1,120,534	XXX
12.4 NAIC 4							0	0.0	0	0.0	0	XXX
12.5 NAIC 5							0	0.0	0	0.0	0	XXX
12.6 NAIC 6							0	0.0	0	0.0	0	XXX
12.7 Totals	55,626,477	80,029,428	31,516,577	4,726,229	2,548,397	0	174,447,108	95.2	146,254,780	97.4	174,447,108	XXX
12.8 Line 12.7 as a % of Col. 7	31.9	45.9	18.1	2.7	1.5	0.0	100.0	XXX	XXX	XXX	100.0	XXX
12.9 Line 12.7 as a % of Line 10.7, Col. 7, Section 10	30.3	43.7	17.2	2.6	1.4	0.0	95.2	XXX	XXX	XXX	95.2	XXX
13. Total Privately Placed Bonds												
13.1 NAIC 1	0	6,532,768	0	0	0	0	6,532,768	3.6	839,901	0.6	XXX	6,532,768
13.2 NAIC 2	12,812	1,579,493	749,998	0	0	0	2,342,303	1.3	3,038,738	2.0	XXX	2,342,303
13.3 NAIC 3	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
13.4 NAIC 4	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
13.5 NAIC 5	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
13.6 NAIC 6	0	0	0	0	0	0	0	0.0	0	0.0	XXX	0
13.7 Totals	12,812	8,112,261	749,998	0	0	0	8,875,071	4.8	3,878,639	2.6	XXX	8,875,071
13.8 Line 13.7 as a % of Col. 7	0.1	91.4	8.5	0.0	0.0	0.0	100.0	XXX	XXX	XXX	XXX	100.0
13.9 Line 13.7 as a % of Line 10.7, Col. 7, Section 10	0.0	4.4	0.4	0.0	0.0	0.0	4.8	XXX	XXX	XXX	XXX	4.8

(a) Includes \$ 8,135,176 freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A.

(b) Includes \$ current year, \$ prior year of bonds with Z designations and \$ current year \$ prior year of bonds with Z* designations. The letter "Z" means the NAIC designation was not assigned by the Securities Valuation Office (SVO) at the date of the statement. "Z*" means the SVO could not evaluate the obligation because valuation procedures for the security class are under regulatory review.

(c) Includes \$ current year, \$ prior year of bonds with 5* designations and \$ current year \$ prior year of bonds with 6* designations. "5*" means the NAIC designation was assigned by the (SVO) in reliance on the insurer's certification that the issuer is current in all principal and interest payments. "6*" means the NAIC designation was assigned by the SVO due to inadequate certification of principal and interest payments.

(d) Includes the following amount of short-term and cash equivalent bonds by NAIC designation: NAIC 1 \$ 36,287,609 ; NAIC 2 \$ 0 ; NAIC 3 \$ 0 ; NAIC 4 \$ 0 ; NAIC 5 \$ 0 ; NAIC 6 \$ 0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1A - SECTION 2

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 10.6	9 Total from Col. 6 Prior Year	10 % From Col. 7 Prior Year	11 Total Publicly Traded	12 Total Privately Placed
1. U.S. Governments												
1.1 Issuer Obligations	36,287,609	30,460,374	0	0	0	XXX	66,747,983	36.4	300,006	0.2	66,747,983	0
1.2 Residential Mortgage-Backed Securities	563,692	1,453,080	861,431	671,133	243,001	XXX	3,792,337	2.1	3,461,558	2.3	3,792,337	0
1.3 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
1.4 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
1.5 Totals	36,851,301	31,913,454	861,431	671,133	243,001	XXX	70,540,320	38.5	3,761,564	2.5	70,540,320	0
2. All Other Governments												
2.1 Issuer Obligations						XXX	0	0.0		0.0		0
2.2 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
2.3 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
2.4 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
2.5 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0
3. U.S. States, Territories and Possessions, Guaranteed												
3.1 Issuer Obligations	2,240,259	1,355,566	2,984,259	0	0	XXX	6,580,084	3.6	6,664,799	4.4	6,580,084	0
3.2 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
3.3 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
3.4 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
3.5 Totals	2,240,259	1,355,566	2,984,259	0	0	XXX	6,580,084	3.6	6,664,799	4.4	6,580,084	0
4. U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed												
4.1 Issuer Obligations	1,691,238	4,224,887	1,178,723	0	0	XXX	7,094,848	3.9	7,235,647	4.8	7,094,848	0
4.2 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
4.3 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
4.4 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
4.5 Totals	1,691,238	4,224,887	1,178,723	0	0	XXX	7,094,848	3.9	7,235,647	4.8	7,094,848	0
5. U.S. Special Revenue & Special Assessment Obligations etc., Non-Guaranteed												
5.1 Issuer Obligations	834,443	1,494,253	15,864,485	0	0	XXX	18,193,181	9.9	17,231,853	11.5	18,193,181	0
5.2 Residential Mortgage-Backed Securities	3,076,595	8,115,508	4,951,161	4,055,096	2,305,396	XXX	22,503,756	12.3	18,872,282	12.6	22,503,756	0
5.3 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
5.4 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
5.5 Totals	3,911,038	9,609,761	20,815,646	4,055,096	2,305,396	XXX	40,696,937	22.2	36,104,135	24.0	40,696,937	0
6. Industrial and Miscellaneous												
6.1 Issuer Obligations	7,808,387	35,702,911	5,382,836	0	0	XXX	48,894,134	26.7	89,282,593	59.5	42,470,847	6,423,287
6.2 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
6.3 Commercial Mortgage-Backed Securities	2,755,666	2,445,382	1,043,680	0	0	XXX	6,244,728	3.4	6,804,734	4.5	5,642,728	602,000
6.4 Other Loan-Backed and Structured Securities	0	2,889,728	0	0	0	XXX	2,889,728	1.6	279,947	0.2	1,039,944	1,849,784
6.5 Totals	10,564,053	41,038,021	6,426,516	0	0	XXX	58,028,590	31.7	96,367,274	64.2	49,153,519	8,875,071
7. Hybrid Securities												
7.1 Issuer Obligations	381,400	0	0	0	0	XXX	381,400	0.2		0.0	381,400	0
7.2 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
7.3 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
7.4 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
7.5 Totals	381,400	0	0	0	0	XXX	381,400	0.2	0	0.0	381,400	0
8. Parent, Subsidiaries and Affiliates												
8.1 Issuer Obligations						XXX	0	0.0		0.0		0
8.2 Residential Mortgage-Backed Securities						XXX	0	0.0		0.0		0
8.3 Commercial Mortgage-Backed Securities						XXX	0	0.0		0.0		0
8.4 Other Loan-Backed and Structured Securities						XXX	0	0.0		0.0		0
8.5 Totals	0	0	0	0	0	XXX	0	0.0	0	0.0	0	0

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1A - SECTION 2 (Continued)

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 No Maturity Date	7 Total Current Year	8 Col. 7 as a % of Line 10.6	9 Total from Col. 6 Prior Year	10 % From Col. 7 Prior Year	11 Total Publicly Traded	12 Total Privately Placed
9. SVO Identified Funds												
9.1 Exchange Traded Funds Identified by the SVO	XXX	XXX	XXX	XXX	XXX		0	0.0	XXX	XXX		0
9.2 Bond Mutual Funds Identified by the SVO	XXX	XXX	XXX	XXX	XXX		0	0.0	XXX	XXX		0
9.3 Totals	XXX	XXX	XXX	XXX	XXX	0	0	0.0	XXX	XXX	0	0
10. Total Bonds Current Year												
10.1 Issuer Obligations	49,243,336	73,237,991	25,410,303	0	0	XXX	147,891,630	80.7	XXX	XXX	141,468,343	6,423,287
10.2 Residential Mortgage-Backed Securities	3,640,287	9,568,588	5,812,592	4,726,229	2,548,397	XXX	26,296,093	14.3	XXX	XXX	26,296,093	0
10.3 Commercial Mortgage-Backed Securities	2,755,666	2,445,382	1,043,680	0	0	XXX	6,244,728	3.4	XXX	XXX	5,642,728	802,000
10.4 Other Loan-Backed and Structured Securities	0	2,889,728	0	0	0	XXX	2,889,728	1.6	XXX	XXX	1,039,944	1,849,784
10.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX	0	0	0.0	XXX	XXX	0	0
10.6 Totals	55,639,289	88,141,689	32,266,575	4,726,229	2,548,397	0	183,322,179	100.0	XXX	XXX	174,447,108	8,875,071
10.7 Line 10.6 as a % of Col. 7	30.4	48.1	17.6	2.6	1.4	0.0	100.0	XXX	XXX	XXX	95.2	4.8
11. Total Bonds Prior Year												
11.1 Issuer Obligations	48,827,046	44,393,509	27,494,343	0	0	XXX	XXX	XXX	120,714,898	80.4	116,836,259	3,878,639
11.2 Residential Mortgage-Backed Securities	3,224,904	8,598,512	5,329,259	3,803,684	1,377,481	XXX	XXX	XXX	22,333,840	14.9	22,333,840	0
11.3 Commercial Mortgage-Backed Securities	2,650,132	2,827,093	1,327,509	0	0	XXX	XXX	XXX	6,804,734	4.5	6,804,734	0
11.4 Other Loan-Backed and Structured Securities	0	279,947	0	0	0	XXX	XXX	XXX	279,947	0.2	279,947	0
11.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
11.6 Totals	54,702,082	56,099,061	34,151,111	3,803,684	1,377,481	XXX	XXX	XXX	150,133,419	100.0	146,254,780	3,878,639
11.7 Line 11.6 as a % of Col. 9	36.4	37.4	22.7	2.5	0.9	XXX	XXX	XXX	100.0	XXX	97.4	2.6
12. Total Publicly Traded Bonds												
12.1 Issuer Obligations	49,230,524	67,577,514	24,660,305	0	0	XXX	141,468,343	77.2	116,836,259	77.8	141,468,343	XXX
12.2 Residential Mortgage-Backed Securities	3,640,287	9,568,588	5,812,592	4,726,229	2,548,397	XXX	26,296,093	14.3	22,333,840	14.9	26,296,093	XXX
12.3 Commercial Mortgage-Backed Securities	2,755,666	1,843,382	1,043,680	0	0	XXX	5,642,728	3.1	6,804,734	4.5	5,642,728	XXX
12.4 Other Loan-Backed and Structured Securities	0	1,039,944	0	0	0	XXX	1,039,944	0.6	279,947	0.2	1,039,944	XXX
12.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX	0	0	0.0	XXX	XXX	0	XXX
12.6 Totals	55,626,477	80,029,428	31,516,577	4,726,229	2,548,397	0	174,447,108	95.2	146,254,780	97.4	174,447,108	XXX
12.7 Line 12.6 as a % of Col. 7	31.9	45.9	18.1	2.7	1.5	0.0	100.0	XXX	XXX	XXX	100.0	XXX
12.8 Line 12.6 as a % of Line 10.6, Col. 7, Section 10	30.3	43.7	17.2	2.6	1.4	0.0	95.2	XXX	XXX	XXX	95.2	XXX
13. Total Privately Placed Bonds												
13.1 Issuer Obligations	12,812	5,660,477	749,998	0	0	XXX	6,423,287	3.5	3,878,639	2.6	XXX	6,423,287
13.2 Residential Mortgage-Backed Securities	0	0	0	0	0	XXX	0	0.0	0	0.0	XXX	0
13.3 Commercial Mortgage-Backed Securities	0	802,000	0	0	0	XXX	802,000	0.3	0	0.0	XXX	802,000
13.4 Other Loan-Backed and Structured Securities	0	1,849,784	0	0	0	XXX	1,849,784	1.0	0	0.0	XXX	1,849,784
13.5 SVO Identified Funds	XXX	XXX	XXX	XXX	XXX	0	0	0.0	XXX	XXX	XXX	0
13.6 Totals	12,812	8,112,261	749,998	0	0	0	8,875,071	4.8	3,878,639	2.6	XXX	8,875,071
13.7 Line 13.6 as a % of Col. 7	0.1	91.4	8.5	0.0	0.0	0.0	100.0	XXX	XXX	XXX	XXX	100.0
13.8 Line 13.6 as a % of Line 10.6, Col. 7, Section 10	0.0	4.4	0.4	0.0	0.0	0.0	4.8	XXX	XXX	XXX	XXX	4.8

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.
SCHEDULE DA - VERIFICATION BETWEEN YEARS

Short-Term Investments

	1	2	3	4	5
	Total	Bonds	Mortgage Loans	Other Short-term Investment Assets (a)	Investments in Parent, Subsidiaries and Affiliates
1. Book/adjusted carrying value, December 31 of prior year	39,236,887	39,236,887	0	0	0
2. Cost of short-term investments acquired	113,347,193	50,462,398	0	62,884,795	0
3. Accrual of discount	0				
4. Unrealized valuation increase (decrease)	0				
5. Total gain (loss) on disposals	6,823	0	0	6,823	0
6. Deduct consideration received on disposals	116,303,294	16,219,039	0	100,084,255	0
7. Deduct amortization of premium	0				
8. Total foreign exchange change in book/adjusted carrying value	0				
9. Deduct current year's other than temporary impairment recognized	0				
10. Book adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	36,287,609	73,480,246	0	(37,192,637)	0
11. Deduct total nonadmitted amounts	0				
12. Statement value at end of current period (Line 10 minus Line 11)	36,287,609	73,480,246	0	(37,192,637)	0

(a) Indicate the category of such assets, for example, joint ventures, transportation equipment:

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

Schedule DB - Part A - Verification - Options, Caps, Floors, Collars, Swaps and Forwards

NONE

Schedule DB - Part B - Verification - Futures Contracts

NONE

Schedule DB - Part C - Section 1 - Replication (Synthetic Asset) Transactions (RSATs) Open

NONE

Schedule DB-Part C-Section 2-Reconciliation of Replication (Synthetic Asset) Transactions Open

NONE

Schedule DB - Verification - Book/Adjusted Carrying Value, Fair Value and Potential Exposure of
Derivatives

NONE

Schedule E - Verification - Cash Equivalents

NONE

Schedule A - Part 1 - Real Estate Owned

NONE

Schedule A - Part 2 - Real Estate Acquired and Additions Made

NONE

Schedule A - Part 3 - Real Estate Disposed

NONE

Schedule B - Part 1 - Mortgage Loans Owned

NONE

Schedule B - Part 2 - Mortgage Loans Acquired and Additions Made

NONE

Schedule B - Part 3 - Mortgage Loans Disposed, Transferred or Repaid

NONE

Schedule BA - Part 1 - Other Long-Term Invested Assets Owned

NONE

Schedule BA - Part 2 - Other Long-Term Invested Assets Acquired and Additions Made

NONE

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

Schedule BA - Part 3 - Other Long-Term Invested Assets Disposed, Transferred or Repaid

NONE

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book/Adjusted Carrying Value				Interest					Dates	
		3	4	5			8	9			12	13	14	15 Total Foreign Exchange Change in Book/ Adjusted Carrying Value	16	17	18	19	20	21	22
CUSIP Identification	Description	C o d e	F o r e i g n	Bond Char	NAIC Des.	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor- tization) Accretion	Current Year's Other- Than- Temporary Impairment Recognized		Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
92348H-AA-7	VERIZON OWNER TRUST SERIES 2016-24 CLASS A 144A			4	1FE	1,109,885	99.5970	1,105,527	1,110,000	1,109,888	0	4	0	0	1.680	1.689	MON	2,020	0	11/16/2016	05/20/2021
3599999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Other Loan-Backed and Structured Securities						2,889,702	XXX	2,875,577	2,890,000	2,889,728	0	20	0	0	XXX	XXX	XXX	3,099	16,162	XXX	XXX
3899999. Total - Industrial and Miscellaneous (Unaffiliated) Bonds						58,657,709	XXX	57,980,680	57,953,565	58,028,590	(40,423)	(145,038)	0	0	XXX	XXX	XXX	323,245	1,095,949	XXX	XXX
025816-AL-7	AMERICAN EXPRESS COMPANY				1FE	411,348	102.9840	381,041	370,000	381,400	0	(17,123)	0	0	5.150	1.428	FA	7,775	22,755	03/27/2015	08/28/2017
4299999. Subtotal - Bonds - Hybrid Securities - Issuer Obligations						411,348	XXX	381,041	370,000	381,400	0	(17,123)	0	0	XXX	XXX	XXX	7,775	22,755	XXX	XXX
4899999. Total - Hybrid Securities						411,348	XXX	381,041	370,000	381,400	0	(17,123)	0	0	XXX	XXX	XXX	7,775	22,755	XXX	XXX
5599999. Total - Parent, Subsidiaries and Affiliates Bonds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
6099999. Subtotal - SVO Identified Funds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
7799999. Total - Issuer Obligations						113,798,713	XXX	112,349,894	108,821,575	111,604,021	(40,423)	(687,681)	0	0	XXX	XXX	XXX	755,258	2,505,316	XXX	XXX
7899999. Total - Residential Mortgage-Backed Securities						26,371,395	XXX	26,083,739	24,900,252	26,296,093	0	(19,152)	0	0	XXX	XXX	XXX	79,350	745,983	XXX	XXX
7999999. Total - Commercial Mortgage-Backed Securities						6,664,901	XXX	6,303,839	6,166,990	6,244,728	0	(82,966)	0	0	XXX	XXX	XXX	18,804	252,142	XXX	XXX
8099999. Total - Other Loan-Backed and Structured Securities						2,889,702	XXX	2,875,577	2,890,000	2,889,728	0	20	0	0	XXX	XXX	XXX	3,099	16,162	XXX	XXX
8199999. Total - SVO Identified Funds						0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
8399999 - Total Bonds						149,724,711	XXX	147,613,049	142,778,817	147,034,570	(40,423)	(789,779)	0	0	XXX	XXX	XXX	856,511	3,519,603	XXX	XXX

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

Schedule D - Part 2 - Section 1 - Preferred Stocks Owned

NONE

Schedule D - Part 2 - Section 2 - Common Stocks Owned

NONE

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 3

Showing All Long-Term Bonds and Stocks ACQUIRED During Current Year

1	2	3	4	5	6	7	8	9
CUSIP Identification	Description	Foreign	Date Acquired	Name of Vendor	Number of Shares of Stock	Actual Cost	Par Value	Paid for Accrued Interest and Dividends
061736-01-7	OWA II POOL M3802 3.000% 07/20/46		11/22/2016	Deiva Securities		392,400	393,284	2,167
912828-02-3	US TREASURY N/B 1.625% 04/30/19		05/17/2016	Bank of New York Mellon		30,581,250	30,000,000	23,845
05999999 Subtotal - Bonds - U.S. Governments						31,963,650	30,963,284	26,012
31321-7L-7	FLHC POOL V82515 3.500% 06/01/46		07/26/2016	Citigroup Global Markets		1,021,153	965,059	938
313810-2D-2	FNMA POOL AS4371 3.500% 02/01/45		12/09/2016	Goldman Sachs & Co		3,466,725	3,377,537	3,940
3140EV-1B-0	FNMA POOL BC1509 3.000% 08/01/46		08/04/2016	Wachovia Securities		1,743,689	1,670,601	1,392
314123-2F-8	FNMA POOL 982389 4.500% 01/01/40		02/01/2016	Bank of America		814,295	747,274	934
682607-ED-4	MUNICIPAL ELEC AUTH GA SERIES B 5.000% 01/01/21		01/08/2016	Jefferies & Co		841,496	800,000	1,333
649904-FB-6	NEW YORK ST DORM AUTH SALES TA 5.000% 03/15/31		12/08/2016	Citigroup Global Markets		591,905	500,000	5,139
31999999 Subtotal - Bonds - U.S. Special Revenues						8,579,263	8,060,471	13,678
00206R-0R-1	AT&T INC 2.800% 02/17/21		01/29/2016	Bony/Banclays Capital Inc		399,292	400,000	0
002871-AU-3	ABBVIE INC 2.300% 05/14/21		05/09/2016	Bank of America		79,861	80,000	0
00912L-AT-1	AIR LEASE CORP 3.000% 09/15/23		09/09/2016	Various		690,732	700,000	1,015
02665H-BG-5	AMERICAN HONDA FINANCE SERIES MTN 1.700% 09/09/21		09/08/2016	Bank of America Securities		968,060	970,000	0
035242-AJ-5	AMELBER-BUSCH INVEY FIN 2.650% 02/01/21		01/13/2016	Bony/Banclays Capital Inc		1,076,520	1,080,000	0
060510-FI-2	BANK OF AMERICA CORP MTN SERIES L 3.500% 04/19/26		11/30/2016	Paribas		840,999	850,000	3,801
12505J-KD-5	CBL & ASSOCIATES LP 5.950% 12/15/26		12/06/2016	Wachovia Securities		512,538	520,000	0
161175-AJ-2	CHARTER COMM OPT LLC CAP SERIES III 3.579% 07/23/20		12/01/2016	Tax Free Exchange		205,000	205,000	2,609
161571-HC-1	CHASE ISSUANCE TRUST SERIES 2016-A2 CLASS A 1.370% 06/15/21		06/07/2016	J P Morgan		759,998	760,000	0
17275R-BB-6	CISCO SYSTEMS INC 1.400% 09/20/19		09/13/2016	Citigroup Global Markets		638,290	640,000	0
172867-AK-8	CITIGROUP INC 2.700% 03/30/21		06/02/2016	Citigroup Global Markets		822,747	620,000	3,209
20826F-AS-5	CONOCOPHILLIPS COMPANY 4.200% 03/15/21		03/03/2016	J P Morgan		364,818	365,000	0
233851-OK-8	DANIEL CHRYSLER FINANCE NA SE SERIES 144A 2.200% 10/30/21		10/26/2016	Citigroup Global Markets		1,249,650	1,250,000	0
25272K-AA-1	DIAMOND 1 FIN DIAMOND 2 SERIES 144A 3.480% 06/01/19		05/17/2016	J P Morgan		409,898	410,000	0
36251H-AA-0	GS MORTGAGE SECURITIES TRUST SERIES 206-1CE2 CLASS A 144A 2.465% 02/15/33		03/10/2016	Goldman Sachs & Co		602,000	602,000	0
381455-AJ-5	GOLDMAN SACHS GROUP INC 2.350% 11/15/21		11/18/2016	First Tennessee Capital		1,072,544	1,100,000	4,021
41283L-AQ-0	HARLEY-DAVIDSON FINANCIAL SERV SERIES 144A 2.250% 01/15/19		01/05/2016	J P Morgan		359,957	360,000	0
437076-BL-5	HOME DEPOT INC 2.000% 04/01/21		02/03/2016	J P Morgan		313,879	315,000	0
49446R-AP-4	KIMCO REALTY CORP 2.800% 10/01/26		08/09/2016	Bony/Banclays Capital Inc		287,590	290,000	0
49446R-AR-0	KIMCO REALTY CORP 2.700% 03/01/24		11/01/2016	Wachovia Securities		606,883	610,000	0
594918-BP-8	MICROSOFT CORP 1.550% 08/08/21		08/01/2016	MTSSUS63XX		469,496	480,000	0
60871R-KE-0	MILSON COORS BREWING CO 1.450% 07/15/19		06/28/2016	Bank of America		204,896	205,000	0
61746B-ED-4	MORGAN STANLEY SERIES MTN 2.625% 11/17/21		11/18/2016	Goldman Sachs & Co		1,634,226	1,650,000	722
654740-JL-3	NISSAN MOTOR ACCEPTANCE SERIES 144A 2.000% 03/08/19		03/02/2016	Bank of America		629,490	630,000	0
654740-AS-8	NISSAN MOTOR ACCEPTANCE SERIES 144A 1.900% 09/14/21		09/07/2016	Citigroup Global Markets		259,506	260,000	0
68389L-BL-8	ORACLE CORPORATION 2.400% 09/15/23		08/01/2016	Citigroup Global Markets		553,141	550,000	990
693304-AU-1	PECO ENERGY CO 1.700% 08/15/21		09/14/2016	Morgan Stanley		999,720	1,000,000	0
69333R-ED-4	PNC BANK NA SERIES MTN 2.150% 04/29/21		11/18/2016	Goldman Sachs & Co		594,072	600,000	860
69371R-M4-4	PACCAR FINANCIAL CORP SERIES MTN 1.650% 08/11/21		08/04/2016	Mitsubishi Securities		174,766	175,000	0
742718-EN-5	PROCTER AND GAMBLE CO 1.850% 02/02/21		01/28/2016	Citigroup Global Markets		84,984	85,000	0
742718-ED-8	PROCTER AND GAMBLE CO 1.700% 11/03/21		10/31/2016	Morgan Stanley		1,496,925	1,500,000	0
78355H-KC-2	RYDER SYSTEM INC SERIES MTN 2.250% 09/01/21		11/01/2016	Wizhu Securities		207,569	208,000	0
843646-AJ-9	SOUTHERN POWER CO SERIES D 1.950% 12/15/19		11/10/2016	Wizhu Securities		386,900	400,000	0
85208H-AJ-8	SPRINT SPECTRUM SPEC 1 SERIES A-1 3.360% 09/20/21		10/20/2016	Goldman Sachs & Co		204,997	205,000	0
855244-AJ-8	STARBUCKS CORP 2.100% 02/04/21		02/01/2016	Goldman Sachs & Co		264,849	265,000	0
92343V-DG-6	VERIZON COMMUNICATIONS SERIES 1.750% 08/15/21		07/27/2016	Goldman Sachs & Co		273,801	275,000	0
923471-AA-4	VERIZON OWNER TRUST SERIES 16-1A CLASS A 144A 1.420% 01/20/21		07/12/2016	Bank of America		736,875	740,000	0
92348L-AA-7	VERIZON OWNER TRUST SERIES 2016-2A CLASS A 144A 1.680% 05/20/21		11/16/2016	Bank of America		1,159,879	1,110,000	0
38999999 Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						22,384,440	22,475,000	17,227
83999997 Total - Bonds - Part 3						62,527,353	61,498,755	56,915
83999998 Total - Bonds - Part 5						15,009,383	1,440,343	2,788
83999999 Total - Bonds						77,536,736	62,939,098	59,703
89999997 Total - Preferred Stocks - Part 3						0	XXX	0
89999998 Total - Preferred Stocks - Part 5						0	XXX	0
89999999 Total - Preferred Stocks						0	XXX	0
97999997 Total - Common Stocks - Part 3						0	XXX	0
97999998 Total - Common Stocks - Part 5						0	XXX	0
97999999 Total - Common Stocks						0	XXX	0
98999999 Total - Preferred and Common Stocks						0	XXX	0
99999999 Totals						77,536,736	XXX	59,703

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 4

Showing All Long-Term Bonds and Stocks SOLD, REDEEMED or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21
CUSIP Identification	Description	For- eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Con- sideration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	11 Unrealized Valuation Increase/ Decrease	12 Current Year's (Amor- tization)/ Accretion	13 Current Year's Other- Than- Temporary Impairment Recognized	14 Total Change in Book/ Adjusted Carrying Value (11+12-13)	15 Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Con- tractual Maturity Date
075887-BD-0	BECTION DICKINSON AND CO 1.800% 12/15/17		11/30/2016	Corporate Action		51,319		51,000	51,000	0	0	0	0	0	51,000	0	319	319	910	12/15/2017
097014-AN-4	BOEING CAPITAL CORP 2.125% 08/15/16		08/15/2016	Maturity		400,000	400,000	420,008	402,743	0	(2,743)	0	(2,743)	0	400,000	0	0	0	8,500	08/15/2016
097023-BE-4	BOEING CO 0.950% 05/15/18		11/22/2016	Wachovia Securities		169,045	170,000	168,128	169,104	0	340	0	340	0	169,444	0	(400)	(400)	1,673	05/15/2018
110122-AS-7	BRISTOL-MYERS SQUIBB CO 0.875% 08/01/17		11/01/2016	Goldman Sachs & Co		499,675	500,000	495,885	498,670	0	705	0	705	0	499,374	0	301	301	5,505	08/01/2017
161175-AK-0	CHARTER COMM OPT LLC SERIES 144A 3.575%		05/24/2016	Tax Free Exchange		205,000	205,000	205,000	205,000	0	0	0	0	0	205,000	0	0	0	6,135	07/23/2020
17275R-AK-8	CISCO SYSTEMS INC 3.150% 03/14/17		12/09/2016	BONY/TORONTO DOMINION		402,200	400,000	435,120	409,158	0	(7,224)	0	(7,224)	0	401,934	0	266	266	15,715	03/14/2017
194160-DI-5	COLGATE-PALMOLIVE CO SERIES MTN 1.300%		12/09/2016	Pershing		900,234	900,000	913,221	903,072	0	(2,808)	0	(2,808)	0	900,264	0	(30)	(30)	16,510	01/15/2017
24422E-FN-1	JOHN DEERE CAPITAL CORP SERIES MTN 1.400%		12/09/2016	BONY/TORONTO DOMINION		400,360	400,000	401,656	400,434	0	(341)	0	(341)	0	400,092	0	268	268	6,969	03/15/2017
25488P-CS-3	WALT DISNEY COMPANY SERIES MTN 1.125%		12/09/2016	BONY/TORONTO DOMINION		400,036	400,000	399,980	399,995	0	4	0	4	0	399,999	0	37	37	5,975	02/15/2017
30161W-AP-8	EXELON GENERATION CO LLC 2.950% 01/15/20		09/14/2016	Morgan Stanley		174,410	170,000	169,968	169,974	0	4	0	4	0	169,978	0	4,432	4,432	5,907	01/15/2020
378272-AD-0	GLENCORE FUNDING LLC SERIES 144A 2.500%		12/14/2016	Corporate Action		1,121,010	1,110,000	1,104,472	1,106,905	0	816	0	816	0	1,107,721	0	13,289	13,289	35,652	01/15/2019
38144L-AB-6	GOLDMAN SACH GROUP INC 6.250% 09/01/17		11/18/2016	Bony/Barclays Capital Inc Redemption		1,140,414	1,100,000	1,289,024	1,175,950	0	(40,461)	0	(40,461)	0	1,135,489	0	4,925	4,925	84,410	09/01/2017
384780-AA-0	GRAIN SPECTRUM FUNDING II SERIES 144A 3.250% 10/10/19		10/10/2016	100,000		6,212	6,212	6,212	6,212	0	0	0	0	0	6,212	0	0	0	153	10/10/2019
42809H-AE-7	HESS CORP 1.300% 06/15/17		10/28/2016	Call 100,4160		225,936	225,000	224,732	224,688	0	75	0	75	0	224,942	0	994	994	2,543	06/15/2017
438516-AS-5	HONEYWELL INTERNATIONAL INC 5.300%		03/15/17	Corporate Action		356,143	350,000	414,306	366,946	0	(11,689)	0	(11,689)	0	355,257	0	886	886	20,920	03/15/2017
458140-AH-3	INTEL CORP 1.950% 10/01/16		10/01/2016	Maturity		400,000	400,000	415,172	402,720	0	(2,720)	0	(2,720)	0	400,000	0	0	0	7,800	10/01/2016
458200-HC-8	IBM CORP 1.250% 02/06/17		12/09/2016	BONY/TORONTO DOMINION		300,147	300,000	300,012	300,003	0	(3)	0	(3)	0	300,000	0	147	147	5,073	02/06/2017
46629H-JA-9	J.P. MORGAN CHASE & CO 3.150% 07/05/16		07/05/2016	Maturity		2,020,000	2,020,000	2,125,598	2,037,288	0	(17,288)	0	(17,288)	0	2,020,000	0	0	0	53,630	07/05/2016
50177A-AS-8	US COMMERCIAL CONDUIT MORTGAGE SERIES 2007-3 CLASS AAB 5.517% 07/15/44		12/15/2016	Paydown		243,115	243,115	278,709	252,215	0	(9,099)	0	(9,099)	0	243,115	0	0	0	5,794	07/15/2044
548661-CS-4	LOWE'S COMPANIES 2.125% 04/15/16		04/15/2016	Maturity		315,000	315,000	326,646	315,662	0	(662)	0	(662)	0	315,000	0	0	0	3,347	04/15/2016
589331-AD-7	MERCK & CO, INC 0.700% 05/18/16		03/02/2016	Pershing		1,050,368	1,050,000	1,049,717	1,049,964	0	18	0	18	0	1,049,981	0	386	386	2,225	05/18/2016
617446-H5-1	MORGAN STANLEY MTN 5.550% 04/27/17		11/18/2016	Citigroup Global Markets		1,679,601	1,650,000	1,861,052	1,723,289	0	(49,361)	0	(49,361)	0	1,673,928	0	5,673	5,673	98,189	04/27/2017
637432-MN-2	NATIONAL RURAL UTILITIES 3.050% 03/01/16		02/16/2016	Call 100,1110		350,389	350,000	374,147	351,115	0	(836)	0	(836)	0	350,279	0	110	110	4,893	03/01/2016
674599-BZ-7	OCCIDENTAL PETROLEUM CORP 2.500% 02/01/16		02/01/2016	Maturity		400,000	400,000	424,104	400,599	0	(599)	0	(599)	0	400,000	0	0	0	5,000	02/01/2016
683476-BM-4	PNC FUNDING CORP 2.700% 09/19/16		08/22/2016	Call 100,0000		400,000	400,000	416,138	402,542	0	(2,542)	0	(2,542)	0	400,000	0	0	0	9,980	09/19/2016
695359-DI-1	PNC BANK NA MTN 1.500% 10/18/17		11/18/2016	Wachovia Securities		630,538	630,000	629,860	629,932	0	34	0	34	0	629,965	0	570	570	10,389	10/18/2017
742718-DI-8	PROCTER AND GAMBLE CO 1.450% 08/15/16		08/15/2016	Maturity		500,000	500,000	513,380	502,097	0	(2,097)	0	(2,097)	0	500,000	0	0	0	7,250	08/15/2016
857477-AH-6	STATE STREET CORP 2.875% 03/07/16		03/07/2016	Maturity		250,000	250,000	266,743	250,850	0	(850)	0	(850)	0	250,000	0	0	0	3,594	03/07/2016
882508-AR-5	TEXAS INSTRUMENTS INC 2.375% 05/16/16		05/16/2016	Maturity		400,000	400,000	421,584	402,118	0	(2,118)	0	(2,118)	0	400,000	0	0	0	4,776	05/16/2016
883556-BA-9	THERMO FISHER SCIENTIFIC 2.250% 08/15/16		04/19/2016	Call 100,5560		402,224	400,000	415,904	402,448	0	(1,179)	0	(1,179)	0	401,269	0	955	955	6,100	08/15/2016
89236T-AL-9	TOYOTA MOTO CREDIT CORP 0.800% 05/17/16		05/17/2016	Maturity		670,000	670,000	669,725	669,965	0	35	0	35	0	670,000	0	0	0	2,680	05/17/2016
91159H-HB-9	US BANCORP SERIES MTN 2.200% 11/15/16		10/14/2016	Call 100,0000		100,000	100,000	104,937	100,963	0	(963)	0	(963)	0	100,000	0	0	0	2,011	11/15/2016
91159H-HD-5	US BANCORP SERIES MTN 1.650% 05/15/17		12/09/2016	BONY/TORONTO DOMINION		400,528	400,000	402,468	400,683	0	(501)	0	(501)	0	400,182	0	346	346	7,113	05/15/2017
92277G-AC-1	VENTAS REALTY LP/CAP CRP 1.250% 04/17/17		12/09/2016	Pershing		44,974	45,000	44,917	44,964	0	27	0	27	0	44,990	0	(16)	(16)	650	04/17/2017
92343I-BD-5	VERIZON COMMUNICATIONS SERIES 2.000%		11/01/16	Corporate Action		391,801	389,000	404,047	391,970	0	(918)	0	(918)	0	391,052	0	749	749	3,307	11/01/2016
92343I-BD-5	VERIZON COMMUNICATIONS SERIES 2.000%		04/08/2016	Call 100,7750		11,065	11,000	11,425	11,084	0	(27)	0	(27)	0	11,057	0	28	28	96	11/01/2016
92343I-BN-3	VERIZON COMMUNICATIONS SERIES 2.500%		09/15/16	Corporate Action		310,341	308,000	307,763	307,942	0	25	0	25	0	307,967	0	2,377	2,377	4,256	09/15/2016
38999999	Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)					21,024,489	20,892,611	22,019,196	21,202,258	0	(217,538)	0	(217,538)	0	20,984,716	0	39,774	39,774	604,167	XXX

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 4

Showing All Long-Term Bonds and Stocks SOLD, REDEEMED or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21
CUSIP Identification	Description	For- eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Con- sideration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	11 Unrealized Valuation Increase/ Decrease	12 Current Year's (Amor- tization)/ Accretion	13 Current Year's Other- Than- Temporary Impairment Recognized	14 Total Change in Book/ Adjusted Carrying Value (11+12-13)	15 Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Con- tractual Maturity Date
8399997	Total - Bonds - Part 4					25,132,865	25,000,987	26,422,849	25,559,121	0	(486,025)	0	(486,025)	0	25,093,092	0	39,774	39,774	699,362	XXX
8399998	Total - Bonds - Part 5					15,085,563	1,440,243	15,009,363		0	(20,579)	0	(20,579)	0	14,988,803	0	96,761	96,761	30,364	XXX
8399999	Total - Bonds					40,218,428	26,441,230	41,432,232	25,559,121	0	(486,604)	0	(486,604)	0	40,081,895	0	136,535	136,535	729,726	XXX
8999997	Total - Preferred Stocks - Part 4					0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX
8999998	Total - Preferred Stocks - Part 5					0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX
8999999	Total - Preferred Stocks					0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX
784644-76-3	SPDR BLOOMBERG BARCLAYS INTERM ETF		06/28/2016	ItaliachBeth	57,780,000	4,657,237		3,046,848	4,249,403	(1,202,556)	0	0	(1,202,556)	0	3,046,848	0	1,610,390	1,610,390	55,742	XXX
921937-83-5	VANGUARD ETF		07/08/2016	ItaliachBeth	6,000,000	509,000		496,365	484,560	11,805	0	0	11,805	0	496,365	0	12,635	12,635	6,062	XXX
921946-40-6	VANGUARD HIGH DIV YIELD ETF		06/28/2016	ItaliachBeth	72,436,000	4,973,550		3,363,210	4,835,103	(1,471,893)	0	0	(1,471,893)	0	3,363,210	0	1,610,340	1,610,340	76,492	XXX
922908-74-4	VANGUARD LARGE-CAP		06/28/2016	ItaliachBeth	52,220,000	4,254,422		2,683,444	4,256,974	(1,573,531)	0	0	(1,573,531)	0	2,683,444	0	1,570,979	1,570,979	53,264	XXX
9099999	Subtotal - Common Stocks - Industrial and Miscellaneous (Unaffiliated)					14,394,209	XXX	9,589,867	13,826,040	(4,236,175)	0	0	(4,236,175)	0	9,589,867	0	4,804,344	4,804,344	191,560	XXX
9799997	Total - Common Stocks - Part 4					14,394,209	XXX	9,589,867	13,826,040	(4,236,175)	0	0	(4,236,175)	0	9,589,867	0	4,804,344	4,804,344	191,560	XXX
9799998	Total - Common Stocks - Part 5					0	XXX	0	0	0	0	0	0	0	0	0	0	0	0	XXX
9799999	Total - Common Stocks					14,394,209	XXX	9,589,867	13,826,040	(4,236,175)	0	0	(4,236,175)	0	9,589,867	0	4,804,344	4,804,344	191,560	XXX
9899999	Total - Preferred and Common Stocks					14,394,209	XXX	9,589,867	13,826,040	(4,236,175)	0	0	(4,236,175)	0	9,589,867	0	4,804,344	4,804,344	191,560	XXX
9999999	Totals					54,612,637	XXX	51,022,099	39,385,161	(4,236,175)	(486,604)	0	(4,722,779)	0	49,671,762	0	4,940,879	4,940,879	921,296	XXX

E14.2

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 5

Showing All Long-Term Bonds and Stocks ACQUIRED During Year and Fully DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	11	Change in Book/Adjusted Carrying Value					17	18	19	20	21
CUSIP Identification	Description	Foreign	Date Acquired	Name of Vendor	Disposal Date	Name of Purchaser	Par Value (Bonds) or Number of Shares (Stock)	Actual Cost	Consideration	Book/ Adjusted Carrying Value at Disposal	12	13	14	15	16	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Interest and Dividends Received During Year	Paid for Accrued Interest and Dividends
361795-9C-7	GNMA 11 POOL 1A3802 3.000% 07/20/46		11/22/2016	Delta Securities	12/01/2016	Paydown	11,645	11,876	11,645	11,645	0	(231)	0	(231)	0	0	0	0	29	26
0599999	Subtotal - Bonds - U.S. Governments						11,645	11,876	11,645	11,645	0	(231)	0	(231)	0	0	0	0	29	26
3132L-YL-7	PHLIC POOL V82515 3.500% 06/01/46		07/26/2016	Citigroup Global Markets	12/01/2016	Paydown	29,245	30,945	29,245	29,245	0	(1,700)	0	(1,700)	0	0	0	0	242	28
3140EV-VB-0	FNMA POOL BC1509 3.000% 08/01/46		08/04/2016	Wachovia Securities	12/01/2016	Paydown	29,399	30,686	29,399	29,399	0	(1,286)	0	(1,286)	0	0	0	0	197	24
314120-2H-8	FNMA POOL 932389 4.500% 01/01/40		02/01/2016	Bank of America	12/01/2016	Paydown	195,300	212,816	195,300	195,300	0	(17,516)	0	(17,516)	0	0	0	0	4,175	244
3199999	Subtotal - Bonds - U.S. Special Revenues						253,944	274,447	253,944	253,944	0	(20,502)	0	(20,502)	0	0	0	0	4,614	296
161175-AR-5	CHARTER COMM OPT LLC CAP SERIES 144A 3.575% 07/23/20		05/24/2016	Tax Free Exchange	12/01/2016	Tax Free Exchange	205,000	205,000	205,000	205,000	0	0	0	0	0	0	0	0	6,277	2,466
464287-22-6	ISHARES BARCLAYS AGGREGATE BON 0.000%		06/28/2016	WallachBeth	07/08/2016	WallachBeth	25,375	2,854,622	2,872,464	2,854,622	0	0	0	0	0	0	17,842	17,842	0	0
464287-24-2	ISHARES IBOXX INV GRD CORP BON 0.000%		06/28/2016	WallachBeth	07/08/2016	WallachBeth	23,636	2,887,312	2,937,482	2,887,312	0	0	0	0	0	0	50,170	50,170	0	0
464288-63-8	ISHARES INTERMEDIATE CREDIT 0.000%		06/28/2016	WallachBeth	07/08/2016	WallachBeth	19,576	2,175,040	2,182,921	2,175,040	0	0	0	0	0	0	7,881	7,881	0	0
48203R-AL-8	JUNIPER NETWORKS, INC 3.125% 02/26/19		02/23/2016	J P Morgan	12/01/2016	Baird & Co	800,000	799,384	813,992	799,538	0	154	0	154	0	0	14,454	14,454	19,444	0
784644-47-4	SPDR BLOOMBERG BARCLAYS SHORT 0.000%		06/28/2016	WallachBeth	07/08/2016	WallachBeth	47,126	1,450,416	1,449,211	1,450,416	0	0	0	0	0	0	11,205	11,205	0	0
92205C-4D-9	ISHARES VANGUARD GROUP INTERM 0.000%		06/28/2016	WallachBeth	07/08/2016	WallachBeth	53,941	4,351,286	4,358,904	4,351,286	0	0	0	0	0	0	7,619	7,619	0	0
3899999	Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						1,174,654	14,723,060	14,819,974	14,723,214	0	154	0	154	0	0	96,761	96,761	25,721	2,466
8399998	Total - Bonds						1,440,243	15,009,383	15,085,563	14,988,803	0	(20,579)	0	(20,579)	0	0	96,761	96,761	30,364	2,788
8999998	Total - Preferred Stocks						0	0	0	0	0	0	0	0	0	0	0	0	0	0
9799998	Total - Common Stocks						0	0	0	0	0	0	0	0	0	0	0	0	0	0
9899999	Total - Preferred and Common Stocks						0	0	0	0	0	0	0	0	0	0	0	0	0	0
9999999	Totals							15,009,383	15,085,563	14,988,803	0	(20,579)	0	(20,579)	0	0	96,761	96,761	30,364	2,788

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

Schedule D-Part 6-Section 1-Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

NONE

Schedule D - Part 6 - Section 2

NONE

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE DA - PART 1

Showing All SHORT-TERM INVESTMENTS Owned December 31 of Current Year

1	2	Codes		5	6	7	8	Change in Book/Adjusted Carrying Value				13	14	Interest						21	
		3	4					9	10	11	12			15	16	17	18	19	20		
CUSIP Identification	Description	Code	For- eign	Date Acquired	Name of Vendor	Maturity Date	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor- tization)/ Accretion	Current Year's Other- Than- Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Par Value	Actual Cost	Amount Due and Accrued Dec. 31 of Current Year on Bonds not in Default	Non- Admitted Due and Accrued	Rate of	Effective Rate of	When Paid	Amount Received During Year	Paid for Accrued Interest	
0599999	Total - U.S. Government Bonds						0	0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
1099999	Total - All Other Government Bonds						0	0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
1799999	Total - U.S. States, Territories and Possessions Bonds						0	0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
2499999	Total - U.S. Political Subdivisions Bonds						0	0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
3199999	Total - U.S. Special Revenues Bonds						0	0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
3899999	Total - Industrial and Miscellaneous (Unaffiliated) Bonds						0	0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
4899999	Total - Hybrid Securities						0	0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
5599999	Total - Parent, Subsidiaries and Affiliates Bonds						0	0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
6099999	Subtotal - SVO Identified Funds						0	0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
7799999	Total - Issuer Obligations						0	0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
7899999	Total - Residential Mortgage-Backed Securities						0	0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
7999999	Total - Commercial Mortgage-Backed Securities						0	0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
8099999	Total - Other Loan-Backed and Structured Securities						0	0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
8199999	Total - SVO Identified Funds						0	0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
8399999	Total Bonds						0	0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
8699999	Total - Parent, Subsidiaries and Affiliates						0	0	0	0	0	XXX	0	0	0	0	XXX	XXX	XXX	0	0
318451-56-7	FIRST AMERICAN TREASURY OBLIG Z TAXABLE GOVT AGENCY MINT			12/29/2016	Various	XXX	34,193,235	0	0	0	0	0	34,193,235	0	0	0	0.000	0.000		11,265	0
082480-70-0	BLACKROCK FEDERAL FUND 30			12/30/2016	Various	XXX	1,794,374	0	0	0	0	0	1,794,374	0	0	0	0.000	0.000		135	0
	State of Florida Cash Deposit			01/01/2016	Various	XXX	300,000	0	0	0	0	0	0	0	0	0	0.000	0.000		0	0
8899999	Subtotal - Exempt Money Market Mutual Funds - as Identified by the SVO						36,287,609	0	0	0	0	XXX	35,987,609	0	0	0	XXX	XXX	XXX	11,400	0
	BELLS FARGO ADVANTAGE HERITAGE INSTL CLASS			01/01/2016	No Broker	12/31/2017	0	0	0	0	0	0	0	0	0	0	0.000	0.000		11,194	0
	DREYFUS INSTL CASH ADVANTAGE			01/01/2016	No Broker	12/31/2017	0	0	0	0	0	0	0	0	0	0	0.000	0.000		1,054	0
	DREYFUS CASH MANAGEMENT ADMIN			01/01/2016	No Broker	12/31/2017	0	0	0	0	0	0	0	0	0	0	0.000	0.000		36	0
9099999	Subtotal - Other Short-Term Invested Assets						0	0	0	0	0	XXX	0	0	0	0	XXX	XXX	XXX	12,284	0
9199999	Totals						36,287,609	0	0	0	0	XXX	35,987,609	0	0	0	XXX	XXX	XXX	23,684	0

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

Schedule DB - Part A - Section 1 - Options, Caps, Floors, Collars, Swaps and Forwards Open

NONE

Schedule DB - Part A - Section 2 - Options, Caps, Floors, Collars, Swaps and Forwards Terminated

NONE

Schedule DB - Part B - Section 1 - Futures Contracts Open

NONE

Schedule DB - Part B - Section 1B - Brokers with whom cash deposits have been made

NONE

Schedule DB - Part B - Section 2 - Futures Contracts Terminated

NONE

Schedule DB - Part D - Section 1 - Counterparty Exposure for Derivative Instruments Open

NONE

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged By

NONE

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged To

NONE

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE DL - PART 1
SECURITIES LENDING COLLATERAL ASSETS

Reinvested Collateral Assets Owned December 31 Current Year

1 CUSIP Identification	2 Description	3 Code	4 NAIC Designation/ Market Indicator	5 Fair Value	6 Book/Adjusted Carrying Value	7 Maturity Date
0599999. Total - U.S. Government Bonds				0	0	XXX
1099999. Total - All Other Government Bonds				0	0	XXX
1799999. Total - U.S. States, Territories and Possessions Bonds				0	0	XXX
2499999. Total - U.S. Political Subdivisions Bonds				0	0	XXX
3199999. Total - U.S. Special Revenues Bonds				0	0	XXX
000000-00-0	PAYABLE/RECEIVABLE		1	(453)	(11,105)	01/03/2017
000000-00-0	J.P. MORGAN SECURITIES LLC		1	65,412	65,412	01/03/2017
3299999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations				64,959	64,307	XXX
000000-00-0	NORRA SECURITIES INT. INC. REPO		1	220,998	220,998	01/03/2017
000000-00-0	BERILL LYNCH PIERCE FENNER & SMITH INC REPO		1	220,998	220,998	01/03/2017
000000-00-0	CITIGROUP GLOBAL MARKETS INC REPO		1	220,998	220,998	01/03/2017
000000-00-0	RBC DOMINION SECURITIES INC ON REPO		1	220,998	220,998	01/03/2017
3399999. Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Residential Mortgage-Backed Securities				883,992	883,992	XXX
3899999. Total - Industrial and Miscellaneous (Unaffiliated) Bonds				948,951	948,299	XXX
4899999. Total - Hybrid Securities				0	0	XXX
5599999. Total - Parent, Subsidiaries and Affiliates Bonds				0	0	XXX
6099999. Subtotal - SVO Identified Funds				0	0	XXX
6199999. Total - Issuer Obligations				64,959	64,307	XXX
6299999. Total - Residential Mortgage-Backed Securities				883,992	883,992	XXX
6399999. Total - Commercial Mortgage-Backed Securities				0	0	XXX
6499999. Total - Other Loan-Backed and Structured Securities				0	0	XXX
6599999. Total - SVO Identified Funds				0	0	XXX
6699999. Total Bonds				948,951	948,299	XXX
7099999. Total - Preferred Stocks				0	0	XXX
7599999. Total - Common Stocks				0	0	XXX
7699999. Total - Preferred and Common Stocks				0	0	XXX
9999999 - Totals				948,951	948,299	XXX

General Interrogatories:

1. Total activity for the year Fair Value \$ (5,860,696) Book/Adjusted Carrying Value \$ (5,860,851)
2. Average balance for the year Fair Value \$ 3,223,352 Book/Adjusted Carrying Value \$ 3,222,713
3. Reinvested securities lending collateral assets book/adjusted carrying value included in this schedule by NAIC designation:
NAIC 1 \$ 948,299 NAIC 2 \$ 0 NAIC 3 \$ NAIC 4 \$ NAIC 5 \$ NAIC 6 \$

SCHEDULE DL - PART 2
SECURITIES LENDING COLLATERAL ASSETS

[illegible]

Fair Value \$	Book/Adjusted Carrying Value \$
Fair Value \$	Book/Adjusted Carrying Value \$

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE E - PART 1 - CASH

1	2	3	4	5	6	7
Depository	Code	Rate of Interest	Amount of Interest Received During Year	Amount of Interest Accrued December 31 of Current Year	Balance	*
Wells Fargo					(8,701,526)	XXX
JP Morgan					105,072	XXX
Bank of America					22,435,196	XXX
0199998 Deposits in ... depositories which do not exceed the allowable limit in any one depository (See instructions) - open depositories	XXX	XXX				XXX
0199999. Totals - Open Depositories	XXX	XXX	0	0	13,838,742	XXX
0299998 Deposits in ... depositories which do not exceed the allowable limit in any one depository (See instructions) - suspended depositories	XXX	XXX				XXX
0299999. Totals - Suspended Depositories	XXX	XXX	0	0	0	XXX
0399999. Total Cash on Deposit	XXX	XXX	0	0	13,838,742	XXX
0499999. Cash in Company's Office	XXX	XXX	XXX	XXX		XXX
.....						
.....						
.....						
.....						
.....						
.....						
.....						
.....						
.....						
0599999 Total - Cash	XXX	XXX	0	0	13,838,742	XXX

TOTALS OF DEPOSITORY BALANCES ON THE LAST DAY OF EACH MONTH DURING THE CURRENT YEAR

1. January.....	17,401,976	4. April.....	(5,199,379)	7. July.....	(27,020,345)	10. October.....	(31,047,114)
2. February.....	20,470,450	5. May.....	(38,932,943)	8. August.....	(29,377,721)	11. November.....	(11,037,151)
3. March.....	6,331,008	6. June.....	(46,737,797)	9. September.....	(32,767,647)	12. December.....	13,838,742

Show Investments Owned December 31 of Current Year

NONE

Attachment 2014 Amerigroup Florida
Annual Health Statement — Page 113

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

SCHEDULE E - PART 3 - SPECIAL DEPOSITS

States, Etc.	1 Type of Deposit	2 Purpose of Deposit	Deposits For the Benefit of All Policyholders		All Other Special Deposits	
			3 Book/Adjusted Carrying Value	4 Fair Value	5 Book/Adjusted Carrying Value	6 Fair Value
1. Alabama .....AL						
2. Alaska .....AK						
3. Arizona .....AZ						
4. Arkansas .....AR						
5. California .....CA						
6. Colorado .....CO						
7. Connecticut .....CT						
8. Delaware .....DE						
9. District of Columbia .....DC						
10. Florida .....FL	0	FL ACHA IOD, DOEI IOD, Surplus Deposit	38,758,682	39,081,653		
11. Georgia .....GA						
12. Hawaii .....HI						
13. Idaho .....ID						
14. Illinois .....IL						
15. Indiana .....IN						
16. Iowa .....IA						
17. Kansas .....KS						
18. Kentucky .....KY						
19. Louisiana .....LA						
20. Maine .....ME						
21. Maryland .....MD						
22. Massachusetts .....MA						
23. Michigan .....MI						
24. Minnesota .....MN						
25. Mississippi .....MS						
26. Missouri .....MO						
27. Montana .....MT						
28. Nebraska .....NE						
29. Nevada .....NV						
30. New Hampshire .....NH						
31. New Jersey .....NJ						
32. New Mexico .....NM						
33. New York .....NY						
34. North Carolina .....NC						
35. North Dakota .....ND						
36. Ohio .....OH						
37. Oklahoma .....OK						
38. Oregon .....OR						
39. Pennsylvania .....PA						
40. Rhode Island .....RI						
41. South Carolina .....SC						
42. South Dakota .....SD						
43. Tennessee .....TN						
44. Texas .....TX						
45. Utah .....UT						
46. Vermont .....VT						
47. Virginia .....VA						
48. Washington .....WA						
49. West Virginia .....WV						
50. Wisconsin .....WI						
51. Wyoming .....WY						
52. American Samoa .....AS						
53. Guam .....GU						
54. Puerto Rico .....PR						
55. U.S. Virgin Islands .....VI						
56. Northern Mariana Islands .....MP						
57. Canada .....CAN						
58. Aggregate Alien and Other .....OT	XXX	XXX	0	0	0	0
59. Subtotal	XXX	XXX	38,758,682	39,081,653	0	0
DETAILS OF WRITE-INS						
5801.						
5802.						
5803.						
5898. Summary of remaining write-ins for Line 58 from overflow page	XXX	XXX	0	0	0	0
5899. Totals (Lines 5801 thru 5803 plus 5898)(Line 58 above)	XXX	XXX	0	0	0	0



Relief from the five-year rotation requirement for lead audit partner



Relief from the one-year cooling off period for independent CPA



Relief from the Requirements for Audit Committees



SUPPLEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.
MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For The Year Ended December 31, 2016
(To Be Filed by March 1)

FOR THE STATE OF _____
NAIC Group Code _____ NAIC Company Code _____
ADDRESS (City, State and Zip Code) _____
Person Completing This Exhibit _____
Title _____

1	2	3	4	5	6	7	8	9					10			11			12		
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Policies Issued Through 2013		14	15	Policies Issued in 2014; 2015; 2016		18				
											Incurred Claims				Incurred Claims						
											12	13			16	17					
Amount	Percent of Premiums Earned	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives															

1. If response in Column 1 is no, give full and complete details _____

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss. (a)(1) for this date. _____

2.1 Address: _____

2.2 Contact Person and Phone Number: _____

3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B). _____

3.1 Address: _____

3.2 Contact Person and Phone Number: _____

4. Explain any policies identified above as policy type "O": _____



SUPPLEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.
MEDICARE PART D COVERAGE SUPPLEMENT
(Net of Reinsurance)

NAIC Group Code 0671		(To Be Filed by March 1)		NAIC Company Code 95093	
		Individual Coverage		Group Coverage	
		1 Insured	2 Uninsured	3 Insured	4 Uninsured
				5 Total Cash	
1. Premiums Collected					
1.1 Standard Coverage					
1.11 With Reinsurance Coverage			XXX		XXX
1.12 Without Reinsurance Coverage			XXX		XXX
1.13 Risk-Corridor Payment Adjustments			XXX		XXX
1.2 Supplemental Benefits			XXX		XXX
2. Premiums Due and Uncollected-change					
2.1 Standard Coverage					
2.11 With Reinsurance Coverage			XXX		XXX
2.12 Without Reinsurance Coverage			XXX		XXX
2.2 Supplemental Benefits			XXX		XXX
3. Unearned Premium and Advance Premium-change					
3.1 Standard Coverage					
3.11 With Reinsurance Coverage			XXX		XXX
3.12 Without Reinsurance Coverage			XXX		XXX
3.2 Supplemental Benefits			XXX		XXX
4. Risk-Corridor Payment Adjustments-change					
4.1 Receivable			XXX		XXX
4.2 Payable			XXX		XXX
5. Earned Premiums					
5.1 Standard Coverage					
5.11 With Reinsurance Coverage			XXX		XXX
5.12 Without Reinsurance Coverage			XXX		XXX
5.13 Risk-Corridor Payment Adjustments			XXX		XXX
5.2 Supplemental Benefits			XXX		XXX
6. Total Premiums			XXX		XXX
7. Claims Paid					
7.1 Standard Coverage					
7.11 With Reinsurance Coverage			XXX		XXX
7.12 Without Reinsurance Coverage			XXX		XXX
7.2 Supplemental Benefits			XXX		XXX
8. Claim Reserves and Liabilities-change					
8.1 Standard Coverage					
8.11 With Reinsurance Coverage			XXX		XXX
8.12 Without Reinsurance Coverage			XXX		XXX
8.2 Supplemental Benefits			XXX		XXX
9. Health Care Receivables-change					
9.1 Standard Coverage					
9.11 With Reinsurance Coverage			XXX		XXX
9.12 Without Reinsurance Coverage			XXX		XXX
9.2 Supplemental Benefits			XXX		XXX
10. Claims Incurred					
10.1 Standard Coverage					
10.11 With Reinsurance Coverage			XXX		XXX
10.12 Without Reinsurance Coverage			XXX		XXX
10.2 Supplemental Benefits			XXX		XXX
11. Total Claims			XXX		XXX
12. Reinsurance Coverage and Low Income Cost Sharing					
12.1 Claims Paid - Net of Reimbursements Applied	XXX		XXX		
12.2 Reimbursements Received but Not Applied-change	XXX		XXX		
12.3 Reimbursements Receivable-change	XXX		XXX		XXX
12.4 Health Care Receivables-change	XXX		XXX		XXX
13. Aggregate Policy Reserves-change					XXX
14. Expenses Paid			XXX		XXX
15. Expenses Incurred			XXX		XXX
16. Underwriting Gain/Loss			XXX		XXX
17. Cash Flow Results	XXX	XXX	XXX	XXX	

NONE



Non-Guaranteed Opinion for Exhibit 5



Participating Opinion for Exhibit 5

SUPPLEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

Schedule SIS
NONE

Schedule SIS II
NONE

Schedule SIS III
NONE

Schedule SIS IV
NONE

SUPPLEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

Life Supplement Cover

NONE

Life Supplement - Exhibit 5 - Aggregate Reserve for Life Contracts

NONE

Life Supplement - Exhibit 5 - Interrogatories

NONE

Life Supplement - Exhibit 7 - Deposit-Type Contracts

NONE

Life Supplement - Schedule S - Part 1 - Section 1

NONE

Life Supplement - Schedule S - Part 3 - Section 1

NONE



SUPPLEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

DIRECT BUSINESS IN THE STATE OF

DURING THE YEAR 2016

NAIC Group Code 0671

LIFE INSURANCE

NAIC Company Code 95093

	1 Ordinary	2 Credit Life (Group and Individual)	3 Group	4 Industrial	5 Total
DIRECT PREMIUMS AND ANNUITY CONSIDERATIONS					
1. Life insurance					
2. Annuity considerations					
3. Deposit-type contract funds		XXX		XXX	
4. Other considerations					
5. Totals (Sum of Lines 1 to 4)					
DIRECT DIVIDENDS TO POLICYHOLDERS					
Life Insurance:					
6.1 Paid in cash or left on deposit					
6.2 Applied to pay renewal premiums					
6.3 Applied to provide paid-up additions or shorten the endowment or premium-paying period					
6.4 Other					
6.5 Totals (sum of Line 6.1 to 6.4)					
Annuities:					
7.1 Paid in cash or left on deposit					
7.2 Applied to provide paid-up annuities					
7.3 Other					
7.4 Totals (sum of Lines 7.1 to 7.3)					
8. Grand Totals (Lines 6.5 plus 7.4)					
DIRECT CLAIMS AND BENEFITS PAID					
9. Death benefits					
10. Matured endowments					
11. Annuity benefits					
12. Surrender values and withdrawals for life contracts					
13. Aggregate write-ins for miscellaneous direct claims and benefits paid					
14. All other benefits, except accident and health					
15. Totals					
DETAILS OF WRITE-INS					
1301.					
1302.					
1303.					
1398. Summary of Line 13 from overflow page					
1399. Totals (Lines 1301 thru 1303 plus 1398) (Line 13 above)					

DIRECT DEATH BENEFITS AND MATURED ENDOWMENTS INCURRED	Ordinary		Credit Life (Group and Individual)		Group		Industrial		Total	
	1	2	3	4	5	6	7	8	9	10
	No.	Amount	No. of Ind. Pols. & Gr. Certifs.	Amount	No. of Certifs.	Amount	No.	Amount	No.	Amount
16. Unpaid December 31, prior year										
17. Incurred during current year Settled during current year:										
18.1 By payment in full										
18.2 By payment on compromised claims										
18.3 Totals paid										
18.4 Reduction by compromise										
18.5 Amount rejected										
18.6 Total settlements										
19. Unpaid Dec. 31, current year (16+17-18.6)										
POLICY EXHIBIT										
20. In force December 31, prior year			(a)		No. of Policies					
21. Issued during year										
22. Other changes to in force (Net)										
23. In force December 31 of current year			(a)							

(a) Includes Individual Credit Life Insurance prior year \$, current year \$
Includes Group Credit Life Insurance Loans less than or equal to 60 months at issue, prior year \$, current year \$
Loans greater than 60 months at issue BUT NOT GREATER THAN 120 MONTHS, prior year \$, current year \$

ACCIDENT AND HEALTH INSURANCE

	1 Direct Premiums	2 Direct Premiums Earned	3 Dividends Paid Or Credited On Direct Business	4 Direct Losses Paid	5 Direct Losses Incurred
24. Group Policies (b)					
24.1 Federal Employees Health Benefits Plan premium (b)					
24.2 Credit (Group and Individual)					
24.3 Collectively renewable policies (b)					
24.4 Medicare Title XVIII exempt from state taxes or fees Other Individual Policies:					
25.1 Non-cancelable (b)					
25.2 Guaranteed renewable (b)					
25.3 Non-renewable for stated reasons only (b)					
25.4 Other accident only					
25.5 All other (b)					
25.6 Totals (sum of Lines 25.1 to 25.5)					
26. Totals (Lines 24 + 24.1 + 24.2 + 24.3 + 24.4 + 25.6)					

(b) For health business on indicated lines report: Number of persons insured under PPO managed care products0 and number of persons
insured under indemnity only products0 .

SUPPLEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

P&C Supplement Cover

NONE

P&C Supplement - Schedule F - Part 1

NONE

P&C Supplement - Schedule F - Part 3

NONE

P&C Supplement - Schedule P - Part 1 - Summary

NONE

P&C Supplement - Schedule P - Part 1A - Homeowners/Farmowners

NONE

P&C Supplement - Schedule P - Part 1B - Private Passenger Auto Liability/Medical

NONE

P&C Supplement - Schedule P - Part 1C - Commercial Auto/Truck Liability/Medical

NONE

P&C Supplement - Schedule P - Part 1D - Workers' Compensation (Excluding Excess Workers'
Compensation)

NONE

P&C Supplement - Schedule P - Part 1E - Commercial Multiple Peril

NONE

P&C Supplement - Schedule P - Part 1F - Section 1 - Medical Professional Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 1F - Section 2 - Medical Professional Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 1G - Special Liability (Ocean Marine, Aircraft (all perils), Boiler
and Machinery)

NONE

P&C Supplement - Schedule P - Part 1H - Section 1 - Other Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 1H - Section 2 - Other Liability - Claims-Made

NONE

SUPPLEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

P&C Supplement - Schedule P - Part 1I - Special Property (Fire, Allied Lines...)

NONE

P&C Supplement - Schedule P - Part 1J - Auto Physical Damage

NONE

P&C Supplement - Schedule P - Part 1K - Fidelity/Surety

NONE

P&C Supplement - Schedule P - Part 1L - Other (Including Credit, Accident and Health)

NONE

P&C Supplement - Schedule P - Part 1M - International

NONE

P&C Supplement - Schedule P - Part 1N - Reinsurance - Nonproportional Assumed Property

NONE

P&C Supplement - Schedule P - Part 1O - Reinsurance - Nonproportional Assumed Liability

NONE

P&C Supplement - Schedule P - Part 1P - Reinsurance - Nonproportional Assumed Financial Lines

NONE

P&C Supplement - Schedule P - Part 1R - Section 1 - Products Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 1R - Section 2 - Products Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 1S - Financial Guaranty/Mortgage Guaranty

NONE

P&C Supplement - Schedule P - Part 1T - Warranty

NONE

P&C Supplement - Schedule P - Part 2 - Summary

NONE

P&C Supplement - Schedule P - Part 2A - Homeowners/Farmowners

NONE

SUPPLEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

P&C Supplement - Schedule P - Part 2B - Private Passenger Auto Liability/Medical

NONE

P&C Supplement - Schedule P - Part 2C - Commercial Auto/Truck Liability/Medical

NONE

P&C Supplement - Schedule P - Part 2D - Workers' Compensation (Excluding Excess Workers' Compensation)

NONE

P&C Supplement - Schedule P - Part 2E - Commercial Multiple Peril

NONE

P&C Supplement - Schedule P - Part 2F - Section 1 - Medical Professional Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 2F - Section 2 - Medical Professional Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 2G - Special Liability (Ocean Marine, Aircraft (all perils), Boiler and Machinery)

NONE

P&C Supplement - Schedule P - Part 2H - Section 1 - Other Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 2H - Section 2- Other Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 2I - Special Property

NONE

P&C Supplement - Schedule P - Part 2J - Auto Physical Damage

NONE

P&C Supplement - Schedule P - Part 2K - Fidelity/Surety

NONE

P&C Supplement - Schedule P - Part 2L - Other (Including Credit, Accident and Health)

NONE

P&C Supplement - Schedule P - Part 2M - International

NONE

SUPPLEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

P&C Supplement - Schedule P - Part 2N - Reinsurance - Nonproportional Assumed Property

NONE

P&C Supplement - Schedule P - Part 2O - Reinsurance - Nonproportional Assumed Liability

NONE

P&C Supplement - Schedule P - Part 2P - Reinsurance - Nonproportional Assumed Financial Lines

NONE

P&C Supplement - Schedule P - Part 2R - Section 1 - Products Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 2R - Section 2 - Products Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 2S - Financial Guaranty/Mortgage Guaranty

NONE

P&C Supplement - Schedule P - Part 2T - Warranty

NONE



SUPPLEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.
EXHIBIT OF PREMIUMS AND LOSSES (Statutory Page 14)

NAIC Group Code 0671

BUSINESS IN THE STATE OF

DURING THE YEAR 2016

NAIC Company Code 95093

Line of Business	Gross Premiums, Including Policy and Membership Fees, Less Return Premiums and Premiums on Policies not Taken		Dividends Paid or Credited to Policyholders on Direct Business	Direct Unearned Premium Reserves	Direct Losses Paid (deducting salvage)	Direct Losses Incurred	Direct Losses Unpaid	Direct Defense and Cost Containment Expense Paid	Direct Defense and Cost Containment Expense Incurred	Direct Defense and Cost Containment Expense Unpaid	Commissions and Brokerage Expenses	Taxes, Licenses and Fees
	1 Direct Premiums Written	2 Direct Premiums Earned										
1. Fire												
2.1 Allied lines												
2.2 Multiple peril crop												
2.3 Federal flood												
2.4 Private crop												
2.5 Private flood												
3. Farmowners multiple peril												
4. Homeowners multiple peril												
5.1 Commercial multiple peril (non-liability portion)												
5.2 Commercial multiple peril (liability portion)												
6. Mortgage guaranty												
8. Ocean marine												
9. Inland marine												
10. Financial guaranty												
11. Medical professional liability												
12. Earthquake												
13. Group accident and health (b)												
14. Credit accident and health (group and individual)												
15.1 Collectively renewable accident and health (b)												
15.2 Non-cancelable accident and health(b)												
15.3 Guaranteed renewable accident and health(b)												
15.4 Non-renewable for stated reasons only (b)												
15.5 Other accident only												
15.6 Medicare Title XVIII exempt from state taxes or fees												
15.7 All other accident and health (b)												
15.8 Federal employees health benefits plan premium (b)												
16. Workers' compensation												
17.1 Other Liability - occurrence												
17.2 Other Liability - claims made												
17.3 Excess workers' compensation												
18. Products liability												
19.1 Private passenger auto no-fault (personal injury protection)												
19.2 Other private passenger auto liability												
19.3 Commercial auto no-fault (personal injury protection)												
19.4 Other commercial auto liability												
21.1 Private passenger auto physical damage												
21.2 Commercial auto physical damage												
22. Aircraft (all perils)												
23. Fidelity												
24. Surety												
26. Burglary and theft												
27. Boiler and machinery												
28. Credit												
30. Warranty												
34. Aggregate write-ins for other lines of business												
35. TOTALS (a)												
DETAILS OF WRITE-INS												
3401.												
3402.												
3403.												
3498. Summary of remaining write-ins for Line 34 from overflow page												
3499. Totals (Lines 3401 thru 3403 plus 3498)(Line 34 above)												

NONE

(a) Finance and service charges not included in Lines 1 to 35 \$

(b) For health business on indicated lines report: Number of persons insured under PPO managed care products and number of persons insured under indemnity only products

ALPHABETICAL INDEX

ANNUAL STATEMENT BLANK

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ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.

Prior Year Validation Data

1.	XXASU900029	PYPAGE ASSETS L28C3 = ASSETS L28C4.....	208,392,920
2.	XXASN000272	PYPAGE REVEX2 L49C1 = REVEX2 L33C1.....	75,684,471
3.	XXASU900102	PYPAGE ASSETS L05 C1 = CASH L19.1C1.....	62,452,557
4.	XXASU900066	PYPAGE SCAVER L09C2 = SCAVER L01C2.....	
5.	XXASU900067	PYPAGE SCBVER L11C2 = SCBVER L01C2.....	
6.	XXASU900068	PYPAGE SCBAVER L11C2 = SCBAVER L01C2.....	
7.	XXASU090298	PYPAGE SCDVER L10C2 = SCDVER L01C2.....	124,722,573
8.	XXASU095082	PYPAGE SCDAPT1 L9199999C8 = SCAVER L01C1.....	39,236,887
9.	XXASU099985	PYPAGE SCDBPTCSN2 L07C9 = SCDBPTCSN2 L01C1.....	
10.	XXASU099986	PYPAGE SCDBPTCSN2 L07C10 = SCDBPTCSN2 L01C2.....	
11.	XXASU900058	PYPAGE SCEPT2 L8699999C6 = SCEVER L01C1.....	
12.	XXASN000339	PYPAGE REVEX1 L02C2 = GENINTPT2 L02.2C5.....	1,309,626,197
13.	XXASN000341	PYPAGE LIAB L01C3 + L02C3 + L04C3 + L07C3 = GENINTPT2 L02.5C5.....	100,120,951
14.	XXAAU900307	PYPAGE SHCEPT1 - GT L05.5C15 = SHCEPT1 - GT L05.4C15.....	0
15.	PXASU900138	PYPAGE SCDBPTAVER L09C2 = SCDBPTAVER L09C1.....	
16.	PXASU900140	PYPAGE SCDBPTBVER L06C4 = SCDBPTBVER L01C4.....	
17.	PXASU900141	PYPAGE SCDBPTBSN1 L1449999C15 = SCDBPTBVER L03.12C1.....	
18.	PXASU900142	PYPAGE SCDBPTBSN1 L1449999C18 = SCDBPTBVER L03.14C1.....	
19.	PXASU900143	PYPAGE SCDBPTBSN1 L1449999C17 = SCDBPTBVER L03.22C1.....	
20.	PXASU900144	PYPAGE SCDBPTBSN1 L1449999C19 = SCDBPTBVER L03.24C1.....	

ANNUAL STATEMENT FOR THE YEAR 2016 OF THE Amerigroup Florida, Inc.
ANNUAL DISKETTE TRANSMITTAL FORM AND CERTIFICATION (HEALTH)

Name of Insurer AMERIGROUP Florida, Inc.
Date 04/01/2016 FEIN 65-0318864
NAIC Group # 0671 NAIC Company # 95093

THIS FORM IS REQUIRED FOR ALL DISKETTE TRANSMITTALS. PLEASE PROVIDE ANY ADDITIONAL COMMENTS THAT MAY HELP TO IDENTIFY DISKETTE CONTENT.

A.		MARCH	APRIL	JUNE
	1. Is this the first time you've submitted this filing? (Y/N)		YES	
	2. Is this being re-filed at the request of the NAIC or a state insurance department? (Y/N)		NO	
	3. Is this being re-filed due to changes to the data originally filed? (Y/N) (IF "YES", ENCLOSE HARD COPY PAGES FOR THE CHANGES.)		NO	
	4. Other? (Y/N) (If "yes", attach an explanation.)		NO	

B. Additional comments if necessary for clarification:

C. Diskette Contact Person:

Bette Lou Gronseth

Phone: 757-518-3638

Address: 4425 Corporation Lane Virginia Beach VA 23462

D. Software Vendor: Eagle Technology Management

Version: 2016

E. Have material validation failures been addressed in the explanation file?

Yes ☒ No ☐

The undersigned hereby certifies, according to the best of his/her knowledge and belief: that the diskettes submitted with this form were prepared in compliance with the NAIC specifications, that the diskettes have been tested against the validations included with these specifications, and that annual statement information required to be contained on diskette is identical to the information in the 2016 Annual Statement blank filed with the insurer's domiciliary state insurance department. In addition, the diskettes submitted have been scanned through a virus detection software package, and no viruses are present on the diskettes. The virus detection software used was (name)

McAfee (version number) 4.8.0.1938

Signed

Type Name and Title:

Bette L. Gronseth, Director II Regulatory Reporting

Schedule Qtr - G

[illegible]

AUTH - F.A.C. RULE 69O-191.075(6)

Attachment 2014 Amerigroup Florida
Annual Health Statement — Page 134

Schedule Qtr - D

Individually list prepaid expenses with account balances greater than 10% of Total Prepaid Expenses

AUTH - F.A.C. RULE 69O-191.075(6)

<p>ANNUAL STATEMENT</p> <p>OF THE</p> <p>AMERIGROUP Florida, Inc.</p> <p>of</p> <p>Tampa</p> <p>in the state of</p> <p>Florida</p> <p>TO THE</p> <p>Insurance Department</p> <p>OF THE STATE OF</p> <p>Florida</p> <p>FOR THE YEAR ENDED DECEMBER 31, 2015</p>
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HEALTH

2015

2015



HEALTH ANNUAL STATEMENT

FOR THE YEAR ENDED DECEMBER 31, 2015
OF THE CONDITION AND AFFAIRS OF THE

AMERIGROUP Florida, Inc.

NAIC Group Code 0671 (Current) 0671 (Prior) NAIC Company Code 95093 Employer's ID Number 65-0318864

Organized under the Laws of Florida, State of Domicile or Port of Entry Florida

Country of Domicile United States of America

Licensed as business type: Health Maintenance Organization

Is HMO Federally Qualified? Yes [] No [X]

Incorporated/Organized 02/01/1992 Commenced Business 10/01/1993

Statutory Home Office 4200 West Cypress Street, Suite 900 Tampa, FL, US 33607
(Street and Number) (City or Town, State, Country and Zip Code)

Main Administrative Office 4425 Corporation Lane 757-490-6900
(Street and Number) (Area Code) (Telephone Number)
Virginia Beach, VA, US 23462
(City or Town, State, Country and Zip Code)

Mail Address 4425 Corporation Lane Virginia Beach, VA, US 23462
(Street and Number or P.O. Box) (City or Town, State, Country and Zip Code)

Primary Location of Books and Records 4425 Corporation Lane 757-490-6900
(Street and Number) (Area Code) (Telephone Number)
Virginia Beach, VA, US 23462
(City or Town, State, Country and Zip Code)

Internet Website Address www.amerigroup.com

Statutory Statement Contact Bette Lou Gronseth 757-518-3638
(Name) (Area Code) (Telephone Number)
Bette.Gronseth@amerigroup.com 757-557-6742
(E-mail Address) (FAX Number)

OFFICERS

Chairperson Charles Brian Shipp Vice President/COO Judith Lynn Peterson

President/CEO Maria Lourdes Rivas # Vice President/Assistant Secretary Jack Louis Young

OTHER

Kathleen Susan Kiefer, Secretary Robert David Kretschmer, Treasurer Eric (Rick) Kenneth Noble, Assistant Treasurer
Mark Daniel Justus, Valuation Actuary

DIRECTORS OR TRUSTEES

Carter Allen Beck Maria Lourdes Rivas # Wayne Scott DeVeydt
Catherine Irene Kelaghan Judith Lynn Peterson Charles Brian Shipp

State of Florida SS:
County of Tampa

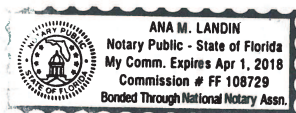
The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an exact copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Maria Lourdes Rivas Robert David Kretschmer Kathleen Susan Kiefer
President/CEO Treasurer Secretary

Subscribed and sworn to before me this 29 day of March, 2016

[Signature]

a. Is this an original filing? Yes [X] No []
b. If no,
1. State the amendment number
2. Date filed
3. Number of pages attached



ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

ASSETS

	Current Year			Prior Year
	1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 Net Admitted Assets
1. Bonds (Schedule D)	110,896,532		110,896,532	115,840,845
2. Stocks (Schedule D):				
2.1 Preferred stocks			0	0
2.2 Common stocks	13,826,041		13,826,041	13,943,531
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens			0	0
3.2 Other than first liens			0	0
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less \$ encumbrances)			0	0
4.2 Properties held for the production of income (less \$ encumbrances)			0	0
4.3 Properties held for sale (less \$ encumbrances)			0	0
5. Cash (\$ 23,215,670 , Schedule E - Part 1), cash equivalents (\$, Schedule E - Part 2) and short-term investments (\$ 39,236,887 , Schedule DA)	62,452,557		62,452,557	59,491,088
6. Contract loans, (including \$ premium notes)			0	0
7. Derivatives (Schedule DB)			0	0
8. Other invested assets (Schedule BA)			0	0
9. Receivables for securities	5,836		5,836	0
10. Securities lending reinvested collateral assets (Schedule DL)	6,809,150		6,809,150	5,497,979
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	193,990,116	0	193,990,116	194,773,443
13. Title plants less \$ charged off (for Title insurers only)			0	0
14. Investment income due and accrued	800,456		800,456	778,265
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	6,042,339		6,042,339	7,127,849
15.2 Deferred premiums and agents' balances and installments booked but deferred and not yet due (including \$ earned but unbilled premiums)			0	0
15.3 Accrued retrospective premiums (\$) and contracts subject to redetermination (\$)	880,739		880,739	0
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers			0	0
16.2 Funds held by or deposited with reinsured companies			0	0
16.3 Other amounts receivable under reinsurance contracts			0	0
17. Amounts receivable relating to uninsured plans	329,726		329,726	1,701,632
18.1 Current federal and foreign income tax recoverable and interest thereon			0	7,333,579
18.2 Net deferred tax asset	5,576,211		5,576,211	4,901,804
19. Guaranty funds receivable or on deposit			0	0
20. Electronic data processing equipment and software	12,618		12,618	40,149
21. Furniture and equipment, including health care delivery assets (\$)	2,494,874	2,494,874	0	0
22. Net adjustment in assets and liabilities due to foreign exchange rates			0	0
23. Receivables from parent, subsidiaries and affiliates	189,499	189,499	0	22,146
24. Health care (\$ 460,893) and other amounts receivable	10,582,252	10,121,359	460,893	1,121,489
25. Aggregate write-ins for other than invested assets	8,422,717	8,122,895	299,822	1,633,074
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	229,321,547	20,928,627	208,392,920	219,433,430
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0	0
28. Total (Lines 26 and 27)	229,321,547	20,928,627	208,392,920	219,433,430
DETAILS OF WRITE-INS				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	0	0	0	0
2501. Goodwill, Intangibles, and Covenant not to Compete	8,069,210	8,069,210	0	0
2502. Prepaids	53,685	53,685	0	0
2503. State Income Taxes Receivable	299,822		299,822	1,633,074
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	8,422,717	8,122,895	299,822	1,633,074

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

LIABILITIES, CAPITAL AND SURPLUS

	Current Year			Prior Year
	1 Covered	2 Uncovered	3 Total	4 Total
1. Claims unpaid (less \$0 reinsurance ceded)	96,061,391		96,061,391	81,781,184
2. Accrued medical incentive pool and bonus amounts	3,497,761		3,497,761	2,285,913
3. Unpaid claims adjustment expenses.....	3,280,587		3,280,587	2,649,718
4. Aggregate health policy reserves, including the liability of \$0 for medical loss ratio rebate per the Public Health Service Act.....	333,978		333,978	2,062,033
5. Aggregate life policy reserves.....			0	0
6. Property/casualty unearned premium reserves.....			0	0
7. Aggregate health claim reserves.....	227,821		227,821	214,727
8. Premiums received in advance.....			0	24,029,523
9. General expenses due or accrued.....	889,919		889,919	866,371
10.1 Current federal and foreign income tax payable and interest thereon (including \$ on realized capital gains (losses))	368,772		368,772	0
10.2 Net deferred tax liability.....			0	0
11. Ceded reinsurance premiums payable.....			0	0
12. Amounts withheld or retained for the account of others.....			0	0
13. Remittances and items not allocated.....	8,257,157		8,257,157	8,656,218
14. Borrowed money (including \$ current) and interest thereon \$ (including \$ current).....			0	0
15. Amounts due to parent, subsidiaries and affiliates.....	9,876,638		9,876,638	4,708,161
16. Derivatives.....			0	0
17. Payable for securities.....			0	0
18. Payable for securities lending	6,809,150		6,809,150	5,497,979
19. Funds held under reinsurance treaties (with \$ authorized reinsurers, \$0 unauthorized reinsurers and \$0 certified reinsurers).....			0	0
20. Reinsurance in unauthorized and certified (\$) companies			0	0
21. Net adjustments in assets and liabilities due to foreign exchange rates			0	0
22. Liability for amounts held under uninsured plans.....	402,654		402,654	12,899
23. Aggregate write-ins for other liabilities (including \$ current).....	2,702,621	0	2,702,621	3,062,776
24. Total liabilities (Lines 1 to 23).....	132,708,449	0	132,708,449	135,827,502
25. Aggregate write-ins for special surplus funds.....	XXX	XXX	20,965,043	21,492,886
26. Common capital stock.....	XXX	XXX	100	100
27. Preferred capital stock.....	XXX	XXX		
28. Gross paid in and contributed surplus.....	XXX	XXX	70,184,970	70,184,970
29. Surplus notes.....	XXX	XXX	0	
30. Aggregate write-ins for other than special surplus funds.....	XXX	XXX	0	0
31. Unassigned funds (surplus).....	XXX	XXX	(15,465,642)	(8,072,028)
32. Less treasury stock, at cost:				
32.1 shares common (value included in Line 26 \$).....	XXX	XXX		
32.2 shares preferred (value included in Line 27 \$).....	XXX	XXX		
33. Total capital and surplus (Lines 25 to 31 minus Line 32).....	XXX	XXX	75,684,471	83,605,928
34. Total liabilities, capital and surplus (Lines 24 and 33).....	XXX	XXX	208,392,920	219,433,430
DETAILS OF WRITE-INS				
2301. Escheat Liability	875,238		875,238	487,486
2302. ACA PCP Fee Increase	1,827,383		1,827,383	2,575,290
2303.			0	0
2398. Summary of remaining write-ins for Line 23 from overflow page.....	0	0	0	0
2399. Totals (Lines 2301 thru 2303 plus 2398)(Line 23 above)	2,702,621	0	2,702,621	3,062,776
2501. Estimated ACA Health Insurer Fee	XXX	XXX	20,965,043	21,492,886
2502.	XXX	XXX		
2503.	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page.....	XXX	XXX	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	XXX	XXX	20,965,043	21,492,886
3001.	XXX	XXX		
3002.	XXX	XXX		
3003.	XXX	XXX		
3098. Summary of remaining write-ins for Line 30 from overflow page.....	XXX	XXX	0	0
3099. Totals (Lines 3001 thru 3003 plus 3098)(Line 30 above)	XXX	XXX	0	0

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

STATEMENT OF REVENUE AND EXPENSES

	Current Year		Prior Year
	1 Uncovered	2 Total	3 Total
1. Member Months.....	XXX	4,608,418	3,613,410
2. Net premium income (including \$ non-health premium income)	XXX	1,309,626,197	938,450,419
3. Change in unearned premium reserves and reserve for rate credits	XXX	199,969	(195,015)
4. Fee-for-service (net of \$ medical expenses)	XXX	0	0
5. Risk revenue	XXX	0	0
6. Aggregate write-ins for other health care related revenues	XXX	0	0
7. Aggregate write-ins for other non-health revenues	XXX	0	0
8. Total revenues (Lines 2 to 7)	XXX	1,309,826,166	938,255,404
Hospital and Medical:			
9. Hospital/medical benefits		683,640,899	523,973,795
10. Other professional services		66,537,302	43,817,297
11. Outside referrals		0	0
12. Emergency room and out-of-area		119,317,809	107,381,436
13. Prescription drugs		210,136,548	133,591,837
14. Aggregate write-ins for other hospital and medical	0	79,384,877	52,391,401
15. Incentive pool, withhold adjustments and bonus amounts		3,882,263	3,317,530
16. Subtotal (Lines 9 to 15)	0	1,162,899,698	864,473,296
Less:			
17. Net reinsurance recoveries		0	0
18. Total hospital and medical (Lines 16 minus 17)	0	1,162,899,698	864,473,296
19. Non-health claims (net)			
20. Claims adjustment expenses, including \$52,494,254 cost containment expenses		79,803,226	51,537,238
21. General administrative expenses		65,958,505	56,823,350
22. Increase in reserves for life and accident and health contracts (including \$ increase in reserves for life only)		(1,535,613)	1,535,613
23. Total underwriting deductions (Lines 18 through 22).....	0	1,307,125,816	974,369,497
24. Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	2,700,350	(36,114,093)
25. Net investment income earned (Exhibit of Net Investment Income, Line 17)		3,474,158	3,032,598
26. Net realized capital gains (losses) less capital gains tax of \$(222,491)		(412,408)	150,646
27. Net investment gains (losses) (Lines 25 plus 26)	0	3,061,750	3,183,244
28. Net gain or (loss) from agents' or premium balances charged off [(amount recovered \$) (amount charged off \$)]			
29. Aggregate write-ins for other income or expenses	0	0	0
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	5,762,100	(32,930,849)
31. Federal and foreign income taxes incurred	XXX	7,697,859	(6,279,326)
32. Net income (loss) (Lines 30 minus 31)	XXX	(1,935,759)	(26,651,523)
DETAILS OF WRITE-INS			
0601.	XXX		
0602.	XXX		
0603.	XXX		
0698. Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0
0699. Totals (Lines 0601 thru 0603 plus 0698)(Line 6 above)	XXX	0	0
0701.	XXX		
0702.	XXX		
0703.	XXX		
0798. Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0
0799. Totals (Lines 0701 thru 0703 plus 0798)(Line 7 above)	XXX	0	0
1401. Ambulance, DME, Home Health Care, Other LTSS		79,384,877	52,391,401
1402.			
1403.			
1498. Summary of remaining write-ins for Line 14 from overflow page	0	0	0
1499. Totals (Lines 1401 thru 1403 plus 1498)(Line 14 above)	0	79,384,877	52,391,401
2901.			
2902.			
2903.			
2998. Summary of remaining write-ins for Line 29 from overflow page	0	0	0
2999. Totals (Lines 2901 thru 2903 plus 2998)(Line 29 above)	0	0	0

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

STATEMENT OF REVENUE AND EXPENSES (Continued)

	1 Current Year	2 Prior Year
CAPITAL AND SURPLUS ACCOUNT		
33. Capital and surplus prior reporting year.....	83,605,928	73,421,154
34. Net income or (loss) from Line 32	(1,935,759)	(26,651,523)
35. Change in valuation basis of aggregate policy and claim reserves		
36. Change in net unrealized capital gains (losses) less capital gains tax of \$(145,932)	(271,018)	684,857
37. Change in net unrealized foreign exchange capital gain or (loss)		
38. Change in net deferred income tax	528,475	1,792,767
39. Change in nonadmitted assets	(6,243,155)	(641,327)
40. Change in unauthorized and certified reinsurance	0	0
41. Change in treasury stock	0	0
42. Change in surplus notes	0	0
43. Cumulative effect of changes in accounting principles.....		
44. Capital Changes:		
44.1 Paid in	0	0
44.2 Transferred from surplus (Stock Dividend)	0	0
44.3 Transferred to surplus.....		
45. Surplus adjustments:		
45.1 Paid in	0	35,000,000
45.2 Transferred to capital (Stock Dividend)		
45.3 Transferred from capital		
46. Dividends to stockholders		
47. Aggregate write-ins for gains or (losses) in surplus	0	0
48. Net change in capital and surplus (Lines 34 to 47)	(7,921,457)	10,184,774
49. Capital and surplus end of reporting period (Line 33 plus 48)	75,684,471	83,605,928
DETAILS OF WRITE-INS		
4701.		0
4702.		0
4703.		0
4798. Summary of remaining write-ins for Line 47 from overflow page	0	0
4799. Totals (Lines 4701 thru 4703 plus 4798)(Line 47 above)	0	0

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

CASH FLOW

	1	2
	Current Year	Prior Year
Cash from Operations		
1. Premiums collected net of reinsurance	1,285,808,972	953,562,484
2. Net investment income	4,745,195	4,441,223
3. Miscellaneous income	0	0
4. Total (Lines 1 through 3)	1,290,554,167	958,003,707
5. Benefit and loss related payments	1,151,307,850	832,599,999
6. Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts		
7. Commissions, expenses paid and aggregate write-ins for deductions	142,883,953	107,410,495
8. Dividends paid to policyholders		
9. Federal and foreign income taxes paid (recovered) net of \$ tax on capital gains (losses)	(226,983)	1,479,214
10. Total (Lines 5 through 9)	1,293,964,820	941,489,708
11. Net cash from operations (Line 4 minus Line 10)	(3,410,653)	16,513,999
Cash from Investments		
12. Proceeds from investments sold, matured or repaid:		
12.1 Bonds	46,456,084	25,144,745
12.2 Stocks	0	0
12.3 Mortgage loans	0	0
12.4 Real estate	0	0
12.5 Other invested assets	0	0
12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	0	864
12.7 Miscellaneous proceeds	0	0
12.8 Total investment proceeds (Lines 12.1 to 12.7)	46,456,084	25,145,609
13. Cost of investments acquired (long-term only):		
13.1 Bonds	43,243,560	21,009,563
13.2 Stocks	496,365	0
13.3 Mortgage loans	0	0
13.4 Real estate	0	0
13.5 Other invested assets	0	0
13.6 Miscellaneous applications	1,317,007	2,385,095
13.7 Total investments acquired (Lines 13.1 to 13.6)	45,056,932	23,394,658
14. Net increase (decrease) in contract loans and premium notes	0	0
15. Net cash from investments (Line 12.8 minus Line 13.7 minus Line 14)	1,399,152	1,750,951
Cash from Financing and Miscellaneous Sources		
16. Cash provided (applied):		
16.1 Surplus notes, capital notes	0	0
16.2 Capital and paid in surplus, less treasury stock	0	35,000,000
16.3 Borrowed funds	0	0
16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	0
16.5 Dividends to stockholders	0	11,500,000
16.6 Other cash provided (applied)	4,972,970	6,194,852
17. Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6)	4,972,970	29,694,852
RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS		
18. Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	2,961,469	47,959,802
19. Cash, cash equivalents and short-term investments:		
19.1 Beginning of year	59,491,088	11,531,286
19.2 End of year (Line 18 plus Line 19.1)	62,452,557	59,491,088
Note: Supplemental disclosures of cash flow information for non-cash transactions:		
20.0001. Depreciation	461,133	249,714

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.
ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Net premium income	1,309,626,197	60,587,416					43,935,852	1,051,493,442	153,609,487	
2. Change in unearned premium reserves and reserve for rate credit	199,969						199,969			
3. Fee-for-service (net of \$ medical expenses)	0									XXX
4. Risk revenue	0									XXX
5. Aggregate write-ins for other health care related revenues	0	0	0	0	0	0	0	0	0	XXX
6. Aggregate write-ins for other non-health care related revenues	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
7. Total revenues (Lines 1 to 6)	1,309,826,166	60,587,416	0	0	0	0	44,135,821	1,051,493,442	153,609,487	0
8. Hospital/medical benefits	683,640,899	29,736,382					19,734,160	529,270,384	104,899,973	XXX
9. Other professional services	66,537,302	1,730,986					1,236,332	60,385,428	3,184,556	XXX
10. Outside referrals	0									XXX
11. Emergency room and out-of-area	119,317,809	5,824,965					5,441,396	106,411,880	1,639,568	XXX
12. Prescription drugs	210,136,548	14,260,573					3,265,917	190,502,685	2,107,373	XXX
13. Aggregate write-ins for other hospital and medical	79,384,877	1,592,421	0	0	0	0	2,745,844	44,944,747	30,101,865	XXX
14. Incentive pool, withhold adjustments and bonus amounts	3,882,263						69,382	2,203,114	1,609,767	XXX
15. Subtotal (Lines 8 to 14)	1,162,899,698	53,145,327	0	0	0	0	32,493,031	933,718,238	143,543,102	XXX
16. Net reinsurance recoveries	0									XXX
17. Total medical and hospital (Lines 15 minus 16)	1,162,899,698	53,145,327	0	0	0	0	32,493,031	933,718,238	143,543,102	XXX
18. Non-health claims (net)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
19. Claims adjustment expenses including \$ 52,494,254 cost containment expenses	79,803,226	6,381,379					3,125,078	65,755,566	4,541,213	
20. General administrative expenses	65,958,505	5,274,301					2,582,922	54,347,904	3,753,378	
21. Increase in reserves for accident and health contracts	(1,535,613)	(64,411)						(1,154,567)	(316,635)	XXX
22. Increase in reserves for life contracts	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
23. Total underwriting deductions (Lines 17 to 22)	1,307,125,816	64,736,596	0	0	0	0	38,201,031	1,052,667,131	151,521,058	0
24. Total underwriting gain or (loss) (Line 7 minus Line 23)	2,700,350	(4,149,180)	0	0	0	0	5,934,790	(1,173,889)	2,088,429	0
DETAILS OF WRITE-INS										
0501.										XXX
0502.										XXX
0503.										XXX
0598. Summary of remaining write-ins for Line 5 from overflow page	0	0	0	0	0	0	0	0	0	XXX
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above)	0	0	0	0	0	0	0	0	0	XXX
0601.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0602.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0603.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0698. Summary of remaining write-ins for Line 6 from overflow page	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
1301. Ambulance, DME, Home Health Care, Other LTSS	79,384,877	1,592,421					2,745,844	44,944,747	30,101,865	XXX
1302.										XXX
1303.										XXX
1398. Summary of remaining write-ins for Line 13 from overflow page	0	0	0	0	0	0	0	0	0	XXX
1399. Totals (Lines 1301 thru 1303 plus 1398) (Line 13 above)	79,384,877	1,592,421	0	0	0	0	2,745,844	44,944,747	30,101,865	XXX

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 1 - PREMIUMS

Line of Business	1 Direct Business	2 Reinsurance Assumed	3 Reinsurance Ceded	4 Net Premium Income (Cols. 1 + 2 - 3)
1. Comprehensive (hospital and medical)	60,587,416			60,587,416
2. Medicare Supplement				0
3. Dental only				0
4. Vision only				0
5. Federal Employees Health Benefits Plan	0			0
6. Title XVIII - Medicare	43,935,852			43,935,852
7. Title XIX - Medicaid	1,205,102,929			1,205,102,929
8. Other health				0
9. Health subtotal (Lines 1 through 8)	1,309,626,197	0	0	1,309,626,197
10. Life	0			0
11. Property/casualty	0			0
12. Totals (Lines 9 to 11)	1,309,626,197	0	0	1,309,626,197

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2 - CLAIMS INCURRED DURING THE YEAR

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Payments during the year:										
1.1 Direct	1,148,637,435	58,537,300					33,493,763	916,088,292	140,518,080	
1.2 Reinsurance assumed	0	0					0	0	0	
1.3 Reinsurance ceded	0	0					0	0	0	
1.4 Net	1,148,637,435	58,537,300	0	0	0	0	33,493,763	916,088,292	140,518,080	0
2. Paid medical incentive pools and bonuses	2,670,415						11,167	1,515,280	1,143,968	
3. Claim liability December 31, current year from Part 2A:										
3.1 Direct	96,061,391	3,633,063	0	0	0	0	3,379,741	75,489,236	13,559,351	0
3.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
3.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
3.4 Net	96,061,391	3,633,063	0	0	0	0	3,379,741	75,489,236	13,559,351	0
4. Claim reserve December 31, current year from Part 2D:										
4.1 Direct	227,821							227,821		
4.2 Reinsurance assumed	0							0		
4.3 Reinsurance ceded	0							0		
4.4 Net	227,821	0	0	0	0	0	0	227,821	0	0
5. Accrued medical incentive pools and bonuses, current year	3,497,761						56,991	1,467,575	1,973,195	
6. Net healthcare receivables (a)	3,913,301	845,890					357,750	2,477,003	232,658	
7. Amounts recoverable from reinsurers December 31, current year	0									
8. Claim liability December 31, prior year from Part 2A:										
8.1 Direct	81,781,184	8,179,146	0	0	0	0	4,092,105	57,598,495	11,911,438	0
8.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
8.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
8.4 Net	81,781,184	8,179,146	0	0	0	0	4,092,105	57,598,495	11,911,438	0
9. Claim reserve December 31, prior year from Part 2D:										
9.1 Direct	214,727							214,727		
9.2 Reinsurance assumed	0							0		
9.3 Reinsurance ceded	0							0		
9.4 Net	214,727	0	0	0	0	0	0	214,727	0	0
10. Accrued medical incentive pools and bonuses, prior year	2,285,913						(1,224)	779,741	1,507,396	
11. Amounts recoverable from reinsurers December 31, prior year	0									
12. Incurred Benefits:										
12.1 Direct	1,159,017,435	53,145,327	0	0	0	0	32,423,649	931,515,124	141,933,335	0
12.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
12.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
12.4 Net	1,159,017,435	53,145,327	0	0	0	0	32,423,649	931,515,124	141,933,335	0
13. Incurred medical incentive pools and bonuses	3,882,263	0	0	0	0	0	69,382	2,203,114	1,609,767	0

(a) Excludes \$297,531 loans or advances to providers not yet expensed.

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2A - CLAIMS LIABILITY END OF CURRENT YEAR

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Reported in Process of Adjustment:										
1.1 Direct	37,769,280	1,583,204					1,157,182	25,891,959	9,136,935	
1.2 Reinsurance assumed .....	.0									
1.3 Reinsurance ceded .....	.0									
1.4 Net	37,769,280	1,583,204	.0	.0	.0	.0	1,157,182	25,891,959	9,136,935	.0
2. Incurred but Unreported:										
2.1 Direct	58,292,111	2,049,859					2,222,559	49,597,277	4,422,416	
2.2 Reinsurance assumed .....	.0									
2.3 Reinsurance ceded .....	.0									
2.4 Net	58,292,111	2,049,859	.0	.0	.0	.0	2,222,559	49,597,277	4,422,416	.0
3. Amounts Withheld from Paid Claims and Capitations:										
3.1 Direct .....	.0									
3.2 Reinsurance assumed .....	.0									
3.3 Reinsurance ceded .....	.0									
3.4 Net .....	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
4. TOTALS:										
4.1 Direct	96,061,391	3,633,063	.0	.0	.0	.0	3,379,741	75,489,236	13,559,351	.0
4.2 Reinsurance assumed .....	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
4.3 Reinsurance ceded0	.0	.0	.0	.0	.0	.0	.0	.0	.0
4.4 Net	96,061,391	3,633,063	.0	.0	.0	.0	3,379,741	75,489,236	13,559,351	.0

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2B - ANALYSIS OF CLAIMS UNPAID - PRIOR YEAR - NET OF REINSURANCE

Line of Business	Claims Paid During the Year		Claim Reserve and Claim Liability December 31 of Current Year		5 Claims Incurred in Prior Years (Columns 1 + 3)	6 Estimated Claim Reserve and Claim Liability December 31 of Prior Year
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid December 31 of Prior Year	4 On Claims Incurred During the Year		
1. Comprehensive (hospital and medical)	6,711,504	51,882,461	(8,066)	3,641,129	6,703,438	8,179,146
2. Medicare Supplement					0	0
3. Dental Only					0	0
4. Vision Only					0	0
5. Federal Employees Health Benefits Plan					0	0
6. Title XVIII - Medicare	2,740,678	32,917,468	57,726	3,322,015	2,798,404	4,092,105
7. Title XIX - Medicaid	55,622,623	864,614,698	(291,406)	76,008,463	55,331,217	57,813,222
8. Other health	14,163,473	126,355,950	123,584	13,435,767	14,287,057	11,911,438
9. Health subtotal (Lines 1 to 8)	79,238,278	1,075,770,577	(118,162)	96,407,374	79,120,116	81,995,911
10. Healthcare receivables (a)	986,563	9,298,158			986,563	0
11. Other non-health					0	0
12. Medical incentive pools and bonus amounts	2,192,830	477,585	834,851	2,662,910	3,027,681	2,285,913
13. Totals (Lines 9 - 10 + 11 + 12)	80,444,545	1,066,950,004	716,689	99,070,284	81,161,234	84,281,824

(a) Excludes \$ 297,531 loans or advances to providers not yet expensed.

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Comprehensive (Hospital & Medical)

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	10,623	13,317	13,561	13,527	13,513
2. 2011	79,107	83,411	83,406	83,402	83,379
3. 2012	XXX	77,150	79,931	79,812	79,569
4. 2013	XXX	XXX	61,962	71,529	71,474
5. 2014	XXX	XXX	XXX	59,040	66,035
6. 2015	XXX	XXX	XXX	XXX	51,032

Section B - Incurred Health Claims - Comprehensive (Hospital & Medical)

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	13,523	13,734	13,562	13,527	13,513
2. 2011	84,192	83,439	83,436	83,403	83,379
3. 2012	XXX	80,905	80,104	79,799	79,564
4. 2013	XXX	XXX	72,755	71,681	71,438
5. 2014	XXX	XXX	XXX	67,079	66,066
6. 2015	XXX	XXX	XXX	XXX	54,674

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Comprehensive (Hospital & Medical)

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2011	85,015	83,379	2,634	3.2	86,013	90.5	0	0	86,013	90.5
2. 2012	87,705	79,569	2,724	3.4	82,293	93.8	(5)	0	82,288	93.8
3. 2013	80,098	71,474	5,521	9.1	77,995	97.4	(36)	(1)	77,958	97.3
4. 2014	73,418	66,035	7,219	10.9	73,254	99.8	31	1	73,286	99.8
5. 2015	60,587	51,032	5,581	10.9	56,613	93.4	3,642	123	60,378	99.7

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Title XVIII

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	2,243	1,885	1,778	1,767	1,788
2. 2011	23,875	26,002	26,006	25,990	25,968
3. 2012	XXX	20,682	23,901	23,871	23,777
4. 2013	XXX	XXX	21,838	24,489	24,348
5. 2014	XXX	XXX	XXX	26,994	29,712
6. 2015	XXX	XXX	XXX	XXX	30,665

Section B - Incurred Health Claims - Title XVIII

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	2,246	1,888	1,778	1,767	1,788
2. 2011	27,328	25,901	25,966	25,988	25,968
3. 2012	XXX	23,887	23,860	23,859	23,778
4. 2013	XXX	XXX	24,888	24,519	24,355
5. 2014	XXX	XXX	XXX	31,069	29,762
6. 2015	XXX	XXX	XXX	XXX	34,044

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Title XVIII

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2011	28,566	25,968	483	1.9	26,451	92.6	0	0	26,451	92.6
2. 2012	25,029	23,777	592	2.5	24,369	97.4	1	0	24,370	97.4
3. 2013	29,447	24,348	1,622	6.7	25,970	88.2	7	0	25,977	88.2
4. 2014	31,601	29,712	2,365	8.0	32,077	101.5	50	2	32,129	101.7
5. 2015	44,136	30,665	2,734	8.9	33,399	75.7	3,379	114	36,892	83.6

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Title XIX

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	19,169	18,975	21,386	21,554	21,498
2. 2011	351,540	369,190	370,905	371,052	370,889
3. 2012	XXX	366,536	386,081	386,555	386,378
4. 2013	XXX	XXX	357,222	382,849	384,432
5. 2014	XXX	XXX	XXX	576,925	631,772
6. 2015	XXX	XXX	XXX	XXX	859,093

Section B - Incurred Health Claims - Title XIX

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	20,357	20,611	21,488	21,554	21,498
2. 2011	378,354	370,182	370,751	371,056	370,889
3. 2012	XXX	388,916	385,361	386,491	386,354
4. 2013	XXX	XXX	382,420	383,101	384,195
5. 2014	XXX	XXX	XXX	635,326	631,733
6. 2015	XXX	XXX	XXX	XXX	936,578

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Title XIX

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2011	408,399	370,889	11,841	3.2	382,730	93.7	0	0	382,730	93.7
2. 2012	440,991	386,378	13,855	3.6	400,233	90.8	(24)	(1)	400,208	90.8
3. 2013	436,265	384,432	29,355	7.6	413,787	94.8	(237)	(7)	413,543	94.8
4. 2014	697,605	631,772	40,975	6.5	672,747	96.4	(39)	(2)	672,706	96.4
5. 2015	1,051,493	859,093	56,949	6.6	916,042	87.1	77,485	2,579	996,106	94.7

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Other

Year in Which Losses Were Incurred	Cumulative Net Amounts Paid				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	1,287	1,262	1,259	1,261	1,262
2. 2011	32,938	34,319	34,314	34,309	34,308
3. 2012	XXX	34,955	36,506	36,516	36,517
4. 2013	XXX	XXX	33,773	44,415	44,406
5. 2014	XXX	XXX	XXX	119,664	134,941
6. 2015	XXX	XXX	XXX	XXX	126,160

Section B - Incurred Health Claims - Other

Year in Which Losses Were Incurred	Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
	1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior	1,288	1,266	1,259	1,261	1,262
2. 2011	34,582	34,462	34,284	34,310	34,308
3. 2012	XXX	36,767	36,408	36,515	36,517
4. 2013	XXX	XXX	46,990	44,403	44,406
5. 2014	XXX	XXX	XXX	133,095	135,910
6. 2015	XXX	XXX	XXX	XXX	140,724

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Other

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2011	46,015	34,308	1,331	3.9	35,639	77.5	0	0	35,639	77.5
2. 2012	47,955	36,517	1,588	4.3	38,105	79.5	0	0	38,105	79.5
3. 2013	53,653	44,406	3,515	7.9	47,921	89.3	0	0	47,921	89.3
4. 2014	135,631	134,941	1,050	0.8	135,991	100.3	969	4	136,964	101.0
5. 2015	153,610	126,160	3,843	3.0	130,003	84.6	14,564	469	145,036	94.4

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Grand Total

Year in Which Losses Were Incurred		Cumulative Net Amounts Paid				
		1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior		33,322	35,439	37,984	38,109	38,061
2. 2011		487,460	512,922	514,631	514,753	514,544
3. 2012		XXX	499,323	526,419	526,754	526,241
4. 2013		XXX	XXX	474,795	523,282	524,660
5. 2014		XXX	XXX	XXX	782,623	862,460
6. 2015		XXX	XXX	XXX	XXX	1,066,950

Section B - Incurred Health Claims - Grand Total

Year in Which Losses Were Incurred		Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
		1 2011	2 2012	3 2013	4 2014	5 2015
1. Prior		37,414	37,499	38,087	38,109	38,061
2. 2011		524,456	513,984	514,457	514,757	514,544
3. 2012		XXX	530,475	525,733	526,664	526,213
4. 2013		XXX	XXX	527,053	523,704	524,394
5. 2014		XXX	XXX	XXX	866,569	863,471
6. 2015		XXX	XXX	XXX	XXX	1,166,020

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Grand Total

Years in which Premiums were Earned and Claims were Incurred	1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2011	577,995	514,544	16,289	3.2	530,833	91.8	0	0	530,833	91.8
2. 2012	601,680	526,241	18,759	3.6	545,000	90.6	(28)	(1)	544,971	90.6
3. 2013	599,463	524,660	41,013	7.8	565,673	94.4	(266)	(8)	565,399	94.3
4. 2014	938,255	862,460	51,609	6.0	914,069	97.4	1,011	5	915,085	97.5
5. 2015	1,309,826	1,066,950	69,107	6.5	1,136,057	86.7	99,070	3,285	1,238,412	94.5

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2D - AGGREGATE RESERVE FOR ACCIDENT AND HEALTH CONTRACTS ONLY

	1	2	3	4	5	6	7	8	9
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
1. Unearned premium reserves .....	.0								
2. Additional policy reserves (a) .....	.0								
3. Reserve for future contingent benefits .....	.0								
4. Reserve for rate credits or experience rating refunds (including \$) for investment income	326,451						326,451		
5. Aggregate write-ins for other policy reserves	7,527	.0	.0	.0	.0	.0	7,527	.0	.0
6. Totals (gross)	333,978	.0	.0	.0	.0	.0	333,978	.0	.0
7. Reinsurance ceded .....	.0								
8. Totals (Net)(Page 3, Line 4)	333,978	.0	.0	.0	.0	.0	333,978	.0	.0
9. Present value of amounts not yet due on claims .....	.0								
10. Reserve for future contingent benefits	227,821							227,821	
11. Aggregate write-ins for other claim reserves .....	.0	.0	.0	.0	.0	.0	.0	.0	.0
12. Totals (gross)	227,821	.0	.0	.0	.0	.0	.0	227,821	.0
13. Reinsurance ceded .....	.0								
14. Totals (Net)(Page 3, Line 7)	227,821	0	0	0	0	0	0	227,821	0
DETAILS OF WRITE-INS									
0501. Risk Adjustment Redetermination	7,527						7,527		
0502.									
0503.									
0598. Summary of remaining write-ins for Line 5 from overflow page.....	.0	.0	.0	.0	.0	.0	.0	.0	.0
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above)	7,527	0	0	0	0	0	7,527	0	0
1101.									
1102.									
1103.									
1198. Summary of remaining write-ins for Line 11 from overflow page0	.0	.0	.0	.0	.0	.0	.0	.0
1199. Totals (Lines 1101 thru 1103 plus 1198) (Line 11 above)	0	0	0	0	0	0	0	0	0

(a) Includes \$ premium deficiency reserve.

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 3 - ANALYSIS OF EXPENSES

	Claim Adjustment Expenses		3 General Administrative Expenses	4 Investment Expenses	5 Total
	1 Cost Containment Expenses	2 Other Claim Adjustment Expenses			
1. Rent (\$ for occupancy of own building).....	1,808,462	805,502	(723,828)	(2,175)	1,887,961
2. Salary, wages and other benefits	36,645,517	13,145,807	19,479,263	58,543	69,329,130
3. Commissions (less \$ ceded plus \$ assumed)			104,992		104,992
4. Legal fees and expenses	2,123		727,497	2,186	731,806
5. Certifications and accreditation fees					0
6. Auditing, actuarial and other consulting services	3,867,247	277,479	5,460,166	16,410	9,621,302
7. Traveling expenses	577,119	58,025	646,257	1,942	1,283,343
8. Marketing and advertising	951,057	10,796	1,955,369	5,877	2,923,099
9. Postage, express and telephone	1,923,578	393,928	1,832,468	5,507	4,155,481
10. Printing and office supplies	65,970	10,560	137,018	412	213,960
11. Occupancy, depreciation and amortization	0	0	0	0	0
12. Equipment	12,558	5,216	533,274	1,603	552,651
13. Cost or depreciation of EDP equipment and software	1,133,028	84,207	4,911,934	14,762	6,143,931
14. Outsourced services including EDP, claims, and other services	3,144,829	5,059,225	1,443,958	4,340	9,652,352
15. Boards, bureaus and association fees	28,282	0	203,891	613	232,786
16. Insurance, except on real estate	0	0	485,308	1,459	486,767
17. Collection and bank service charges	1,000	0	129,003	388	130,391
18. Group service and administration fees	0	0	192	1	193
19. Reimbursements by uninsured plans	0	0	0	0	0
20. Reimbursements from fiscal intermediaries	0	0	0	0	0
21. Real estate expenses	7,337	606	1,364,281	4,100	1,376,324
22. Real estate taxes	0	0	25,751	0	25,751
23. Taxes, licenses and fees:					
23.1 State and local insurance taxes	646	0	1,325,361	0	1,326,007
23.2 State premium taxes	0	0	0	0	0
23.3 Regulatory authority licenses and fees	13,702	45	51,948	0	65,695
23.4 Payroll taxes	2,299,854	813,050	1,187,937	0	4,300,841
23.5 Other (excluding federal income and real estate taxes)	0	0	21,359,970	0	21,359,970
24. Investment expenses not included elsewhere	0	0	0	146,892	146,892
25. Aggregate write-ins for expenses	11,945	6,644,526	3,316,495	9,967	9,982,933
26. Total expenses incurred (Lines 1 to 25)	52,494,254	27,308,972	65,958,505	272,827	(a) .....146,034,558
27. Less expenses unpaid December 31, current year ..	3,280,587		889,919		4,170,506
28. Add expenses unpaid December 31, prior year	2,649,718		866,371		3,516,089
29. Amounts receivable relating to uninsured plans, prior year					0
30. Amounts receivable relating to uninsured plans, current year			329,726		329,726
31. Total expenses paid (Lines 26 minus 27 plus 28 minus 29 plus 30)	51,863,385	27,308,972	66,264,683	272,827	145,709,867
DETAILS OF WRITE-INS					
2501. Capitation Administrative Fee			3,024,006		3,024,006
2502. Pharmacy Administrative Fee		2,497,507			2,497,507
2503. Claims Related Fees		3,968,482			3,968,482
2598. Summary of remaining write-ins for Line 25 from overflow page	11,945	178,537	292,489	9,967	492,938
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	11,945	6,644,526	3,316,495	9,967	9,982,933

(a) Includes management fees of \$125,803,550 to affiliates and \$ to non-affiliates.

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

EXHIBIT OF NET INVESTMENT INCOME

	1 Collected During Year	2 Earned During Year
1. U.S. government bonds	(a) 79,437	85,454
1.1 Bonds exempt from U.S. tax	(a) .....	.....
1.2 Other bonds (unaffiliated)	(a) 3,052,560	3,066,625
1.3 Bonds of affiliates	(a) .....	.....
2.1 Preferred stocks (unaffiliated)	(b) .....	.....
2.11 Preferred stocks of affiliates	(b) .....	.....
2.2 Common stocks (unaffiliated) .....	.....	.....
2.21 Common stocks of affiliates	540,560	540,560
3. Mortgage loans	(c) .....	.....
4. Real estate	(d) .....	.....
5. Contract Loans .....	.....	.....
6. Cash, cash equivalents and short-term investments	(e) 20,625	21,491
7. Derivative instruments	(f) .....	.....
8. Other invested assets .....	.....	.....
9. Aggregate write-ins for investment income	31,610	32,855
10. Total gross investment income	3,724,792	3,746,985
11. Investment expenses	(g)	272,827
12. Investment taxes, licenses and fees, excluding federal income taxes	(g)	0
13. Interest expense	(h) .....	.....
14. Depreciation on real estate and other invested assets	(i) .....	.....
15. Aggregate write-ins for deductions from investment income .....	.....	0
16. Total deductions (Lines 11 through 15) .....	.....	272,827
17. Net investment income (Line 10 minus Line 16) .....	.....	3,474,158
DETAILS OF WRITE-INS		
0901. Miscellaneous Income	11	11
0902. Securities Lending	31,599	32,844
0903. ....	.....	.....
0998. Summary of remaining write-ins for Line 9 from overflow page	0	0
0999. Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)	31,610	32,855
1501. ....	.....	.....
1502. ....	.....	.....
1503. ....	.....	.....
1598. Summary of remaining write-ins for Line 15 from overflow page .....	.....	0
1599. Totals (Lines 1501 thru 1503 plus 1598) (Line 15, above) .....	.....	0

- (a) Includes \$10,086 accrual of discount less \$1,303,881 amortization of premium and less \$14,509 paid for accrued interest on purchases.
- (b) Includes \$ accrual of discount less \$ amortization of premium and less \$ paid for accrued dividends on purchases.
- (c) Includes \$ accrual of discount less \$ amortization of premium and less \$ paid for accrued interest on purchases.
- (d) Includes \$ for company's occupancy of its own buildings; and excludes \$ interest on encumbrances.
- (e) Includes \$ accrual of discount less \$ amortization of premium and less \$ paid for accrued interest on purchases.
- (f) Includes \$ accrual of discount less \$ amortization of premium.
- (g) Includes \$ investment expenses and \$ investment taxes, licenses and fees, excluding federal income taxes, attributable to segregated and Separate Accounts.
- (h) Includes \$ interest on surplus notes and \$ interest on capital notes.
- (i) Includes \$ depreciation on real estate and \$ depreciation on other invested assets.

EXHIBIT OF CAPITAL GAINS (LOSSES)

	1 Realized Gain (Loss) On Sales or Maturity	2 Other Realized Adjustments	3 Total Realized Capital Gain (Loss) (Columns 1 + 2)	4 Change in Unrealized Capital Gain (Loss)	5 Change in Unrealized Foreign Exchange Capital Gain (Loss)
1. U.S. Government bonds	0	0	0	0	0
1.1 Bonds exempt from U.S. tax .....	.....	.....	.....	.....	.....
1.2 Other bonds (unaffiliated)	(634,899)	0	(634,899)	196,905	0
1.3 Bonds of affiliates	0	0	0	0	0
2.1 Preferred stocks (unaffiliated)	0	0	0	0	0
2.11 Preferred stocks of affiliates	0	0	0	0	0
2.2 Common stocks (unaffiliated)	0	0	0	(613,855)	0
2.21 Common stocks of affiliates	0	0	0	0	0
3. Mortgage loans	0	0	0	0	0
4. Real estate	0	0	0	0	0
5. Contract loans	0	0	0	0	0
6. Cash, cash equivalents and short-term investments	0	0	0	0	0
7. Derivative instruments	0	0	0	0	0
8. Other invested assets	0	0	0	0	0
9. Aggregate write-ins for capital gains (losses)	0	0	0	0	0
10. Total capital gains (losses)	(634,899)	0	(634,899)	(416,950)	0
DETAILS OF WRITE-INS					
0901. ....	.....	.....	.....	.....	.....
0902. ....	.....	.....	.....	.....	.....
0903. ....	.....	.....	.....	.....	.....
0998. Summary of remaining write-ins for Line 9 from overflow page	0	0	0	0	0
0999. Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)	0	0	0	0	0

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

EXHIBIT OF NON-ADMITTED ASSETS

	1	2	3
	Current Year Total Nonadmitted Assets	Prior Year Total Nonadmitted Assets	Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
1. Bonds (Schedule D)			0
2. Stocks (Schedule D):			
2.1 Preferred stocks			0
2.2 Common stocks			0
3. Mortgage loans on real estate (Schedule B):			
3.1 First liens			0
3.2 Other than first liens			0
4. Real estate (Schedule A):			
4.1 Properties occupied by the company			0
4.2 Properties held for the production of income			0
4.3 Properties held for sale			0
5. Cash (Schedule E - Part 1), cash equivalents (Schedule E - Part 2) and short-term investments (Schedule DA)			0
6. Contract loans			0
7. Derivatives (Schedule DB)			0
8. Other invested assets (Schedule BA)			0
9. Receivables for securities			0
10. Securities lending reinvested collateral assets (Schedule DL)			0
11. Aggregate write-ins for invested assets	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	0	0	0
13. Title plants (for Title insurers only)			0
14. Investment income due and accrued			0
15. Premiums and considerations:			
15.1 Uncollected premiums and agents' balances in the course of collection			0
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due			0
15.3 Accrued retrospective premiums and contracts subject to redetermination			0
16. Reinsurance:			
16.1 Amounts recoverable from reinsurers			0
16.2 Funds held by or deposited with reinsured companies			0
16.3 Other amounts receivable under reinsurance contracts			0
17. Amounts receivable relating to uninsured plans			0
18.1 Current federal and foreign income tax recoverable and interest thereon			0
18.2 Net deferred tax asset			0
19. Guaranty funds receivable or on deposit			0
20. Electronic data processing equipment and software			0
21. Furniture and equipment, including health care delivery assets	2,494,874	1,158,001	(1,336,873)
22. Net adjustment in assets and liabilities due to foreign exchange rates			0
23. Receivable from parent, subsidiaries and affiliates	189,499		(189,499)
24. Health care and other amounts receivable	10,121,359	5,249,931	(4,871,428)
25. Aggregate write-ins for other than invested assets	8,122,895	8,277,540	154,645
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	20,928,627	14,685,472	(6,243,155)
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0
28. Total (Lines 26 and 27)	20,928,627	14,685,472	(6,243,155)
DETAILS OF WRITE-INS			
1101.			
1102.			
1103.			
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0
1199. Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	0	0	0
2501. Goodwill, Intangibles, and Covenant not to Compete	8,069,210	8,069,210	0
2502. Prepaids	53,685	208,330	154,645
2503.			
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	8,122,895	8,277,540	154,645

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

EXHIBIT 1 - ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS ONLY

Source of Enrollment	Total Members at End of					6 Current Year Member Months
	1 Prior Year	2 First Quarter	3 Second Quarter	4 Third Quarter	5 Current Year	
1. Health Maintenance Organizations	364,108	377,883	383,751	391,470	392,725	4,608,418
2. Provider Service Organizations						
3. Preferred Provider Organizations						
4. Point of Service						
5. Indemnity Only						
6. Aggregate write-ins for other lines of business	0	0	0	0	0	0
7. Total	364,108	377,883	383,751	391,470	392,725	4,608,418
DETAILS OF WRITE-INS						
0601.						
0602.						
0603.						
0698. Summary of remaining write-ins for Line 6 from overflow page	0	0	0	0	0	0
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	0	0	0	0	0

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

EXHIBIT 3 - HEALTH CARE RECEIVABLES

1 Name of Debtor	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 Over 90 Days	6 Nonadmitted	7 Admitted
Express Scripts, Inc.	0	114,410	346,483	1,799,741	1,799,741	460,893
CVS Caremark				24,353	24,353	
0199998. Aggregate Pharmaceutical Rebate Receivables Not Individually Listed						
0199999. Total Pharmaceutical Rebate Receivables	0	114,410	346,483	1,824,094	1,824,094	460,893
0299998. Aggregate Claim Overpayment Receivables Not Individually Listed	101,276	349,715	810,351	3,145,194	4,406,536	
0299999. Total Claim Overpayment Receivables	101,276	349,715	810,351	3,145,194	4,406,536	0
0399998. Aggregate Loans and Advances to Providers Not Individually Listed				297,531	297,531	
0399999. Total Loans and Advances to Providers	0	0	0	297,531	297,531	0
0499998. Aggregate Capitation Arrangement Receivables Not Individually Listed				2,684,535	2,684,535	
0499999. Total Capitation Arrangement Receivables	0	0	0	2,684,535	2,684,535	0
0599998. Aggregate Risk Sharing Receivables Not Individually Listed						
0599999. Total Risk Sharing Receivables	0	0	0	0	0	0
0699998. Aggregate Other Receivables Not Individually Listed	900,176			8,487	908,663	
0699999. Total Other Receivables	900,176	0	0	8,487	908,663	0
0799999 Gross health care receivables	1,001,452	464,125	1,156,834	7,959,841	10,121,359	460,893

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

EXHIBIT 3A - ANALYSIS OF HEALTH CARE RECEIVABLES COLLECTED AND ACCRUED

Type of Health Care Receivable	Health Care Receivables Collected During the Year		Health Care Receivables Accrued as of December 31 of Current Year		5	6
	1 On Amounts Accrued Prior to January 1 of Current Year	2 On Amounts Accrued During the Year	3 On Amounts Accrued December 31 of Prior Year	4 On Amounts Accrued During the Year	Health Care Receivables in Prior Years (Columns 1 + 3)	Estimated Health Care Receivables Accrued as of December 31 of Prior Year
1. Pharmaceutical rebate receivables	1,647,583	1,290,231	98,951	2,186,036	1,746,534	2,649,066
2. Claim overpayment receivables	1,152,055	3,229,300	702,179	3,704,357	1,854,234	1,873,949
3. Loans and advances to providers				297,531	0	0
4. Capitation arrangement receivables				2,684,535	0	998,588
5. Risk sharing receivables					0	0
6. Other health care receivables.....	425,993	395,381	185,433	723,230	611,426	849,817
7. Totals (Lines 1 through 6)	3,225,631	4,914,912	986,563	9,595,689	4,212,194	6,371,420

Note that the accrued amounts in Columns 3, 4, and 6 are the total health care receivables, not just the admitted portion.

EXHIBIT 4 - CLAIMS UNPAID AND INCENTIVE POOL, WITHHOLD AND BONUS (Reported and Unreported)

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.
EXHIBIT 7 PART 1- SUMMARY OF TRANSACTIONS WITH PROVIDERS

	1	2	3	4	5	6
Payment Method	Direct Medical Expense Payment	Column 1 as a % of Total Payments	Total Members Covered	Column 3 as a % of Total Members	Column 1 Expenses Paid to Affiliated Providers	Column 1 Expenses Paid to Non-Affiliated Providers
Capitation Payments:						
1. Medical groups	39,225,744	3.4	392,725	100.0		39,225,744
2. Intermediaries .....	.0	0.0		.0		
3. All other providers	11,994,571	1.0	392,725	100.0		11,994,571
4. Total capitation payments	51,220,315	4.5	785,450	200.0	0	51,220,315
Other Payments:						
5. Fee-for-service	28,168,216	2.5	XXX	XXX		28,168,216
6. Contractual fee payments	1,065,335,603	92.8	XXX	XXX		1,065,335,603
7. Bonus/withhold arrangements - fee-for-service .....	.0	0.0	XXX	XXX		
8. Bonus/withhold arrangements - contractual fee payments	2,670,415	0.2	XXX	XXX		2,670,415
9. Non-contingent salaries .....	.0	0.0	XXX	XXX		
10. Aggregate cost arrangements .....	.0	0.0	XXX	XXX		
11. All other payments .....	.0	0.0	XXX	XXX		
12. Total other payments	1,096,174,234	95.5	XXX	XXX	0	1,096,174,234
13. TOTAL (Line 4 plus Line 12)	1,147,394,549	100%	XXX	XXX	0	1,147,394,549

EXHIBIT 7 - PART 2 - SUMMARY OF TRANSACTIONS WITH INTERMEDIARIES

1	2	3	4	5	6
NAIC Code	Name of Intermediary	Capitation Paid	Average Monthly Capitation	Intermediary's Total Adjusted Capital	Intermediary's Authorized Control Level RBC
	NONE				
9999999 Totals			XXX	XXX	XXX

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

EXHIBIT 8 - FURNITURE, EQUIPMENT AND SUPPLIES OWNED

		1	2	3	4	5	6
Description		Cost	Improvements	Accumulated Depreciation	Book Value Less Encumbrances	Assets Not Admitted	Net Admitted Assets
1.	Administrative furniture and equipment	6,224,952		(3,730,078)	2,494,874	2,494,874	
2.	Medical furniture, equipment and fixtures						
3.	Pharmaceuticals and surgical supplies						
4.	Durable medical equipment						
5.	Other property and equipment						
6.	Total	6,224,952	0	(3,730,078)	2,494,874	2,494,874	0

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies

A. Accounting Practices

The accompanying financial statements of AMERIGROUP Florida, Inc. (the "Company") have been prepared in conformity with the National Association of Insurance Commissioners' ("NAIC") *Annual Statement Instructions* and in accordance with accounting practices prescribed by the NAIC *Accounting Practice and Procedures Manual* ("NAIC SAP"), subject to any deviations prescribed or permitted by the Florida Department of Financial Services ("Florida DFS").

For the years ended December 31, 2015 and December 31, 2014, there were no differences between the Company's net loss and capital and surplus between NAIC SAP and practices prescribed and permitted by the state of Florida.

	State of Domicile	2015	2014
Net Loss			
(1) AMERIGROUP Florida, Inc. (Page 4, Line 32, Columns 2 & 3)	Florida	\$ (1,935,759)	\$ (26,651,523)
(2) States Prescribed Practices that increase(decrease) NAIC SAP:	Florida	-	-
(3) State Permitted Practices that increase(decrease) NAIC SAP:	Florida	-	-
(4) NAIC SAP (1 - 2 - 3 = 4)	Florida	\$ (1,935,759)	\$ (26,651,523)
Surplus			
(5) AMERIGROUP Florida, Inc. (Page 3, Line 33, Columns 3 & 4)	Florida	\$ 75,684,471	\$ 83,605,928
(6) States Prescribed Practices that increase(decrease) NAIC SAP:	Florida	(189,499)	-
(7) State Permitted Practices that increase(decrease) NAIC SAP:	Florida	-	-
(8) NAIC SAP (5 - 6 - 7 = 8)	Florida	\$ 75,873,970	\$ 83,605,928

B. Use of Estimates in the Preparation of the Financial Statements

Preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

C. Accounting Policies

Health premium revenues, based on membership records and premiums rates for each membership category within each county, are recognized as revenue during the period in which the Company is obligated to provide service to members. Premiums are reported net of excess loss reinsurance ceded and experience rating refunds. Premiums paid before the effective service month are recorded on the balance sheet as premiums received in advance and are subsequently credited to income as earned during the coverage period. Premium rates are subject to approval by Centers for Medicare, Medicaid Services, and CMS. Costs, such as premium taxes and other underwriting expenses are charged to operations as incurred.

In addition, the Company uses the following accounting policies:

- Short-term investments include investments with maturities of less than one year at the date of acquisition and are reported at amortized cost, which approximates fair value. Non-investment grade short-term investments are stated at the lower of amortized cost or fair value.
- Investment grade bonds not backed by other loans are stated at amortized cost, with amortization calculated based on the modified scientific method, using lower of yield to call or yield to maturity. Non-investment grade bonds are stated at the lower of amortized cost or fair value as determined by various third-party pricing sources.
- Common stocks of unaffiliated companies are stated at fair value based upon security ratings prescribed by various third-party pricing sources.
- The Company has no investments in preferred stocks.
- The Company has no mortgage loans - real estate.
- Loan-backed securities are stated at amortized cost. Pre-payment assumptions for loan-backed securities and structured securities were obtained from broker-dealer survey values or internal estimates. These assumptions are consistent with the current interest rate and economic environment. The retrospective adjustment method is used to value all loan-backed securities. Non-investment grade loan-backed securities are stated at the lower of amortized cost or fair value.
- The Company has no investments in subsidiaries, controlled and affiliated companies.
- The Company has no investments in joint ventures, partnerships or limited liability companies.
- The Company has no derivative instruments.
- The Company does not anticipate investment income as a factor in the premium deficiency calculations.

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

11. Unpaid claims and claims adjustment expenses include management's best estimate of amounts based on historical claim development patterns and certain individual case estimates. The established liability considers health benefit provisions, business practices, economic conditions and other factors that may materially affect the cost, frequency and severity of claims. Liabilities for unpaid claims and claim adjustment expenses are based on assumptions and estimates, and while management believes such estimates are reasonable, the ultimate liability may be in excess of or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed and changes in estimates are incorporated into current period estimates.
12. The Company has not modified its capitalization policy from the prior period.
13. Pharmacy rebate receivables are recorded when earned based upon actual rebate receivables billed and an estimate of receivables based upon current utilization of specific pharmaceuticals and provider contract terms. All pharmaceutical rebates receivables are considered non-admitted due to their collectability beyond 90 days.

D. Going Concern

Not Applicable.

2. Accounting Changes and Corrections of Errors

There were no accounting changes or corrections of errors during the years ended December 31, 2015 and 2014.

3. Business Combinations and Goodwill

- | | |
|-------------------------------------|-----------------|
| A. Statutory Purchase Method | Not applicable. |
| B. Statutory Merger | Not applicable. |
| C. Assumption Reinsurance | Not applicable. |
| D. Impairment Loss | Not applicable. |

4. Discontinued Operations

The Company had no operations that were discontinued during 2015 or 2014.

5. Investments

A. Mortgage Loans, including Mezzanine Real Estate Loans

The Company did not have investments in mortgage loans at December 31, 2015 or 2014.

B. Debt Restructuring

The Company did not have invested assets that were restructured debt at December 31, 2015 or 2014.

C. Reverse Mortgages

The Company did not have investments in reverse mortgages at December 31, 2015 or 2014.

D. Loan-Backed Securities

1. Prepayment assumptions for single-class and multi-class mortgage-backed and asset-backed securities were obtained from broker-dealer survey values or internal estimates. The Company used various third-party pricing sources in determining the market value of its loan-back securities.
2. The Company did not hold other-than-temporary impairments on its loan-backed securities at December 31, 2015 and 2014.
3. The Company did not hold other-than-temporarily impairments on its loan-backed securities at December 31, 2015 and 2014.
4. The Company had no impaired securities for which an other-than-temporary impairment had not been recognized in earnings as a realized loss at December 31, 2015 and 2014.
5. The Company had no impaired loan-backed securities at December 31, 2015 and 2014.

E. Repurchase Agreements and/or Securities Lending Transactions

1. The Company did not enter into repurchase agreements at December 31, 2015 or 2014.
2. The Company participates in a securities lending program whereby marketable securities in its investment portfolio are transferred to independent brokers or dealers based on, among other things,

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

their creditworthiness in exchange for collateral initially equal to at least 102% of the market value of the loaned securities. The Company receives the collateral in cash or securities, and if cash is received the cash collateral is thereafter invested according to guidelines of the Company's Investment Policy.

3. Collateral Received

a. Aggregate amount collateral received

1. Repurchase agreement – Not applicable.

	Fair Value
2. Securities Lending	
a. Open	4,625,943
b. 30 days or less	-
c. 31 to 60 days	-
d. 61 to 90 days	-
e. Greater than 90 days	-
f. Subtotal	4,625,943
g. Securities received	2,183,704
h. Total collateral received	<u>6,809,647</u>

3. Dollar repurchase agreement – Not applicable.

b. The fair value of that collateral and of the portion of that collateral that it has sold or repledged	<u>\$ 6,809,647</u>
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c. The Company receives cash collateral in an amount in excess of the fair value of the securities lent. The Company reinvests the cash collateral into short-term investments.

4. Not applicable.

5. Collateral Reinvestment

a. Aggregate amount collateral reinvested

1. Repurchase agreement – Not applicable.

	Amortized Cost	Fair Value
2. Securities Lending		
a. Open	\$ -	\$ -
b. 30 days or less	4,400,433	4,401,067
c. 31 to 60 days	100,016	99,982
d. 61 to 90 days	124,997	124,894
e. 91 to 120 days	-	-
f. 121 to 180 days	-	-
g. 181 to 365 days	-	-
h. 1 to 2 years	-	-
i. 2 to 3 years	-	-
j. Greater than 3 years	-	-
k. Subtotal	\$ 4,625,446	\$ 4,625,943
l. Securities received	2,183,704	2,183,704
m. Total collateral reinvested	<u>\$ 6,809,150</u>	<u>\$ 6,809,647</u>

3. Dollar repurchase agreement – Not applicable.

b. Not applicable.

6. Not applicable.

7. Not applicable.

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

F. Real Estate

The Company did not have investments in real estate and did not engage in retail land sales operations during 2015 or 2014.

G. Investments in Low-Income Housing Tax Credits

The Company did not invest in properties generating low-income housing tax credits during 2015 or 2014.

H. Restricted Assets

1. Restricted assets (including pledged)

	1	2	3	4	5	6
Restricted Asset Category	Total Gross Restricted From Current Year	Total Gross Restricted From Prior Year	Increase/ (Decrease) (Col. 1 minus Col. 2)	Total Current Year Admitted Restricted	Percentage Gross Restricted to Total Assets	Percentage Admitted Restricted to Total Admitted Assets
a. Subject to contractual obligation for which liability is not shown	\$ -	\$ -	\$ -	\$ -	-	-
b. Collateral held under security lending agreements	6,809,150	5,497,979	1,311,171	6,809,150	2.97%	3.27%
c. Subject to repurchase agreements	-	-	-	-	-	-
d. Subject to reverse repurchase agreements	-	-	-	-	-	-
e. Subject to dollar repurchase agreements	-	-	-	-	-	-
f. Subject to dollar reverse repurchase agreements	-	-	-	-	-	-
g. Placed under option contracts	-	-	-	-	-	-
h. Letter stock or securities restricted as to sale - excluding FHLB capital stock	-	-	-	-	-	-
i. FHLB capital stock	-	-	-	-	-	-
j. On deposit with states	38,846,192	40,084,373	(1,238,181)	38,846,192	16.94%	18.64%
k. On deposit with other regulatory bodies	-	-	-	-	-	-
l. Pledged collateral to FHLB (including assets backing funding agreements)	-	-	-	-	-	-
m. Pledged as collateral not captured in other categories	-	-	-	-	-	-
n. Other restricted assets	-	-	-	-	-	-
o. Total Restricted Assets	<u>\$ 45,655,342</u>	<u>\$ 45,582,352</u>	<u>\$ 72,990</u>	<u>\$ 45,655,342</u>	19.91%	21.91%

2. Not applicable.

3. Not applicable.

I. Working Capital Finance Investments

The Company did not have any working capital finance investments as December 31, 2015 and 2014.

J. Offsetting and Netting of Assets and Liabilities

The Company did not have any offsetting and netting of assets and liabilities at December 31, 2015 and 2014.

K. Structured Notes

The Company did not have any structured notes at December 31, 2015 and 2014.

6. Joint Ventures, Partnerships and Limited Liability Companies

A. The Company has no investments in joint ventures, partnerships, or limited liability companies that exceeded 10% of its admitted assets at December 31, 2015 or 2014.

B. The Company did not recognize impairment write downs for its investments in joint ventures, partnerships or limited liability companies during 2015 or 2014.

7. Investment Income

A. All investment income due and accrued with amounts that are over 90 days past due is non-admitted.

B. At December 31, 2015 and 2014, there was no non-admitted accrued investment interest income.

8. Derivative Instruments

The Company has no derivative instruments.

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

9. Income Taxes

A. The components of net deferred tax assets (liabilities):

1. The components of net deferred tax asset (liabilities) at December 31 are as follows:

12/31/2015		
(1)	(2)	(3)
Ordinary	Capital	(Col 1+2) Total
(a) Gross deferred tax assets	\$ 7,069,987	\$ - \$ 7,069,987
(b) Statutory valuation allowance adjustments	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	7,069,987	- 7,069,987
(d) Deferred tax assets nonadmitted	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	7,069,987	- 7,069,987
(f) Deferred tax liabilities	1,609	1,492,167 1,493,776
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	\$ 7,068,378	\$ (1,492,167) \$ 5,576,211

12/31/2014		
(4)	(5)	(6)
Ordinary	Capital	(Col 4+5) Total
(a) Gross deferred tax assets	\$ 6,521,620	\$ - \$ 6,521,620
(b) Statutory valuation allowance adjustments	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	6,521,620	- 6,521,620
(d) Deferred tax assets nonadmitted	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	6,521,620	- 6,521,620
(f) Deferred tax liabilities	3,045	1,616,771 1,619,816
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	\$ 6,518,575	\$ (1,616,771) \$ 4,901,804

Change		
(7)	(8)	(9)
(Col 1-4) Ordinary	(Col 2-5) Capital	(Col 7+8) Total
(a) Gross deferred tax assets	\$ 548,367	\$ - \$ 548,367
(b) Statutory valuation allowance adjustments	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	548,367	- 548,367
(d) Deferred tax assets nonadmitted	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	548,367	- 548,367
(f) Deferred tax liabilities	(1,436)	(124,604) (126,040)
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	\$ 549,803	\$ 124,604 \$ 674,407

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

2. The amount of admitted adjusted gross deferred tax assets under each component of SSAP 101 as of December 31 is as follows:

12/31/2015		
(1)	(2)	(3)
Ordinary	Capital	(Col 1+2) Total

Admission Calculation Components SSAP No. 101

(a) Federal income taxes paid in prior years recoverable through loss carrybacks	\$ 6,214,537	\$ -	\$ 6,214,537
(b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation (the lesser of 2(b)1 and 2(b)2 below)	163,960	-	163,960
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	163,960	-	163,960
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	10,514,346
(c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	691,490	-	691,490
(d) Deferred tax assets admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	\$ 7,069,987	\$ -	\$ 7,069,987

12/31/2014		
(4)	(5)	(6)
Ordinary	Capital	(Col 4+5) Total

Admission Calculation Components SSAP No. 101

(a) Federal income taxes paid in prior years recoverable through loss carrybacks	\$ 4,237,403	\$ -	\$ 4,237,403
(b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation (the lesser of 2(b)1 and 2(b)2 below)	1,620,174	-	1,620,174
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	1,620,174	-	1,620,174
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	11,799,596
(c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	664,043	-	664,043
(d) Deferred tax assets admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	\$ 6,521,620	\$ -	\$ 6,521,620

Change		
(7)	(8)	(9)
(Col 1-4) Ordinary	(Col 2-5) Capital	(Col 7+8) Total

Admission Calculation Components SSAP No. 101

(a) Federal income taxes paid in prior years recoverable through loss carrybacks	\$ 1,977,134	\$ -	\$ 1,977,134
(b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation (the lesser of 2(b)1 and 2(b)2 below)	(1,456,214)	-	(1,456,214)
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	(1,456,214)	-	(1,456,214)
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	(1,285,250)
(c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	27,447	-	27,447
(d) Deferred tax assets admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	\$ 548,367	\$ -	\$ 548,367

3.	2015	2014
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)2 above	\$ 70,095,642	\$ 78,663,972

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

4. Impact of tax planning strategies

12/31/2015		12/31/2014		Change	
(1)	(2)	(3)	(4)	(5)	(6)
Ordinary	Capital	Ordinary	Capital	(Col 1-3) Ordinary	(Col 2-4) Capital

(a) Determination of adjusted gross deferred tax assets and net admitted deferred tax assets by tax character as a percentage

1 Adjusted gross DTAs amount from Note 9A1(c)	\$ 7,069,987	\$ -	\$ 6,521,620	\$ -	\$ 548,367	\$ -
2 Percentage of adjusted gross DTAs by tax character attributable to the impact of tax planning strategies	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
3 Net admitted adjusted gross DTAs amount from Note 9A1(c)	\$ 7,069,987	\$ -	\$ 6,521,620	\$ -	\$ 548,367	\$ -
4 Percentage of net admitted adjusted gross DTAs by tax character admitted because of the impact of tax planning strategies	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

(b) Does the Company's tax-planning strategies include the use of reinsurance? Yes ☐ No ☒

B. The Company has no unrecognized deferred tax liabilities at December 31, 2015 and 2014.

C. Current income taxes incurred consist of the following major components:

(1)	(2)	(3)
12/31/2015	12/31/2014	(Col 1-2) Change
\$ 7,697,859	\$ (6,279,326)	\$ 13,977,185
-	-	-
7,697,859	(6,279,326)	13,977,185
(222,491)	79,772	(302,263)
-	-	-
-	-	-
\$ 7,475,368	\$ (6,199,554)	\$ 13,674,922

1. Current Income Tax

- (a) Federal
(b) Foreign
(c) Subtotal
(d) Federal income tax expense on net capital gains
(e) Utilization of capital loss carry-forwards
(f) Other
(g) Federal and foreign income taxes incurred

2. Deferred Tax Assets:

(a) Ordinary

(1) Discounting of unpaid losses	\$ 278,869	\$ 260,705	\$ 18,164
(2) Unearned premium reserve	-	1,682,067	(1,682,067)
(3) Policyholder reserves	1,713,126	903,086	810,040
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	877,514	559,505	318,009
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables - nonadmitted	3,609,954	1,839,781	1,770,173
(11) Net operating loss carryforward	-	-	-
(12) Tax credit carry-forward	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	9,087	-	9,087.00
(14) Accrued future expenses	47,529	-	47,529
(15) Amortization	516,271	724,801	(208,530)
(16) Partnership income	-	-	-
(17) Premium deficiency reserves	-	537,465	(537,465)
(18) Prepaid expenses	17,637	14,210	3,427
(99) Subtotal	7,069,987	6,521,620	548,367

(b) Statutory valuation allowance adjustment

(c) Nonadmitted

(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)

(e) Capital:

(1) Investments	\$ -	\$ -	\$ -
(2) Net capital loss carryforward	-	-	-
(3) Real estate	-	-	-
(4) Other (including items <5% of total capital tax assets)	-	-	-
(5) Investment Partnership	-	-	-
(99) Subtotal	-	-	-

(f) Statutory valuation allowance adjustment

(g) Nonadmitted

(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)

(i) Admitted deferred tax assets (2d + 2h)

\$ 7,069,987	\$ 6,521,620	\$ 548,367
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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

3. Deferred Tax Liabilities:

(a) Ordinary:			
(1) Investments	\$ -	\$ -	\$ -
(2) Fixed assets	-	-	-
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities)	-	-	-
(6) Amortization	-	-	-
(7) Discount of coordination of benefits	1,609	3,045	(1,436)
(99) Subtotal	1,609	3,045	(1,436)
(b) Capital:			
(1) Investments	1,492,167	1,616,771	(124,604)
(2) Real estate	-	-	-
(3) Other (including items <5% of total capital tax liabilities)	-	-	-
(99) Subtotal	1,492,167	1,616,771	(124,604)
(c) Deferred tax liabilities (3a99 + 3b99)	1,493,776	1,619,816	(126,040)
4. Net deferred tax assets/liabilities (2i - 3C)	\$ 5,576,211	\$ 4,901,804	\$ 674,407

D. The Company's income tax expense and change in deferred income taxes differs from the amount obtained by applying the federal statutory income tax rate of 35% for the year ended December 31 as follows:

	2015	2014
Tax expense computed using federal statutory rate	\$ 1,938,863	\$ (11,497,877)
Change in nonadmitted assets	(2,185,104)	(224,464)
Tax exempt income and dividend received	(389,430)	(363,795)
Prior year true-ups and adjustments	(1,657)	62,149
Revenue agent report settlements and FIN48	-	(94,120)
ACA health insurer fee	7,440,707	3,969,042
Contributions	-	95,386
Other	143,514	61,358
Total	\$ 6,946,893	\$ (7,992,321)
Federal income taxes incurred	\$ 7,475,368	\$ (6,199,554)
Change in net deferred income taxes	(528,475)	(1,792,767)
Total statutory income taxes	\$ 6,946,893	\$ (7,992,321)

E. Operating loss carryforwards:

- The Company has no operating loss carryforwards and no tax credit carryforwards as of December 31, 2015.
- The following are income taxes incurred in the current and prior year(s) that will be available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2015	\$ 6,887,282	\$ -	\$ 6,887,282
2014	-	-	-
2013	N/A	3,079,000	3,079,000

- The Company has no protective tax deposits reported as admitted assets under Section 6603 of the Internal Revenue Code as of December 31, 2015 and 2014.

F. The following companies will be included in the consolidated federal income tax return with their parent Anthem, Inc. as of December 31, 2015, and either are current members of the consolidated tax sharing agreement or are in the process of being added to the consolidated tax sharing agreement. Allocation of federal income taxes with affiliates subject to the tax sharing agreement is based upon separate income tax return calculations with credit for net losses that can be used on a consolidated basis. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

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American Imaging Management, Inc.	DeCare Dental Health International, LLC
AMERIGROUP Community Care of New Mexico, Inc.	DeCare Dental Networks, LLC
AMERIGROUP Corporation	DeCare Dental, LLC
AMERIGROUP Florida, Inc.	Designated Agent Company, Inc.
Amerigroup Insurance Company	EHC Benefits Agency, Inc.
AMERIGROUP Iowa, Inc.	Empire HealthChoice Assurance, Inc.
Amerigroup Kansas, Inc.	Empire HealthChoice HMO, Inc.
AMERIGROUP Louisiana, Inc.	Forty-Four Forty-Four Forest Park Redevelopment Corp
AMERIGROUP Maryland, Inc.	Golden West Health Plan, Inc.
AMERIGROUP Nevada, Inc.	Government Health Services, LLC
AMERIGROUP New Jersey, Inc.	Greater Georgia Life Insurance Company
AMERIGROUP Ohio, Inc.	Health Core, Inc.
AMERIGROUP Pennsylvania, Inc.	Health Management Corporation
Amerigroup Services, Inc.	HealthKeepers, Inc.
AMERIGROUP Tennessee, Inc.	HealthLink HMO, Inc.
AMERIGROUP Texas, Inc.	HealthLink, Inc.
AMERIGROUP Washington, Inc.	HealthPlus HP, LLC (fka AMERIGROUP New York, LLC)
AMGP Georgia Managed Care Company, Inc.	Healthy Alliance Life Insurance Company
Anthem Blue Cross Life and Health Insurance Company	HMO Colorado, Inc.
Anthem Financial, Inc.	HMO Missouri, Inc.
Anthem Health Insurance Company of Nevada	Imaging Management Holdings, LLC
Anthem Health Plans of Kentucky, Inc.	Imaging Providers of Texas
Anthem Health Plans of Maine, Inc.	Matthew Thornton Health Plan, Inc.
Anthem Health Plans of New Hampshire, Inc.	National Government Services, Inc.
Anthem Health Plans of Virginia, Inc.	OneNation Insurance Company
Anthem Health Plans, Inc.	Park Square Holdings, Inc.
Anthem Holding Corp.	Park Square I, Inc.
Anthem Insurance Companies, Inc.	Park Square II, Inc.
Anthem Kentucky Managed Care Plan, Inc.	PHP Holdings, Inc.
Anthem Life & Disability Insurance Company	R&P Realty, Inc.
Anthem Southeast, Inc.	Resolution Health, Inc.
Anthem UM Services, Inc.	RightCHOICE Managed Care, Inc.
Anthem, Inc.	Rocky Mountain Hospital and Medical Service, Inc.
Arcus Enterprises, Inc.	SellCore, Inc.
ARCUS HealthyLiving Services, Inc.	Simply Healthcare Holdings, Inc.
Associated Group, Inc.	Simply Healthcare Plans, Inc.
Better Health, Inc.	Southeast Services, Inc.
Blue Cross and Blue Shield of Georgia, Inc.	State Sponsored Business UM Services, Inc.
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	The Anthem Companies of California, Inc.
Blue Cross Blue Shield of Wisconsin	The Anthem Companies, Inc.
Blue Cross of California	Tidgewell Associates, Inc.
Blue Cross of California Partnership Plan, Inc.	TrustSolutions, LLC
CareMore Health Group, Inc.	UNICARE Health Plan of Kansas, Inc.
CareMore Health Plan	UNICARE Health Plan of West Virginia, Inc.
CareMore Health Plan of Arizona, Inc.	UNICARE Health Plans of Texas, Inc.
CareMore Health Plan of Colorado, Inc.	UNICARE Illinois Services, Inc.
CareMore Health Plan of Georgia, Inc.	UNICARE Life & Health Insurance Company
CareMore Health Plan of Nevada	UNICARE National Services, Inc.
CareMore Health Plan of Texas, Inc.	UNICARE Specialty Services, Inc.
CareMore Health System	UtiliMed IPA, Inc.
CareMore Holdings, Inc.	WellPoint Behavioral Health, Inc.
Cerulean Companies, Inc.	WellPoint California Services, Inc.
Claim Management Services, Inc.	WellPoint Dental Services, Inc.
Community Insurance Company	WellPoint Holding Corporation
CompCare Health Services Insurance Corporation	WellPoint Information Technology Services, Inc.
Crossroads Acquisition Corp	WellPoint Insurance Services, Inc.
DeCare Analytics, LLC	WellPoint Military Care Corporation

G. Not applicable.

10. Information Concerning Parent, Subsidiaries, Affiliates, and Other Related Parties

A. Nature of the Relationship

The Company is a Florida domiciled stock insurance company and is a wholly-owned subsidiary of PHP Holding, Inc, which is own by AMERIGROUP Corporation (“AGP”). AGP is a wholly-own subsidiary of ATH Holding Company, LLC (“ATH Holding”), which is an indirect wholly-owned subsidiary of Anthem, Inc. (“Anthem”), a publicly traded company owning 100% of the outstanding shares of the Physicians Healthcare Plan Holding, Inc. (PHP Holdings, Inc.). The shareholders of Anthem approved a proposal to amend its articles of incorporation to change the name to Anthem, Inc. from WellPoint, Inc. The name change was effective December 2, 2014.

On July 24, 2015, the Company’s ultimate parent company, Anthem Inc. (“Anthem”), and Cigna Corporation (“Cigna”) entered into an Agreement and Plan of Merger dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and a direct wholly-owned subsidiary of Anthem, pursuant to which Anthem will acquire all outstanding shares of Cigna.

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The acquisition is expected to close in the second half of 2016 and is subject to certain state regulatory approvals, standard closing conditions, customary approvals required under the Hart-Scott-Rodino Antitrust Improvements Act and the approval of both the Anthem, Inc. shareholders and Cigna's stockholders.

B. Significant Transactions for Each Period

The following significant transactions took place between the Company and its affiliates:

The Company received a \$35,000,000 on December 31, 2014 of capital contributions from its parent. The Company received no capital contributions from its parent for the year ended December 31, 2015.

The Company paid no dividends for the years ended December 31, 2015 and 2014.

C. Intercompany Management and Service Arrangements

There were no changes to the intercompany management and service arrangements, and there were no additional arrangements entered into during 2015 or 2014. The amounts of transactions under such agreements are presented in Schedule Y, Part 2.

D. Amounts Due to or from Related Parties

At December 31, 2015 and 2014, the Company reported \$0 and 22,146 due from affiliates and \$9,876,638 and \$4,708,161 due to affiliates, respectively. The receivable and payable balances represent intercompany transactions that will be settled in accordance with the settlement terms of the intercompany agreement.

E. Guarantees or Contingencies for Related Parties

The Company did not enter into guarantees or undertakings for the benefit of an affiliate which would result in a material contingent exposure of the Company's or any affiliated insurer's assets or liabilities.

F. Management and Service Contracts and Cost Sharing Arrangements

Effective January 1, 2014 the Company entered into an administrative services agreement with its affiliated companies. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The costs and expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Costs include expenses such as salaries, employee benefits, communications, advertising, consulting services, billing, accounting, underwriting, and product development, which support the Company's operations. These costs are allocated based on various utilization statistics.

G. Nature of Control Relationships that Could Affect Operations or Financial Position

AGP owns all the outstanding shares of the Company. The Company's ultimate parent is Anthem, Inc.

H. Amount deducted for Investment in Upstream Company

The Company does not own shares of upstream intermediate entities or Anthem.

I. Detail of Investments in Affiliates Greater than 10% of Admitted Assets

The Company does not have investment in affiliates greater than 10% of admitted assets.

J. Write-down for Impairments of Investments in Subsidiaries, Controlled or Affiliated Companies

The Company did not write-down any investments in subsidiaries, controlled or affiliated companies as of December 31, 2015 and 2014.

K. Investment in a Foreign Insurance Subsidiary

The Company does not have investments in foreign insurance subsidiaries.

L. Investment in Downstream Non-insurance Holding Companies

The Company does not have investments in downstream non-insurance holding companies.

11. Debt

A. Capital Notes

The Company had no capital notes outstanding at December 31, 2015 and 2014.

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B. All Other Debt

The Company had no other debt outstanding at December 31, 2015 and 2014.

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefits Plans

A. Defined Benefit Plan

Not applicable – See Note 12G.

B. Not applicable – See Note 12G.

C. Not applicable – See Note 12G.

D. Not applicable – See Note 12G.

E. Defined Contribution Plan

Not applicable – See Note 12G.

F. Multiemployer Plan

The Company does not participate in a multiemployer plan.

G. Consolidated/Holding Company Plans

The Company participates in a deferred compensation plan sponsored by Anthem which covers certain employees. The deferred amounts are payable according to the terms and subject to the conditions of said deferred compensation agreements. Anthem allocates a share of the total accumulated costs of this plan to the Company based on the number of allocated employees subject to the deferred compensation agreements. During 2015 and 2014, these costs totaled \$51,071 and \$14,830. The Company has no legal obligation for benefits under this plan.

The Company participates in the Anthem 401(k) Retirement Savings Plan, sponsored by ATH Holding and covering substantially all employees. Voluntary employee contributions are matched by ATH Holding subject to certain limitations. ATH Holding allocates a share of the total accumulated costs of this plan to the Company based on the number of allocated employees. During 2015 and 2014, these costs totaled \$1,714,522 and \$1,466,394, respectively. The Company has no legal obligation for benefits under these plans.

H. Post Employment Benefits and Compensated Absences

Liabilities for earned not yet taken vacation and severance benefits have been accrued as of December 31, 2015 and 2014.

I. Impact of Medicare Modernization Act on Postretirement Benefits (INT 04-17)

Not applicable.

13. Capital and Surplus, Shareholder's Dividend Restrictions and Quasi-Reorganizations

1. Outstanding Shares

As of December 31, 2015, the Company has 1,000 shares of \$1 par value common stock authorized. The number of shares issued and outstanding is 100.

2. Preferred Stock

The Company has no preferred stock outstanding.

3. Dividend Restrictions

Per the *Florida Statute 641.365*, there are certain limitations exist on the Company's ability to pay dividends to its parent. The Company may pay funds only from accumulated surplus funds that were derived from realized net operating profits on its business and net realized capital gains. Prior written approval by the Florida DFS is required for payment of any dividend which would result in these accumulated surplus funds being less than zero. Florida DFS approval is not required if the dividend to be paid is less than the greater of 1) ten percent of the Company's accumulated surplus or 2) the Company's entire net operating profit, including realized capital gains, for the immediately preceding calendar year.

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4. Dividends Paid

See Footnote 10B.

5. Maximum Ordinary Dividends During 2016

Within the limitations of (3) above, the Company may pay no dividends during 2015 without prior approval.

6. Unassigned Surplus Restrictions

Unassigned surplus funds are not restricted at December 31, 2015.

7. Mutual Surplus Advances

Not applicable.

8. Company Stock Held for Special Purpose

There are no shares of stock held for special purposes at December 31, 2015.

9. Changes in Special Surplus Funds

The changes in balances of special surplus funds from the prior year are due to amounts segregated for the estimated 2016 Affordable Care Act ("ACA") health insurer fee.

10. Changes in Unassigned Funds

The portion of unassigned funds represented by cumulative unrealized gains and losses was \$4,236,174 at December 31, 2015.

11. Surplus Notes

The Company has not issued any surplus notes or debentures of similar obligations.

12. Restatement due to Prior Quasi-reorganization

The Company has no restatements due to prior quasi-reorganizations.

13. Quasi-reorganization over Prior 10 years

The Company has not been involved in a quasi-reorganization during the past 10 years.

14. Liabilities, Contingencies and Assessments

A. Contingent Commitments

The Company has no contingent commitments at December 31, 2015.

B. Assessments

1. The Company is subject to guaranty fund and other assessments by the state(s) in which it writes business. Guaranty fund assessments are accrued at the time of insolvencies. Other assessments are accrued either at the time of the assessment or at the time the losses are incurred.

The State of Florida has not issued a guaranty fund assessment, and the Company has not recorded a liability for an assessment as of December 31, 2015.

2. Not applicable.

C. Gain Contingencies

The Company has no gain contingencies at December 31, 2015.

D. Claims-Related Extra Contractual Obligations and Bad Faith Losses Stemming from Lawsuits

Not applicable.

E. Joint and Several Liabilities

Not applicable.

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F. All Other Contingencies

In February 2015, Anthem reported that it was the target of a sophisticated external cyber-attack. The attackers gained unauthorized access to certain of Anthem's information technology systems and obtained personal information related to many individuals and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that Anthem will not identify additional information that was accessed or obtained.

Anthem has continued to implement security enhancements since this incident and is supporting federal law enforcement efforts to identify the responsible parties. Upon discovery of the cyber-attack, Anthem took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate its systems and identify solutions based on the evolving landscape. Anthem is providing credit monitoring and identity protection services to those who have been affected by this cyber-attack. Anthem has incurred expenses subsequent to the cyber-attack to investigate and remediate this matter and expects to continue to incur expenses of this nature in the foreseeable future. Anthem will recognize these expenses in the periods in which they are incurred.

Actions have been filed in various federal and state courts, and other claims have been or may be asserted against Anthem on behalf of current or former members, current or former employees, other individuals, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber-attack. State and federal agencies, including state insurance regulators, state attorneys general, the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigation, are investigating events related to the cyber-attack, including how it occurred, its consequences and Anthem's responses. Although Anthem is cooperating in these investigations, Anthem may be subject to fines or other obligations, which may have an adverse effect on how Anthem operates its business and results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation in February 2015 and was subsequently heard by the Panel in May 2015. In June 2015, the Panel entered its order transferring the consolidated matter to the U.S. District Court for the Northern District of California. The U.S. District Court entered its Case Management Order in September 2015. Anthem has filed a Motion to Dismiss several of the counts that are before the U.S. District Court. There remain a few state court cases that are presently proceeding outside of the Multidistrict Litigation.

Anthem has contingency plans and insurance coverage for certain expenses and potential liabilities of this nature. The coverage has been sufficient to cover the majority of claims and liabilities incurred to date. While a loss from these matters is reasonably possible, Anthem cannot reasonably estimate a range of possible losses because the investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

The Company is involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental and administrative proceedings. These investigations, audits and reviews include routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and Federal Agencies. Such investigations could result in the imposition of civil or criminal fines, penalties and other sanctions. The Company believes that any liability that may result from any one of these actions is unlikely to have a material adverse effect on the Company's financial position or results of operations.

At December 31, 2015 and 2014, the Company reported admitted assets of \$7,252,804 and \$8,829,481 respectively in premium receivables due from policyholders and agents and receivables due from uninsured plans. The receivables are not deemed to be uncollectible, therefore, no provision for uncollectible amounts have been recorded. The potential for any additional loss is not believed to be material to the Company's financial condition.

15. Leases

A. Lessee Operating Lease

1. The Company leases office space, office equipment, EDP equipment, software and terminal lines under various noncancelable operating leases. Related lease expense for 2015 and 2014 was \$2,564,331 and \$426,215, respectively.
2. At January 1, 2016, the minimum aggregate rental commitments are as follows:

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Year Ending December 31	Operating Leases
2016	\$ 2,719,005
2017	2,855,665
2018	2,906,449
2019	2,285,735
2020	1,366,589
Total	\$ 12,133,443

3. The Company has not entered into any material sale-leaseback transactions.

B. Lessor Leases

1. The Company has not entered into any operating leases.
2. The Company has not entered into any leverage leases.

16. Information about Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk

The Company has no significant financial instruments with off-balance sheet risk.

Financial instruments that potentially subject the Company to concentration of credit risk consist primarily of investment securities. All investment securities are managed by professional investment managers within policies authorized by the board of directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. As of December 31, 2015, there were no significant concentrations.

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. Transfers of Receivables Reported as Sales

Not applicable at December 31, 2015 and 2014.

B. Transfer and Servicing of Financial Assets

1. The Company participates in a securities lending program whereby marketable securities in its investment portfolio are transferred to independent brokers or dealers. At December 31, 2015, the fair value of securities loaned was \$6,809,647 and the carrying value of securities loaned was \$6,721,845.
2. – 7. Not applicable.

C. Wash Sales

1. In the course of the Company's asset management, securities may be sold and reacquired within 30 days of the sale date to enhance the yield on the investments.
2. At December 31, 2015 and 2014, there were no wash sales involving securities with an NAIC designation of 3 or below or unrated.

18. Gain or Loss to the Reporting Entity from Uninsured A&H Plans and the Uninsured Portion of Partially Insured Plans

A. Administrative Services Only ("ASO") Plans

Not applicable in December 31, 2015 and 2014.

B. Administrative Services Contract ("ASC") Plans

Not applicable in December 31, 2015 and 2014.

C. Medicare or Other Similarly Structured Cost-Based Reimbursement Contract

Not applicable at December 31, 2015 and 2014.

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

No premiums were written by managing general agents or third party administrators during the years ended December 31, 2015 and 2014.

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20. Fair Value

A. Fair Value Measurements

1. Fair Value Measurements at Reporting Date

Description for each class of asset or liability	(Level 1)	(Level 2)	(Level 3)	Total
a. Assets at fair value				
Bonds				
Industrial and Misc	\$ -	\$ -	\$ -	\$ -
Total bonds	\$ -	\$ -	\$ -	\$ -
Common stock				
Industrial and Misc	\$ 13,826,041	\$ -	\$ -	\$ 13,826,041
Total common stocks	\$ 13,826,041	\$ -	\$ -	\$ 13,826,041
Total assets at fair value	\$ 13,826,041	\$ -	\$ -	\$ 13,826,041

2. There are no investments in Level 3 as of December 31, 2015 and 2014.

3. The Company's policy is to recognize transfers between Levels, if any, as of the beginning of the reporting period.

4. Fair values of fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level 1 or Level 2 inputs, for the determination of fair value to facilitate fair value measurements and disclosures. United States Government securities represent Level 1 securities, while Level 2 securities primarily include corporate securities, securities from states, municipalities and political subdivisions and residential mortgage-backed securities. For securities not actively traded, the third party pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds.

Fair values of equity securities are generally designated as Level 1 and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level 2.

There have been no significant changes in the valuation techniques during the current period.

B. Fair Value Measurements Under Other Accounting Pronouncements

Not applicable at December 31, 2015 and 2014.

C. Financial Instruments

Type of Financial Instrument	Aggregated Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practicable (Carrying Value)
Bonds	\$ 112,422,204	\$ 110,896,532	\$ -	\$ 112,422,204	\$ -	\$ -
Common Stock	13,826,041	13,826,041	13,826,041	-	-	-
Short Term Inv & MMFs	39,238,366	39,236,887	38,738,887	499,479	-	-
Securities Lending Collateral	6,809,647	6,809,150	6,709,665	99,982	-	-
	\$ 172,296,258	\$ 170,768,610	\$ 59,274,593	\$ 113,021,665	\$ -	\$ -

D. Not Practicable to Estimate Fair Value

There are no financial instruments that were not practicable to estimate fair value.

21. Other Items

A. Unusual or Infrequent Items

Not applicable at December 31, 2015 and 2014.

B. Troubled Debt Restructuring: Debtors

Not applicable at December 31, 2015 and 2014.

C. Other Disclosures

Not applicable at December 31, 2015 and 2014.

D. Business Interruption Insurance Recoveries

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The Company has reported no recoveries for business interruption for the years ended December 31, 2015 and 2014.

E. State Transferable and Non-Transferable Tax Credits

The Company did not have state transferable tax credits at December 31, 2015 and 2014.

F. Subprime Mortgage-Related Risk Exposure

1. The Company's investment strategy of providing safety and preservation of capital, sufficient liquidity to meet cash flow requirements and the attainment of a competitive after-tax investment return is supported by a well diversified portfolio consisting of many different types of investments. The portion of the Company's investment portfolio with subprime mortgage-related risk exposure is relatively small in comparison to the overall investment portfolio, and consists of investment grade securities with no exposure to collateralized debt obligations. All mortgage related investments are monitored closely as part of the quarterly investment review performed by the Anthem Investment Impairment Review Committee.
2. The Company did not carry investments in subprime mortgage loans in its portfolio at December 31, 2015 or 2014.
3. The Company did not have subprime mortgage-related risk exposure at December 31, 2015 or 2014.
4. The Company did not underwrite Mortgage Guaranty or Financial Guaranty insurance coverage at December 31, 2015.

G. Retained Assets

The Company did not have any retained assets at December 31, 2015 and 2014.

22. Events Subsequent

The Company is subject to an annual fee under section 9010 of the Affordable Care Act ("ACA"). A health insurance company's portion of the annual fee becomes payable once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. The Company has written health insurance subject to the ACA assessment and expects to conduct health insurance business in 2016. The Company reflected its estimated portion of the fee payable on September 30, 2016 in special surplus. The annual fee under section 9010 of the ACA has been suspended for 2017 and will resume for 2018 and beyond.

	Current Year	Prior Year
A. Did the reporting entity write accident and health insurance premium that is subject to Section 9010 of the Federal Affordable Care Act (YES/NO)?	YES	
B. ACA fee assessment payable for the upcoming year	\$ 20,965,043	\$ 21,492,886
C. ACA fee assessment paid	\$ 21,259,163	\$ 11,340,119
D. Premium written subject to ACA 9010 assessment	\$ 1,156,733,460	\$ 805,328,358
E. Total Adjusted Capital before surplus adjustment (Five-Year Historical Line 14)	\$ 75,684,471	
F. Total Adjusted Capital after surplus adjustment (Five-Year Historical Line 14 minus Line 22B above)	\$ 54,719,428	
G. Authorized Control Level (Five-Year Historical Line 15)	\$ 39,030,423	
H. Would reporting the ACA assessment as of December 31, 2015 have triggered an RBC action level (YES/NO)?	NO	

Subsequent events have been considered through March 31, 2016 for the statutory statement issued on March 31, 2016. There were no other events occurring subsequent to December 31, 2015 requiring recognition or disclosure.

23. Reinsurance

A. Ceded Reinsurance Report

Section 1 – General Interrogatories

1. Are any of the reinsurers that are listed in Schedule S as non-affiliated owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?

Yes () No (X)

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2. Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled, directly or indirectly, by an insured, a beneficiary, a creditor or an insured or any other person not primarily engaged in the insurance business?

Yes () No (X)

Section 2 – Ceded Reinsurance Report – Part A

1. Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credits?

Yes () No (X)

2. Does the reporting entity have any reinsurance agreements in effect such that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same insurer, exceed the total direct premium collected under reinsured policies?

Yes () No (X)

Section 3 – Ceded Reinsurance Report – Part B

1. What is the estimated amount of the aggregate reduction in surplus, (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2) above of termination of ALL reinsurance agreements, by either party, as of the date of this statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

Not Applicable.

2. Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement include policies or contract that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes () No (X)

B. Uncollectible Reinsurance

The Company has no uncollectible reinsurance at December 31, 2015 and 2014.

C. Commutation of Ceded Reinsurance

The Company has not commuted ceded reinsurance during 2015 and 2014.

D. Certified Reinsurer Rating Downgraded or Status Subject Revocation

The Company has no downgraded certified reinsurer ratings or status subject revocations during 2015 and 2014.

24. Retrospectively Rated Contracts and Contracts Subject to Redetermination

- A. The Company's contract with CMS includes provisions for which the premiums vary based on loss experience. The Company estimates retrospective premium adjustments through the review of each retrospectively rated account, comparing the claim development with that anticipated in the policy contracts.

- B. The Company records accrued retrospective premium as an adjustment to earned premium.

- C. The amount of net premiums written by the Company at December 31, 2015 and 2014 that were subject to retrospective rating features was \$1,309,626,197 and \$105,214,066 respectively, which represents 100.0% and 11.2% of the total net premiums written. No other net premiums written by the Company are subject to retrospective rating features.

- D. In accordance with the NAIC Accounting Practices and Procedures Manual, medical loss ratio rebates in accordance with the Federal 2010 Patient Protection and Affordable Care Act and Public Health Service Act, are to be reported in accordance with SSAP No. 66 - *Retrospectively Rated Contracts* ("SSAP No. 66"). A retrospectively rated contract is one which has the final policy premium calculated based on the loss experience of the insured during the term of the policy (including loss development after the term of the policy) and the stipulated formula set forth in the policy, or in the case of medical loss ratio rebates, a formula required by law. The Company based the incurred and unpaid liability amounts reported below based on its underwriting experience; actuarial, tax, and accounting estimates and assumptions at the

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financial statement date; as well as regulations and guidance available that is not final and subject to change prior to settlement. Accordingly, the Company's use of estimates and assumptions in the preparation of the statutory based financial statements and related footnote disclosures may differ from actual results. Hence, the amounts reported herein are for financial reporting purposes solely and not intended to be used for settlement purposes.

Medical loss ratio rebates accrued pursuant to the Public Health Service Act are as follows:

	Individual	Small Group Employer	Large Group Employer	Other Categories with Rebates	Total
Prior Reporting Year					
(1) Medical loss ratio rebates incurred	\$ -	\$ -	\$ -	\$ -	\$ -
(2) Medical loss ratio rebates paid	-	-	-	-	-
(3) Medical loss ratio rebates unpaid	-	-	-	-	-
(4) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(5) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(6) Rebate unpaid net of reinsurance	XXX	XXX	XXX	XXX	\$ -
Current Reporting Year-to-Date					
(7) Medical loss ratio rebates incurred	\$ -	\$ -	\$ -	\$ -	\$ -
(8) Medical loss ratio rebates paid	-	-	-	-	-
(9) Medical loss ratio rebates unpaid	-	-	-	-	-
(10) Plus reinsurance assumed amounts	XXX	XXX	XXX	XXX	-
(11) Less reinsurance ceded amounts	XXX	XXX	XXX	XXX	-
(12) Rebate unpaid net of reinsurance	XXX	XXX	XXX	XXX	\$ -

E. Risk-Sharing Provisions of the Affordable Care Act ("ACA")

1. Did the reporting entity write accident and health insurance premium which is subject to the Affordable Care Act risk sharing provisions (YES/NO)? No

2. Impact of Risk-Sharing Provisions of the Affordable Care Act on Admitted Assets, Liabilities and Revenue for the Current Year

Not applicable.

3. Roll-forward of prior year ACA risk-sharing provisions for the following asset (gross of any nonadmission) and liability balances, along with the reasons for adjustments to prior year balance.

Not applicable.

25. Change in Incurred Claims and Claim Adjustment Expenses

The estimated cost of claims and claim adjustment expense attributable to insured events of prior years increased by \$4,291,440 during 2015. This is approximately 4.9% of unpaid claims and claim adjustment expense of \$86,931,541 as of December 31, 2014. The deficiency reflects the increases in estimated claims expenses as a result of claim payments during the year, and as additional information is received regarding claims incurred prior to 2015. Recent claim development trends are also taken into account in evaluating the overall adequacy of unpaid claims and claim adjustment expense.

26. Intercompany Pooling Arrangements

Not applicable at December 31, 2015 and 2014.

27. Structured Settlements

Not applicable at December 31, 2015 and 2014.

28. Health Care Receivables

A. Pharmaceutical Rebate Receivables

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Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More Than 180 Days After Billing
4Q15	176,439	623,082	—	—	—
3Q15	162,326	758,431	—	—	—
2Q15	82,753	515,091	—	701,191	—
1Q15	237,128	282,063	—	551,528	39,088
4Q14	569,971	648,825	—	359,128	339,397
3Q14	705,786	689,827	—	395,594	291,709
2Q14	922,876	864,464	—	606,291	257,485
1Q14	915,677	980,151	—	732,360	247,761
4Q13	789,305	903,461	—	689,608	213,853
3Q13	759,526	896,670	—	697,907	198,763
2Q13	748,724	812,102	—	645,464	166,638
1Q13	724,048	803,788	—	626,998	177,354

B. Risk Sharing Receivables

Not applicable at December 31, 2015 and 2014.

29. Participating Policies

Not applicable at December 31, 2015 and 2014.

30. Premium Deficiency Reserves

1. Liability carried for premium deficiency reserves \$ 0
2. Date of the most recent evaluation of this liability December 31, 2015
3. Was anticipated investment income utilized in the calculation? Yes ☐ No ☒

The Company recorded premium deficiency reserves of \$1,535,613 at December 31, 2014.

31. Anticipated Salvage and Subrogation

The Company took into account estimated anticipated subrogation and other recoveries in its determination of the liability for unpaid claims and reduced the liability by \$1,157,000 and \$554,000 at December 31, 2015 and 2014, respectively.

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GENERAL INTERROGATORIES

**PART 1 - COMMON INTERROGATORIES
GENERAL**

- 1.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? Yes [X] No []
If yes, complete Schedule Y, Parts 1, 1A and 2
- 1.2 If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent, or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations? Yes [X] No [] N/A []
- 1.3 State Regulating? Florida
- 2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? Yes [] No [X]
- 2.2 If yes, date of change:
- 3.1 State as of what date the latest financial examination of the reporting entity was made or is being made. 12/31/2014
- 3.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released. 12/31/2012
- 3.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date). 03/01/2014
- 3.4 By what department or departments?
Florida Office of Insurance Regulation
- 3.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments? Yes [X] No [] N/A []
- 3.6 Have all of the recommendations within the latest financial examination report been complied with? Yes [X] No [] N/A []
- 4.1 During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity), receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.11 sales of new business? Yes [] No [X]
4.12 renewals? Yes [] No [X]
- 4.2 During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.21 sales of new business? Yes [] No [X]
4.22 renewals? Yes [] No [X]
- 5.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? Yes [] No [X]
- 5.2 If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.
- | 1
Name of Entity | 2
NAIC Company Code | 3
State of Domicile |
|---------------------|------------------------|------------------------|
| | | |
- 6.1 Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? Yes [] No [X]
- 6.2 If yes, give full information:
- 7.1 Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity? Yes [] No [X]
- 7.2 If yes,
7.21 State the percentage of foreign control; %
7.22 State the nationality(s) of the foreign person(s) or entity(s) or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact; and identify the type of entity(s) (e.g., individual, corporation or government, manager or attorney in fact).
- | 1
Nationality | 2
Type of Entity |
|------------------|---------------------|
| | |

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? Yes [] No [X]

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? Yes [] No [X]

8.4 If response to 8.3 is yes, please provide below the names and location (city and state of the main office) of any affiliates regulated by a federal regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC

9. What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?
Ernst & Young LLP, 111 Monument Circle, Suite 2600, Indianapolis, IN 46204

10.1 Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation? Yes [] No [X]

10.2 If the response to 10.1 is yes, provide information related to this exemption:

10.3 Has the insurer been granted any exemptions related to the other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 18A of the Model Regulation, or substantially similar state law or regulation? Yes [] No [X]

10.4 If the response to 10.3 is yes, provide information related to this exemption:

10.5 Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws? Yes [X] No [] N/A []

10.6 If the response to 10.5 is no or n/a, please explain

11. What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?
Mark Justus, FSA, MAAA, Director and Actuary III (employee); 3350 Peachtree Road, Atlanta, GA 30326

12.1 Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly? Yes [] No [X]

12.11 Name of real estate holding company
12.12 Number of parcels involved
12.13 Total book/adjusted carrying value \$

12.2 If, yes provide explanation:

13. **FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:**

13.1 What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?

13.2 Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located? Yes [] No []

13.3 Have there been any changes made to any of the trust indentures during the year? Yes [] No []

13.4 If answer to (13.3) is yes, has the domiciliary or entry state approved the changes? Yes [] No [] N/A []

14.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? Yes [X] No []

(a) Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
(b) Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
(c) Compliance with applicable governmental laws, rules and regulations;
(d) The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
(e) Accountability for adherence to the code.

14.11 If the response to 14.1 is No, please explain:

14.2 Has the code of ethics for senior managers been amended? Yes [X] No []

14.21 If the response to 14.2 is yes, provide information related to amendment(s).
Minor revisions were made in February 2015. Specifically, the language was modified for the following policy changes contained within the code: Community Service, Business Entertainment, Vendor Relationships, Prohibition on Discrimination in Marketing and Enrollment, and Business Relationships with Pharmaceutical Manufacturers. Additionally the Chief Executive Officer's letter was updated, a letter from the Chief Compliance Officer was added and certain informational sections were removed.

14.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes [] No [X]

14.31 If the response to 14.3 is yes, provide the nature of any waiver(s).

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

- 15.1 Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List? Yes [] No [X]
- 15.2 If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.

1 American Bankers Association (ABA) Routing Number	2 Issuing or Confirming Bank Name	3 Circumstances That Can Trigger the Letter of Credit	4 Amount

BOARD OF DIRECTORS

16. Is the purchase or sale of all investments of the reporting entity passed upon either by the board of directors or a subordinate committee thereof? Yes [X] No []
17. Does the reporting entity keep a complete permanent record of the proceedings of its board of directors and all subordinate committees thereof? Yes [X] No []
18. Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict with the official duties of such person? Yes [X] No []

FINANCIAL

19. Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)? Yes [] No [X]
- 20.1 Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):
- | | | |
|---|----|--|
| 20.11 To directors or other officers | \$ | |
| 20.12 To stockholders not officers | \$ | |
| 20.13 Trustees, supreme or grand (Fraternal Only) | \$ | |
- 20.2 Total amount of loans outstanding at the end of year (inclusive of Separate Accounts, exclusive of policy loans):
- | | | |
|---|----|--|
| 20.21 To directors or other officers | \$ | |
| 20.22 To stockholders not officers | \$ | |
| 20.23 Trustees, supreme or grand (Fraternal Only) | \$ | |
- 21.1 Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reported in the statement? Yes [] No [X]
- 21.2 If yes, state the amount thereof at December 31 of the current year:
- | | | |
|----------------------------|----|--|
| 21.21 Rented from others | \$ | |
| 21.22 Borrowed from others | \$ | |
| 21.23 Leased from others | \$ | |
| 21.24 Other | \$ | |
- 22.1 Does this statement include payments for assessments as described in the Annual Statement Instructions other than guaranty fund or guaranty association assessments? Yes [] No [X]
- 22.2 If answer is yes:
- | | | |
|--|----|--|
| 22.21 Amount paid as losses or risk adjustment | \$ | |
| 22.22 Amount paid as expenses | \$ | |
| 22.23 Other amounts paid | \$ | |
- 23.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? Yes [X] No []
- 23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: \$ 0

INVESTMENT

- 24.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date? (Other than securities lending programs addressed in 24.03) Yes [X] No []
- 24.02 If no, give full and complete information relating thereto
- 24.03 For security lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet. (an alternative is to reference Note 17 where this information is also provided) The company's securities lending program authorizes lending agents to loan securities to approved borrowers for a negotiated fee. These loans are collateralized with 102% cash and the collateral is invested according to guidelines of the company's Investment Policy. For Statutory reporting, the collateral is carried off-balance sheet.
- 24.04 Does the Company's security lending program meet the requirements for a conforming program as outlined in the Risk-Based Capital Instructions? Yes [X] No [] N/A []
- 24.05 If answer to 24.04 is yes, report amount of collateral for conforming programs. \$ 6,809,150
- 24.06 If answer to 24.04 is no, report amount of collateral for other programs. \$
- 24.07 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract? Yes [X] No [] N/A []
- 24.08 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%? Yes [X] No [] N/A []
- 24.09 Does the reporting entity or the reporting entity's securities lending agent utilize the Master Securities Lending Agreement (MSLA) to conduct securities lending? Yes [X] No [] N/A []

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

24.10 For the reporting entity's security lending program state the amount of the following as December 31 of the current year:

24.101 Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2	\$	6,809,647
24.102 Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2	\$	6,809,150
24.103 Total payable for securities lending reported on the liability page	\$	6,809,150

25.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity, or has the reporting entity sold or transferred any assets subject to a put option contract that is currently in force? (Exclude securities subject to Interrogatory 21.1 and 24.03). Yes [X] No []

25.2 If yes, state the amount thereof at December 31 of the current year:

25.21 Subject to repurchase agreements	\$
25.22 Subject to reverse repurchase agreements	\$
25.23 Subject to dollar repurchase agreements	\$
25.24 Subject to reverse dollar repurchase agreements	\$
25.25 Placed under option agreements	\$
25.26 Letter stock or securities restricted as to sale - excluding FHLB Capital Stock	\$
25.27 FHLB Capital Stock	\$
25.28 On deposit with states	\$
25.29 On deposit with other regulatory bodies	\$
25.30 Pledged as collateral - excluding collateral pledged to an FHLB	\$
25.31 Pledged as collateral to FHLB - including assets backing funding agreements	\$
25.32 Other	\$

25.3 For category (25.26) provide the following:

1 Nature of Restriction	2 Description	3 Amount

26.1 Does the reporting entity have any hedging transactions reported on Schedule DB? Yes [] No [X]

26.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes [] No [] N/A [X]
If no, attach a description with this statement.

27.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity? Yes [] No [X]

27.2 If yes, state the amount thereof at December 31 of the current year: \$

28. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? Yes [X] No []

28.01 For agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian's Address
Bank of New York Mellon Corporation	One BNY Mellon Center Room 151-1035 Pittsburgh, PA 15258

28.02 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

28.03 Have there been any changes, including name changes, in the custodian(s) identified in 28.01 during the current year? Yes [] No [X]

28.04 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

28.05 Identify all investment advisors, brokers/dealers or individuals acting on behalf of brokers/dealers that have access to the investment accounts, handle securities and have authority to make investments on behalf of the reporting entity:

1 Central Registration Depository Number(s)	2 Name	3 Address
105006	Deutsche Asset Management	New York, NY
113878	McDonnell Investment Management, LLC	Oak Brook, IL

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

29.1 Does the reporting entity have any diversified mutual funds reported in Schedule D, Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5(b)(1)])?

Yes [] No [X]

29.2 If yes, complete the following schedule:

1 CUSIP #	2 Name of Mutual Fund	3 Book/Adjusted Carrying Value
29.2999 - Total		0

29.3 For each mutual fund listed in the table above, complete the following schedule:

1 Name of Mutual Fund (from above table)	2 Name of Significant Holding of the Mutual Fund	3 Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	4 Date of Valuation

30. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

	1 Statement (Admitted) Value	2 Fair Value	3 Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
30.1 Bonds	150,133,419	151,660,570	1,527,151
30.2 Preferred stocks	0		0
30.3 Totals	150,133,419	151,660,570	1,527,151

30.4 Describe the sources or methods utilized in determining the fair values:

Fair values were obtained from third-party pricing sources. If a security was not priced by a third-party pricing source, internal analytical systems or broker quotes were utilized.

31.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D?

Yes [] No [X]

31.2 If the answer to 31.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source?

Yes [] No []

31.3 If the answer to 31.2 is no, describe the reporting entity's process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D:

32.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Investment Analysis Office been followed?

Yes [X] No []

32.2 If no, list exceptions:

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

OTHER

33.1 Amount of payments to trade associations, service organizations and statistical or rating bureaus, if any?\$

33.2 List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations and statistical or rating bureaus during the period covered by this statement.

1 Name	2 Amount Paid

34.1 Amount of payments for legal expenses, if any?\$573,370

34.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.

1 Name	2 Amount Paid
Hogan Lovells	170,164

35.1 Amount of payments for expenditures in connection with matters before legislative bodies, officers or departments of government, if any?\$216,000

35.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid
Larry J. Overton & Associates	96,000
Corcoran & Johnston	120,000
Lobbying expenses disclosed reflect amounts reported in the Lobbyist Disclosure Reports filed with the Secretary of State as well as the cost of external contractors who provided lobbying services to the Company. The amount may include expenses that may have been paid by an affiliate on behalf of the Company and, as a result, may not be included in the Underwriting Gain reported on page 4 of the 2015 Annual Statement.	

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

PART 2 - HEALTH INTERROGATORIES

1.1 Does the reporting entity have any direct Medicare Supplement Insurance in force? Yes [] No [X]

1.2 If yes, indicate premium earned on U.S. business only. \$

1.3 What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit? \$

1.31 Reason for excluding

1.4 Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above \$

1.5 Indicate total incurred claims on all Medicare Supplement Insurance. \$ 0

1.6 Individual policies:

Most current three years:

1.61 Total premium earned \$ 0

1.62 Total incurred claims \$ 0

1.63 Number of covered lives 0

All years prior to most current three years:

1.64 Total premium earned \$ 0

1.65 Total incurred claims \$ 0

1.66 Number of covered lives 0

1.7 Group policies:

Most current three years:

1.71 Total premium earned \$ 0

1.72 Total incurred claims \$ 0

1.73 Number of covered lives 0

All years prior to most current three years:

1.74 Total premium earned \$ 0

1.75 Total incurred claims \$ 0

1.76 Number of covered lives 0

2. Health Test:

	1 Current Year	2 Prior Year
2.1 Premium Numerator	1,309,626,197	938,450,419
2.2 Premium Denominator	1,309,626,197	938,450,419
2.3 Premium Ratio (2.1/2.2)	1.000	1.000
2.4 Reserve Numerator	100,120,951	86,343,857
2.5 Reserve Denominator	100,120,951	86,343,857
2.6 Reserve Ratio (2.4/2.5)	1.000	1.000

3.1 Has the reporting entity received any endowment or gift from contracting hospitals, physicians, dentists, or others that is agreed will be returned when, as and if the earnings of the reporting entity permits? Yes [] No [X]

3.2 If yes, give particulars:

4.1 Have copies of all agreements stating the period and nature of hospitals', physicians', and dentists' care offered to subscribers and dependents been filed with the appropriate regulatory agency? Yes [X] No []

4.2 If not previously filed, furnish herewith a copy(ies) of such agreement(s). Do these agreements include additional benefits offered? Yes [] No []

5.1 Does the reporting entity have stop-loss reinsurance? Yes [] No [X]

5.2 If no, explain:

5.3 Maximum retained risk (see instructions)

5.31 Comprehensive Medical \$

5.32 Medical Only \$

5.33 Medicare Supplement \$

5.34 Dental & Vision \$

5.35 Other Limited Benefit Plan \$

5.36 Other \$

6. Describe arrangement which the reporting entity may have to protect subscribers and their dependents against the risk of insolvency including hold harmless provisions, conversion privileges with other carriers, agreements with providers to continue rendering services, and any other agreements:

7.1 Does the reporting entity set up its claim liability for provider services on a service date basis?..... Yes [X] No []

7.2 If no, give details

8. Provide the following information regarding participating providers:

8.1 Number of providers at start of reporting year14,256

8.2 Number of providers at end of reporting year16,169

9.1 Does the reporting entity have business subject to premium rate guarantees? Yes [] No [X]

9.2 If yes, direct premium earned:

9.21 Business with rate guarantees between 15-36 months...\$

9.22 Business with rate guarantees over 36 months\$

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

- 10.1 Does the reporting entity have Incentive Pool, Withhold or Bonus Arrangements in its provider contracts? Yes [☒] No [☐]
- 10.2 If yes:
- | | | |
|--|----------|-----------|
| 10.21 Maximum amount payable bonuses..... | \$ | 3,497,761 |
| 10.22 Amount actually paid for year bonuses..... | \$ | 2,670,415 |
| 10.23 Maximum amount payable withholds..... | \$ | |
| 10.24 Amount actually paid for year withholds..... | \$ | |
- 11.1 Is the reporting entity organized as:
- | | |
|--|---|
| 11.12 A Medical Group/Staff Model..... | Yes [<input type="checkbox"/>] No [<input checked="" type="checkbox"/>] |
| 11.13 An Individual Practice Association (IPA), or, .. | Yes [<input type="checkbox"/>] No [<input checked="" type="checkbox"/>] |
| 11.14 A Mixed Model (combination of above)? | Yes [<input checked="" type="checkbox"/>] No [<input type="checkbox"/>] |
- 11.2 Is the reporting entity subject to Statutory Minimum Capital and Surplus Requirements? Yes [☒] No [☐]
- 11.3 If yes, show the name of the state requiring such minimum capital and surplus. Florida
- 11.4 If yes, show the amount required. \$
- 11.5 Is this amount included as part of a contingency reserve in stockholder's equity? Yes [☐] No [☒]
- 11.6 If the amount is calculated, show the calculation
2% December 31, 2015 annualized premiums from Income Statement = 2% * \$1,309,626,197 + \$3,000,000 (PHP consent order) = 29,192,524
12. List service areas in which reporting entity is licensed to operate:

1 Name of Service Area
Brevard
Broward
Hardee
Highlands
Hillsborough
Lake
Manatee
Miami-Dade
Monroe
Pasco
Palm Beach
Pinellas
Polk
Orange
Osceola
Sarasota
Seminole
Volusia

- 13.1 Do you act as a custodian for health savings accounts? Yes [☐] No [☒]
- 13.2 If yes, please provide the amount of custodial funds held as of the reporting date. \$
- 13.3 Do you act as an administrator for health savings accounts? Yes [☐] No [☒]
- 13.4 If yes, please provide the balance of funds administered as of the reporting date. \$
- 14.1 Are any of the captive affiliates reported on Schedule S, Part 3, authorized reinsurers? Yes [☐] No [☐] N/A [☒]
- 14.2 If the answer to 14.1 is yes, please provide the following:

1 Company Name	2 NAIC Company Code	3 Domiciliary Jurisdiction	4 Reserve Credit	Assets Supporting Reserve Credit		
				5 Letters of Credit	6 Trust Agreements	7 Other

15. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded):

15.1 Direct Premium Written\$

15.2 Total Incurred Claims\$

15.3 Number of Covered Lives

*Ordinary Life Insurance Includes
Term (whether full underwriting, limited underwriting, let issue, "short form app")
Whole Life (whether full underwriting, limited underwriting, let issue, "short form app")
Variable Life (with or without secondary guarantee)
Universal Life (with or without secondary guarantee)
Variable Universal Life (with or without secondary guarantee)

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

FIVE-YEAR HISTORICAL DATA

	1 2015	2 2014	3 2013	4 2012	5 2011
Balance Sheet (Pages 2 and 3)					
1. Total admitted assets (Page 2, Line 28)	208,392,920	219,433,430	155,734,148	118,391,216	113,143,698
2. Total liabilities (Page 3, Line 24)	132,708,449	135,827,502	82,312,994	40,871,014	49,265,033
3. Statutory minimum capital and surplus requirement	29,192,524	21,769,008	14,993,600	15,033,596	14,559,899
4. Total capital and surplus (Page 3, Line 33)	75,684,471	83,605,928	73,421,154	77,520,202	63,878,665
Income Statement (Page 4)					
5. Total revenues (Line 8)	1,309,826,166	938,255,404	599,462,959	601,679,818	577,994,950
6. Total medical and hospital expenses (Line 18)	1,162,899,698	864,473,296	523,370,721	520,920,122	519,282,832
7. Claims adjustment expenses (Line 20)	79,803,226	51,537,238	41,192,030	15,818,014	16,472,571
8. Total administrative expenses (Line 21)	65,958,505	56,823,350	25,603,756	49,470,432	52,744,276
9. Net underwriting gain (loss) (Line 24)	2,700,350	(36,114,093)	9,296,452	15,471,250	(10,504,729)
10. Net investment gain (loss) (Line 27)	3,061,750	3,183,244	1,770,216	991,278	1,201,482
11. Total other income (Lines 28 plus 29) .....	.0	.0	23,500	23,263	.0
12. Net income or (loss) (Line 32)	(1,935,759)	(26,651,523)	6,759,103	11,541,636	(3,064,292)
Cash Flow (Page 6)					
13. Net cash from operations (Line 11)	(3,410,653)	16,513,999	24,936,007	6,930,116	(45,805,968)
Risk-Based Capital Analysis					
14. Total adjusted capital	75,684,471	83,605,928	73,421,154	77,520,202	63,878,665
15. Authorized control level risk-based capital	39,030,423	36,144,939	18,641,375	18,862,444	18,936,640
Enrollment (Exhibit 1)					
16. Total members at end of period (Column 5, Line 7)	392,725	364,108	239,177	256,002	256,580
17. Total members months (Column 6, Line 7)	4,608,418	3,613,410	2,947,017	3,146,682	3,101,235
Operating Percentage (Page 4) (Item divided by Page 4, sum of Lines 2, 3 and 5) x 100.0					
18. Premiums earned plus risk revenue (Line 2 plus Lines 3 and 5)	100.0	100.0	100.0	100.0	100.0
19. Total hospital and medical plus other non-health (Lines 18 plus Line 19)	88.8	92.1	87.3	86.6	89.8
20. Cost containment expenses	4.0	4.0	5.0	2.0	2.2
21. Other claims adjustment expenses	2.1	1.5	1.9	0.6	0.6
22. Total underwriting deductions (Line 23)	99.8	103.8	98.4	97.4	101.8
23. Total underwriting gain (loss) (Line 24)	0.2	(3.8)	1.6	2.6	(1.8)
Unpaid Claims Analysis (U&I Exhibit, Part 2B)					
24. Total claims incurred for prior years (Line 13, Col. 5)	81,161,234	49,404,878	30,593,009	30,287,092	35,952,720
25. Estimated liability of unpaid claims-[prior year (Line 13, Col. 6)]	84,281,824	51,501,048	34,275,305	38,174,388	39,673,717
Investments in Parent, Subsidiaries and Affiliates					
26. Affiliated bonds (Sch. D Summary, Line 12, Col. 1) .....	.0	.0	.0	.0	.0
27. Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1) .....	.0	.0	.0	.0	.0
28. Affiliated common stocks (Sch. D Summary, Line 24, Col. 1) .....	.0	.0	.0	.0	.0
29. Affiliated short-term investments (subtotal included in Schedule DA Verification, Col. 5, Line 10) .....	.0	.0	.0	.0	.0
30. Affiliated mortgage loans on real estate					
31. All other affiliated					
32. Total of above Lines 26 to 31 .....	.0	.0	.0	.0	.0
33. Total investment in parent included in Lines 26 to 31 above					

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3, Accounting Changes and Correction of Errors? Yes [] No []
If no, please explain:



ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION AMERIGROUP Florida, Inc.

2. Tampa, FL

NAIC Group Code	0671	BUSINESS IN THE STATE OF		Florida		DURING THE YEAR				2015		(LOCATION)		NAIC Company Code		95093	
		1	2	3	4	5	6	7	8	9	10						
		Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other						
Total Members at end of:																	
1. Prior Year		364,108	42,395						2,831	314,695	4,187						
2. First Quarter		377,883	41,054						3,125	328,888	4,816						
3. Second Quarter		383,751	41,966						3,231	333,938	4,616						
4. Third Quarter		391,470	40,169						3,147	343,670	4,484						
5. Current Year		392,725	41,563						2,524	340,957	7,681						
6. Current Year Member Months		4,608,418	492,997						36,538	4,023,582	55,301						
Total Member Ambulatory Encounters for Year:																	
7. Physician		2,093,620	165,783						44,809	1,879,571	3,457						
8. Non-Physician		2,221,109	60,399						37,131	1,683,597	439,982						
9. Total		4,314,729	226,182	0	0	0	0	0	81,940	3,563,168	443,439						
10. Hospital Patient Days Incurred		193,818	4,086						7,878	162,903	18,951						
11. Number of Inpatient Admissions		40,011	994						1,096	37,693	228						
12. Health Premiums Written (b)		1,309,626,197	60,587,416						43,935,852	1,051,493,442	153,609,487						
13. Life Premiums Direct		0															
14. Property/Casualty Premiums Written		0															
15. Health Premiums Earned		1,309,826,166	60,587,416						44,135,821	1,051,493,442	153,609,487						
16. Property/Casualty Premiums Earned		0															
17. Amount Paid for Provision of Health Care Services		1,147,394,549	57,691,410						33,147,180	915,126,569	141,429,390						
18. Amount Incurred for Provision of Health Care Services		1,162,899,698	53,145,327						32,493,030	933,718,239	143,543,102						

(a) For health business: number of persons insured under PPO managed care products and number of persons insured under indemnity only products
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$43,935,852



ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION AMERIGROUP Florida, Inc.

2. Tampa, FL

NAIC Group Code	0671	BUSINESS IN THE STATE OF	Grand Total		4	5	DURING THE YEAR		7	(LOCATION)		95093
			Comprehensive (Hospital & Medical)				2015			NAIC Company Code		
			2	3			6	8		9	10	
		1										
		Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other	
Total Members at end of:												
1. Prior Year		364,108	42,395	0	0	0	0	0	2,831	314,695	4,187	
2. First Quarter		377,883	41,054	0	0	0	0	0	3,125	328,888	4,816	
3. Second Quarter		383,751	41,966	0	0	0	0	0	3,231	333,938	4,616	
4. Third Quarter		391,470	40,169	0	0	0	0	0	3,147	343,670	4,484	
5. Current Year		392,725	41,563	0	0	0	0	0	2,524	340,957	7,681	
6. Current Year Member Months		4,608,418	492,997	0	0	0	0	0	36,538	4,023,582	55,301	
Total Member Ambulatory Encounters for Year:												
7. Physician		2,093,620	165,783	0	0	0	0	0	44,809	1,879,571	3,457	
8. Non-Physician		2,221,109	60,399	0	0	0	0	0	37,131	1,683,597	439,982	
9. Total		4,314,729	226,182	0	0	0	0	0	81,940	3,563,168	443,439	
10. Hospital Patient Days Incurred		193,818	4,086	0	0	0	0	0	7,878	162,903	18,951	
11. Number of Inpatient Admissions		40,011	994	0	0	0	0	0	1,096	37,693	228	
12. Health Premiums Written (b)		1,309,626,197	60,587,416	0	0	0	0	0	43,935,852	1,051,493,442	153,609,487	
13. Life Premiums Direct		0	0	0	0	0	0	0	0	0	0	
14. Property/Casualty Premiums Written		0	0	0	0	0	0	0	0	0	0	
15. Health Premiums Earned.....		1,309,826,166	60,587,416	0	0	0	0	0	44,135,821	1,051,493,442	153,609,487	
16. Property/Casualty Premiums Earned		0	0	0	0	0	0	0	0	0	0	
17. Amount Paid for Provision of Health Care Services.....		1,147,394,549	57,691,410	0	0	0	0	0	33,147,180	915,126,569	141,429,390	
18. Amount Incurred for Provision of Health Care Services		1,162,899,698	53,145,327	0	0	0	0	0	32,493,030	933,718,239	143,543,102	

(a) For health business: number of persons insured under PPO managed care products0 and number of persons insured under indemnity only products0
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$43,935,852

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

Schedule S - Part 1 - Section 2

NONE

Schedule S - Part 2

NONE

Schedule S - Part 3 - Section 2

NONE

Schedule S - Part 4

NONE

Schedule S - Part 4 - Bank Footnote

NONE

Schedule S - Part 5

NONE

Schedule S - Part 5 - Bank Footnote

NONE

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE S - PART 6

Five Year Exhibit of Reinsurance Ceded Business (000 Omitted)

	1 2015	2 2014	3 2013	4 2012	5 2011
A. OPERATIONS ITEMS					
1. Premiums .....	.0	.0	.0	.0	.0
2. Title XVIII - Medicare .....	.0	.0	.1	.4	.3
3. Title XIX - Medicaid .....	.0	.0	.59	142	148
4. Commissions and reinsurance expense allowance					
5. Total hospital and medical expenses					
B. BALANCE SHEET ITEMS					
6. Premiums receivable					
7. Claims payable .....	.0	.0	.0	.0	.0
8. Reinsurance recoverable on paid losses .....	.0	.0	.0	.0	.0
9. Experience rating refunds due or unpaid					
10. Commissions and reinsurance expense allowances due					
11. Unauthorized reinsurance offset					
12. Offset for reinsurance with Certified Reinsurers					XXX
C. UNAUTHORIZED REINSURANCE (DEPOSITS BY AND FUNDS WITHHELD FROM)					
13. Funds deposited by and withheld from (F) .....	.0	.0	.0	.0	.0
14. Letters of credit (L) .....	.0	.0	.0	.0	.0
15. Trust agreements (T) .....	.0	.0	.0	.0	.0
16. Other (O) .....	.0	.0	.0	.0	.0
D. REINSURANCE WITH CERTIFIED REINSURERS (DEPOSITS BY AND FUNDS WITHHELD FROM)					
17. Multiple Beneficiary Trust .....			.0	.0	XXX
18. Funds deposited by and withheld from (F) .....			.0	.0	XXX
19. Letters of credit (L) .....			.0	.0	XXX
20. Trust agreements (T) .....			.0	.0	XXX
21. Other (O) .....			.0	.0	XXX

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE S - PART 7

Restatement of Balance Sheet to Identify Net Credit For Ceded Reinsurance

	1 As Reported (net of ceded)	2 Restatement Adjustments	3 Restated (gross of ceded)
ASSETS (Page 2, Col. 3)			
1. Cash and invested assets (Line 12)	193,990,116		193,990,116
2. Accident and health premiums due and unpaid (Line 15)	6,923,078		6,923,078
3. Amounts recoverable from reinsurers (Line 16.1)	0		0
4. Net credit for ceded reinsurance	XXX	0	0
5. All other admitted assets (Balance)	7,479,726		7,479,726
6. Total assets (Line 28)	208,392,920	0	208,392,920
LIABILITIES, CAPITAL AND SURPLUS (Page 3)			
7. Claims unpaid (Line 1)	96,061,391		96,061,391
8. Accrued medical incentive pool and bonus payments (Line 2)	3,497,761		3,497,761
9. Premiums received in advance (Line 8)	0		0
10. Funds held under reinsurance treaties with authorized and unauthorized reinsurers (Line 19 first inset amount plus second inset amount)	0		0
11. Reinsurance in unauthorized companies (Line 20 minus inset amount)	0		0
12. Reinsurance with Certified Reinsurers (Line 20 inset amount)			0
13. Funds held under reinsurance treaties with Certified Reinsurers (Line 19 third inset amount)	0		0
14. All other liabilities (Balance)	33,149,297		33,149,297
15. Total liabilities (Line 24)	132,708,449	0	132,708,449
16. Total capital and surplus (Line 33)	75,684,471	XXX	75,684,471
17. Total liabilities, capital and surplus (Line 34)	208,392,920	0	208,392,920
NET CREDIT FOR CEDED REINSURANCE			
18. Claims unpaid	0		
19. Accrued medical incentive pool	0		
20. Premiums received in advance	0		
21. Reinsurance recoverable on paid losses	0		
22. Other ceded reinsurance recoverables	0		
23. Total ceded reinsurance recoverables	0		
24. Premiums receivable	0		
25. Funds held under reinsurance treaties with authorized and unauthorized reinsurers	0		
26. Unauthorized reinsurance	0		
27. Reinsurance with Certified Reinsurers	0		
28. Funds held under reinsurance treaties with Certified Reinsurers	0		
29. Other ceded reinsurance payables/offsets	0		
30. Total ceded reinsurance payables/offsets	0		
31. Total net credit for ceded reinsurance	0		

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE T PREMIUMS AND OTHER CONSIDERATIONS**Allocated by States and Territories**

1 States, etc.	2 Active Status	Direct Business Only							9 Deposit-Type Contracts
		3 Accident & Health Premiums	4 Medicare Title XVIII	5 Medicaid Title XIX	6 Federal Employees Health Benefits Plan Premiums	7 Life & Annuity Premiums & Other Considerations	8 Property/Casualty Premiums	9 Total Columns 2 Through 8	
1. Alabama	AL	N						.0	
2. Alaska	AK	N						.0	
3. Arizona	AZ	N						.0	
4. Arkansas	AR	N						.0	
5. California	CA	N						.0	
6. Colorado	CO	N						.0	
7. Connecticut	CT	N						.0	
8. Delaware	DE	N						.0	
9. District of Columbia	DC	N						.0	
10. Florida	FL	60,587,416	43,935,852	1,205,102,929				1,309,626,197	
11. Georgia	GA	N						.0	
12. Hawaii	HI	N						.0	
13. Idaho	ID	N						.0	
14. Illinois	IL	N						.0	
15. Indiana	IN	N						.0	
16. Iowa	IA	N						.0	
17. Kansas	KS	N						.0	
18. Kentucky	KY	N						.0	
19. Louisiana	LA	N						.0	
20. Maine	ME	N						.0	
21. Maryland	MD	N						.0	
22. Massachusetts	MA	N						.0	
23. Michigan	MI	N						.0	
24. Minnesota	MN	N						.0	
25. Mississippi	MS	N						.0	
26. Missouri	MO	N						.0	
27. Montana	MT	N						.0	
28. Nebraska	NE	N						.0	
29. Nevada	NV	N						.0	
30. New Hampshire	NH	N						.0	
31. New Jersey	NJ	N						.0	
32. New Mexico	NM	N						.0	
33. New York	NY	N						.0	
34. North Carolina	NC	N						.0	
35. North Dakota	ND	N						.0	
36. Ohio	OH	N						.0	
37. Oklahoma	OK	N						.0	
38. Oregon	OR	N						.0	
39. Pennsylvania	PA	N						.0	
40. Rhode Island	RI	N						.0	
41. South Carolina	SC	N						.0	
42. South Dakota	SD	N						.0	
43. Tennessee	TN	N						.0	
44. Texas	TX	N						.0	
45. Utah	UT	N						.0	
46. Vermont	VT	N						.0	
47. Virginia	VA	N						.0	
48. Washington	WA	N						.0	
49. West Virginia	WV	N						.0	
50. Wisconsin	WI	N						.0	
51. Wyoming	WY	N						.0	
52. American Samoa	AS	N						.0	
53. Guam	GU	N						.0	
54. Puerto Rico	PR	N						.0	
55. U.S. Virgin Islands	VI	N						.0	
56. Northern Mariana Islands	MP	N						.0	
57. Canada	CAN	N						.0	
58. Aggregate other alien	OT	XXX	.0	.0	.0	.0	.0	.0	.0
59. Subtotal	XXX	60,587,416	43,935,852	1,205,102,929	.0	.0	.0	1,309,626,197	.0
60. Reporting entity contributions for Employee Benefit Plans	XXX							.0	
61. Total (Direct Business)	(a) 1	60,587,416	43,935,852	1,205,102,929	0	0	0	1,309,626,197	0
DETAILS OF WRITE-INS									
58001.	XXX								
58002.	XXX								
58003.	XXX								
58998. Summary of remaining write-ins for Line 58 from overflow page	XXX	.0	.0	.0	.0	.0	.0	.0	.0
58999. Totals (Lines 58001 through 58003 plus 58998)(Line 58 above)	XXX	0	0	0	0	0	0	0	0

(L) Licensed or Chartered - Licensed Insurance Carrier or Domiciled RRG; (R) Registered - Non-domiciled RRGs; (Q) Qualified - Qualified or Accredited Reinsurer; (E) Eligible - Reporting Entities eligible or approved to write Surplus Lines in the state; (N) None of the above - Not allowed to write business in the state.

Explanation of basis of allocation by states, premiums by state, etc.

by states, premiums by state, etc.

(a) Insert the number of L responses except for Canada and Other Alien.

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

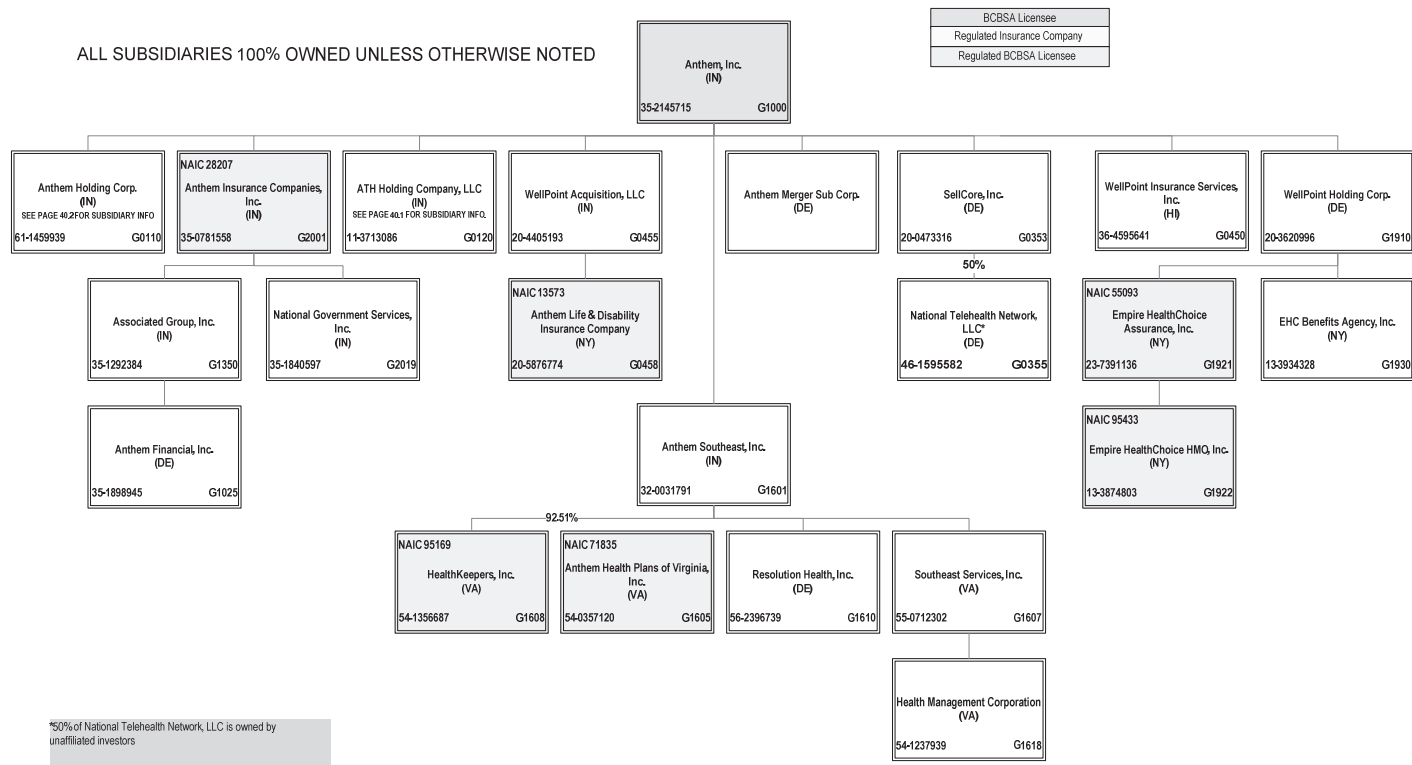
SCHEDULE T - PART 2
INTERSTATE COMPACT - EXHIBIT OF PREMIUMS WRITTEN

Allocated by States and Territories

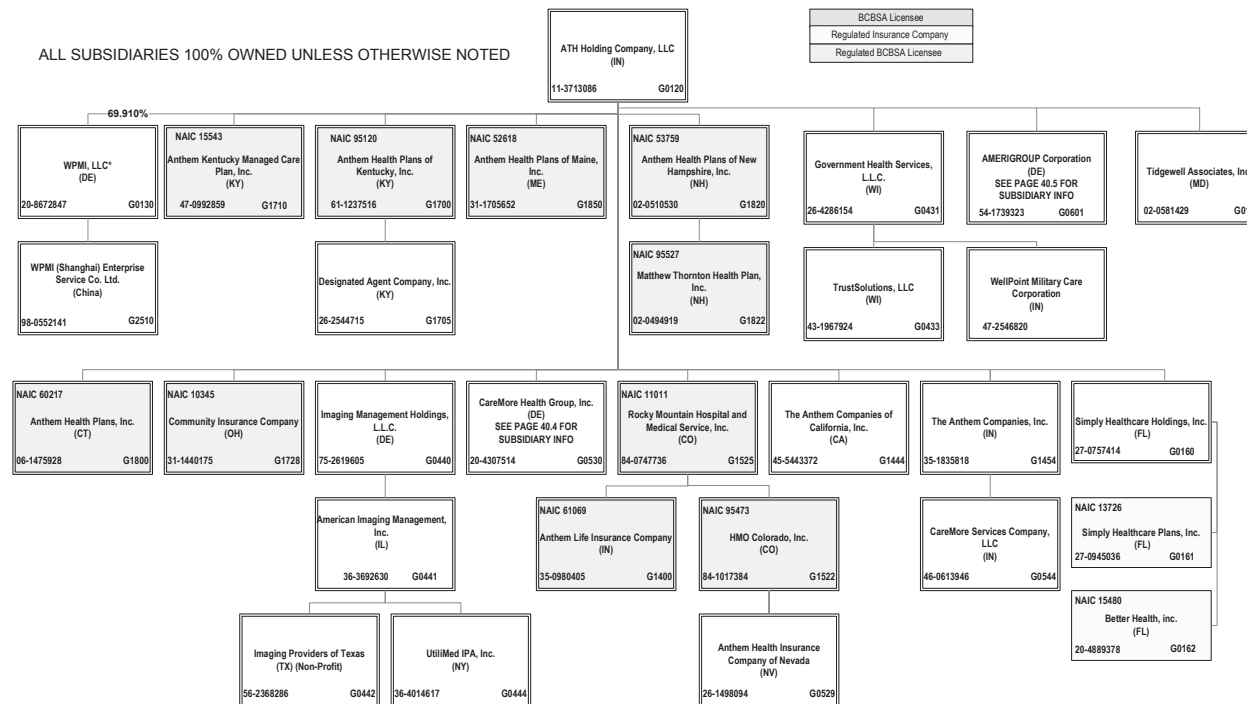
States, Etc.	Direct Business Only					
	1 Life (Group and Individual)	2 Annuities (Group and Individual)	3 Disability Income (Group and Individual)	4 Long-Term Care (Group and Individual)	5 Deposit-Type Contracts	6 Totals
1. Alabama AL						
2. Alaska AK						
3. Arizona AZ						
4. Arkansas AR						
5. California CA						
6. Colorado CO						
7. Connecticut CT						
8. Delaware DE						
9. District of Columbia DC						
10. Florida FL						
11. Georgia GA						
12. Hawaii HI						
13. Idaho ID						
14. Illinois IL						
15. Indiana IN						
16. Iowa IA						
17. Kansas KS						
18. Kentucky KY						
19. Louisiana LA						
20. Maine ME						
21. Maryland MD						
22. Massachusetts MA						
23. Michigan MI						
24. Minnesota MN						
25. Mississippi MS						
26. Missouri MO						
27. Montana MT						
28. Nebraska NE						
29. Nevada NV						
30. New Hampshire NH						
31. New Jersey NJ						
32. New Mexico NM						
33. New York NY						
34. North Carolina NC						
35. North Dakota ND						
36. Ohio OH						
37. Oklahoma OK						
38. Oregon OR						
39. Pennsylvania PA						
40. Rhode Island RI						
41. South Carolina SC						
42. South Dakota SD						
43. Tennessee TN						
44. Texas TX						
45. Utah UT						
46. Vermont VT						
47. Virginia VA						
48. Washington WA						
49. West Virginia WV						
50. Wisconsin WI						
51. Wyoming WY						
52. American Samoa AS						
53. Guam GU						
54. Puerto Rico PR						
55. U.S. Virgin Islands VI						
56. Northern Mariana Islands MP						
57. Canada CAN						
58. Aggregate Other Alien OT						
59. Total						

NONE

SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

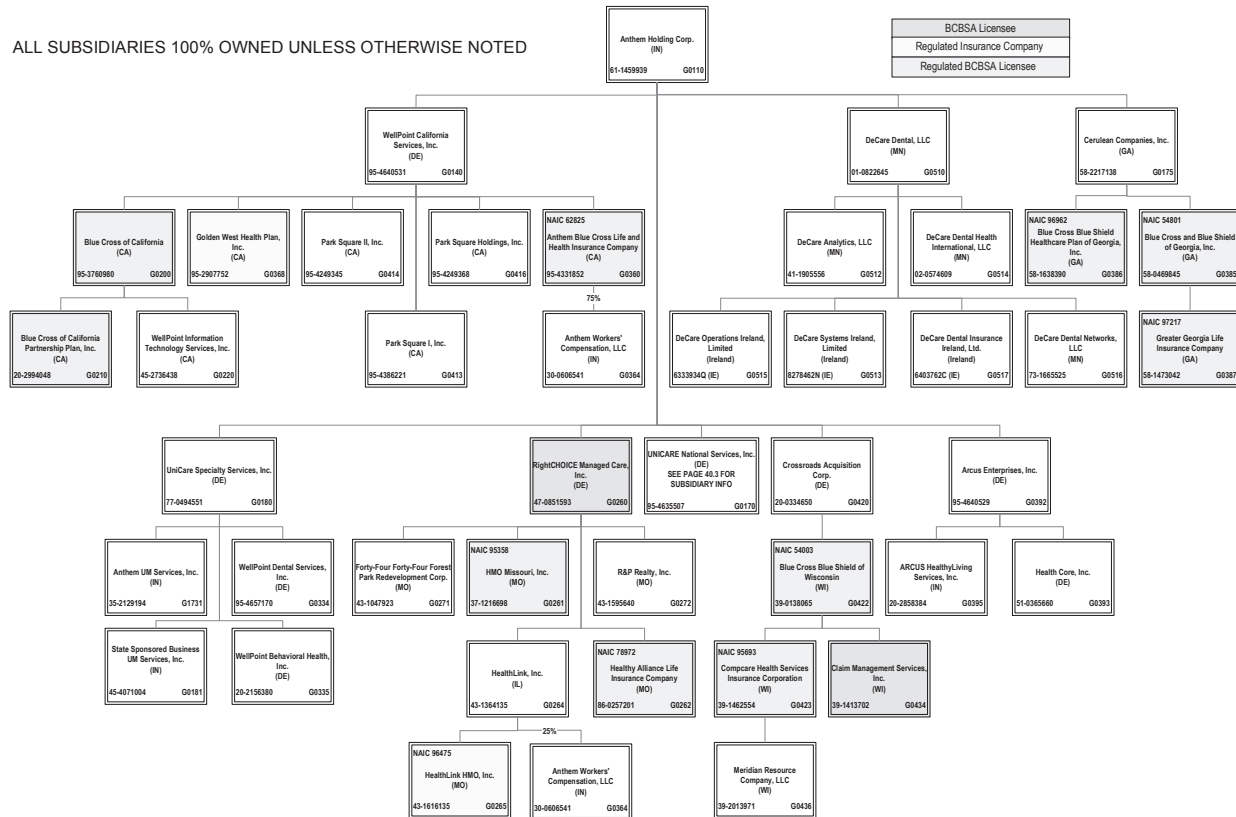


SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

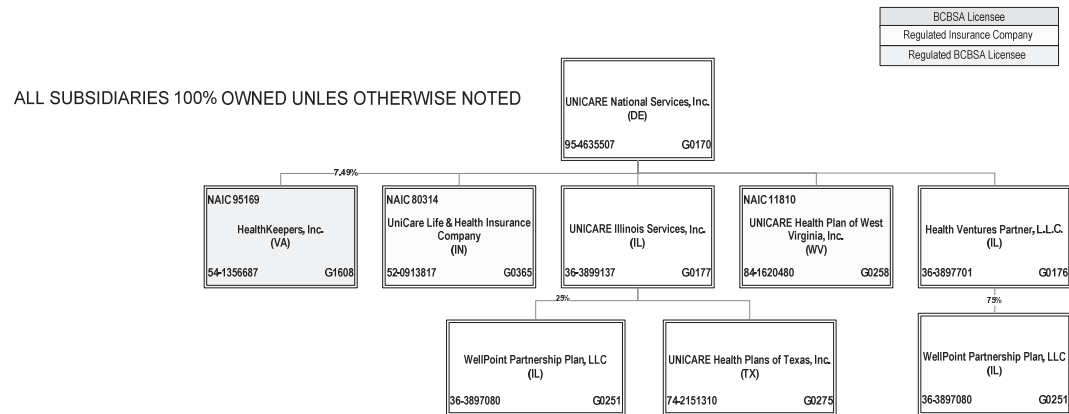


*30.09% of WPMI, LLC is owned by unaffiliated investors

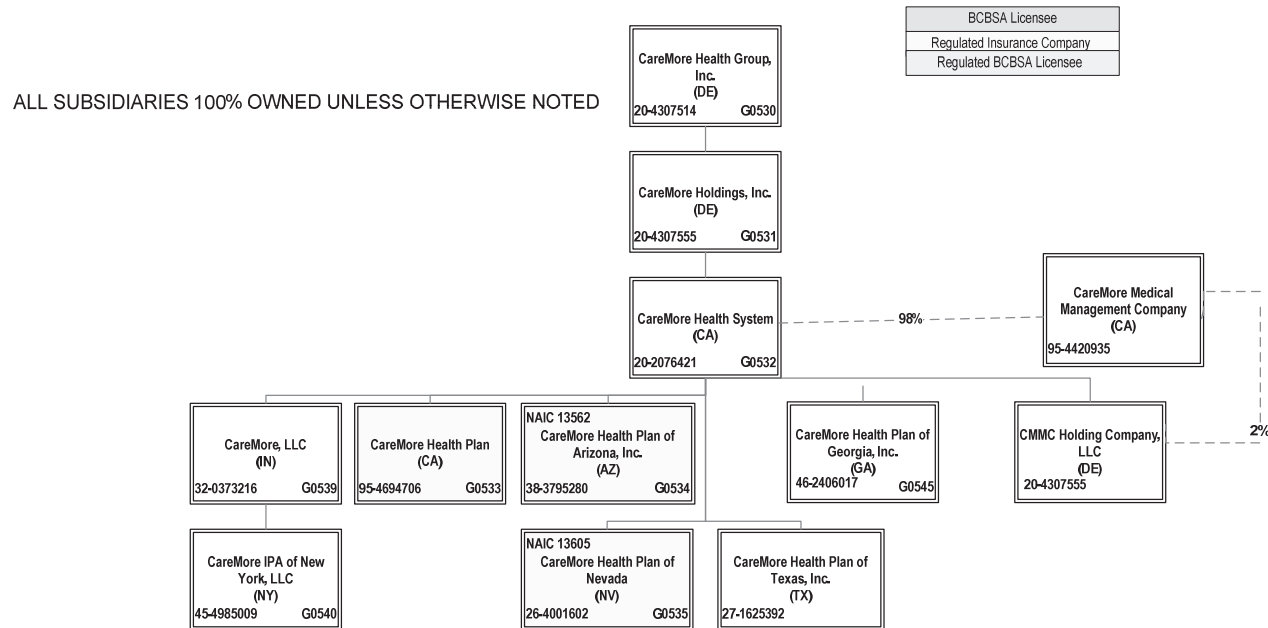
SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



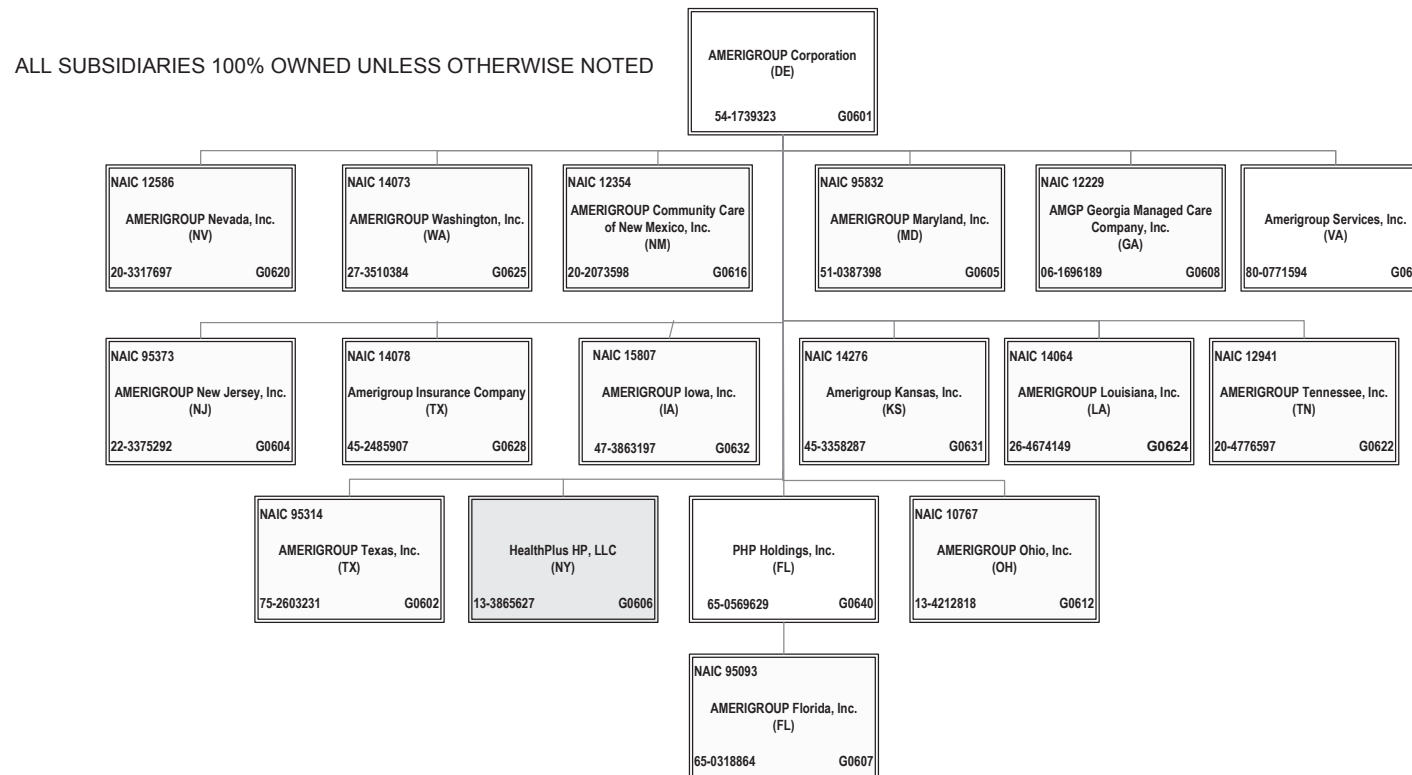
SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE Y
PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domestic Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	*
.0671	Anthem, Inc.		36-3692630				American Imaging Management, Inc.	IL	NIA	Imaging Management Holdings, L.L.C.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	12354	20-2073598				AMERIGROUP Community Care of New Mexico, Inc.	NM	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	95093	65-0318864				AMERIGROUP Corporation	DE	UIP	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	14078	45-2489907				AMERIGROUP Florida, Inc.	FL		PHP Holdings, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	15807	47-3863197				Amerigroup Insurance Company	TX	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	14276	45-3358287				AMERIGROUP Iowa, Inc.	IA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	14064	46-4674149				Amerigroup Kansas, Inc.	KS	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	95832	51-0387398				AMERIGROUP Louisiana, Inc.	LA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	1258	20-3317897				AMERIGROUP Maryland, Inc.	MD	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	95373	22-3375292				AMERIGROUP Nevada, Inc.	NV	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	10767	13-4212818				AMERIGROUP New Jersey, Inc.	NJ	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		80-0771594				AMERIGROUP Ohio, Inc.	OH	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	12941	20-4776597				Amerigroup Services, Inc.	VA	NIA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	95314	75-2603231				AMERIGROUP Tennessee, Inc.	TN	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	14073	27-3510384				AMERIGROUP Texas, Inc.	TX	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	12229	06-1696189				AMERIGROUP Washington, Inc.	WA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.						AWP Georgia Managed Care Company, Inc.	GA	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	62825	95-4331852				Anthem Blue Cross Life and Health Insurance Company	CA	IA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		35-1888945				Anthem Financial, Inc.	DE	NIA	Associated Group, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		26-1498094				Anthem Health Insurance Company of Nevada	NV	NIA	HIO Colorado, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	95120	61-1237516				Anthem Health Plans of Kentucky, Inc.	KY	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	52618	31-1705652				Anthem Health Plans of Maine, Inc.	ME	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.						Anthem Health Plans of New Hampshire, Inc.							
.0671	Anthem, Inc.	53759	02-0510530				Anthem Health Plans of Virginia, Inc.	NH	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	71835	54-0357120	40003317			Anthem Southeast, Inc.	VA	IA	Anthem Southeast, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	60217	06-1475928				Anthem Health Plans, Inc.	CT	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		61-1459939				Anthem Holding Corp.	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		35-2145715		6324	New York Stock Exchange (NYSE)	Anthem, Inc.	IN	UIP				Anthem, Inc.	
.0671	Anthem, Inc.	28207	35-0781558				Anthem Insurance Companies, Inc.	IN	IA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	15545	47-0962869				Anthem Kentucky Managed Care Plan, Inc.	KY	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.						Anthem Life & Disability Insurance Company							
.0671	Anthem, Inc.	13573	20-5876774					NV	IA	WellPoint Acquisition, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.									Rocky Mountain Hospital and Medical Service, Inc.				
.0671	Anthem, Inc.	61069	35-0980405				Anthem Life Insurance Company	IN	IA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.						Anthem Merger Sub Corp.	DE	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		32-0031791				Anthem Southeast, Inc.	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		35-2129194				Anthem UM Services, Inc.	IN	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		30-0606541				Anthem Workers' Compensation, LLC	IN	NIA	Anthem Blue Cross Life and Health Insurance Company	Ownership	75.000	Anthem, Inc.	
.0671	Anthem, Inc.		30-0606541				Anthem Workers' Compensation, LLC	IN	NIA	HealthLink, Inc.	Ownership	25.000	Anthem, Inc.	
.0671	Anthem, Inc.		95-4640529				Arcus Enterprises, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		20-2858384				ARCUS HealthLiving Services, Inc.	IN	NIA	Arcus Enterprises, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		35-1292384				Associated Group, Inc.	IN	NIA	Anthem Insurance Companies, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		11-3713086				ATH Holding Company, LLC	IN	UIP	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	15480	20-4889378				Better Health, Inc.	FL	IA	Simply Healthcare Holdings, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.						Blue Cross and Blue Shield of Georgia, Inc.	GA	IA	Cerulean Companies, Inc.	Ownership	100.000	Anthem, Inc.	

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE Y
PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	*
.0671	Anthem, Inc.	96962	58-1638390				Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	GA	IA	Cerulean Companies, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	54003	39-0138065				Blue Cross Blue Shield of Wisconsin	WI	IA	Crossroads Acquisition Corp.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		95-3703980				Blue Cross of California	CA	IA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	.0101
.0671	Anthem, Inc.		20-2994048				Blue Cross of California Partnership Plan, Inc.	CA	IA	Blue Cross of California	Ownership	100.000	Anthem, Inc.	.0102
.0671	Anthem, Inc.		20-4307514				Caremore Health Group, Inc.	DE	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		95-4694706				Caremore Health Plan	CA	IA	Caremore Health System	Ownership	100.000	Anthem, Inc.	.0103
.0671	Anthem, Inc.	13562	38-3795280				Caremore Health Plan of Arizona, Inc.	AZ	IA	Caremore Health System	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		46-2406017				Caremore Health Plan of Georgia, Inc.	GA	NIA	Caremore Health System	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	13605	26-4019032				Caremore Health Plan of Nevada	NV	IA	Caremore Health System	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		27-1625392				Caremore Health Plan of Texas, Inc.	TX	IA	Caremore Health System	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		20-4307555				Caremore Holdings, Inc.	DE	NIA	Caremore Health Group, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		45-4985009				Caremore IPA of New York, LLC	NY	NIA	Caremore, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		32-0373216				Caremore, LLC	IN	NIA	Caremore Health System	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		20-2076421				Caremore Health System	CA	NIA	Caremore Holdings, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		95-4420935				Caremore Medical Management Company	CA	NIA	Caremore Health System	Ownership	98.000	Anthem, Inc.	
.0671	Anthem, Inc.		95-4420935				Caremore Medical Management Company	CA	NIA	OMC Holding Company, LLC	Ownership	2.000	Anthem, Inc.	
.0671	Anthem, Inc.		46-0613949				Caremore Services Company, LLC	IN	NIA	The Anthem Companies, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		58-2217138				Cerulean Companies, Inc.	GA	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		39-1413702				Claim Management Services, Inc.	WI	NIA	Blue Cross Blue Shield of Wisconsin	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		20-4307555				OMC Holding Company, LLC	DE	NIA	Caremore Health System	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	10345	31-1440175				Community Insurance Company	OH	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		95693	39-1462554			Comcare Health Services Insurance Corporation	WI	IA	Blue Cross Blue Shield of Wisconsin	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		20-0334650				Crossroads Acquisition Corp.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		41-1905556				DeCare Analytics, LLC	MN	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		02-0574609				DeCare Dental Health International, LLC	MN	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.						DeCare Dental Insurance Ireland, Ltd.	JRL	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		73-1665525				DeCare Dental Networks, LLC	MN	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		01-0822645				DeCare Dental, LLC	MN	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.						DeCare Operations Ireland, Limited	JRL	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		26-2541715				DeCare Systems Ireland, Limited	JRL	NIA	DeCare Dental, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		13-3934328				Designated Agent Company, Inc.	NY	NIA	Anthem Health Plans of Kentucky, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	55093	23-7391136				ERC Benefits Agency, Inc.	NY	IA	WellPoint Holding Corp	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		13-3874903				Empire HealthChoice Assurance, Inc.	NY	IA	WellPoint Holding Corp	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	95433	13-3874903				Empire HealthChoice HMO, Inc.	NY	IA	Empire HealthChoice Assurance, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		43-1047923				Forty-Four Forty-Four Forest Park Redevelopment Corp.	MO	NIA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		95-2907752				Golden West Health Plan, Inc.	CA	IA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	.0104
.0671	Anthem, Inc.		26-4286154				Government Health Services, LLC	WI	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	97217	58-1473042				Greater Georgia Life Insurance Company	GA	IA	Blue Cross and Blue Shield of Georgia, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		51-0365660				Health Core, Inc.	DE	NIA	Arcus Enterprises, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		54-1237939				Health Management Corporation	VA	NIA	Southeast Services, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		36-3897701				Health Ventures Partner, L.L.C.	IL	NIA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	95169	54-1356687				HealthKeepers, Inc.	VA	IA	Anthem Southeast, Inc.	Ownership	92.510	Anthem, Inc.	
.0671	Anthem, Inc.	95169	54-1356687				HealthKeepers, Inc.	VA	IA	UNICARE National Services, Inc.	Ownership	7.490	Anthem, Inc.	
.0671	Anthem, Inc.	96475	45-1616135				HealthLink HMO, Inc.	MO	IA	HealthLink, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		45-1594135				HealthLink, Inc.	IL	NIA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		13-3865827				HealthPlus HP, LLC	NY	IA	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	.0100

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE Y
PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domestic Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	*
.0671	Anthem, Inc.	78972	86-0257201				Healthy Alliance Life Insurance Company	MO	IA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	95473	84-1017384				HMO Colorado, Inc.	CO	IA	Rocky Mountain Hospital and Medical Service, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	95358	37-1216688				HMO Missouri, Inc.	MO	IA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		75-2519605				Imaging Management Holdings, L.L.C.	DE	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		56-2388286				Imaging Providers of Texas (non-profit)	TX	NIA	American Imaging Management, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	95527	02-0494919				Matthew Thornton Health Plan, Inc.	NH	IA	Anthem Health Plans of New Hampshire, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		39-2013971				Meridian Resource Company, LLC	WI	NIA	CompCare Health Services Insurance Corporation	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		35-1840297				National Government Services, Inc.	DE	NIA	Anthem Insurance Companies, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		46-1595582				National Telehealth Network, LLC	DE	NIA	Salicore, Inc.	Ownership	50.000	Anthem, Inc.	5105
.0671	Anthem, Inc.		95-4249368				Park Square Holdings, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		95-4386221				Park Square I, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		95-4249345				Park Square II, Inc.	CA	NIA	WellPoint California Services, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		65-0569629				PHP Holdings, Inc.	FL	UDP	AMERIGROUP Corporation	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		43-1595640				R & P Realty, Inc.	MO	NIA	RightCHOICE Managed Care, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		96-2396739				Resolution Health, Inc.	DE	NIA	Anthem Southeast, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		47-0851593				RightCHOICE Managed Care, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.						Rocky Mountain Hospital and Medical Service, Inc.	CO	IA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	11011	84-0747736				SellCore, Inc.	DE	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		20-0473316				Simply Healthcare Holdings, Inc.	FL	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		27-0757414				Simply Healthcare Plans, Inc.	FL	IA	Simply Healthcare Holdings, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	13726	27-0945036				Southeast Services, Inc.	VA	NIA	Anthem Southeast, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		55-0712302				State Sponsored Business UM Services, Inc.	IN	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		45-4071004				The Anthem Companies, Inc.	IN	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		35-1835818				The Anthem Companies of California, Inc.	CA	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		45-5443372				Tidgewell Associates, Inc.	MO	NIA	ATH Holding Company, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		02-0581429				TrustSolutions, LLC	WI	NIA	Government Health Services, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		43-1967924				UNICARE Health Plan of West Virginia, Inc.	WV	IA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	11810	84-1620480				UNICARE Health Plans of Texas, Inc.	TX	IA	UNICARE Illinois Services, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		74-2151310				UNICARE Illinois Services, Inc.	IL	NIA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.	80314	52-0913817				UNICARE Life & Health Insurance Company	IN	IA	UNICARE National Services, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		95-4635507				UNICARE National Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		77-0494551				UNICARE Specialty Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		36-4014617				Utilimed IPA, Inc.	NY	NIA	American Imaging Management, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		20-4405193				WellPoint Acquisition, LLC	IN	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		20-2150380				WellPoint Behavioral Health, Inc.	DE	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		95-4649331				WellPoint California Services, Inc.	DE	NIA	Anthem Holding Corp.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		95-4657170				WellPoint Dental Services, Inc.	DE	NIA	UNICARE Specialty Services, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		20-3620996				WellPoint Holding Corp.	DE	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.						WellPoint Information Technology Services, Inc.	CA	NIA	Blue Cross of California	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		45-2736438				WellPoint Insurance Services, Inc.	HI	NIA	Anthem, Inc.	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		36-4595941				WellPoint Military Care Corporation	IN	NIA	Government Health Services, LLC	Ownership	100.000	Anthem, Inc.	
.0671	Anthem, Inc.		47-2546820				WellPoint Partnership Plan, LLC	IL	NIA	Health Ventures Partner, L.L.C.	Ownership	75.000	Anthem, Inc.	
.0671	Anthem, Inc.		36-3897080				WellPoint Partnership Plan, LLC	IL	NIA	UNICARE Illinois Services, Inc.	Ownership	25.000	Anthem, Inc.	

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	*
..0671 ..	Anthem, Inc. ....	.....	98-0552141 ..	.....	.....	.....	IPMII (Shanghai) Enterprise Service Co. Ltd. ....	..CHN...	..NIA...	IPMII, LLC	Ownership.....	..100.000 ..	Anthem, Inc. ....	.....
..0671 ..	Anthem, Inc. ....	.....	20-8672847 ..	.....	.....	.....	IPMII, LLC	..DE...	..NIA...	ATH Holding Company, LLC	Ownership.....	..69.910 ..	Anthem, Inc. ....	..0106 ..

Asterisk	Explanation
0100	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the New York State Department of Health.
0101	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0102	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0103	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0104	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0105	50% owned by unaffiliated investors

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1	2	3	4	5	6	7	8	9	10	11	12	13
NAIC Company Code	ID Number	Names of Insurers and Parent, Subsidiaries or Affiliates	Shareholder Dividends	Capital Contributions	Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	Management Agreements and Service Contracts	Income/ (Disbursements) Incurred Under Reinsurance Agreements	*	Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	Totals	Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
	36-3692630	American Imaging Management, Inc.					(38,492,417)				(38,492,417)	
12354	20-2073598	AMERIGROUP Community Care of New Mexico, Inc.					(794,276)				(794,276)	
	54-1739323	AMERIGROUP Corporation	77,700,000				86,724,878				164,424,878	
95093	65-0318864	AMERIGROUP Florida, Inc.					(125,581,745)				(125,581,745)	
14078	45-2485907	AMERIGROUP Insurance Company					(54,328,274)				(54,328,274)	
15807	47-3863197	AMERIGROUP Iowa, Inc.		71,000,000			(8,729,674)				62,270,326	
14276	45-3358287	AMERIGROUP Kansas, Inc.					(80,060,605)				(80,060,605)	
14064	26-4674149	AMERIGROUP Louisiana, Inc.		15,000,000			(53,542,973)				(38,542,973)	
95832	51-0387398	AMERIGROUP Maryland, Inc.	(20,000,000)				(110,007,756)				(130,007,756)	
12586	20-3317697	AMERIGROUP Nevada, Inc.		10,000,000			(65,358,532)				(55,358,532)	
95373	22-3375292	AMERIGROUP New Jersey, Inc.	(77,700,000)				(144,874,688)				(222,574,688)	
10767	13-4212818	AMERIGROUP Ohio Inc					160,755				160,755	
12941	20-4776597	AMERIGROUP Tennessee, Inc.					(203,108,064)				(203,108,064)	
95314	75-2603231	AMERIGROUP Texas, Inc.					(389,975,890)				(389,975,890)	
14073	27-3510384	AMERIGROUP Washington, Inc.					(56,114,711)				(56,114,711)	
12229	06-1696189	AMGP Georgia Managed Care Company, Inc.	(13,600,000)				(158,935,552)				(172,535,552)	
62825	95-4331852	Anthem Blue Cross Life and Health Insurance Company, Inc.	(305,600,000)				(1,021,188,675)	(5,154,126)			(1,331,942,801)	6,377,529
60217	06-1475928	Anthem Health Plans, Inc.	(106,900,000)				(315,728,591)				(422,628,591)	
95120	61-1237516	Anthem Health Plans of Kentucky, Inc.	(125,000,000)				(389,032,778)				(514,032,778)	
52618	31-1705652	Anthem Health Plans of Maine, Inc.	(19,100,000)				(113,334,069)				(132,434,069)	
53759	02-0510530	Anthem Health Plans of New Hampshire, Inc.	(15,000,000)				(54,088,119)	1,268			(69,086,851)	
71835	54-0357120	Anthem Health Plans of Virginia, Inc.	(234,900,000)				(589,253,725)	4,372,035			(819,781,690)	(2,278,504)
	11-3713086	ATH Holding Company, LLC (G0120)					60,818,767				60,818,767	
28207	35-0781558	Anthem Insurance Companies, Inc.	(389,000,000)				(1,282,029,451)	1,736,083			(1,669,293,368)	(34,270,356)
15543	47-0992859	Anthem Kentucky Managed Care Plan, Inc.		15,000,000			(63,745,125)				(48,745,125)	
13573	20-5876774	Anthem Life and Disability Insurance Company					(1,317,592)				(1,317,592)	
61069	35-0980405	Anthem Life Insurance Company	(34,300,000)				(42,435,918)	14,187,151			(62,548,767)	6,865,000
	35-2145715	Anthem, Inc.	2,672,300,000	(133,507,076)			6,193,479,084				8,732,272,008	
15480	20-4889378	Better Health, Inc.					(26,429,994)				(26,429,994)	
54801	58-0469845	Blue Cross and Blue Shield of Georgia, Inc.	(55,000,000)	(5,000,000)			(385,122,411)				(445,122,411)	
96962	58-1638390	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	(40,000,000)				(370,179,369)				(410,179,369)	
54003	39-0138065	Blue Cross Blue Shield of Wisconsin	(79,300,000)				(133,307,003)	65			(212,606,938)	
	95-3760980	Blue Cross of California	(300,000,000)	(50,000,000)			(1,309,509,777)	281,493			(1,659,228,284)	
	20-2994048	Blue Cross of California Partnership Plan, Inc.					(321,212,908)				(321,212,908)	
	20-2076421	Caremore Health System					25,260,827				25,260,827	
	95-4694706	Caremore Health Plan	(30,000,000)				(159,410,247)				(189,410,247)	
13562	38-3975280	Caremore Health Plan of Arizona, Inc.					(66,483,692)				(66,483,692)	

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE Y








PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1	2	3	4	5	6	7	8	9	10	11	12	13
NAIC Company Code	ID Number	Names of Insurers and Parent, Subsidiaries or Affiliates	Shareholder Dividends	Capital Contributions	Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	Management Agreements and Service Contracts	Income/ (Disbursements) Incurred Under Reinsurance Agreements	*	Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	Totals	Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
13753	27-1848815	Caremore Health Plan of Colorado, Inc.					(1,865)				(1,865)	
13605	26-4001602	Caremore Health Plan of Nevada		7,000,000			(22,136,212)				(15,136,212)	
10345	31-1440175	Community Insurance Company	(276,800,000)				(933,914,831)				(1,210,714,831)	
95693	39-1462554	Compcare Health Services Insurance Corporation	(10,700,000)				(93,511,063)				(104,211,063)	
	01-0822645	DeCare Dental, LLC					(46,954,399)				(46,954,399)	
55093	23-7391136	Empire HealthChoice Assurance, Inc.	(300,000,000)				(586,829,515)				(886,829,515)	
95433	13-3874803	Empire HealthChoice HMO, Inc.					(146,998,590)				(146,998,590)	
	95-2907752	Golden West Health Plan, Inc.					(617,754)				(617,754)	
97217	58-1473042	Greater Georgia Life Insurance Company		5,000,000			(5,331,863)				(331,863)	
	51-0365660	Health Core, Inc.					(20,179,330)				(20,179,330)	
95169	54-1356687	HealthKeepers, Inc.		15,000,000			(384,825,789)	(4,372,035)			(374,197,824)	2,278,504
96475	43-1616135	HealthLink HMO, Inc.					7,712,475				7,712,475	
	43-1364135	HealthLink, Inc.					(65,916,503)				(65,916,503)	
	13-3865627	HealthPlus LLC					(335,111,835)				(335,111,835)	
78972	86-0257201	Healthy Alliance Life Insurance Company ..	(110,700,000)				(287,947,230)				(398,647,230)	
95473	84-1017384	HMO Colorado, Inc.					(43,392,627)				(43,392,627)	
95358	37-1216698	HMO Missouri, Inc.	(800,000)				(15,700,029)				(16,500,029)	
	98-0408753	HTH Re, LTD						5,154,126			5,154,126	(6,377,529)
95527	02-0494919	Matthew Thornton Health Plan, Inc.	(25,000,000)				(94,896,948)				(119,896,948)	
	35-1840597	National Government Services, Inc.					(20,571,487)				(20,571,487)	
85286	75-1461960	OneNation Insurance Company	(77,100,000)	507,076			(805,309)				(77,398,233)	
11011	84-0747736	Rocky Mountain Hospital and Medical Service, Inc.	(73,700,000)				(289,684,503)	(190,546)			(363,575,049)	
13726	27-0945036	Simply Healthcare Plans, Inc.					13,429,921				13,429,921	
	35-1835818	The Anthem Companies, Inc.					4,840,567,913				4,840,567,913	
	45-5443372	The Anthem Companies of California, Inc.					159,570,275				159,570,275	
	61-1459939	Anthem Holding Corp.					(14,984,321)				(14,984,321)	
12805	20-4842073	UNICARE Health Plan of Kansas, Inc.					423,129				423,129	
11810	84-1620480	UNICARE Health Plan of West Virginia, Inc.										
			(5,900,000)				(40,534,849)				(46,434,849)	
95420	74-2151310	UNICARE Health Plans of Texas, Inc.					536,623				536,623	
80314	52-0913817	UNICARE Life & Health Insurance Company ..	(23,900,000)				(76,287,576)	(16,015,514)			(116,203,090)	27,405,356
	45-2736438	WellPoint Information Technology Services ..										
				50,000,000			296,591,038				346,591,038	
	36-3897080	WellPoint Partnership Plan, Inc.					(24,426,656)				(24,426,656)	
9999999 Control Totals			0	0	0	0	0	0	XXX	0	0	0

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.
SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

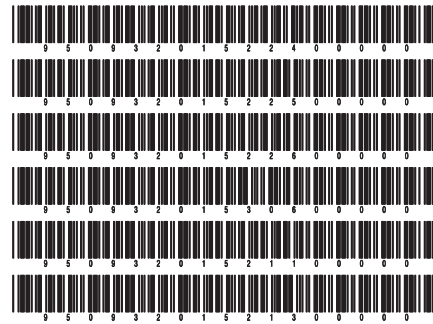
The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

	Responses
MARCH FILING	
1. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?	SEE EXPLANATION
2. Will an actuarial opinion be filed by March 1?	SEE EXPLANATION
3. Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?	SEE EXPLANATION
4. Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1?	SEE EXPLANATION
APRIL FILING	
5. Will Management's Discussion and Analysis be filed by April 1?	YES
6. Will the Supplemental Investment Risks Interrogatories be filed by April 1?	YES
7. Will the Accident and Health Policy Experience Exhibit be filed by April 1?	YES
JUNE FILING	
8. Will an audited financial report be filed by June 1?	YES
9. Will Accountant's Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?	YES
AUGUST FILING	
10. Will Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile by August 1?	YES
The following supplemental reports are required to be filed as part of your annual statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.	
MARCH FILING	
11. Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?	NO
12. Will the Supplemental Life data due March 1 be filed with the state of domicile and the NAIC?	NO
13. Will the Supplemental Property/Casualty data due March 1 be filed with the state of domicile and the NAIC?	NO
14. Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1?	NO
15. Will the actuarial opinion on participating and non-participating policies as required in Interrogatories 1 and 2 on Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
16. Will the actuarial opinion on non-guaranteed elements as required in Interrogatory 3 to Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
17. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?	NO
18. Will an approval from the reporting entity's state of domicile for relief related to the five-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1?	NO
19. Will an approval from the reporting entity's state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1?	NO
20. Will an approval from the reporting entity's state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?	NO
APRIL FILING	
21. Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?	NO
22. Will the Supplemental Life data due April 1 be filed with the state of domicile and the NAIC?	NO
23. Will the Supplemental Property/Casualty Insurance Expense Exhibit due April 1 be filed with any state that requires it, and, if so, the NAIC?	NO
24. Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?	YES
25. Will the regulator only (non-public) Supplemental Health Care Exhibit's Expense Allocation Report be filed with the state of domicile and the NAIC by April 1?	YES
AUGUST FILING	
26. Will Management's Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?	YES
Explanations:	
1. The annual filing for Florida isn't due until April 1, 2016.	
2. The annual filing for Florida isn't due until April 1, 2016.	
3. The RBC isn't required by the state of Florida.	
4. The RBC isn't required by the state of Florida.	
11.	
12.	
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18.	
19.	
20.	
21.	
22.	
23.	
Bar Codes:	
11. Medicare Supplement Insurance Experience Exhibit [Document Identifier 360]	
12. Life Supplement [Document Identifier 205]	
13. Property/Casualty Supplement [Document Identifier 207]	
14. SIS Stockholder Information Supplement [Document Identifier 420]	
15. Participating Opinion for Exhibit 5 [Document Identifier 371]	
16. Non-Guaranteed Opinion for Exhibit 5 [Document Identifier 370]	
17. Medicare Part D Coverage Supplement [Document Identifier 365]	

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

18. Relief from the five-year rotation requirement for lead audit partner [Document Identifier 224]
19. Relief from the one-year cooling off period for independent CPA [Document Identifier 225]
20. Relief from the Requirements for Audit Committees [Document Identifier 226]
21. Long-Term Care Experience Reporting Forms [Document Identifier 306]
22. Life Supplement [Document Identifier 211]
23. Property/Casualty Supplement Insurance Expense Exhibit [Document Identifier 213]



ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

OVERFLOW PAGE FOR WRITE-INS

Additional Write-ins for Underwriting and Investment Exhibit Part 3 Line 25

	Claim Adjustment Expenses		3 General Administrative Expenses	4 Investment Expenses	5 Total
	1 Cost Containment Expenses	2 Other Claim Adjustment Expenses			
2504. Miscellaneous	11,945	178,537	292,489	9,967	492,938
2597. Summary of remaining write-ins for Line 25 from overflow page	11,945	178,537	292,489	9,967	492,938

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SUMMARY INVESTMENT SCHEDULE

Investment Categories	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
	1 Amount	2 Percentage	3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage
1. Bonds:						
1.1 U.S. treasury securities		0.000		2,183,704	2,183,704	1.126
1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
1.21 Issued by U.S. government agencies		0.000		.0	.0	0.000
1.22 Issued by U.S. government sponsored agencies		0.000		.0	.0	0.000
1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)		0.000		.0	.0	0.000
1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S.:						
1.41 States, territories and possessions general obligations	6,664,799	3.436	6,664,799		6,664,799	3.436
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	7,235,647	3.730	7,235,647		7,235,647	3.730
1.43 Revenue and assessment obligations	17,231,853	8.883	17,231,853		17,231,853	8.883
1.44 Industrial development and similar obligations		0.000		.0	.0	0.000
1.5 Mortgage-backed securities (includes residential and commercial MBS):						
1.51 Pass-through securities:						
1.511 Issued or guaranteed by GNMA	3,461,558	1.784	3,461,558		3,461,558	1.784
1.512 Issued or guaranteed by FNMA and FHLMC	17,764,964	9.158	17,764,964		17,764,964	9.158
1.513 All other		0.000		3,230,826	3,230,826	1.665
1.52 CMOs and REMICs:						
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	1,107,318	0.571	1,107,318		1,107,318	0.571
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521		0.000		.0	.0	0.000
1.523 All other	6,804,734	3.508	6,804,734		6,804,734	3.508
2. Other debt and other fixed income securities (excluding short-term):						
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	49,870,932	25.708	49,870,932	1,394,620	51,265,552	26.427
2.2 Unaffiliated non-U.S. securities (including Canada)	754,727	0.389	754,727		754,727	0.389
2.3 Affiliated securities		0.000		.0	.0	0.000
3. Equity interests:						
3.1 Investments in mutual funds		0.000		.0	.0	0.000
3.2 Preferred stocks:						
3.21 Affiliated		0.000		.0	.0	0.000
3.22 Unaffiliated		0.000		.0	.0	0.000
3.3 Publicly traded equity securities (excluding preferred stocks):						
3.31 Affiliated		0.000		.0	.0	0.000
3.32 Unaffiliated	13,826,041	7.127	13,826,041		13,826,041	7.127
3.4 Other equity securities:						
3.41 Affiliated		0.000		.0	.0	0.000
3.42 Unaffiliated		0.000		.0	.0	0.000
3.5 Other equity interests including tangible personal property under lease:						
3.51 Affiliated		0.000		.0	.0	0.000
3.52 Unaffiliated		0.000		.0	.0	0.000
4. Mortgage loans:						
4.1 Construction and land development		0.000		.0	.0	0.000
4.2 Agricultural		0.000		.0	.0	0.000
4.3 Single family residential properties		0.000		.0	.0	0.000
4.4 Multifamily residential properties		0.000		.0	.0	0.000
4.5 Commercial loans		0.000		.0	.0	0.000
4.6 Mezzanine real estate loans		0.000		.0	.0	0.000
5. Real estate investments:						
5.1 Property occupied by company		0.000	.0		.0	0.000
5.2 Property held for production of income (including \$ of property acquired in satisfaction of debt)		0.000	.0		.0	0.000
5.3 Property held for sale (including \$ of property acquired in satisfaction of debt)		0.000	.0		.0	0.000
6. Contract loans		0.000	.0		.0	0.000
7. Derivatives		0.000	.0		.0	0.000
8. Receivables for securities	5,836	0.003	5,836		5,836	0.003
9. Securities Lending (Line 10, Asset Page reinvested collateral)	6,809,150	3.510	6,809,150	XXX	XXX	XXX
10. Cash, cash equivalents and short-term investments	62,452,557	32.194	62,452,557		62,452,557	32.194
11. Other invested assets		0.000			.0	0.000
12. Total invested assets	193,990,116	100.000	193,990,116	6,809,150	193,990,116	100.000

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

Schedule A - Verification - Real Estate

NONE

Schedule B - Verification - Mortgage Loans

NONE

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.
SCHEDULE BA - VERIFICATION BETWEEN YEARS
Other Long-Term Invested Assets

1.	Book/adjusted carrying value, December 31 of prior year	
2.	Cost of acquired:	
2.1	Actual cost at time of acquisition (Part 2, Column 8)	
2.2	Additional investment made after acquisition (Part 2, Column 9)	
3.	Capitalized deferred interest and other:	
3.1	Totals, Part 1, Column 16	
3.2	Totals, Part 3, Column 12	
4.	Accrual of discount	
5.	Unrealized valuation increase (decrease):	
5.1	Totals, Part 1, Column 13	
5.2	Totals, Part 3, Column 9	
6.	Total gain (loss) on disposals, Part 3, Column 19	
7.	Deduct amounts received on disposals, Part 3, Column 16	
8.	Deduct amortization of premium and depreciation	
9.	Total foreign exchange change in book/adjusted carrying value:	
9.1	Totals, Part 1, Column 17	
9.2	Totals, Part 3, Column 14	
10.	Deduct current year's other than temporary impairment recognized:	
10.1	Totals, Part 1, Column 15	
10.2	Totals, Part 3, Column 11	
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	
12.	Deduct total nonadmitted amounts	
13.	Statement value at end of current period (Line 11 minus Line 12)	

NONE

SCHEDULE D - VERIFICATION BETWEEN YEARS
Bonds and Stocks

1.	Book/adjusted carrying value, December 31 of prior year	129,784,376
2.	Cost of bonds and stocks acquired, Part 3, Column 7	43,739,925
3.	Accrual of discount	10,086
4.	Unrealized valuation increase (decrease):	
4.1.	Part 1, Column 12	0
4.2.	Part 2, Section 1, Column 15	
4.3.	Part 2, Section 2, Column 13	(613,855)
4.4.	Part 4, Column 11	196,905
		(416,950)
5.	Total gain (loss) on disposals, Part 4, Column 19	(634,899)
6.	Deduction consideration for bonds and stocks disposed of, Part 4, Column 7	46,456,084
7.	Deduct amortization of premium	1,303,881
8.	Total foreign exchange change in book/adjusted carrying value:	
8.1.	Part 1, Column 15	0
8.2.	Part 2, Section 1, Column 19	
8.3.	Part 2, Section 2, Column 16	0
8.4.	Part 4, Column 15	0
		0
9.	Deduct current year's other than temporary impairment recognized:	
9.1.	Part 1, Column 14	0
9.2.	Part 2, Section 1, Column 17	
9.3.	Part 2, Section 2, Column 14	0
9.4.	Part 4, Column 13	0
		0
10.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	124,722,573
11.	Deduct total nonadmitted amounts	0
12.	Statement value at end of current period (Line 10 minus Line 11)	124,722,573

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE D - SUMMARY BY COUNTRY

Long-Term Bonds and Stocks OWNED December 31 of Current Year

Description		1 Book/Adjusted Carrying Value	2 Fair Value	3 Actual Cost	4 Par Value of Bonds
BONDS	1. United States	3,461,558	3,431,875	3,465,016	3,315,062
	2. Canada				
	3. Other Countries				
	4. Totals	3,461,558	3,431,875	3,465,016	3,315,062
U.S. States, Territories and Possessions (Direct and guaranteed)	5. Totals	6,664,799	7,036,786	6,970,954	6,325,000
U.S. Political Subdivisions of States, Territories and Possessions (Direct and guaranteed)	6. Totals	7,235,647	7,607,729	7,683,485	6,645,000
U.S. Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions	7. Totals	36,104,135	37,248,810	36,796,938	33,254,808
Industrial and Miscellaneous and Hybrid Securities (unaffiliated)	8. United States	56,675,666	56,341,219	57,949,177	55,986,178
	9. Canada				
	10. Other Countries	754,727	755,785	754,630	755,000
	11. Totals	57,430,393	57,097,004	58,703,807	56,741,178
Parent, Subsidiaries and Affiliates	12. Totals				
	13. Total Bonds	110,896,532	112,422,204	113,620,200	106,281,048
PREFERRED STOCKS	14. United States				
	15. Canada				
	16. Other Countries				
	17. Totals	0	0	0	
Parent, Subsidiaries and Affiliates	18. Totals				
	19. Total Preferred Stocks	0	0	0	
COMMON STOCKS	20. United States	13,826,041	13,826,041	9,589,866	
	21. Canada				
	22. Other Countries				
	23. Totals	13,826,041	13,826,041	9,589,866	
Parent, Subsidiaries and Affiliates	24. Totals				
	25. Total Common Stocks	13,826,041	13,826,041	9,589,866	
	26. Total Stocks	13,826,041	13,826,041	9,589,866	
	27. Total Bonds and Stocks	124,722,573	126,248,245	123,210,066	

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1A - SECTION 1

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 9.7	8 Total from Col. 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed (a)
1. U.S. Governments											
1.1 NAIC 1	554,828	823,104	739,159	989,534	654,939	3,761,564	2.5	2,679,233	1.8	5,007,808	(1,246,244)
1.2 NAIC 2						0	0.0	0	0.0	0	0
1.3 NAIC 3						0	0.0	0	0.0	0	0
1.4 NAIC 4						0	0.0	0	0.0	0	0
1.5 NAIC 5						0	0.0	0	0.0	0	0
1.6 NAIC 6						0	0.0	0	0.0	0	0
1.7 Totals	554,828	823,104	739,159	989,534	654,939	3,761,564	2.5	2,679,233	1.8	5,007,808	(1,246,244)
2. All Other Governments											
2.1 NAIC 1						0	0.0	0	0.0	0	0
2.2 NAIC 2						0	0.0	0	0.0	0	0
2.3 NAIC 3						0	0.0	0	0.0	0	0
2.4 NAIC 4						0	0.0	0	0.0	0	0
2.5 NAIC 5						0	0.0	0	0.0	0	0
2.6 NAIC 6						0	0.0	0	0.0	0	0
2.7 Totals	0	0	0	0	0	0	0.0	0	0.0	0	0
3. U.S. States, Territories and Possessions etc., Guaranteed											
3.1 NAIC 1	0	3,651,814	3,012,985	0	0	6,664,799	4.4	6,747,130	4.4	6,664,798	1
3.2 NAIC 2						0	0.0	0	0.0	0	0
3.3 NAIC 3						0	0.0	0	0.0	0	0
3.4 NAIC 4						0	0.0	0	0.0	0	0
3.5 NAIC 5						0	0.0	0	0.0	0	0
3.6 NAIC 6						0	0.0	0	0.0	0	0
3.7 Totals	0	3,651,814	3,012,985	0	0	6,664,799	4.4	6,747,130	4.4	6,664,798	1
4. U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed											
4.1 NAIC 1	0	2,173,297	5,062,350	0	0	7,235,647	4.8	7,373,188	4.8	7,235,647	0
4.2 NAIC 2						0	0.0	0	0.0	0	0
4.3 NAIC 3						0	0.0	0	0.0	0	0
4.4 NAIC 4						0	0.0	0	0.0	0	0
4.5 NAIC 5						0	0.0	0	0.0	0	0
4.6 NAIC 6						0	0.0	0	0.0	0	0
4.7 Totals	0	2,173,297	5,062,350	0	0	7,235,647	4.8	7,373,188	4.8	7,235,647	0
5. U.S. Special Revenue & Special Assessment Obligations, etc., Non-Guaranteed											
5.1 NAIC 1	3,280,082	9,234,534	20,052,827	2,814,150	722,542	36,104,135	24.0	36,510,218	23.9	36,104,138	(3)
5.2 NAIC 2						0	0.0	0	0.0	0	0
5.3 NAIC 3						0	0.0	0	0.0	0	0
5.4 NAIC 4						0	0.0	0	0.0	0	0
5.5 NAIC 5						0	0.0	0	0.0	0	0
5.6 NAIC 6						0	0.0	0	0.0	0	0
5.7 Totals	3,280,082	9,234,534	20,052,827	2,814,150	722,542	36,104,135	24.0	36,510,218	23.9	36,104,138	(3)

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 9.7	8 Total from Col. 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed (a)
6. Industrial & Miscellaneous (Unaffiliated)											
6.1 NAIC 1	49,351,334	20,927,111	1,327,509	0	0	71,605,954	47.7	78,760,175	51.6	69,519,807	2,086,147
6.2 NAIC 2	1,515,838	19,289,201	3,956,281	0	0	24,761,320	16.5	16,722,255	11.0	21,722,582	3,038,738
6.3 NAIC 3						0	0.0	0	0.0		0
6.4 NAIC 4						0	0.0	3,803,085	2.5		0
6.5 NAIC 5						0	0.0	0	0.0		0
6.6 NAIC 6						0	0.0	0	0.0		0
6.7 Totals	50,867,172	40,216,312	5,283,790	0	0	96,367,274	64.2	99,285,515	65.1	91,242,389	5,124,885
7. Hybrid Securities											
7.1 NAIC 1						0	0.0	0	0.0		0
7.2 NAIC 2						0	0.0	0	0.0		0
7.3 NAIC 3						0	0.0	0	0.0		0
7.4 NAIC 4						0	0.0	0	0.0		0
7.5 NAIC 5						0	0.0	0	0.0		0
7.6 NAIC 6						0	0.0	0	0.0		0
7.7 Totals	0	0	0	0	0	0	0.0	0	0.0	0	0
8. Parent, Subsidiaries and Affiliates											
8.1 NAIC 1						0	0.0	0	0.0		0
8.2 NAIC 2						0	0.0	0	0.0		0
8.3 NAIC 3						0	0.0	0	0.0		0
8.4 NAIC 4						0	0.0	0	0.0		0
8.5 NAIC 5						0	0.0	0	0.0		0
8.6 NAIC 6						0	0.0	0	0.0		0
8.7 Totals	0	0	0	0	0	0	0.0	0	0.0	0	0

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 9.7	8 Total from Col. 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed (a)
9. Total Bonds Current Year											
9.1 NAIC 1	(d) 53,186,244	36,809,860	30,194,830	3,803,684	1,377,481	125,372,099	83.5	XXX	XXX	124,532,198	839,901
9.2 NAIC 2	(d) 1,515,838	19,289,201	3,956,281	.0	.0	24,761,320	16.5	XXX	XXX	21,722,582	3,038,738
9.3 NAIC 3	(d) .0	.0	.0	.0	.0	.0	.0	XXX	XXX	.0	.0
9.4 NAIC 4	(d) .0	.0	.0	.0	.0	.0	.0	XXX	XXX	.0	.0
9.5 NAIC 5	(d) .0	.0	.0	.0	.0	.0	.0	XXX	XXX	.0	.0
9.6 NAIC 6	(d) .0	.0	.0	.0	.0	.0	.0	XXX	XXX	.0	.0
9.7 Totals	54,702,082	56,099,061	34,151,111	3,803,684	1,377,481	150,133,419	100.0	XXX	XXX	146,254,780	3,878,639
9.8 Line 9.7 as a % of Col. 6	36.4	37.4	22.7	2.5	0.9	100.0	XXX	XXX	XXX	97.4	2.6
10. Total Bonds Prior Year											
10.1 NAIC 1	45,179,648	51,993,617	28,856,387	4,245,601	1,794,691	XXX	XXX	132,069,944	86.5	130,475,842	1,594,102
10.2 NAIC 2	665,280	11,335,879	4,721,096	.0	.0	XXX	XXX	16,722,255	11.0	14,866,320	1,855,935
10.3 NAIC 3	.0	.0	.0	.0	.0	XXX	XXX	.0	.0	.0	.0
10.4 NAIC 4	.0	.0	.0	.0	.0	XXX	XXX	3,803,085	2.5	3,803,085	.0
10.5 NAIC 5	.0	.0	.0	.0	.0	XXX	XXX	.0	.0	.0	.0
10.6 NAIC 6	.0	.0	.0	.0	.0	XXX	XXX	.0	.0	.0	.0
10.7 Totals	45,844,928	63,329,496	33,577,483	4,245,601	5,597,776	XXX	XXX	152,595,284	100.0	149,145,247	3,450,037
10.8 Line 10.7 as a % of Col. 8	30.0	41.5	22.0	2.8	3.7	XXX	XXX	100.0	XXX	97.7	2.3
11. Total Publicly Traded Bonds											
11.1 NAIC 1	53,934,485	35,221,718	30,194,830	3,803,684	1,377,481	124,532,198	82.9	130,475,842	85.5	124,532,198	XXX
11.2 NAIC 2	1,515,838	17,697,330	2,509,414	.0	.0	21,722,582	14.5	14,866,320	9.7	21,722,582	XXX
11.3 NAIC 3	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	XXX
11.4 NAIC 4	.0	.0	.0	.0	.0	.0	.0	3,803,085	2.5	.0	XXX
11.5 NAIC 5	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	XXX
11.6 NAIC 6	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	XXX
11.7 Totals	55,450,323	52,919,048	32,704,244	3,803,684	1,377,481	146,254,780	97.4	149,145,247	97.7	146,254,780	XXX
11.8 Line 11.7 as a % of Col. 6	37.9	36.2	22.4	2.6	0.9	100.0	XXX	XXX	XXX	100.0	XXX
11.9 Line 11.7 as a % of Line 9.7, Col. 6, Section 9	36.9	35.2	21.8	2.5	0.9	97.4	XXX	XXX	XXX	97.4	XXX
12. Total Privately Placed Bonds											
12.1 NAIC 1	(748,241)	1,588,142	.0	.0	.0	839,901	.6	1,594,102	1.0	XXX	839,901
12.2 NAIC 2	.0	1,591,871	1,446,867	.0	.0	3,038,738	2.0	1,855,935	1.2	XXX	3,038,738
12.3 NAIC 3	.0	.0	.0	.0	.0	.0	.0	.0	.0	XXX	.0
12.4 NAIC 4	.0	.0	.0	.0	.0	.0	.0	.0	.0	XXX	.0
12.5 NAIC 5	.0	.0	.0	.0	.0	.0	.0	.0	.0	XXX	.0
12.6 NAIC 6	.0	.0	.0	.0	.0	.0	.0	.0	.0	XXX	.0
12.7 Totals	(748,241)	3,180,013	1,446,867	.0	.0	3,878,639	2.6	3,450,037	2.3	XXX	3,878,639
12.8 Line 12.7 as a % of Col. 6	(19.3)	82.0	37.3	.0	.0	100.0	XXX	XXX	XXX	XXX	100.0
12.9 Line 12.7 as a % of Line 9.7, Col. 6, Section 9	(0.5)	2.1	1.0	0.0	0.0	2.6	XXX	XXX	XXX	XXX	2.6

(a) Includes \$ 4,626,886 freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A.

(b) Includes \$ current year, \$ prior year of bonds with Z designations and \$ current year \$ prior year of bonds with Z designations. The letter "Z" means the NAIC designation was not assigned by the Securities Valuation Office (SVO) at the date of the statement. "Z" means the SVO could not evaluate the obligation because valuation procedures for the security class are under regulatory review.

(c) Includes \$ current year, \$ prior year of bonds with 5 designations and \$ current year \$ prior year of bonds with 6 designations. "5" means the NAIC designation was assigned by the (SVO) in reliance on the insurer's certification that the issuer is current in all principal and interest payments. "6" means the NAIC designation was assigned by the SVO due to inadequate certification of principal and interest payments.

(d) Includes the following amount of non-rated short-term and cash equivalent bonds by NAIC designation: NAIC 1 \$ 498,000 ; NAIC 2 \$ 0 ; NAIC 3 \$ 0 ; NAIC 4 \$ 0 ; NAIC 5 \$ 0 ; NAIC 6 \$ 0

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1A - SECTION 2

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 9.5	8 Total from Col. 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed
1. U.S. Governments											
1.1 Issuer Obligations	300,006	0	0	0	0	300,006	0.2	1,546,129	1.0	1,546,251	(1,246,245)
1.2 Residential Mortgage-Backed Securities	254,822	823,104	739,159	989,534	654,939	3,461,558	2.3	1,133,104	0.7	3,461,557	1
1.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
1.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
1.5 Totals	554,828	823,104	739,159	989,534	654,939	3,761,564	2.5	2,679,233	1.8	5,007,808	(1,246,244)
2. All Other Governments											
2.1 Issuer Obligations	0	0	0	0	0	0	0.0	0	0.0	0	0
2.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
2.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
2.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
2.5 Totals	0	0	0	0	0	0	0.0	0	0.0	0	0
3. U.S. States, Territories and Possessions, Guaranteed											
3.1 Issuer Obligations	0	3,651,814	3,012,985	0	0	6,664,799	4.4	6,747,130	4.4	6,664,798	1
3.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
3.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
3.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
3.5 Totals	0	3,651,814	3,012,985	0	0	6,664,799	4.4	6,747,130	4.4	6,664,798	1
4. U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed											
4.1 Issuer Obligations	0	2,173,297	5,062,350	0	0	7,235,647	4.8	7,373,188	4.8	7,235,647	0
4.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
4.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
4.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
4.5 Totals	0	2,173,297	5,062,350	0	0	7,235,647	4.8	7,373,188	4.8	7,235,647	0
5. U.S. Special Revenue & Special Assessment Obligations etc., Non-Guaranteed											
5.1 Issuer Obligations	310,000	1,459,126	15,462,727	0	0	17,231,853	11.5	15,742,572	10.3	17,231,853	0
5.2 Residential Mortgage-Backed Securities	2,970,082	7,775,408	4,590,100	2,814,150	722,542	18,872,282	12.6	20,767,646	13.6	18,872,285	(3)
5.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
5.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
5.5 Totals	3,280,082	9,234,534	20,052,827	2,814,150	722,542	36,104,135	24.0	36,510,218	23.9	36,104,138	(3)
6. Industrial and Miscellaneous											
6.1 Issuer Obligations	48,217,040	37,109,272	3,956,281	0	0	89,282,593	59.5	91,662,819	60.1	84,157,704	5,124,889
6.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
6.3 Commercial Mortgage-Backed Securities	2,650,132	2,827,093	1,327,509	0	0	6,804,734	4.5	7,622,696	5.0	6,804,735	(1)
6.4 Other Loan-Backed and Structured Securities	0	279,947	0	0	0	279,947	0.2	0	0.0	279,950	(3)
6.5 Totals	50,867,172	40,216,312	5,283,790	0	0	96,367,274	64.2	99,285,515	65.1	91,242,389	5,124,885
7. Hybrid Securities											
7.1 Issuer Obligations	0	0	0	0	0	0	0.0	0	0.0	0	0
7.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
7.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
7.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
7.5 Totals	0	0	0	0	0	0	0.0	0	0.0	0	0
8. Parent, Subsidiaries and Affiliates											
8.1 Issuer Obligations	0	0	0	0	0	0	0.0	0	0.0	0	0
8.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
8.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
8.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
8.5 Totals	0	0	0	0	0	0	0.0	0	0.0	0	0

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1A - SECTION 2 (Continued)

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

	1	2	3	4	5	6	7	8	9	10	11
Distribution by Type	1 Year or Less	Over 1 Year Through 5 Years	Over 5 Years Through 10 Years	Over 10 Years Through 20 Years	Over 20 Years	Total Current Year	Col. 6 as a % of Line 9.5	Total from Col. 6 Prior Year	% From Col. 7 Prior Year	Total Publicly Traded	Total Privately Placed
9. Total Bonds Current Year											
9.1 Issuer Obligations	48,827,046	44,393,509	27,494,343	0	0	120,714,898	80.4	XXX	XXX	116,836,253	3,878,645
9.2 Residential Mortgage-Backed Securities	3,224,904	8,598,512	5,329,259	3,803,684	1,377,481	22,333,840	14.9	XXX	XXX	22,333,842	(2)
9.3 Commercial Mortgage-Backed Securities	2,650,132	2,827,093	1,327,509	0	0	6,804,734	4.5	XXX	XXX	6,804,735	(1)
9.4 Other Loan-Backed and Structured Securities	0	279,947	0	0	0	279,947	0.2	XXX	XXX	279,950	(3)
9.5 Totals	54,702,082	56,099,061	34,151,111	3,803,684	1,377,481	150,133,419	100.0	XXX	XXX	146,254,780	3,878,639
9.6 Line 9.5 as a % of Col. 6	36.4	37.4	22.7	2.5	0.9	100.0	XXX	XXX	XXX	97.4	2.6
10. Total Bonds Prior Year											
10.1 Issuer Obligations	41,583,165	50,857,204	26,828,384	0	3,803,085	XXX	XXX	123,071,838	80.7	119,621,801	3,450,037
10.2 Residential Mortgage-Backed Securities	2,898,621	7,815,021	5,146,816	4,245,601	1,794,691	XXX	XXX	21,900,750	14.4	21,900,750	0
10.3 Commercial Mortgage-Backed Securities	1,363,142	4,657,271	1,602,283	0	0	XXX	XXX	7,622,696	5.0	7,622,696	0
10.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	XXX	XXX	0	0.0	0	0
10.5 Totals	45,844,928	63,329,496	33,577,483	4,245,601	5,597,776	XXX	XXX	152,595,284	100.0	149,145,247	3,450,037
10.6 Line 10.5 as a % of Col. 8	30.0	41.5	22.0	2.8	3.7	XXX	XXX	100.0	XXX	97.7	2.3
11. Total Publicly Traded Bonds											
11.1 Issuer Obligations	49,575,287	41,213,490	26,047,476	0	0	116,836,253	77.8	119,621,801	78.4	116,836,253	XXX
11.2 Residential Mortgage-Backed Securities	3,224,903	8,598,515	5,329,259	3,803,684	1,377,481	22,333,842	14.9	21,900,750	14.4	22,333,842	XXX
11.3 Commercial Mortgage-Backed Securities	2,650,133	2,827,093	1,327,509	0	0	6,804,735	4.5	7,622,696	5.0	6,804,735	XXX
11.4 Other Loan-Backed and Structured Securities	0	279,950	0	0	0	279,950	0.2	0	0.0	279,950	XXX
11.5 Totals	55,450,323	52,919,048	32,704,244	3,803,684	1,377,481	146,254,780	97.4	149,145,247	97.7	146,254,780	XXX
11.6 Line 11.5 as a % of Col. 6	37.9	36.2	22.4	2.6	0.9	100.0	XXX	XXX	XXX	100.0	XXX
11.7 Line 11.5 as a % of Line 9.5, Col. 6, Section 9	36.9	35.2	21.8	2.5	0.9	97.4	XXX	XXX	XXX	97.4	XXX
12. Total Privately Placed Bonds											
12.1 Issuer Obligations	(748,241)	3,180,019	1,446,867	0	0	3,878,645	2.6	3,450,037	2.3	XXX	3,878,645
12.2 Residential Mortgage-Backed Securities	(1)	(3)	0	0	0	(2)	0.0	0	0.0	XXX	(2)
12.3 Commercial Mortgage-Backed Securities	(1)	0	0	0	0	(1)	0.0	0	0.0	XXX	(1)
12.4 Other Loan-Backed and Structured Securities	0	(3)	0	0	0	(3)	0.0	0	0.0	XXX	(3)
12.5 Totals	(748,241)	3,180,013	1,446,867	0	0	3,878,639	2.6	3,450,037	2.3	XXX	3,878,639
12.6 Line 12.5 as a % of Col. 6	(19.3)	82.0	37.3	0.0	0.0	100.0	XXX	XXX	XXX	XXX	100.0
12.7 Line 12.5 as a % of Line 9.5, Col. 6, Section 9	(0.5)	2.1	1.0	0.0	0.0	2.6	XXX	XXX	XXX	XXX	2.6

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.
SCHEDULE DA - VERIFICATION BETWEEN YEARS

Short-Term Investments

	1	2	3	4	5
	Total	Bonds	Mortgage Loans	Other Short-term Investment Assets (a)	Investments in Parent, Subsidiaries and Affiliates
1. Book/adjusted carrying value, December 31 of prior year	36,754,439	36,754,439	0	0	0
2. Cost of short-term investments acquired	22,813,210	22,813,210	0	0	0
3. Accrual of discount	0				
4. Unrealized valuation increase (decrease)	0				
5. Total gain (loss) on disposals	0				
6. Deduct consideration received on disposals	20,330,762	20,330,762	0	0	0
7. Deduct amortization of premium	0				
8. Total foreign exchange change in book/adjusted carrying value	0				
9. Deduct current year's other than temporary impairment recognized	0				
10. Book adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	39,236,887	39,236,887	0	0	0
11. Deduct total nonadmitted amounts	0				
12. Statement value at end of current period (Line 10 minus Line 11)	39,236,887	39,236,887	0	0	0

(a) Indicate the category of such assets, for example, joint ventures, transportation equipment:

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

Schedule DB - Part A - Verification - Options, Caps, Floors, Collars, Swaps and Forwards

NONE

Schedule DB - Part B - Verification - Futures Contracts

NONE

Schedule DB - Part C - Section 1 - Replication (Synthetic Asset) Transactions (RSATs) Open

NONE

Schedule DB-Part C-Section 2-Reconciliation of Replication (Synthetic Asset) Transactions Open

NONE

Schedule DB - Verification - Book/Adjusted Carrying Value, Fair Value and Potential Exposure of
Derivatives

NONE

Schedule E - Verification - Cash Equivalents

NONE

Schedule A - Part 1 - Real Estate Owned

NONE

Schedule A - Part 2 - Real Estate Acquired and Additions Made

NONE

Schedule A - Part 3 - Real Estate Disposed

NONE

Schedule B - Part 1 - Mortgage Loans Owned

NONE

Schedule B - Part 2 - Mortgage Loans Acquired and Additions Made

NONE

Schedule B - Part 3 - Mortgage Loans Disposed, Transferred or Repaid

NONE

Schedule BA - Part 1 - Other Long-Term Invested Assets Owned

NONE

Schedule BA - Part 2 - Other Long-Term Invested Assets Acquired and Additions Made

NONE

SI11, SI12, SI13, SI14, SI15, E01, E02, E03, E04, E05, E06, E07, E08

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

Schedule BA - Part 3 - Other Long-Term Invested Assets Disposed, Transferred or Repaid

N O N E

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	Bond Char	NAIC Des.	Actual Cost	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization) Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date		
36179R-BF-6	GNMA II POOL 102/253	2	1	1	1,323,171	1,014,620	1,316,581	1,297,226	1,322,791	0	(180)	0	3.300	2.784	MON	3,243	22,701	05/14/2015	04/20/2045		
36179R-LP-2	GNMA II POOL 103/304	2	1	1	287,355	104,590	286,928	274,724	287,204	0	(172)	0	3.300	3.051	MON	801	1,633	09/18/2015	08/20/2045		
36179R-WI-5	GNMA II POOL 103/310	2	1	1	878,717	104,890	878,919	841,884	878,428	0	(289)	0	3.300	3.117	MON	2,458	7,367	09/01/2015	08/20/2045		
36180A-V6-6	GNMA POOL AD9937	2	1	1	473,593	104,680	457,524	437,782	472,309	0	66	0	3.300	2.124	MON	1,277	15,321	04/08/2013	03/20/2043		
36180A-Z2-6	GNMA POOL AD7257	2	1	1	356,426	104,300	345,445	330,361	355,371	0	(192)	0	3.300	2.375	MON	965	11,584	03/15/2013	03/15/2043		
36204C-Z3-1	GNMA POOL 726/322	2	1	1	145,744	110,320	146,197	132,485	145,365	0	(195)	0	3.300	2.174	MON	532	6,625	03/15/2013	08/15/2038		
02999999	Subtotal - Bonds - U.S. Governments - Residential Mortgage-Backed Securities				3,465,016	XXX	3,431,875	3,315,062	3,461,558	0	(873)	0	0	XXX	XXX	XXX	9,294	65,201	XXX	XXX	
05999999	Total - U.S. Government Bonds				3,465,016	XXX	3,431,875	3,315,062	3,461,558	0	(873)	0	0	XXX	XXX	XXX	9,294	65,201	XXX	XXX	
10999999	Total - All Other Government Bonds				0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX	
373383-4H-7	GEORGIA ST		1	1FE	258,260	106,450	239,533	225,000	231,987	0	(14,495)	0	5.000	2.870	JJ	5,625	11,250	09/14/2009	07/01/2019		
419791-10-4	HAWAII ST		1	1FE	438,660	111,680	446,792	400,000	424,116	0	(17,368)	0	5.000	2.940	FA	8,333	20,000	07/14/2011	02/01/2019		
604129-V5-2	MINNESOTA ST		1	1FE	162,659	110,260	165,444	150,000	161,389	0	(14,255)	0	5.000	1.971	MON	3,125	7,500	09/29/2010	07/01/2020		
677321-3H-6	OHIO STATE		1	1FE	3,069,192	115,150	3,224,452	2,800,000	3,012,986	0	(27,948)	0	4.000	2.770	MON	18,667	112,000	12/12/2013	11/01/2022		
70914P-DB-5	PENNSYLVANIA ST		1	1FE	2,128,260	106,620	2,132,580	2,000,000	2,034,369	0	(20,665)	0	5.000	3.870	FA	41,667	100,000	02/11/2011	08/01/2022		
97705L-LB-5	WISCONSIN ST		1	1FE	549,837	111,140	500,013	450,000	491,517	0	(14,199)	0	5.000	1.653	MON	3,750	22,500	10/13/2011	11/01/2018		
97705L-RL-3	WISCONSIN ST		1	1FE	323,886	109,320	327,872	320,000	338,435	0	(13,493)	0	5.000	3.730	MON	2,500	15,000	02/14/2011	05/01/2021		
11999999	Subtotal - Bonds - U.S. States, Territories and Possessions - Issuer Obligations				6,970,954	XXX	7,036,786	6,325,000	6,664,799	0	(62,331)	0	0	XXX	XXX	XXX	83,667	288,250	XXX	XXX	
17999999	Total - U.S. States, Territories and Possessions Bonds				6,970,954	XXX	7,036,786	6,325,000	6,664,799	0	(62,331)	0	0	XXX	XXX	XXX	83,667	288,250	XXX	XXX	
181059-0A-7	CLARK CNTY NEW SCH DIST		1	1FE	1,835,295	117,890	1,767,135	1,900,000	1,718,059	0	(19,272)	0	5.000	2.181	JD	3,333	75,000	10/12/2012	06/15/2021		
195491-3C-3	COLUMBUS OHIO		1	1FE	474,108	113,460	453,860	400,000	435,267	0	(19,593)	0	5.000	1.911	JD	7,000	20,000	10/12/2011	07/01/2019		
239219-5D-9	DALLAS TEXAS		1	1FE	460,425	104,890	435,331	415,000	429,491	0	(12,688)	0	5.000	1.941	FA	7,639	20,750	07/10/2013	02/15/2017		
34133P-K2-3	FLORIDA ST BRD ED		1	1FE	1,638,112	117,840	1,649,802	1,400,000	1,567,977	0	(28,515)	0	5.000	2.610	JD	5,833	70,000	06/26/2013	06/01/2023		
34133P-Q3-5	FLORIDA ST BRD ED SERIES C		1	1FE	820,088	118,760	825,537	825,000	892,517	0	(11,521)	0	5.000	2.450	JD	2,188	26,250	07/19/2013	06/01/2021		
442331-TN-4	HOUSTON TEX		1	1FE	1,144,050	105,010	1,050,160	1,000,000	1,028,655	0	(23,825)	0	5.000	2.491	MS	16,667	50,000	12/07/2010	03/01/2017		
75844B-WI-6	REESE CREEK HPT DIST FLA		1	1FE	1,194,811	118,030	1,245,294	1,140,000	1,183,797	0	(14,848)	0	5.250	4.632	JD	4,988	59,850	08/15/2013	06/01/2030		
796237-JG-5	SAN ANTONIO TEXAS		1	1FE	316,596	106,680	282,670	265,000	279,884	0	(9,294)	0	5.000	1.400	FA	5,521	13,250	12/09/2011	08/01/2017		
18999999	Subtotal - Bonds - U.S. Political Subdivisions - Issuer Obligations				7,683,485	XXX	7,607,729	6,645,000	7,235,647	0	(137,540)	0	0	XXX	XXX	XXX	96,369	335,100	XXX	XXX	
24999999	Total - U.S. Political Subdivisions Bonds				7,683,485	XXX	7,607,729	6,645,000	7,235,647	0	(137,540)	0	0	XXX	XXX	XXX	96,369	335,100	XXX	XXX	
047870-WI-3	ATLANTA GEORGIA WATER REVENUE		1	1FE	280,075	120,260	288,629	240,000	277,344	0	(12,731)	0	5.000	3.070	MON	2,000	7,633	02/26/2015	11/01/2030		
13077C-A5-3	CALIFORNIA ST UNIV SERIES A		1	1FE	800,860	124,330	894,712	800,000	880,368	0	(18,788)	0	5.000	3.521	MON	6,667	40,000	07/23/2013	11/01/2025		
440445-A5-3	HOUSTON TEX UTIL SYS REV SER C		1	1FE	307,103	120,910	324,489	270,000	301,663	0	(13,222)	0	5.000	3.380	MON	1,725	13,500	03/13/2014	05/15/2028		
49151F-EQ-9	KENTUCKY ST PROPERTY & BLDGS C SERIES A		1	1FE	1,071,682	116,510	1,113,444	955,000	1,046,658	0	(10,101)	0	5.000	3.571	AD	11,938	47,750	06/05/2013	10/01/2029		
539450-BH-2	LOS ANGELES CA INSTITR SYS REV SERIES B		1	1FE	2,033,046	119,850	2,110,132	1,760,000	1,971,330	0	(24,908)	0	5.000	3.170	AD	7,333	88,000	06/05/2013	06/01/2029		
574204-WI-3	MARYLAND ST DEPT TRANS CONS		1	1FE	874,977	105,760	872,487	825,000	862,519	0	(27,649)	0	5.000	1.540	MON	5,875	41,250	10/31/2011	05/01/2017		
58203V-RL-5	METROPOLITAN TRANSIT AUTH NY		1	1FE	2,438,240	121,320	2,426,400	2,000,000	2,392,766	0	(40,043)	0	5.000	2.570	MON	16,667	100,000	07/22/2012	11/01/2022		
592646-6S-7	METROPOLITAN WASHINGTON D C AR SERIES A		1	1FE	217,694	116,810	221,560	190,000	214,200	0	(12,349)	0	5.000	3.311	AD	2,375	9,500	05/30/2014	10/01/2028		
594815-BB-1	MICHIGAN ST BLDG AUTH REVENUE SERIES I		1	1FE	586,155	119,030	595,190	500,000	582,057	0	(14,098)	0	5.000	2.182	AD	5,278	3,125	07/31/2015	04/15/2022		
60146-BB-1	MINNESOTA ST GEN FUND REVENUE		1	1FE	2,169,380	117,050	2,340,100	2,000,000	2,127,425	0	(18,051)	0	5.000	3.830	MS	30,333	100,000	08/06/2013	03/01/2028		
606002-A5-9	MISSOURI JT UNIV ELEC UTIL COMM SERIES A		1	1FE	172,917	117,850	176,784	150,000	171,542	0	(11,375)	0	5.000	4.728	AD	6,625	13,000	11/01/2013	08/01/2029		
646139-AZ-5	NEW JERSEY ST TURNPIKE AUTH SERIES A		1	1FE	1,189,776	117,670	1,235,819	1,050,000	1,170,671	0	(12,038)	0	5.000	3.430	JJ	26,250	58,188	05/14/2014	01/01/2030		
66285H-NB-8	NORTH TEX TRY AUTH REV		1	1FE	398,878	120,010	402,104	335,000	394,297	0	(14,580)	0	5.000	2.541	JJ	8,375	3,164	04/09/2015	01/01/2024		
67760A-JF-3	OHIO ST TPK COMB TRK REV		1	1FE	1,162,249	117,650	1,294,249	1,100,000	1,149,108	0	(5,730)	0	5.250	4.510	FA	21,817	57,750	08/15/2013	02/15/2029		
684517-BH-6	ORANGE CNTY FL SCH BRD CORP SERIES A		1	1FE	1,428,869	117,860	1,532,778	1,300,000	1,411,216	0	(10,782)	0	5.000	3.851	FA	27,083	65,000	03/19/2014	08/01/2029		
71883P-JJ-2	PHOENIX ARIZ CIVIC HPT CORP		1	1FE	383,699	119,120	399,059	335,000	376,619	0	(14,176)	0	5.000	3.311	JJ	8,375	16,750	03/19/2014	07/01/2029		
735389-VJ-4	PORT SEATTLE WASH REV SERIES B		1	1FE	273,491	120,740	283,748	235,000	271,988	0	(11,503)	0	5.000	2.930	MS	4,733	0	07/22/2015	03/01/2026		
79573D-P5-3	SALT RIVER PROJ AZ AGRIC HPT		1	1FE	426,472	111,310	389,603	350,000	382,301	0	(10,755)	0	5.000	2.270	JD	1,458	17,500	10/04/2011	12/01/2018		
812645-GT-5	SEATTLE WASH MUN LIGHT & POWER		1	1FE	867,290	118,910	892,867	700,000	813,484	0	(16,253)	0	5.000	2.270	JD	2,917	35,000	08/07/2012	06/01/2025		
882756-S2-6	TEXAS ST PUB FIN AUTH REV		1	1FE	334,491	100,000	310,000	310,000	310,000	0	(7,204)	0	5.000	2.630	JJ	7,750	15,500	12/15/2010	07/01/2017		
89602H-ZH-1	TRIBOROUGH BRGS & TUNL AUTH NY		1	1FE	234,213	114,620	217,858	190,000	214,307	0	(16,041)	0	5.000	1.981	MON	1,214	9,500	08/23/2012	11/15/2019		
25999999	Subtotal - Bonds - U.S. Special Revenues - Issuer Obligations				17,859,660	XXX	18,362,422	15,535,000	17,231,653	0	(222,237)	0	0	XXX	XXX	XXX	204,788	733,838	XXX	XXX	
312801-RL-5	FLHWC GOLD POOL 007013		1	1	384,795	111,310	384,756	371,328	380,339	0	(188)	0	3.300	2.967	MON	1,570	16,750	02/19/2015	12/01/2018		
312806-K2-7	FLHWC GOLD POOL 007213		1	1	384,795	111,310	384,756	371,328	380,339	0	(188)	0	3.300	2.967	MON	1,570	16,750	02/19/2015	12/01/2018		

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes		6	7	Fair Value		10	11	Change in Book/Adjusted Carrying Value		14	15	Interest		20	Dates			
		3	4			8	9			12	13			16	17	18	21	22		
CUSIP Identification	Description	C o d e	B o n d C h a r	NAIC Des.	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization) Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
313540-9F-3	FNMA SERIES 2013-4S CLASS DB				480,076	106.6140	474,048	444,639	461,968	0	(1,002)	0	0	4.000	1.940	MON	1,462	17,785	04/10/2013	12/25/2042
313760-UC-5	PUBLIC MULTIFAMILY STRUCTURED SERIES 4182 CLASS KT				633,715	104.5870	612,242	625,302	625,302	0	(3,345)	0	0	4.300	1.588	MON	1,708	20,493	05/01/2013	05/15/2041
3138AX-IV-8	FNMA POOL AJR001				357,917	106.0950	354,760	334,380	357,269	0	(82)	0	0	4.000	2.515	MON	1,115	13,375	03/27/2013	12/01/2041
3138E1-H8-8	FNMA POOL AJR345				420,428	106.0950	417,010	393,038	419,495	0	(138)	0	0	4.000	2.448	MON	1,310	15,722	03/15/2013	12/01/2041
3138E3-H8-8	FNMA POOL AJR544				386,750	103.3480	388,666	375,349	385,422	0	(983)	0	0	3.000	1.648	MON	938	11,260	04/08/2013	04/01/2027
3138E3-WT-4	FNMA POOL ALJ241				382,148	106.1160	387,748	397,127	381,220	0	(63)	0	0	4.000	2.383	MON	1,124	13,485	04/08/2013	04/01/2041
3138EJ-JR-0	FNMA POOL AL2071				500,784	112.5690	515,187	457,664	499,497	0	(271)	0	0	5.500	2.551	MON	2,098	25,172	05/06/2013	03/01/2040
3138EK-SR-7	FNMA POOL AL3560				873,654	103.5340	853,204	867,118	867,118	0	(2,192)	0	0	3.000	1.776	MON	2,060	24,722	05/03/2013	02/01/2028
3138EK-WK-7	FNMA POOL AL3093				599,599	103.6590	586,673	565,954	597,983	0	(983)	0	0	3.500	2.819	MON	1,651	19,809	03/15/2013	02/01/2043
3138EK-UR-4	FNMA POOL AL3307				555,313	106.4230	551,829	514,372	554,200	0	(331)	0	0	4.000	3.224	MON	3,382	40,585	06/25/2013	11/01/2042
3138EK-IE-1	FNMA POOL AL3344				556,156	109.8840	580,496	592,301	554,305	0	(554)	0	0	4.500	3.272	MON	3,348	40,153	09/20/2013	10/01/2042
3138EL-BR-3	FNMA POOL AL3647				604,632	106.1250	601,268	566,566	604,064	0	(504)	0	0	4.000	2.283	MON	1,889	22,663	12/18/2014	12/01/2042
3138H3-FC-2	FNMA POOL AP5582				1,120,729	103.5320	1,063,129	1,118,765	1,118,765	0	(165)	0	0	3.500	2.642	MON	3,101	37,210	05/24/2013	02/01/2043
3138H3-UR-9	FNMA POOL AP4100				367,050	108.6560	369,331	383,403	366,435	0	(615)	0	0	4.500	2.285	MON	3,313	29,815	03/26/2013	12/01/2044
3138H7-GJ-9	FNMA POOL AT5600				1,236,371	103.5880	1,214,189	1,172,133	1,232,258	0	(2,481)	0	0	3.500	3.001	MON	3,419	41,025	05/24/2013	05/01/2043
3138H3-WT-5	FNMA POOL AX2169				749,856	107.0860	753,650	703,780	748,972	0	(671)	0	0	4.000	2.955	MON	2,346	28,151	11/04/2014	11/01/2044
314020-C7-3	FNMA POOL 725584				269,778	112.3500	277,531	246,938	268,743	0	(327)	0	0	5.500	2.829	MON	1,132	13,581	06/05/2013	07/01/2034
314020-2V-2	FNMA POOL 735286				170,767	110.4250	173,948	157,283	170,148	0	(167)	0	0	5.000	2.484	MON	655	7,863	03/26/2013	03/01/2035
31416B-LD-8	FNMA POOL 995024				975,818	112.5550	1,004,892	893,197	972,925	0	(766)	0	0	5.500	2.762	MON	4,094	49,126	06/05/2013	08/01/2037
31416B-NS-3	FNMA POOL 995112				583,778	112.5040	601,166	534,351	581,905	0	(538)	0	0	5.500	2.766	MON	2,449	29,389	06/05/2013	07/01/2036
31416B-TA-9	FNMA POOL 995245				221,933	109.9860	223,173	221,417	221,417	0	(197)	0	0	5.000	1.779	MON	845	10,145	04/16/2014	07/01/2039
31416C-3V-7	FNMA POOL 995722				288,724	110.3040	273,114	247,801	267,556	0	(183)	0	0	5.000	2.510	MON	1,032	12,380	03/15/2013	05/01/2038
314170-0E-4	FNMA POOL AB9068				415,116	103.3050	403,655	390,741	414,156	0	(256)	0	0	3.500	2.470	MON	1,140	13,676	04/04/2013	04/01/2043
314170-0F-1	FNMA POOL AB9069				457,655	103.3030	444,080	456,255	456,255	0	(669)	0	0	3.500	2.685	MON	1,254	15,046	04/04/2013	04/01/2043
31418A-6B-9	FNMA POOL BA1770				837,406	106.0350	842,321	780,230	836,948	0	(420)	0	0	4.500	2.980	MON	2,926	35,110	07/30/2014	02/01/2044
31418A-L3-3	FNMA POOL BA1186				460,184	104.5400	453,379	433,860	458,166	0	(469)	0	0	3.500	2.215	MON	1,265	15,186	03/15/2013	08/01/2032
31418A-XG-6	FNMA POOL BA3894				607,032	106.9750	605,476	565,997	604,389	0	(607)	0	0	4.000	1.994	MON	1,887	22,640	05/02/2013	09/01/2031
31418A-OK-7	FNMA POOL AE0201				500,883	112.5040	515,596	458,291	499,200	0	(390)	0	0	5.500	2.748	MON	2,101	25,206	06/05/2013	08/01/2037
31418D-4E-4	FNMA POOL AE3525				241,518	106.0730	238,243	224,602	240,969	0	(19)	0	0	4.000	1.937	MON	749	8,984	04/03/2013	03/01/2041
31418E-IL-5	FNMA POOL AE3750				761,295	106.0620	749,856	739,145	759,145	0	(437)	0	0	4.000	2.480	MON	2,356	28,275	05/03/2013	12/01/2040
26999999	Subtotal - Bonds - U.S. Special Revenues - Residential Mortgage-																			
	Backed Securities				18,937,278	XXX	18,886,388	17,659,808	18,872,282	0	(20,709)	0	0	XXX	XXX	XXX	60,925	717,777	XXX	XXX
31999999	Total - U.S. Special Revenues Bonds				36,796,938	XXX	37,248,810	33,254,808	36,104,135	0	(242,946)	0	0	XXX	XXX	XXX	265,713	1,451,616	XXX	XXX
00206R-BF-8	AT&T INC				401,376	100.2760	401,104	400,000	400,407	0	(282)	0	0	1.700	1.627	JD	567	6,800	06/28/2012	06/01/2017
00206R-CL-4	AT&T INC				229,883	98.4620	226,509	230,000	229,903	0	20	0	0	2.450	2.480	JD	16	3,694	04/23/2015	06/30/2020
002871-AN-9	ABBVIE INC				554,434	99.9400	552,407	555,000	554,550	0	117	0	0	1.800	1.855	IN	1,304	4,095	06/05/2015	05/14/2018
023135-AH-9	AMAZON.COM INC				149,270	99.6900	149,535	150,000	149,715	0	146	0	0	1.200	1.301	IN	160	5,000	11/29/2012	11/29/2017
025216-AV-7	AMERICAN EXPRESS COMPANY				411,348	107.0620	396,129	370,000	398,523	0	(12,825)	0	0	6.150	1.428	FA	7,775	11,378	03/27/2015	08/28/2017
026874-C2-9	AMERICAN INTERNATIONAL GROUP				334,323	99.1530	332,163	335,000	334,513	0	151	0	0	2.300	2.343	JA	5,531	7,705	07/09/2014	07/16/2019
031162-BH-9	AMGEN INC				479,640	98.6360	473,433	469,000	473,696	0	46	0	0	2.125	2.141	IN	1,700	5,100	04/28/2015	05/01/2020
032095-AD-3	AMPHENOL CORP				454,536	99.4900	452,680	455,000	454,734	0	153	0	0	1.550	1.585	IN	2,077	7,111	09/09/2014	09/15/2017
037833-AJ-9	APPLE COMPUTER INC				866,790	99.1880	862,936	870,000	868,477	0	640	0	0	1.000	1.076	IN	1,402	8,700	04/30/2013	05/03/2018
037833-BB-9	APPLE COMPUTER INC				359,732	99.6910	358,888	360,000	359,830	0	78	0	0	0.900	0.935	IN	432	1,620	05/06/2015	05/12/2017
053332-AS-7	AUTOTEC INC				299,820	97.0770	294,912	270,000	299,928	0	7	0	0	2.500	2.507	AD	1,108	2,421	04/20/2015	04/15/2021
05531F-AK-9	BBAT CORPORATION SERIES MTN				407,328	100.7710	403,064	400,000	401,856	0	(1,595)	0	0	2.150	1.738	IN	2,365	8,600	06/28/2012	03/22/2017
05531F-AN-3	BBAT CORPORATION				49,927	100.5690	50,285	50,000	49,963	0	14	0	0	2.050	2.081	JD	34	1,025	06/14/2013	06/18/2018
060505-DH-4	BANK OF AMERICA CORP				977,592	106.4210	893,306	840,000	895,219	0	(32,286)	0	0	8.000	1.970	IS	16,800	50,400	05/22/2013	09/01/2017
060507-LH-1	BANK OF AMERICA NA SERIES FID				324,760	99.6860	324,376	325,000	324,929	0	125	0	0	1.125	1.150	IN	477	3,656	11/06/2013	11/14/2016
060510-EX-3	BANK OF AMERICA CORP MTN				1,269,450	100.3280	1,254,075	1,250,000	1,262,965	0	(14,078)	0	0	2.600	2.245	JA	14,866	32,500	05/20/2014	01/15/2019
06409H-BX-6	BANK OF NEW YORK MELLON MTN SERIES MTN				155,279	100.8470	151,271	150,000	150,782	0	(1,310)	0	0	2.300	1.410	JA	1,466	3,450	06/28/2012	07/28/2016
073887-BB-9	BECTON DICKINSON AND CO				411,940	100.5030	402,012	400,000	402,394	0	(2,781)	0	0	1.750	1.043	IN	1,011	7,000	07/09/2012	11/06/2016
073887-BD-9	BECTON DICKINSON AND CO				225,000	98.8550	224,674	225,000	225,000	0	0	0	0	8.800	1.890	JD	180	4,050	12/04/2014	12/15/2017
097014-AH-4	BREXING CAPITAL CORP				420,008	100.6550	402,780	400,000	405,056	0	(15,056)	0	0	2.125	0.847	FA	3,211	8,500	07/09/2012	08/15/2012
097023-BE-4	BREXING CO				168,128	98.8510	168,047	170,000	169,104	0	370	0	0	0.950	1.176	IN	206	1,615	04/30/2013	05/15/2018
110122-AS-7	BRISTOL-MYERS SQUIBB CO				455,865	99.4440	497,220	500,000	498,670	0	829	0	0	0.875	1.045	FA	1,823	4,375	08/07/2012	08/01/2017
128555-CJ-7	CVS/CHARMART CORP				769,430	100.4490	773,457	770,000	769,478	0	48	0	0	2.800	2.916	JA	9,642	0	07/13/2015	07/20/2020

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22																		
		Codes				Fair Value		Fair Value		Change in Book/Adjusted Carrying Value					Interest					Dates																			
CUSIP Identification	Description	C o d e	B o n d C h a r	NAIC Des.	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization) Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date																			
742718-DV-9	PROCTER AND GAMBLE CO			1FE	513,380	100.2500	501,285	500,000	502,097	0	(3,349)	0	0	1.450	0.773	FA	2,738	7,250	08/07/2012	08/15/2016																			
759187-BL-0	REGIONS FINANCIAL CORP SERIES BONT		1	2FE	464,447	99.8500	464,512	465,000	464,514	0	67	0	0	2.250	2.290	MS	3,110	1,278	07/28/2015	08/14/2018																			
776996-AF-3	RYDER INDUSTRIES INC			2FE	568,809	99.3520	569,306	570,000	569,364	0	222	0	0	2.050	2.092	AO	2,921	11,685	05/30/2013	10/01/2018																			
783594-JZ-3	RYDER SYSTEM INC SERIES MTN		1	2FE	249,313	97.3960	243,490	250,000	249,396	0	83	0	0	2.500	2.559	IN	868	3,125	05/04/2015	05/11/2020																			
820286-A0-0	JI SHOOKER CO SERIES III			2FE	189,762	99.5300	189,107	190,000	189,788	0	26	0	0	1.750	1.802	MS	979	0	09/22/2015	03/15/2018																			
824415-AH-3	KINDER MORGAN INC IE			2FE	786,921	103.5310	735,070	710,000	765,345	0	(21,577)	0	0	2.000	3.106	FA	20,705	24,850	02/20/2015	02/01/2018																			
842587-CX-1	SOUTHERN CO			2FE	159,949	99.0810	158,530	160,000	159,972	0	17	0	0	1.300	1.311	FA	786	2,040	08/19/2014	08/15/2017																			
843646-AH-0	SOUTHERN POWER CO			2FE	349,797	99.9570	349,850	350,000	349,808	0	11	0	0	1.850	1.879	JD	791	0	11/12/2015	12/01/2017																			
857477-AH-0	STATE STREET CORP			1FE	286,743	100.3520	250,880	250,000	250,850	0	(4,616)	0	0	2.875	1.011	MS	2,276	7,188	07/06/2012	03/07/2016																			
863667-A0-3	STRYKER CORP			1FE	233,978	99.2810	233,310	235,000	234,533	0	203	0	0	1.300	1.390	AO	764	3,055	03/20/2013	04/01/2018																			
867914-B0-7	SUNTRUST BANKS INC		1	2FE	109,484	100.4950	102,871	100,000	102,519	0	100	0	0	2.500	2.519	IN	2,417	14,500	04/24/2014	05/01/2019																			
871658-AA-1	SYNCHRONY FINANCIAL			2FE	96,916	99.5420	96,556	97,000	96,954	0	28	0	0	1.875	1.905	FA	687	1,839	08/06/2014	08/15/2017																			
882508-AH-0	TEXAS INSTRUMENTS INC			1FE	421,584	100.5530	402,212	400,000	402,118	0	(5,615)	0	0	2.375	0.956	IN	1,188	9,500	06/28/2012	05/16/2016																			
882556-BH-0	TERMO FIBER SCIENTIFIC			1FE	415,904	100.5480	402,192	400,000	402,448	0	(3,886)	0	0	2.250	1.259	FA	3,400	9,000	06/28/2012	08/15/2016																			
885791-AE-1	3M COMPANY MTN			1FE	946,357	99.8590	948,661	950,000	948,896	0	733	0	0	1.000	1.079	JD	132	9,500	06/26/2012	06/26/2017																			
892361-AL-0	TOYOTA MOTOR CREDIT CORP			1FE	669,725	100.0040	670,027	670,000	669,965	0	92	0	0	0.800	0.814	IN	655	5,360	05/14/2013	05/17/2016																			
902494-AH-3	TYSON FOODS INC		1	2FE	159,894	100.0550	160,088	160,000	159,923	0	20	0	0	2.650	2.664	FA	1,602	4,322	08/05/2014	08/15/2019																			
911594-HB-9	US BANCORP SERIES MTN		1	1FE	104,937	100.9640	100,864	100,000	100,963	0	(1,215)	0	0	2.200	0.967	IN	281	2,200	09/10/2012	11/15/2016																			
911594-H0-5	US BANCORP SERIES MTN		1	1FE	402,468	100.3020	401,208	400,000	400,683	0	(519)	0	0	1.650	1.516	IN	843	6,600	06/28/2012	05/15/2017																			
913017-BU-2	UNITED TECHNOLOGIES CORP			1FE	201,249	100.5650	201,130	200,000	200,364	0	(252)	0	0	1.800	1.689	JD	300	3,600	06/01/2012	06/01/2017																			
922770-A0-1	VENTAS REALTY LP/CAP CORP			2FE	44,917	99.2630	44,688	45,000	44,964	0	26	0	0	1.250	1.313	AO	116	563	04/10/2014	04/17/2017																			
923431-B0-5	VERIZON COMMUNICATIONS SERIES			2FE	415,472	100.6230	402,492	400,000	403,054	0	(9,630)	0	0	2.000	1.077	IN	1,333	8,000	07/13/2012	11/01/2016																			
923431-BH-3	VERIZON COMMUNICATIONS SERIES		1	2FE	307,763	100.7900	310,402	308,000	307,942	0	80	0	0	2.500	2.527	MS	2,267	7,700	09/11/2013	09/15/2016																			
923431-DH-2	VERIZON COMMUNICATIONS SERIES		1	2FE	184,443	99.7190	184,480	185,000	184,529	0	73	0	0	3.000	3.048	IN	925	5,581	10/22/2014	11/01/2021																			
928261-AH-0	VISA INC		1	1FE	539,541	99.8140	538,996	540,000	539,545	0	4	0	0	2.200	2.218	JD	561	0	12/09/2015	12/14/2020																			
940748-F0-7	WELLS FARGO & COMPANY MTR			1FE	400,436	100.9820	403,968	400,000	400,127	0	(82)	0	0	2.100	2.076	IN	1,237	8,400	06/28/2012	05/08/2017																			
963320-A5-0	WHLPOOL CORP SERIES 31R			2FE	444,973	99.4830	442,699	445,000	444,983	0	9	0	0	1.650	1.652	IN	1,224	7,281	10/30/2014	11/01/2017																			
983919-A0-6	XILINX CORP			1FE	318,326	99.1080	317,146	320,000	318,908	0	325	0	0	2.125	2.236	MS	2,002	6,800	03/05/2014	03/15/2019																			
005070-AH-3	ACTAVIS FUNDING SEC		F	2FE	754,630	100.1040	755,785	755,000	754,727	0	97	0	0	2.350	2.367	MS	5,372	8,871	03/03/2015	03/12/2018																			
32999999 Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations																																							
073880-AE-0	CLASS A4		2	1FE	1,460,212	104.2970	1,315,463	1,261,267	1,309,909	0	(65,388)	0	0	0	XXX	XXX	XXX	359,755	1,129,379	XXX	XXX																		
073881-AE-8	CLASS A4		2	1FE	1,420,697	102.9250	1,272,821	1,236,649	1,277,873	0	(36,037)	0	0	0	5.471	(0.160)	MON	5,638	69,125	05/17/2013	01/12/2045																		
126288-A0-6	COMM MORTGAGE TRUST SERIES 2013-0R10 CLASS A4		2	1FE	659,167	107.0170	684,909	640,000	655,099	0	(1,752)	0	0	0	4.210	3.867	MON	2,245	26,944	08/01/2013	08/10/2046																		
466426-AV-6	CLASS A2		2	1FE	926,998	101.5780	914,202	900,000	918,840	0	(5,730)	0	0	0	2.892	2.214	MON	2,169	26,026	07/01/2014	08/15/2047																		
501774-AS-8	LB COMMERCIAL CONDUIT MORTGAGE SERIES 2007-C3		2	1FE	1,455,333	103.7540	1,317,130	1,269,474	1,316,989	0	(46,031)	0	0	0	5.517	0.559	MON	3,113	75,873	05/28/2013	07/15/2044																		
92890P-AF-1	HF-RBS COMMERCIAL MORTGAGE TRU SERIES 2013-C14		2	1FE	1,338,969	100.6220	1,308,086	1,300,000	1,326,024	0	(5,137)	0	0	0	2.977	2.536	MON	3,225	38,701	05/22/2013	06/15/2046																		
34999999 Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Commercial Mortgage-Backed Securities																																							
87165L-AF-8	SYNCHRONY CREDIT CARD MASTER SERIES 2015-1 CLASS A		2	1FE	279,944	99.5660	278,785	280,000	279,947	0	5	0	0	0	XXX	XXX	XXX	22,375	308,621	XXX	XXX																		
35999999 Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Other Loan-Backed and Structured Securities																																							
38999999	Total - Industrial and Miscellaneous (Unaffiliated) Bonds				58,703,807	XXX	57,097,004	56,741,178	57,430,393	0	(477,265)	0	0	0	XXX	XXX	XXX	382,425	1,442,940	XXX	XXX																		
48999999	Total - Hybrid Securities				0	XXX	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX																		
55999999	Total - Parent, Subsidiaries and Affiliates Bonds				0	XXX	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX																		
77999999	Total - Issuer Obligations				83,676,586	XXX	83,012,545	78,418,788	81,476,011	0	(759,303)	0	0	0	XXX	XXX	XXX	704,579	2,486,568	XXX	XXX																		
78999999	Total - Residential Mortgage-Backed Securities				22,402,294	XXX	22,316,263	20,974,870	22,333,840	0	(21,582)	0	0	0	XXX	XXX	XXX	70,219	782,978	XXX	XXX																		

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SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value		10	11	Change in Book/Adjusted Carrying Value				Interest				Dates		
		3	4	5			8	9			12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	C o d e	F o r e i g n	Bond Char	NAIC Des.	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amor- tization) Accretion	Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
7999999 - Total - Commercial Mortgage-Backed Securities						7,261,376	XXX	6,812,611	6,607,390	6,804,734	0	(160,075)	0	0	XXX	XXX	XXX	22,375	308,621	XXX	XXX
8099999 - Total - Other Loan-Backed and Structured Securities						279,944	XXX	278,785	280,000	279,947	0	5	0	0	XXX	XXX	XXX	295	4,940	XXX	XXX
8399999 - Total Bonds						113,620,200	XXX	112,422,294	106,281,048	110,896,532	0	(940,955)	0	0	XXX	XXX	XXX	797,468	3,583,107	XXX	XXX

E10.4

SCHEDULE D - PART 2 - SECTION 1

[illegible]Attachment 2015 Amerigroup Florida
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SCHEDULE D - PART 2 - SECTION 2

[illegible]

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 3

Showing All Long-Term Bonds and Stocks ACQUIRED During Current Year

1	2	3	4	5	6	7	8	9
CUSIP Identification	Description	Foreign	Date Acquired	Name of Vendor	Number of Shares of Stock	Actual Cost	Par Value	Paid for Accrued Interest and Dividends
36179R-BB-4	GNMA 11 POOL 942753 3.000% 04/20/45		05/14/2015	Morgan Stanley		1,323,171	1,297,228	2,054
36179R-LP-2	GNMA 11 POOL 943034 3.500% 08/20/45		09/18/2015	Dain Bosworth		287,365	274,724	534
36179R-NH-5	GNMA 11 POOL 943105 3.500% 09/20/45		09/01/2015	J P Morgan		878,717	841,884	1,637
0599999	Subtotal - Bonds - U.S. Governments					2,489,253	2,413,834	4,225
047870-WT-3	ATLANTA GEORGIA WATER REVENUE 5.000% 11/01/30		02/26/2015	Loop Capital Markets		280,075	280,000	.0
313807-WF-9	PLAUC POOL 050768 5.000% 12/01/29		02/10/2015	Hershing		443,737	401,516	913
313810-RH-3	FMAA POOL 454100 4.500% 12/01/44		03/26/2015	Stephens Inc		967,050	883,403	2,871
594615-BB-1	MICHIGAN ST BLDG AUTH REVENUE SERIES I 5.000% 04/15/22		07/31/2015	Chase		586,155	500,000	.0
600092-LP-9	MISSOURI JT MUN ELEC UTIL COMM SERIES A 5.000% 12/01/29		03/13/2015	Chase		172,917	150,000	.0
60265H-WF-8	NORTH TEX TTY AUTH REV 5.000% 01/01/24		04/08/2015	Chase		306,878	335,000	.0
73389-LJ-4	PORT SEATTLE WASH REV SERIES B 5.000% 03/01/26		07/22/2015	Morgan Stanley		273,491	235,000	.0
3199999	Subtotal - Bonds - U.S. Special Revenues					3,122,303	2,744,919	3,484
00206R-CL-4	AT&T INC 2.450% 06/30/20		04/23/2015	J P Morgan		229,883	230,000	.0
002871-AA-9	ABBVIE INC 1.800% 05/14/18		05/05/2015	Bank of America		254,434	255,000	.0
025816-AA-7	AMERICAN EXPRESS COMPANY 6.180% 08/28/17		03/27/2015	Various		411,348	370,000	2,086
031162-BH-9	AMGEN INC 2.125% 05/01/20		04/28/2015	CS First Boston		479,640	480,000	.0
037833-BB-5	APPLE COMPUTER INC 0.900% 05/12/17		05/06/2015	Goldman Sachs & Co		359,752	360,000	.0
053332-AS-1	AUTOZONE INC 2.500% 04/15/21		04/20/2015	US Bancorp		209,920	210,000	.0
136650-LJ-7	CVS/CAREMARK CORP 2.800% 07/20/20		07/13/2015	Bony/Barclays Capital Inc		769,430	770,000	.0
14912L-EL-0	CATERPILLAR FINANCE SE 1.700% 06/16/18		06/11/2015	Bank of America		769,931	770,000	.0
161175-AK-0	CHARTER COMM OPT LLC SERIES 1444 3.579% 07/23/20		07/09/2015	Goldman Sachs & Co		205,000	205,000	.0
25486A-AQ-6	DISCOVER BANK SERIES BKTN 3.100% 06/04/20		06/01/2015	J P Morgan		829,809	830,000	.0
29273R-AQ-2	ENERGY TRANSFER PARTNERS 6.700% 07/01/18		01/12/2015	Bony/Barclays Capital Inc		339,873	300,000	.782
30161H-AP-8	EXELON GENERATION CO LLC 2.950% 01/15/20		01/08/2015	Bony/Barclays Capital Inc		169,968	170,000	.0
316770-BD-0	FIFTH THIRD BANK SERIES MTN 2.150% 08/20/18		08/17/2015	J P Morgan		419,929	420,000	.0
37045J-AI-2	GENERAL MOTORS FINL CO 3.200% 07/13/20		07/06/2015	Bony/Barclays Capital Inc		544,847	545,000	.0
413875-AQ-8	HARRIS CORP 2.700% 04/27/20		04/22/2015	Morgan Stanley		380,000	380,000	.0
44891A-KC-1	HYUNDAI CAPITAL AMERICA SERIES 1444 2.400% 10/30/18		10/27/2015	Deutsche Bank		279,966	280,000	.0
61761J-B3-2	MORGAN STANLEY 2.800% 06/16/20		06/11/2015	Morgan Stanley		249,700	250,000	.0
709599-AI-6	PENNS TRUCK LEASING/PTL SERIES 1444 3.300% 04/01/21		11/04/2015	Deutsche Bank		696,801	700,000	.0
759187-BL-0	REGIONS FINANCIAL CORP SERIES BANT 2.250% 09/14/18		07/28/2015	Goldman Sachs & Co		464,447	465,000	.0
78355H-JZ-3	RYDER SYSTEM INC SERIES MTN 2.500% 05/11/20		05/04/2015	Witubishi Securities		249,313	250,000	.0
832696-AQ-0	JM SMOCKER CO SERIES III 1.750% 03/15/18		09/22/2015	Tax Free Exchange		189,762	190,000	.65
835415-AA-3	KINDER MORGAN INC DE 0.000% 02/01/18		02/20/2015	Wizuho Securities USA		786,821	710,000	3,313
843466-AH-0	SOUTHER POWER CO 1.850% 12/01/17		11/12/2015	Deutsche Bank		349,787	350,000	.0
87165L-AF-8	SYNCRONY CREDIT CARD MASTER SERIES 2015-1 CLASS A 2.370% 03/15/23		03/09/2015	Bank of America		279,944	280,000	.0
92826C-AH-8	VISA INC 2.200% 12/14/20		02/09/2015	Deutsche Bank		539,541	540,000	.0
055070-AH-3	ACTAVIS FUNDING SEC 2.350% 03/12/18	F	03/03/2015	J P Morgan		754,630	755,000	.0
3699999	Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)					11,314,596	11,165,000	6,246
8399997	Total - Bonds - Part 3					16,326,142	16,323,753	13,865
8399998	Total - Bonds - Part 5					26,317,418	1,486,124	654
8399999	Total - Bonds					43,243,560	17,819,877	14,509
8999997	Total - Preferred Stocks - Part 3					0	XXX	0
8999998	Total - Preferred Stocks - Part 5					0	XXX	0
8999999	Total - Preferred Stocks					0	XXX	0
921937-B3-5	VANGUARD ETF		03/12/2015	Direct	6,000,000	496,365	496,365	.0
9099999	Subtotal - Common Stocks - Industrial and Miscellaneous (Unaffiliated)					496,365	XXX	0
9799997	Total - Common Stocks - Part 3					496,365	XXX	0
9799998	Total - Common Stocks - Part 5					0	XXX	0
9799999	Total - Common Stocks					496,365	XXX	0
9899999	Total - Preferred and Common Stocks					496,365	XXX	0
9999999	Totals					43,739,925	XXX	14,509

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 4

Showing All Long-Term Bonds and Stocks SOLD, REDEEMED or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21
CUSIP Identification	Description	For- eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Con- sideration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ Decrease	Current Year's (Amor- tization)/ Accretion	Current Year's Other- Than- Temporary Impairment Recognized	Total Change in Book/ Adjusted Carrying Value (11+12-13)	15 Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Con- tractual Maturity Date
36180U-16-8	GNMA POOL A06907 3.500% 03/20/43		12/01/2015	Paydown		85,179	85,179	70,516	70,315	0	(5,138)	0	(5,138)	0	85,179	0	0	0	1,276	03/20/2043
36180U-16-8	GNMA POOL A07257 3.500% 03/15/43		12/01/2015	Paydown		39,502	39,502	42,599	42,424	0	(2,922)	0	(2,922)	0	39,502	0	0	0	897	03/15/2043
36204C-23-1	GNMA POOL 726282 5.000% 09/15/39		12/01/2015	Paydown		42,980	42,980	47,278	47,189	0	(4,209)	0	(4,209)	0	42,980	0	0	0	1,167	09/15/2039
0599999	Subtotal - Bonds - U.S. Governments					147,661	147,661	160,333	159,928	0	(12,267)	0	(12,267)	0	147,661	0	0	0	3,140	XXX
128916-K2-7	FHLC GOLD POOL 607213 3.500% 11/01/42		12/01/2015	Paydown		47,194	47,194	50,096	50,011	0	(2,817)	0	(2,817)	0	47,194	0	0	0	868	11/01/2042
13164D-3F-4	FHMA SERIES 2013-45 CLASS CB 4.000%		12/25/42	Paydown		85,913	85,913	72,648	71,595	0	(5,682)	0	(5,682)	0	85,913	0	0	0	1,157	12/25/2042
131780-10-3	FHLC MULTIFAMILY STRUCTURED SERIES 4182		12/01/2015	Paydown		93,116	93,116	100,783	99,985	0	(6,869)	0	(6,869)	0	93,116	0	0	0	1,748	05/15/2041
13184X-1V-8	FNMA POOL A36091 4.000% 12/01/41		12/01/2015	Paydown		82,608	82,608	87,015	86,909	0	(4,301)	0	(4,301)	0	82,608	0	0	0	1,340	12/01/2041
131861-H6-8	FNMA POOL A36245 4.000% 12/01/41		12/01/2015	Paydown		82,520	82,520	86,271	86,194	0	(5,584)	0	(5,584)	0	82,520	0	0	0	1,628	12/01/2041
13186B-H6-8	FNMA POOL A65644 3.000% 04/01/27		12/01/2015	Paydown		74,808	74,808	79,471	79,006	0	(4,159)	0	(4,159)	0	74,808	0	0	0	1,328	04/01/2027
13186S-HT-4	FNMA POOL AL0241 4.000% 04/01/41		12/01/2015	Paydown		67,644	67,644	72,664	72,501	0	(4,857)	0	(4,857)	0	67,644	0	0	0	1,515	04/01/2041
13186J-JR-0	FNMA POOL AL2071 5.500% 03/01/40		12/01/2015	Paydown		153,284	153,284	167,736	167,386	0	(14,102)	0	(14,102)	0	153,284	0	0	0	4,316	03/01/2040
13186K-SH-1	FNMA POOL AL3560 5.500% 02/01/28		12/01/2015	Paydown		149,297	149,297	158,276	157,491	0	(8,194)	0	(8,194)	0	149,297	0	0	0	2,856	02/01/2028
13186K-NK-7	FNMA POOL AL3093 3.500% 02/01/43		12/01/2015	Paydown		39,354	39,354	41,601	41,620	0	(2,266)	0	(2,266)	0	39,354	0	0	0	714	02/01/2043
13186K-UG-4	FNMA POOL AL3307 4.000% 11/01/42		12/01/2015	Paydown		168,246	168,246	175,002	174,872	0	(6,626)	0	(6,626)	0	168,246	0	0	0	3,497	11/01/2042
13186K-IE-1	FNMA POOL AL3344 4.500% 10/01/42		12/01/2015	Paydown		125,318	125,318	134,286	134,104	0	(8,788)	0	(8,788)	0	125,318	0	0	0	3,008	10/01/2042
13186L-BR-3	FNMA POOL AL3547 4.000% 12/01/42		12/01/2015	Paydown		146,399	146,399	156,235	156,218	0	(9,620)	0	(9,620)	0	146,399	0	0	0	3,180	12/01/2042
13186J-FC-2	FNMA POOL A65662 3.500% 02/01/43		12/01/2015	Paydown		136,940	136,940	144,339	144,128	0	(7,189)	0	(7,189)	0	136,940	0	0	0	2,779	02/01/2043
13186T-GJ-9	FNMA POOL A75600 3.500% 05/01/43		12/01/2015	Paydown		48,283	48,283	50,929	50,862	0	(2,579)	0	(2,579)	0	48,283	0	0	0	841	05/01/2043
13186T-HT-5	FNMA POOL A72169 4.000% 11/01/44		12/01/2015	Paydown		95,109	95,109	101,335	101,306	0	(6,138)	0	(6,138)	0	95,109	0	0	0	2,645	11/01/2044
13186Z-C7-3	FNMA POOL 725594 5.500% 07/01/34		12/01/2015	Paydown		71,208	71,208	77,785	77,591	0	(6,383)	0	(6,383)	0	71,208	0	0	0	2,699	07/01/2034
13186Z-2V-2	FNMA POOL 732388 5.000% 03/01/35		12/01/2015	Paydown		47,531	47,531	51,615	51,479	0	(8,948)	0	(8,948)	0	47,531	0	0	0	1,299	03/01/2035
13146B-LD-8	FNMA POOL 955024 5.500% 08/01/37		12/01/2015	Paydown		270,789	270,789	295,837	295,192	0	(24,403)	0	(24,403)	0	270,789	0	0	0	7,892	08/01/2037
13146B-HS-3	FNMA POOL 955112 5.500% 07/01/36		12/01/2015	Paydown		162,529	162,529	177,563	177,153	0	(14,824)	0	(14,824)	0	162,529	0	0	0	4,703	07/01/2036
13146B-TA-6	FNMA POOL 955245 5.000% 01/01/39		12/01/2015	Paydown		76,772	76,772	83,989	83,814	0	(7,942)	0	(7,942)	0	76,772	0	0	0	1,959	01/01/2039
13146C-D3-7	FNMA POOL 955722 5.000% 05/01/38		12/01/2015	Paydown		76,987	76,987	83,555	83,373	0	(6,386)	0	(6,386)	0	76,987	0	0	0	2,063	05/01/2038
13147G-CF-4	FNMA POOL A89068 3.500% 04/01/43		12/01/2015	Paydown		49,175	49,175	52,242	52,154	0	(2,979)	0	(2,979)	0	49,175	0	0	0	845	04/01/2043
13147G-CF-1	FNMA POOL A89069 3.500% 04/01/43		12/01/2015	Paydown		34,355	34,355	36,575	36,516	0	(2,161)	0	(2,161)	0	34,355	0	0	0	567	04/01/2043
13148A-6G-8	FNMA POOL BA1770 4.500% 02/01/44		12/01/2015	Paydown		150,738	150,738	161,784	161,603	0	(10,869)	0	(10,869)	0	150,738	0	0	0	3,407	02/01/2044
13148A-JL-3	FNMA POOL BA1166 3.500% 09/01/32		12/01/2015	Paydown		85,117	85,117	90,278	89,980	0	(4,862)	0	(4,862)	0	85,117	0	0	0	1,648	09/01/2032
13148D-KG-6	FNMA POOL MA3894 4.000% 09/01/31		12/01/2015	Paydown		161,004	161,004	172,677	172,098	0	(11,094)	0	(11,094)	0	161,004	0	0	0	3,412	09/01/2031
13149A-GK-7	FNMA POOL A82021 5.500% 08/01/37		12/01/2015	Paydown		139,926	139,926	152,870	152,536	0	(12,609)	0	(12,609)	0	139,926	0	0	0	3,835	08/01/2037
13149D-4K-4	FNMA POOL A83525 4.000% 01/01/41		12/01/2015	Paydown		85,313	85,313	70,232	70,076	0	(4,763)	0	(4,763)	0	85,313	0	0	0	1,540	01/01/2041
13149K-IL-5	FNMA POOL A88750 4.000% 12/01/40		12/01/2015	Paydown		117,048	117,048	126,046	125,777	0	(8,729)	0	(8,729)	0	117,048	0	0	0	2,551	12/01/2040
3199999	Subtotal - Bonds - U.S. Special Revenues					3,064,525	3,064,525	3,293,827	3,285,440	0	(220,915)	0	(220,915)	0	3,064,525	0	0	0	71,348	XXX
00846U-AJ-0	AGILENT TECHNOLOGIES INC 3.875% 07/15/23		02/05/2015			727,643	700,000	696,808	697,233	0	30	0	30	0	697,263	0	30,380	30,380	15,446	07/15/2023
02891D-DE-6	AMERICAN EXPRESS CREDIT SERIES MTN 1.750%		06/12/15			300,000	300,000	306,936	301,127	0	(1,127)	0	(1,127)	0	300,000	0	0	0	2,625	06/12/2015
031162-BR-0	AMGEN INC 1.250% 05/22/17		04/28/2015	Jeffries & Co		1,050,105	1,050,000	1,048,896	1,049,084	0	126	0	126	0	1,049,210	0	895	895	5,797	05/22/2017
073880-AE-9	BEAR STEARNS COMMERCIAL MORTG SERIES 2007- PH17 CLASS AA 5.994% 06/11/50		12/01/2015	Paydown		38,733	38,733	44,843	42,235	0	(3,502)	0	(3,502)	0	38,733	0	0	0	2,121	06/11/2050
07388V-AE-8	T26 CLASS AA 5.471% 01/12/45		12/01/2015	Paydown		42,273	42,273	44,914	42,733	0	(2,641)	0	(2,641)	0	42,273	0	0	0	1,271	01/12/2045
073996-AA-8	RED BATH AND BEYOND INC 3.749% 08/01/24		03/18/2015	RBC Dominion		358,383	345,000	344,997	345,001	0	1	0	1	0	345,001	0	33,391	33,391	8,838	08/01/2024
09047V-MK-7	BLACKROCK INC 1.375% 06/01/15		06/01/2015	Maturity		500,000	500,000	506,333	500,957	0	(927)	0	(927)	0	500,000	0	0	0	3,438	06/01/2015
191216-AK-8	COCA-COLA COMPANY 0.750% 03/13/15		03/13/2015	Maturity		400,000	400,000	401,672	400,125	0	(125)	0	(125)	0	400,000	0	0	0	1,500	03/13/2015
26422E-RV-3	JOHN DEERE CAPITAL CORP 0.700% 09/04/15		09/04/2015	Maturity		90,000	90,000	89,999	89,996	0	14	0	14	0	90,000	0	0	0	630	09/04/2015
264534-CD-3	E I DU PONT DE NEMOURS 1.550% 01/15/16		04/24/2015	Corporate Action		404,604	400,000	415,712	404,728	0	(1,476)	0	(1,476)	0	403,252	0	1,352	1,352	6,132	01/15/2016
27864D-4D-5	EBAY INC 0.700% 02/15/15		07/15/2015	Maturity		400,000	400,000	402,604	400,000	0	(121)	0	(121)	0	400,000	0	0	0	2,600	02/15/2015
27866S-AN-0	ECOLAB INC 1.000% 08/09/15		08/09/2015	Maturity		300,000	300,000	300,789	300,164	0	(164)	0	(164)	0	300,000	0	0	0	3,000	08/09/2015
30219S-AB-4	EXPRESS SCRIPTS HOLDING 2.100% 02/12/15		02/12/2015	Maturity		115,000	115,000	117,203	115,122	0	(122)	0	(122)	0	115,000	0	0	0	1,208	02/12/2015
30962C-GH-9	GENERAL ELECTRIC CAP CORP 1.625% 04/02/18		10/02/2015	Taxable Exchange		498,947	490,000	498,574	499,059	0	232	0	232	0	499,291	0	9,656	9,656	8,493	04/02/2018
381415-GT-5	GOLDMAN SACHS GROUP INC 3.300% 05/03/15		05/03/2015	Maturity		250,000	250,000	259,195	251,204	0	(1,204)	0	(1,204)	0	250,000	0	0	0	4,125	05/03/2015

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 4

Showing All Long-Term Bonds and Stocks SOLD, REDEEMED or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21
CUSIP Identification	Description	Foreign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Con- sideration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ Decrease	Current Year's (Amor- tization)/ Accretion	Current Year's Other- Than- Temporary Impairment Recognized	Total Change in Book/ Adjusted Carrying Value (11+12-13)	15 Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Contractual Maturity Date
384780-AA-0	GRAIN SPECTRUM FUNDING 11 SERIES 144A		10/10/2015	Redemption	100,000	6,212	6,212	6,212	6,212	0	0	0	0	0	6,212	0	0	0	160	10/10/2019
428236-BY-8	HEILETT-PACKARD CO 2.750% 01/14/19		10/14/2015	Corporate Action	325,515	315,000	314,855	314,855	314,862	22	22	0	22	22	314,884	0	0	19,611	0	01/14/2019
458200-HB-0	IBM CORP 0.550% 02/06/15		02/06/2015	Maturity	100,000	100,000	100,000	99,511	99,984	0	16	0	16	16	100,000	0	0	0	275	02/06/2015
468251-NE-9	JP MORGAN CHASE COMMERCIAL MTO SERIES 2005-LDP2 CLASS AA 4.780% 07/15/42		06/01/2015	Paydown	530,000	530,000	569,998	537,960	537,960	0	(7,960)	0	(7,960)	0	530,000	0	0	0	11,433	07/15/2042
494550-BQ-8	KINDER MORGAN ENERGY PARTNERS 3.500% 09/01/23		02/05/2015	Goldman Sachs & Co	582,466	590,000	615,158	611,545	611,545	0	(243)	0	(243)	0	611,302	0	(28,837)	(28,837)	9,120	09/01/2023
501774-AS-8	LB COMMERCIAL CONDUIT MORTGAGE SERIES 2007-C3 CLASS AAB 3.517% 07/15/44		12/11/2015	Paydown	30,526	30,526	34,995	32,775	32,775	0	(2,249)	0	(2,249)	0	30,526	0	0	0	1,021	07/15/2044
565555-AR-7	MEDTRONIC INC 3.000% 03/15/15		03/15/2015	Maturity	500,000	500,000	531,015	500,000	500,000	0	0	0	0	0	500,000	0	0	0	7,500	03/15/2015
611668-AS-0	MONSANTO CO 2.125% 07/15/19		02/05/2015	Mizuho Securities USA	947,997	935,000	934,198	934,276	934,276	0	17	0	17	17	934,293	0	13,704	13,704	12,087	07/15/2019
717081-DD-2	PFIZER INC 0.900% 01/15/17		04/14/2015	RBC Dominion	1,064,070	1,060,000	1,059,039	1,059,039	1,059,039	0	138	0	138	138	1,059,176	0	4,894	4,894	7,208	01/15/2017
784644-41-7	SPDR BARCLAYS HIGH YIELD BD 0.000%		09/10/2015	BallachBeth	3,646,866	3,600,000	3,999,990	3,803,085	3,803,085	196,905	0	0	196,905	196,905	3,999,990	0	(353,124)	(353,124)	165,147	01/01/9999
871829-AP-2	SYSCO CORP 0.550% 06/12/15		06/12/2015	Maturity	500,000	500,000	500,016	500,016	500,016	0	(16)	0	(16)	0	500,000	0	0	0	1,375	06/12/2015
871829-AR-8	SYSCO CORP 1.450% 10/02/17		07/14/2015	Call	101,000	272,700	269,897	269,906	269,906	0	18	0	18	18	269,924	0	2,776	2,776	3,067	10/02/2017
882558-AT-1	TEXAS INSTRUMENTS INC 0.450% 08/03/15		08/03/2015	Maturity	100,000	100,000	99,689	99,864	99,864	0	36	0	36	36	100,000	0	0	0	450	08/03/2015
913017-BH-1	UNITED TECHNOLOGIES CORP 4.875% 05/01/15		05/01/2015	Maturity	160,000	160,000	175,670	162,209	162,209	0	(2,209)	0	(2,209)	0	160,000	0	0	0	3,900	05/01/2015
931142-CX-9	WAL-MART STORES INC 1.500% 10/25/15		10/25/2015	Maturity	750,000	750,000	770,475	755,133	755,133	0	(5,133)	0	(5,133)	0	750,000	0	0	0	11,250	10/25/2015
931422-AG-4	WALGREEN CO 1.000% 03/13/15		03/13/2015	Maturity	250,000	250,000	249,993	249,994	249,994	0	6	0	6	6	250,000	0	0	0	1,250	03/13/2015
940748-FE-5	WELLS FARGO & COMPANY 1.500% 07/01/15		07/01/2015	Maturity	100,000	100,000	101,253	100,000	100,000	0	(219)	0	(219)	0	100,000	0	0	0	2,500	07/01/2015
3899999	Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)				15,342,050	11,716,244	15,802,398	15,470,661	15,470,661	196,905	(31,214)	0	165,691	0	15,636,350	0	(294,302)	(294,302)	315,043	XXXX
172967-BW-9	CITIGROUP INC 6.125% 11/21/17		12/07/2015	Corporate Action	1,982,322	1,800,000	2,126,268	2,013,473	2,013,473	0	(68,313)	0	(68,313)	0	1,945,161	0	17,163	17,163	116,069	11/21/2017
4899999	Subtotal - Bonds - Hybrid Securities				1,982,322	1,800,000	2,126,268	2,013,473	2,013,473	0	(68,313)	0	(68,313)	0	1,945,161	0	17,163	17,163	116,069	XXXX
8399999	Total - Bonds - Part 4				20,516,558	16,728,430	21,382,736	20,929,502	20,929,502	196,905	(332,709)	0	(135,804)	0	20,793,697	0	(277,139)	(277,139)	505,600	XXXX
8399998	Total - Bonds - Part 5				25,939,526	1,496,124	26,317,418	26,317,418	26,317,418	0	(20,131)	0	(20,131)	0	26,297,287	0	(357,760)	(357,760)	351,597	XXXX
8399999	Total - Bonds				46,456,084	18,224,554	47,700,154	20,929,502	20,929,502	196,905	(352,840)	0	(155,935)	0	47,090,984	0	(634,899)	(634,899)	857,197	XXXX
8999997	Total - Preferred Stocks - Part 4				0	XXXX	0	0	0	0	0	0	0	0	0	0	0	0	0	XXXX
8999998	Total - Preferred Stocks - Part 5				0	XXXX	0	0	0	0	0	0	0	0	0	0	0	0	0	XXXX
8999999	Total - Preferred Stocks				0	XXXX	0	0	0	0	0	0	0	0	0	0	0	0	0	XXXX
9799997	Total - Common Stocks - Part 4				0	XXXX	0	0	0	0	0	0	0	0	0	0	0	0	0	XXXX
9799998	Total - Common Stocks - Part 5				0	XXXX	0	0	0	0	0	0	0	0	0	0	0	0	0	XXXX
9799999	Total - Common Stocks				0	XXXX	0	0	0	0	0	0	0	0	0	0	0	0	0	XXXX
9899999	Total - Preferred and Common Stocks				0	XXXX	0	0	0	0	0	0	0	0	0	0	0	0	0	XXXX
9999999	Totals				46,456,084	XXXX	47,700,154	20,929,502	20,929,502	196,905	(352,840)	0	(155,935)	0	47,090,984	0	(634,899)	(634,899)	857,197	XXXX

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 5

Showing All Long-Term Bonds and Stocks ACQUIRED During Year and Fully DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	11	Change in Book/Adjusted Carrying Value					17	18	19	20	21
CUSIP Identification	Description	For- eign	Date Acquired	Name of Vendor	Disposal Date	Name of Purchaser	Par Value (Bonds) or Number of Shares (Stock)	Actual Cost	Consid- eration	Book/ Adjusted Carrying Value at Disposal	12 Unrealized Valuation Increase/ (Decrease)	13 Current Year's (Amort- ization)/ Accretion	14 Current Year's Other- Than- Temporary Impairment Recognized	15 Total Change in Book/ Adjusted Carrying Value (12 + 13 - 14)	16 Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Interest and Dividends Received During Year	Paid for Accrued Interest and Dividends
36179F-BK-8	GNMA II POOL WAC2753 3.000% 04/20/45		05/14/2015	Morgan Stanley	12/01/2015	Paydorn	49,741	50,736	49,741	49,741	0	(995)	0	(995)	0	0	0	0	558	79
36179F-LP-2	GNMA II POOL WAC304 3.500% 06/20/45		09/16/2015	Dein Bover th	12/01/2015	Paydorn	3,776	3,776	3,776	3,776	0	(174)	0	(174)	0	0	0	0	17	7
36179F-NH-5	GNMA II POOL WAC105 3.500% 09/20/45		09/01/2015	J P Morgan	12/01/2015	Paydorn	8,116	8,471	8,116	8,116	0	(355)	0	(355)	0	0	0	0	53	16
0599999	Subtotal - Bonds - U.S. Governments						61,633	63,156	61,633	61,633	0	(1,524)	0	(1,524)	0	0	0	0	628	102
312807-86-9	FHLMC POOL 605769 5.000% 12/01/39		02/10/2015	Pershing	12/01/2015	Paydorn	90,384	99,889	90,384	90,384	0	(9,504)	0	(9,504)	0	0	0	0	2,157	138
313800-8H-3	FHMA POOL AS4100 4.500% 12/01/44		03/26/2015	Stephens Inc	12/01/2015	Paydorn	96,732	105,891	96,732	96,732	0	(9,159)	0	(9,159)	0	0	0	0	2,071	314
3199999	Subtotal - Bonds - U.S. Special Revenues						187,116	205,780	187,116	187,116	0	(18,663)	0	(18,663)	0	0	0	0	4,228	452
464287-44-0	1SHARES BARCLAYS 7-10 YEAR TRE 0.000%		01/28/2015	Direct	10/22/2015	BallachBeth	15,017,173	14,798,057	15,017,173	15,017,173	0	0	0	0	0	0	(219,116)	(219,116)	182,935	0
464288-63-8	1SHARES INTERMEDIATE CREDIT 0.000%		01/28/2015	Direct	10/22/2015	BallachBeth	10,012,258	9,872,618	10,012,258	10,012,258	0	0	0	0	0	0	(139,639)	(139,639)	160,724	0
832696-AC-2	JM SNACKER CO 144A SERIES 144A 1.750%		03/15/2015	Bank of America	09/22/2015	Tax Free Exchange	189,715	189,762	189,762	189,762	0	47	0	47	0	0	0	0	1,681	0
907819-EE-4	UNION PACIFIC CORP 2.250% 06/15/20		06/16/2015	Chase	07/14/2015	First Union Capital Markets	830,000	829,336	830,340	829,345	0	0	0	0	0	0	995	995	1,401	0
3899999	Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)						1,247,375	28,048,482	25,690,777	26,048,538	0	56	0	56	0	0	(357,760)	(357,760)	346,741	0
8399998	Total - Bonds						1,496,124	28,317,416	25,939,526	26,297,287	0	(20,131)	0	(20,131)	0	0	(357,760)	(357,760)	351,597	554
9999998	Total - Preferred Stocks						0	0	0	0	0	0	0	0	0	0	0	0	0	0
9799998	Total - Common Stocks						0	0	0	0	0	0	0	0	0	0	0	0	0	0
9899999	Total - Preferred and Common Stocks						0	0	0	0	0	0	0	0	0	0	0	0	0	0
9999999	Totals						26,317,416	25,939,526	26,297,287	26,297,287	0	(20,131)	0	(20,131)	0	0	(357,760)	(357,760)	351,597	554

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

Schedule D-Part 6-Section 1-Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

NONE

Schedule D - Part 6 - Section 2

NONE

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE DA - PART 1

Showing All SHORT-TERM INVESTMENTS Owned December 31 of Current Year

1	2	Codes		5	6	7	8	Change in Book/Adjusted Carrying Value				13	14	Interest						21
		3	4					9	10	11	12			15	16	17	18	19	20	
CUSIP Identification	Description	Code	Foreign	Date Acquired	Name of Vendor	Maturity Date	Book/Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization)/ Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in Book/Adjusted Carrying Value	Par Value	Actual Cost	Amount Due and Accrued Dec. 31 of Current Year on Bonds not in Default	Non-Admitted Due and Accrued	Rate of	Effective Rate of	When Paid	Amount Received During Year	Paid for Accrued Interest
0599999	Total - U.S. Government Bonds						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
1099999	Total - All Other Government Bonds						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
1799999	Total - U.S. States, Territories and Possessions Bonds						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
2499999	Total - U.S. Political Subdivisions Bonds						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
3199999	Total - U.S. Special Revenues Bonds						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
	IE CAPITAL INTL FUNDING SERIES 144		F	10/02/2015	Taxable Exchange	04/15/2016	498,000	0	0	0	0	498,000	498,000	867	0	0.364	0.364	JAN	0	0
3299999	Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations						498,000	0	0	0	0	498,000	498,000	867	0	XXX	XXX	XXX	0	0
3899999	Total - Industrial and Miscellaneous (Unaffiliated) Bonds						498,000	0	0	0	0	498,000	498,000	867	0	XXX	XXX	XXX	0	0
4899999	Total - Hybrid Securities						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
5599999	Total - Parent, Subsidiaries and Affiliates Bonds						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
7799999	Total - Issuer Obligations						498,000	0	0	0	0	498,000	498,000	867	0	XXX	XXX	XXX	0	0
7899999	Total - Residential Mortgage-Backed Securities						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
7999999	Total - Commercial Mortgage-Backed Securities						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
8099999	Total - Other Loan-Backed and Structured Securities						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
8399999	Total Bonds						498,000	0	0	0	0	498,000	498,000	867	0	XXX	XXX	XXX	0	0
8699999	Total - Parent, Subsidiaries and Affiliates						0	0	0	0	0	XXX	0	0	0	XXX	XXX	XXX	0	0
94975H-29-6	WELLS FARGO ADV TR FL MI-ING TAXABLE TREASURY	SD		12/02/2015	Various		XXX	0	0	0	0	0	0	0	0	0.000	0.000		0	0
	State of Florida Cash Deposit			01/01/2015			XXX	300,000	0	0	0	0	0	0	0	0.000	0.000		0	0
8899999	Subtotal - Exempt Money Market Mutual Funds						300,000	0	0	0	0	XXX	0	0	0	XXX	XXX	XXX	0	0
2618BJ-20-6	DREYFUS CASH MANAGEMENT ADMIN			12/16/2015	Direct		XXX	333,062	0	0	0	0	0	0	0	0.000	0.000		0	0
26200V-10-4	DREYFUS INSTL CASH ADVANTAGE	SD		12/30/2015	Direct		XXX	501,130	0	0	0	0	0	0	0	0.000	0.000		0	0
26200V-10-4	DREYFUS INSTL CASH ADVANTAGE			12/30/2015	Direct		XXX	3,639,466	0	0	0	0	0	0	0	0.000	0.000		0	0
949917-39-7	WELLS FARGO ADVANTAGE HERITAGE INSTL CLASS	SD		12/02/2015	Various		XXX	33,961,920	0	0	0	0	0	0	0	0.000	0.000		9,369	0
949917-39-7	WELLS FARGO ADVANTAGE HERITAGE INSTL CLASS			10/02/2015	Various		XXX	3,303	0	0	0	0	0	0	0	0.000	0.000		5,960	0
8999999	Subtotal - Class One Money Market Mutual Funds						38,438,881	0	0	0	0	XXX	38,438,881	0	0	XXX	XXX	XXX	15,329	0
9199999	Totals						39,236,887	0	0	0	0	XXX	38,936,887	867	0	XXX	XXX	XXX	15,335	0

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

Schedule DB - Part A - Section 1 - Options, Caps, Floors, Collars, Swaps and Forwards Open

NONE

Schedule DB - Part A - Section 2 - Options, Caps, Floors, Collars, Swaps and Forwards Terminated

NONE

Schedule DB - Part B - Section 1 - Futures Contracts Open

NONE

Schedule DB - Part B - Section 1B - Brokers with whom cash deposits have been made

NONE

Schedule DB - Part B - Section 2 - Futures Contracts Terminated

NONE

Schedule DB - Part D - Section 1 - Counterparty Exposure for Derivative Instruments Open

NONE

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged By

NONE

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged To

NONE

E18, E19, E20, E21, E22, E23

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE DL - PART 1
SECURITIES LENDING COLLATERAL ASSETS

Reinvested Collateral Assets Owned December 31 Current Year

1	2	3	4	5	6	7
CUSIP Identification	Description	Code	NAIC Designation/Market Indicator	Fair Value	Book/Adjusted Carrying Value	Maturity Date
912796-FY-9	UNITED STATES TREASURY BILL	.....	.....	49,090	49,090	01/07/2016
912796-SH-6	UNITED STATES TREASURY BILL	.....	.....	17,935	17,935	04/28/2016
912796-OY-9	UNITED STATES TREASURY BILL	.....	.....	109,071	109,071	01/21/2016
912796-HH-2	UNITED STATES TREASURY BILL	.....	.....	139,123	139,123	06/09/2016
912810-PH-2	UNITED STATES TREASURY BOND	.....	.....	2,052	2,052	02/15/2038
912810-BH-6	UNITED STATES TREASURY BOND	.....	.....	275,150	275,150	05/15/2043
912810-RE-0	UNITED STATES TREASURY BOND	.....	.....	82,235	82,235	02/15/2044
912810-RH-3	UNITED STATES TREASURY BOND	.....	.....	83,419	83,419	08/15/2044
912810-JH-9	UNITED STATES TREASURY BOND	.....	.....	9,866	9,866	11/15/2044
912810-TH-2	UNITED STATES TREASURY BOND	.....	.....	14,694	14,694	05/15/2045
912828-AS-4	UNITED STATES TREASURY NOTE	.....	.....	61,717	61,717	11/30/2018
912828-B4-1	UNITED STATES TREASURY NOTE	.....	.....	6,169	6,169	01/31/2016
912828-B6-6	UNITED STATES TREASURY NOTE	.....	.....	15,861	15,861	02/15/2024
912828-C8-1	UNITED STATES TREASURY NOTE	.....	.....	2,609	2,609	04/30/2016
912828-C9-9	US TREASURY INFLATION INDEXED NOTES	.....	.....	49,400	49,400	04/15/2018
912828-F2-1	UNITED STATES TREASURY NOTE	.....	.....	4,394	4,394	09/30/2021
912828-F3-9	UNITED STATES TREASURY NOTE	.....	.....	4,479	4,479	09/30/2019
912828-F9-6	UNITED STATES TREASURY NOTE	.....	.....	6,162	6,162	10/31/2021
912828-G3-8	UNITED STATES TREASURY NOTE	.....	.....	27,867	27,867	11/15/2024
912828-GH-5	UNITED STATES TREASURY NOTE	.....	.....	3,686	3,686	12/31/2018
912828-H6-0	UNITED STATES TREASURY NOTE	.....	.....	27,457	27,457	01/31/2017
912828-HH-4	UNITED STATES TREASURY NOTE	.....	.....	19,146	19,146	02/15/2018
912828-HH-1	UNITED STATES TREASURY NOTE	.....	.....	3,059	3,059	08/15/2017
912828-JH-2	UNITED STATES TREASURY NOTE	.....	.....	209,850	209,850	03/31/2017
912828-K3-3	US TREASURY INFLATION INDEXED NOTES	.....	.....	7,059	7,059	04/15/2020
912828-K4-1	UNITED STATES TREASURY NOTE	.....	.....	46,899	46,899	04/30/2017
912828-L3-2	UNITED STATES TREASURY NOTE	.....	.....	1,666	1,666	08/31/2020
912828-LL-2	UNITED STATES TREASURY NOTE	.....	.....	1,392	1,392	08/31/2016
912828-MH-3	UNITED STATES TREASURY NOTE	.....	.....	22,304	22,304	01/31/2017
912828-NH-4	UNITED STATES TREASURY NOTE	.....	.....	31,503	31,503	04/30/2017
912828-ND-8	UNITED STATES TREASURY NOTE	.....	.....	496	496	05/15/2020
912828-PP-9	US TREASURY INFLATION INDEXED NOTES	.....	.....	2,028	2,028	01/15/2021
912828-PH-3	UNITED STATES TREASURY NOTE	.....	.....	2,106	2,106	01/31/2018
912828-QH-1	UNITED STATES TREASURY NOTE	.....	.....	574	574	07/31/2016
912828-RH-6	UNITED STATES TREASURY NOTE	.....	.....	5,309	5,309	08/15/2021
912828-RE-2	UNITED STATES TREASURY NOTE	.....	.....	1,543	1,543	08/31/2018
912828-SH-9	US TREASURY INFLATION INDEXED NOTES	.....	.....	7,908	7,908	01/15/2022
912828-SH-1	UNITED STATES TREASURY NOTE	.....	.....	1,862	1,862	03/31/2018
912828-SH-4	US TREASURY INFLATION INDEXED NOTES	.....	.....	602	602	04/15/2017
912828-SY-7	UNITED STATES TREASURY NOTE	.....	.....	7,180	7,180	05/31/2017
912828-TE-0	US TREASURY INFLATION INDEXED NOTES	.....	.....	2,985	2,985	07/15/2022
912828-TA-9	UNITED STATES TREASURY NOTE	.....	.....	10,423	10,423	08/15/2022
912828-UA-6	UNITED STATES TREASURY NOTE	.....	.....	7,821	7,821	11/30/2017
912828-UE-8	UNITED STATES TREASURY NOTE	.....	.....	26,885	26,885	12/31/2017
912828-UH-1	US TREASURY INFLATION INDEXED NOTES	.....	.....	127,642	127,642	01/15/2023
912828-UH-8	UNITED STATES TREASURY NOTE	.....	.....	7,818	7,818	02/15/2023
912828-UP-9	UNITED STATES TREASURY NOTE	.....	.....	39,044	39,044	02/28/2018
912828-VB-3	UNITED STATES TREASURY NOTE	.....	.....	215,926	215,926	05/15/2023
912828-VZ-0	UNITED STATES TREASURY NOTE	.....	.....	9,121	9,121	09/30/2020
912828-WE-6	UNITED STATES TREASURY NOTE	.....	.....	11,368	11,368	11/15/2023
912828-XJ-5	UNITED STATES TREASURY NOTE	.....	.....	98,776	98,776	05/15/2024
912828-WJ-0	US TREASURY INFLATION INDEXED NOTES	.....	.....	290,951	290,951	07/15/2024
01999999	Subtotal - Bonds - U.S. Governments - Issuer Obligations			2,183,704	2,183,704	XXX
05999999	Total - U.S. Government Bonds			2,183,704	2,183,704	XXX
10999999	Total - All Other Government Bonds			0	0	XXX
17999999	Total - U.S. States, Territories and Possessions Bonds			0	0	XXX
24999999	Total - U.S. Political Subdivisions Bonds			0	0	XXX
31999999	Total - U.S. Special Revenues Bonds			0	0	XXX
000000-00-0	PAYABLE/RECEIVABLE	.....	.....	(892)	(1,526)	01/01/2016
000000-00-0	ROYAL BANK OF SCOTLAND PLC REPO (USD)	.....	.....	94,191	94,191	01/04/2016
000000-00-0	BNP PARIBAS SECURITIES CORP. REPO	.....	.....	952,572	952,572	01/04/2016
000000-00-0	BNP PARIBAS SECURITIES CORP. REPO	.....	.....	124,370	124,370	01/04/2016
06417H-HL-3	BANK OF NOVA SCOTIA (HOUSTON)	.....	.....	124,894	124,997	03/22/2016
69371R-LJ-8	PACCAR FINANCIAL CORP	.....	.....	99,982	100,016	02/08/2016
32999999	Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations			1,395,117	1,394,620	XXX
000000-00-0	ORIX CAPITAL MARKETS AMERICA REPO	.....	.....	1,076,942	1,076,942	01/04/2016
000000-00-0	HSC SECURITIES USA IND REPO	.....	.....	1,076,942	1,076,942	01/04/2016
000000-00-0	NOMURA SECURITIES INT. INC. REPO	.....	.....	1,076,942	1,076,942	01/04/2016
33999999	Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Residential Mortgage-Backed Securities			3,230,826	3,230,826	XXX
38999999	Total - Industrial and Miscellaneous (Unaffiliated) Bonds			4,625,943	4,625,446	XXX
48999999	Total - Hybrid Securities			0	0	XXX
55999999	Total - Parent, Subsidiaries and Affiliates Bonds			0	0	XXX
61999999	Total - Issuer Obligations			3,578,821	3,578,324	XXX
62999999	Total - Residential Mortgage-Backed Securities			3,230,826	3,230,826	XXX
63999999	Total - Commercial Mortgage-Backed Securities			0	0	XXX
64999999	Total - Other Loan-Backed and Structured Securities			0	0	XXX
65999999	Total Bonds			6,809,647	6,809,150	XXX
70999999	Total - Preferred Stocks			0	0	XXX
75999999	Total - Common Stocks			0	0	XXX
76999999	Total - Preferred and Common Stocks			0	0	XXX
99999999	Totals			6,809,647	6,809,150	XXX

General Interrogatories:

1. Total activity for the year Fair Value \$1,311,424 Book/Adjusted Carrying Value \$1,311,171
2. Average balance for the year Fair Value \$7,788,393 Book/Adjusted Carrying Value \$7,787,819
3. Reinvested securities lending collateral assets book/adjusted carrying value included in this schedule by NAIC designation:
NAIC 1 \$6,714,959 NAIC 2 \$94,191 NAIC 3 \$ NAIC 4 \$ NAIC 5 \$ NAIC 6 \$

SCHEDULE DL - PART 2
SECURITIES LENDING COLLATERAL ASSETS

9999999 - Totals

General Interrogatories:

- | | |
|---------------------|---------------------------------------|
| Fair Value \$ | Book/Adjusted Carrying Value \$ |
| Fair Value \$ | Book/Adjusted Carrying Value \$ |

SCHEDULE E - PART 1 - CASH

TOTALS OF DEPOSITORY BALANCES ON THE LAST DAY OF EACH MONTH DURING THE CURRENT YEAR											
1.	January.....	1,789,909	4.	April.....	(9,114,577)	7.	July.....	(38,093,682)	10.	October.....	(3,162,851)
2.	February.....	(16,713,593)	5.	May.....	(30,928,313)	8.	August.....	(36,169,219)	11.	November.....	(3,850,398)
3.	March.....	(30,652,344)	6.	June.....	(36,778,178)	9.	September.....	(34,237,963)	12.	December.....	23,215,670

SCHEDULE E - PART 2 - CASH EQUIVALENTS

1	2	3	4	5	6	7	8
Description	Code	Date Acquired	Rate of Interest	Maturity Date	Book/Adjusted Carrying Value	Amount of Interest Due and Accrued	Amount Received During Year
NONE							
8699999 - Total Cash Equivalents							

Attachment 2015 Amerigroup Florida
Annual Health Statement — Page 110

ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

SCHEDULE E - PART 3 - SPECIAL DEPOSITS

States, Etc.	1 Type of Deposit	2 Purpose of Deposit	Deposits For the Benefit of All Policyholders		All Other Special Deposits	
			3 Book/Adjusted Carrying Value	4 Fair Value	5 Book/Adjusted Carrying Value	6 Fair Value
1. Alabama	AL					
2. Alaska	AK					
3. Arizona	AZ					
4. Arkansas	AR					
5. California	CA					
6. Colorado	CO					
7. Connecticut	CT					
8. Delaware	DE					
9. District of Columbia	DC					
10. Florida	FL	FL ACHA 100, DOE 100, Surplus Deposit	38,846,192	39,139,483		
11. Georgia	GA					
12. Hawaii	HI					
13. Idaho	ID					
14. Illinois	IL					
15. Indiana	IN					
16. Iowa	IA					
17. Kansas	KS					
18. Kentucky	KY					
19. Louisiana	LA					
20. Maine	ME					
21. Maryland	MD					
22. Massachusetts	MA					
23. Michigan	MI					
24. Minnesota	MN					
25. Mississippi	MS					
26. Missouri	MO					
27. Montana	MT					
28. Nebraska	NE					
29. Nevada	NV					
30. New Hampshire	NH					
31. New Jersey	NJ					
32. New Mexico	NM					
33. New York	NY					
34. North Carolina	NC					
35. North Dakota	ND					
36. Ohio	OH					
37. Oklahoma	OK					
38. Oregon	OR					
39. Pennsylvania	PA					
40. Rhode Island	RI					
41. South Carolina	SC					
42. South Dakota	SD					
43. Tennessee	TN					
44. Texas	TX					
45. Utah	UT					
46. Vermont	VT					
47. Virginia	VA					
48. Washington	WA					
49. West Virginia	WV					
50. Wisconsin	WI					
51. Wyoming	WY					
52. American Samoa	AS					
53. Guam	GU					
54. Puerto Rico	PR					
55. U.S. Virgin Islands	VI					
56. Northern Mariana Islands	MP					
57. Canada	CAN					
58. Aggregate Alien and Other	OT	XXX	0	0	0	0
59. Subtotal	XXX	XXX	38,846,192	39,139,483	0	0
DETAILS OF WRITE-INS						
5801.						
5802.						
5803.						
5898. Summary of remaining write-ins for Line 58 from overflow page	XXX	XXX	0	0	0	0
5899. Totals (Lines 5801 thru 5803 plus 5898)(Line 58 above)	XXX	XXX	0	0	0	0



Relief from the five-year rotation requirement for lead audit partner



Relief from the one-year cooling off period for independent CPA



Relief from the Requirements for Audit Committees



For The Year Ended December 31, 2015
(To Be Filed by March 1)

FOR THE STATE OF
 NAIC Group Code NAIC Company Code
 ADDRESS (City, State and Zip Code)
 Person Completing This Report Telephone Number
 Title

[illegible]

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395ss (a)(1) for this state.

2.1 Address:

2.2 Contact Person and Phone Number:

3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).

3.1 Address:

3.2 Contact Person and Phone Number:

4. Explain any policies identified above as policy type "O".



SUPPLEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.
MEDICARE PART D COVERAGE SUPPLEMENT
(Net of Reinsurance)

NAIC Group Code 0671		(To Be Filed by March 1)		NAIC Company Code 95093	
	Individual Coverage		Group Coverage		5 Total Cash
	1 Insured	2 Uninsured	3 Insured	4 Uninsured	
1. Premiums Collected					
1.1 Standard Coverage					
1.11 With Reinsurance Coverage		XXX		XXX	
1.12 Without Reinsurance Coverage		XXX		XXX	
1.13 Risk-Corridor Payment Adjustments		XXX		XXX	
1.2 Supplemental Benefits		XXX		XXX	
2. Premiums Due and Uncollected-change					
2.1 Standard Coverage					
2.11 With Reinsurance Coverage		XXX		XXX	XXX
2.12 Without Reinsurance Coverage		XXX		XXX	XXX
2.2 Supplemental Benefits		XXX		XXX	XXX
3. Unearned Premium and Advance Premium-change					
3.1 Standard Coverage					
3.11 With Reinsurance Coverage		XXX		XXX	XXX
3.12 Without Reinsurance Coverage		XXX		XXX	XXX
3.2 Supplemental Benefits		XXX		XXX	XXX
4. Risk-Corridor Payment Adjustments-change					
4.1 Receivable		XXX		XXX	XXX
4.2 Payable		XXX		XXX	XXX
5. Earned Premiums					
5.1 Standard Coverage					
5.11 With Reinsurance Coverage		XXX		XXX	XXX
5.12 Without Reinsurance Coverage		XXX		XXX	XXX
5.13 Risk-Corridor Payment Adjustments		XXX		XXX	XXX
5.2 Supplemental Benefits		XXX		XXX	XXX
6. Total Premiums		XXX		XXX	
7. Claims Paid					
7.1 Standard Coverage					
7.11 With Reinsurance Coverage		XXX		XXX	
7.12 Without Reinsurance Coverage		XXX		XXX	
7.2 Supplemental Benefits		XXX		XXX	
8. Claim Reserves and Liabilities-change					
8.1 Standard Coverage					
8.11 With Reinsurance Coverage		XXX		XXX	XXX
8.12 Without Reinsurance Coverage		XXX		XXX	XXX
8.2 Supplemental Benefits		XXX		XXX	XXX
9. Health Care Receivables-change					
9.1 Standard Coverage					
9.11 With Reinsurance Coverage		XXX		XXX	XXX
9.12 Without Reinsurance Coverage		XXX		XXX	XXX
9.2 Supplemental Benefits		XXX		XXX	XXX
10. Claims Incurred					
10.1 Standard Coverage					
10.11 With Reinsurance Coverage		XXX		XXX	XXX
10.12 Without Reinsurance Coverage		XXX		XXX	XXX
10.2 Supplemental Benefits		XXX		XXX	XXX
11. Total Claims		XXX		XXX	
12. Reinsurance Coverage and Low Income Cost Sharing					
12.1 Claims Paid - Net of Reimbursements Applied	XXX		XXX		
12.2 Reimbursements Received but Not Applied-change	XXX		XXX		
12.3 Reimbursements Receivable-change	XXX		XXX		XXX
12.4 Health Care Receivables-change	XXX		XXX		XXX
13. Aggregate Policy Reserves-change					XXX
14. Expenses Paid		XXX		XXX	
15. Expenses Incurred		XXX		XXX	XXX
16. Underwriting Gain/Loss		XXX		XXX	XXX
17. Cash Flow Results	XXX	XXX	XXX	XXX	

NONE



Non-Guaranteed Opinion for Exhibit 5



Participating Opinion for Exhibit 5

SUPPLEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

Schedule SIS
NONE

Schedule SIS II
NONE

Schedule SIS III
NONE

Schedule SIS IV
NONE

420-1, 420-2, 420-3, 420-4

SUPPLEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

Life Supplement Cover

NONE

Life Supplement - Exhibit 5 - Aggregate Reserve for Life Contracts

NONE

Life Supplement - Exhibit 5 - Interrogatories

NONE

Life Supplement - Exhibit 7 - Deposit-Type Contracts

NONE

Life Supplement - Schedule S - Part 1 - Section 1

NONE

Life Supplement - Schedule S - Part 3 - Section 1

NONE

LS01, LS02, LS03, LS04, LS05, LS06



SUPPLEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

DIRECT BUSINESS IN THE STATE OF
NAIC Group Code 0671

LIFE INSURANCE

DURING THE YEAR 2015
NAIC Company Code 95093

	1 Ordinary	2 Credit Life (Group and Individual)	3 Group	4 Industrial	5 Total
DIRECT PREMIUMS AND ANNUITY CONSIDERATIONS					
1. Life insurance					
2. Annuity considerations					
3. Deposit-type contract funds		XXX		XXX	
4. Other considerations					
5. Totals (Sum of Lines 1 to 4)					
DIRECT DIVIDENDS TO POLICYHOLDERS					
Life insurance:					
6.1 Paid in cash or left on deposit					
6.2 Applied to pay renewal premiums					
6.3 Applied to provide paid-up additions or shorten the endowment or premium-paying period					
6.4 Other					
6.5 Totals (sum of Line 6.1 to 6.4)					
Annuities:					
7.1 Paid in cash or left on deposit					
7.2 Applied to provide paid-up annuities					
7.3 Other					
7.4 Totals (sum of Lines 7.1 to 7.3)					
8. Grand Totals (Lines 6.5 plus 7.4)					
DIRECT CLAIMS AND BENEFITS PAID					
9. Death benefits					
10. Matured endowments					
11. Annuity benefits					
12. Surrender values and withdrawals for life contracts ..					
13. Aggregate write-ins for miscellaneous direct claims and benefits paid					
14. All other benefits, except accident and health					
15. Totals					
DETAILS OF WRITE-INS					
1301.					
1302.					
1303.					
1396. Summary of Line 13 from overflow page					
1399. Totals (Lines 1301 thru 1303 plus 1398) (Line 13 above)					

NONE

	Ordinary		Credit Life (Group and Individual)		Group		Industrial		Total	
	1 No.	2 Amount	3 No. of Ind. Pol. & Gr. Certifs.	4 Amount	5 No. of Certifs.	6 Amount	7 No.	8 Amount	9 No.	10 Amount
16. Unpaid December 31, prior year										
17. Incurred during current year: Settled during current year:										
18.1 By payment in full										
18.2 By payment on compromised claims										
18.3 Totals paid										
18.4 Reduction by compromise										
18.5 Amount rejected										
18.6 Total settlements										
19. Unpaid Dec. 31, current year (16+17-18.6)										
POLICY EXHIBIT										
20. In force December 31, prior year			(a)		No. of Policies					
21. Issued during year										
22. Other changes to in force (Net)										
23. In force December 31 of current year			(a)							

(a) Includes Individual Credit Life Insurance prior year \$, current year \$
Includes Group Credit Life Insurance Loans less than or equal to 60 months at issue, prior year \$, current year \$
Loans greater than 60 months at issue BUT NOT GREATER THAN 120 MONTHS, prior year \$, current year \$

ACCIDENT AND HEALTH INSURANCE

	1 Direct Premiums	2 Direct Premiums Earned	3 Dividends Paid Or Credited On Direct Business	4 Direct Losses Paid	5 Direct Losses Incurred
24. Group Policies (b)					
24.1 Federal Employees Health Benefits Plan premium (b)					
24.2 Credit (Group and Individual)					
24.3 Collectively renewable policies (b)					
24.4 Medicare Title XVIII exempt from state taxes or fees Other Individual Policies:					
25.1 Non-cancelable (b)					
25.2 Guaranteed renewable (b)					
25.3 Non-renewable for stated reasons only (b)					
25.4 Other accident only					
25.5 All other (b)					
25.6 Totals (sum of Lines 25.1 to 25.5)					
26. Totals (Lines 24 + 24.1 + 24.2 + 24.3 + 24.4 + 25.6)					

(b) For health business on indicated lines report: Number of persons insured under PPO managed care products0 and number of persons
insured under indemnity only products0 .

LS206

SUPPLEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

P&C Supplement Cover

NONE

P&C Supplement - Schedule F - Part 1

NONE

P&C Supplement - Schedule F - Part 3

NONE

P&C Supplement - Schedule P - Part 1 - Summary

NONE

P&C Supplement - Schedule P - Part 1A - Homeowners/Farmowners

NONE

P&C Supplement - Schedule P - Part 1B - Private Passenger Auto Liability/Medical

NONE

P&C Supplement - Schedule P - Part 1C - Commercial Auto/Truck Liability/Medical

NONE

P&C Supplement - Schedule P - Part 1D - Workers' Compensation (Excluding Excess Workers' Compensation)

NONE

P&C Supplement - Schedule P - Part 1E - Commercial Multiple Peril

NONE

P&C Supplement - Schedule P - Part 1F - Section 1 - Medical Professional Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 1F - Section 2 - Medical Professional Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 1G - Special Liability (Ocean Marine, Aircraft (all perils), Boiler and Machinery)

NONE

P&C Supplement - Schedule P - Part 1H - Section 1 - Other Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 1H - Section 2 - Other Liability - Claims-Made

NONE

PS01, PS02, PS03, PS04, PS05, PS06, PS07, PS08, PS09, PS10, PS11, PS12, PS13, PS14

SUPPLEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

P&C Supplement - Schedule P - Part 1I - Special Property (Fire, Allied Lines...)

NONE

P&C Supplement - Schedule P - Part 1J - Auto Physical Damage

NONE

P&C Supplement - Schedule P - Part 1K - Fidelity/Surety

NONE

P&C Supplement - Schedule P - Part 1L - Other (Including Credit, Accident and Health)

NONE

P&C Supplement - Schedule P - Part 1M - International

NONE

P&C Supplement - Schedule P - Part 1N - Reinsurance - Nonproportional Assumed Property

NONE

P&C Supplement - Schedule P - Part 1O - Reinsurance - Nonproportional Assumed Liability

NONE

P&C Supplement - Schedule P - Part 1P - Reinsurance - Nonproportional Assumed Financial Lines

NONE

P&C Supplement - Schedule P - Part 1R - Section 1 - Products Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 1R - Section 2 - Products Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 1S - Financial Guaranty/Mortgage Guaranty

NONE

P&C Supplement - Schedule P - Part 1T - Warranty

NONE

P&C Supplement - Schedule P - Part 2 - Summary

NONE

P&C Supplement - Schedule P - Part 2A - Homeowners/Farmowners

NONE

PS15, PS16, PS17, PS18, PS19, PS20, PS21, PS22, PS23, PS24, PS25, PS26, PS27, PS28

SUPPLEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

P&C Supplement - Schedule P - Part 2B - Private Passenger Auto Liability/Medical

NONE

P&C Supplement - Schedule P - Part 2C - Commercial Auto/Truck Liability/Medical

NONE

P&C Supplement - Schedule P - Part 2D - Workers' Compensation (Excluding Excess Workers' Compensation)

NONE

P&C Supplement - Schedule P - Part 2E - Commercial Multiple Peril

NONE

P&C Supplement - Schedule P - Part 2F - Section 1 - Medical Professional Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 2F - Section 2 - Medical Professional Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 2G - Special Liability (Ocean Marine, Aircraft (all perils), Boiler and Machinery)

NONE

P&C Supplement - Schedule P - Part 2H - Section 1 - Other Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 2H - Section 2- Other Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 2I - Special Property

NONE

P&C Supplement - Schedule P - Part 2J - Auto Physical Damage

NONE

P&C Supplement - Schedule P - Part 2K - Fidelity/Surety

NONE

P&C Supplement - Schedule P - Part 2L - Other (Including Credit, Accident and Health)

NONE

P&C Supplement - Schedule P - Part 2M - International

NONE

PS28, PS29, PS30

SUPPLEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

P&C Supplement - Schedule P - Part 2N - Reinsurance - Nonproportional Assumed Property

NONE

P&C Supplement - Schedule P - Part 2O - Reinsurance - Nonproportional Assumed Liability

NONE

P&C Supplement - Schedule P - Part 2P - Reinsurance - Nonproportional Assumed Financial Lines

NONE

P&C Supplement - Schedule P - Part 2R - Section 1 - Products Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 2R - Section 2 - Products Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 2S - Financial Guaranty/Mortgage Guaranty

NONE

P&C Supplement - Schedule P - Part 2T - Warranty

NONE



SUPPLEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.
EXHIBIT OF PREMIUMS AND LOSSES (Statutory Page 14)

NAIC Group Code 0671

BUSINESS IN THE STATE OF

DURING THE YEAR 2015

NAIC Company Code 95093

Line of Business	Gross Premiums, Including Policy and Membership Fees, Less Return Premiums and Premiums on Policies Not Taken		Dividends Paid or Credited to Policyholders on Direct Business	Direct Unearned Premium Reserves	Direct Losses Paid (deducting salvage)	Direct Losses Incurred	Direct Losses Unpaid	Direct Defense and Cost Containment Expense Paid	Direct Defense and Cost Containment Expense Incurred	Direct Defense and Cost Containment Expense Unpaid	Commissions and Brokerage Expenses	Taxes, Licenses and Fees
	1 Direct Premiums Written	2 Direct Premiums Earned										
1. Fire												
2.1 Allied lines												
2.2 Multiple peril crop												
2.3 Federal flood												
2.4 Private crop												
3. Farmowners multiple peril												
4. Homeowners multiple peril												
5.1 Commercial multiple peril (non-liability portion)												
5.2 Commercial multiple peril (liability portion)												
6. Mortgage guaranty												
8. Ocean marine												
9. Inland marine												
10. Financial guaranty												
11. Medical professional liability												
12. Earthquake												
13. Group accident and health (b)												
14. Credit accident and health (group and individual)												
15.1 Collectively renewable accident and health (b)												
15.2 Non-cancelable accident and health(b)												
15.3 Guaranteed renewable accident and health(b)												
15.4 Non-renewable for stated reasons only (b)												
15.5 Other accident only												
15.6 Medicare Title XVIII exempt from state taxes or fees												
15.7 All other accident and health (b)												
15.8 Federal employees health benefits plan premium (b)												
16. Workers' compensation												
17.1 Other Liability - occurrence												
17.2 Other Liability - claims made												
17.3 Excess workers' compensation												
18. Products liability												
19.1 Private passenger auto no-fault (personal injury protection)												
19.2 Other private passenger auto liability												
19.3 Commercial auto no-fault (personal injury protection)												
19.4 Other commercial auto liability												
21.1 Private passenger auto physical damage												
21.2 Commercial auto physical damage												
22. Aircraft (all perils)												
23. Fidelity												
24. Surety												
26. Burglary and theft												
27. Boiler and machinery												
28. Credit												
30. Warranty												
34. Aggregate write-ins for other lines of business												
35. TOTALS (a)												
DETAILS OF WRITE-INS												
3401.												
3402.												
3403.												
3498. Summary of remaining write-ins for Line 34 from overflow page												
3499. Totals (Lines 3401 thru 3403 plus 3498)(Line 34 above)												

NONE

(a) Finance and service charges not included in Lines 1 to 35 \$

(b) For health business on indicated lines report: Number of persons insured under PPO managed care products and number of persons insured under indemnity only products

ALPHABETICAL INDEX

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ANNUAL STATEMENT FOR THE YEAR 2015 OF THE Amerigroup Florida, Inc.

Prior Year Validation Data

1.	XXASU900029	PYPage ASSETS L28C3 = ASSETS L28C4.....	219,433,430
2.	XXASN000272	PYPage REVEX2 L49C1 = REVEX2 L33C1.....	83,605,928
3.	XXASU900102	PYPage ASSETS L05 C1 = CASH L19.1C1.....	59,491,088
4.	XXASU900066	PYPage SCAVER L09C2 = SCAVER L01C2.....	
5.	XXASU900067	PYPage SCBAVER L11C2 = SCBAVER L01C2.....	
6.	XXASU900068	PYPage SCBAVER L11C2 = SCBAVER L01C2.....	
7.	XXASU900298	PYPage SCDVER L10C2 = SCDVER L01C2.....	129,784,376
8.	XXASU905062	PYPage SCDAPT1 L919999C8 = SCDVER L01C1.....	96,754,439
9.	XXASU999985	PYPage SCDBPTCSN2 L07C9 = SCDBPTCSN2 L01C1.....	
10.	XXASU999986	PYPage SCDBPTCSN2 L07C10 = SCDBPTCSN2 L01C2.....	
11.	XXASU900058	PYPage SCEPT2 L869999C6 = SCEVER L01C1.....	
12.	XXASN000339	PYPage REVEX1 L02C2 = GENINTPT2 L02.2C5.....	938,450,419
13.	XXASN000341	PYPage LIAB L01C3 + L02C3 + L04C3 + L07C3 = GENINTPT2 L02.5C5.....	86,343,857
14.	XXAAU900307	PYPage SHCEPT1 - GT L05.5C15 = SHCEPT1 - GT L05.4C15.....	
15.	PXASU900138	PYPage SCDBPTAVER L09C2 = SCDBPTAVER L09C1.....	
16.	PXASU900140	PYPage SCDBPTBVER L06C4 = SCDBPTBVER L01C4.....	
17.	PXASU900141	PYPage SCDBPTBSN1 L1449999C15 = SCDBPTBVER L03.12C1.....	
18.	PXASU900142	PYPage SCDBPTBSN1 L1449999C18 = SCDBPTBVER L03.14C1.....	
19.	PXASU900143	PYPage SCDBPTBSN1 L1449999C17 = SCDBPTBVER L03.22C1.....	
20.	PXASU900144	PYPage SCDBPTBSN1 L1449999C19 = SCDBPTBVER L03.24C1.....	

ANNUAL STATEMENT	
OF THE	
AMERIGROUP Florida, Inc.	
of	
Tampa	
in the state of	
Florida	
TO THE	
Insurance Department	
OF THE STATE OF	
Florida	
FOR THE QUARTER ENDED	
DECEMBER 31, 2014	

HEALTH

2014

2014



HEALTH ANNUAL STATEMENT

FOR THE YEAR ENDED DECEMBER 31, 2014
OF THE CONDITION AND AFFAIRS OF THE

AMERIGROUP Florida, Inc.

NAIC Group Code 0671 0671 NAIC Company Code 95093 Employer's ID Number 65-0318864
(Current) (Prior)
Organized under the Laws of Florida, State of Domicile or Port of Entry Florida
Country of Domicile United States of America
Licensed as business type: Health Maintenance Organization
Is HMO Federally Qualified? Yes [] No [X]
Incorporated/Organized 02/01/1992 Commenced Business 10/01/1993
Statutory Home Office 4200 West Cypress Street, Suite 900 Tampa, FL, US 33607
(Street and Number) (City or Town, State, Country and Zip Code)
Main Administrative Office 4425 Corporation Lane
(Street and Number)
Virginia Beach, VA, US 23462 757-490-6900
(City or Town, State, Country and Zip Code) (Area Code) (Telephone Number)
Mail Address 4425 Corporation Lane Virginia Beach, VA, US 23462
(Street and Number or P.O. Box) (City or Town, State, Country and Zip Code)
Primary Location of Books and Records 4425 Corporation Lane
(Street and Number)
Virginia Beach, VA, US 23462 757-490-6900
(City or Town, State, Country and Zip Code) (Area Code) (Telephone Number)
Internet Website Address www.amerigroup.com
Statutory Statement Contact Bette Lou Gronseth 757-518-3638
(Name) (Area Code) (Telephone Number)
Bette.Gronseth@amerigroup.com 757-557-6742
(E-mail Address) (FAX Number)

OFFICERS
Chairperson Charles Brian Shipp Vice President/COO Judith Lynn Peterson #
President/CEO Rosa Maria Cozad Vice President/Assistant Secretary Jack Louis Young

OTHER
Kathleen Susan Kieler Secretary Robert David Kretschmer Treasurer Eric (Rick) Kenneth Noble Assistant Treasurer
Mark Daniel Justus Valuation Actuary

DIRECTORS OR TRUSTEES
Carter Allen Beck Rosa Maria Cozad Wayne Scott DeVeydt
Catherine Irene Kelaghan Judith Lynn Peterson # Charles Brian Shipp

State of Florida SS:
County of Tampa

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement, together with related exhibits, schedules and explanations therein contained, annexed or referred to, is a full and true statement of all the assets and liabilities and of the condition and affairs of the said reporting entity as of the reporting period stated above, and of its income and deductions therefrom for the period ended, and have been completed in accordance with the NAIC Annual Statement Instructions and Accounting Practices and Procedures manual except to the extent that: (1) state law may differ; or, (2) that state rules or regulations require differences in reporting not related to accounting practices and procedures, according to the best of their information, knowledge and belief, respectively. Furthermore, the scope of this attestation by the described officers also includes the related corresponding electronic filing with the NAIC, when required, that is an e-filed copy (except for formatting differences due to electronic filing) of the enclosed statement. The electronic filing may be requested by various regulators in lieu of or in addition to the enclosed statement.

Rosa Maria Cozad Robert David Kretschmer Kathleen Susan Kieler
President/CEO Treasurer Secretary

Subscribed and sworn to before me this 13th day of March 2015
Mercedes Machette
a. Is this an original filing? Yes [X] No []
b. If no,
1. State the amendment number _____
2. Date filed _____
3. Number of pages attached _____





Amerigroup Florida, Inc.

Statement of Actuarial Opinion

This Opinion is	<input checked="" type="checkbox"/> Unqualified	<input type="checkbox"/> Qualified	<input type="checkbox"/> Adverse	<input type="checkbox"/> Inconclusive
Identification Section	<input type="checkbox"/> Prescribed Wording Only	<input checked="" type="checkbox"/> Prescribed Wording with Additional Wording	<input type="checkbox"/> Revised Wording	
Scope Section	<input checked="" type="checkbox"/> Prescribed Wording Only	<input type="checkbox"/> Prescribed Wording with Additional Wording	<input type="checkbox"/> Revised Wording	
Reliance Section	<input type="checkbox"/> Prescribed Wording Only	<input type="checkbox"/> Prescribed Wording with Additional Wording	<input checked="" type="checkbox"/> Revised Wording	
Opinion Section	<input type="checkbox"/> Prescribed Wording Only	<input type="checkbox"/> Prescribed Wording with Additional Wording	<input checked="" type="checkbox"/> Revised Wording	
Relevant Comments			<input checked="" type="checkbox"/> Revised Wording	
<input type="checkbox"/> The Actuarial Memorandum includes "Deviation from Standard" wording regarding conformity with an Actuarial Standard of Practice				

Identification

I, Mark D. Justus, Director & Actuary III, am an employee of Anthem Inc., and a member of the American Academy of Actuaries. I was appointed on October 01, 2013 in accordance with the requirements of the annual statement instructions for Amerigroup Florida, Inc., a subsidiary of Anthem, Inc. I meet the Academy qualification standards for rendering the opinion.

Scope

I have examined the assumptions and methods used in determining loss reserves, actuarial liabilities and related items listed below, as shown in the annual statement of the organization as prepared for filing with state regulatory officials, as of December 31, 2014:

A. Claims unpaid (Page 3, Line 1)	\$81,781,184
B. Accrued medical incentive pool and bonus payments (Page 3, Line 2)	\$2,285,913
C. Unpaid claims adjustment expenses (Page 3, Line 3)	\$2,649,718
D. Aggregate health policy reserves (Page 3, Line 4) including unearned premium reserves, premium deficiency reserves and additional policy reserves from the Underwriting and Investment Exhibit – Part 2D	\$2,062,033
E. Aggregate life policy reserves (Page 3, Line 5)	\$0
F. Property/casualty unearned premium reserves (Page 3, Line 6)	\$0
G. Aggregate health claim reserves (Page 3, Line 7)	\$214,727
H. Any other loss reserves, actuarial liabilities, or related items presented as liabilities in the annual statement	Not Applicable
I. Specified actuarial items presented as assets in the annual statement	Not Applicable

Reliance

In forming my opinion on Unearned Premium Reserves (part of Aggregate Health Policy Reserves) and Legal Claim Reserves (part of Unpaid Claims), I relied upon data prepared by R. David Kretschmer, Senior Vice President, Treasurer and Chief Investment Officer, and Pamela C. Williams, Vice President and Counsel, Anthem Inc. as certified in the attached statements. I evaluated that data for reasonableness and consistency. In forming my opinion on the actuarial adequacy of rates charged, I relied on Kevin T. Geurtsen, Staff VP Medicaid Actuarial.

In other respects, my examination included such review of the actuarial assumptions and actuarial methods and of the underlying basic liability records and such tests of the actuarial calculations as I considered necessary. I also reconciled the underlying basic liability records to the Underwriting and Investment Exhibit, Part 2B of the company's current annual statement.

Opinion

In my opinion, the amounts carried in the balance sheet on account of the items identified above:

- A. Are in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles;
- B. Are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared;
- C. Meet the requirements of the Insurance Laws and regulations of the state of Florida, and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;
- D. Make a good and sufficient provision for all unpaid claims and other actuarial liabilities of the organization under the terms of its contracts and agreements;
- E. Are computed on the basis of assumptions and methods consistent with those used in computing the corresponding items in the annual statement of the preceding year-end; and
- F. Include appropriate provision for all actuarial items that ought to be established.

Florida statute 641.26(1)(f)(1) requires an actuarial certification that the health maintenance organization is "actuarially sound".

In my opinion:

- A. The health maintenance organization is actuarially sound, considering the rates, benefits, expenses and any other funds available for payment of the organization's obligations, including the premium deficiency reserve.
- B. The rates charged are not actuarially adequate to the end of the period for which rates have been guaranteed.
- C. Incurred but not reported claims and claims reported but not fully paid have been adequately provided for.
- D. The health maintenance organization has adequately provided for all obligations required by s.641.35(3)(a).

As noted above, I have relied on Kevin T. Geurtsen that the rates charged are not actuarially adequate to the end of the period to which rates have been guaranteed, as evidenced by the \$1.5M Premium Deficiency Reserve.

The Underwriting and Investment Exhibit, Part 2B was reviewed for reasonableness and consistency with the applicable Actuarial Standards of Practice.

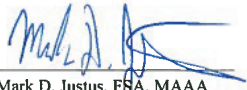
Actuarial methods, considerations, and analyses used in forming my opinion conform to the relevant Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which standards form the basis of this statement of opinion.

Relevant Comments

The liabilities being valued are mainly short term in nature, have no investment income or interest component, are not discounted for interest, and do not fluctuate with changes in the interest rate environment. As a result, no asset adequacy analysis was performed.

My review also included consideration of incentive contracts with service providers and the effect on the reserves. I have not reviewed the financial position of any party related by contract to the Company, including those under a capitation agreement with the Company. I have relied on the opinion of the Company that such parties are in a financial position to meet all liabilities resulting from such contracts.

This opinion has been prepared solely for the Board and management of the Company for filing with insurance regulatory agencies of states in which the Company is licensed.



Mark D. Justus, FSA, MAAA
Anthem, Inc.
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Atlanta, GA 30326
(404) 693-1434
Mark.Justus@Anthem.com
February 20, 2015



Anthem, Inc.
120 Monument Circle
Indianapolis, IN 46204

Investment Assumption Reliance Statement
Amerigroup Florida, Inc.
For 2014 Actuarial Opinion

I, R. David Kretschmer, Senior Vice President, Treasurer and Chief Investment Officer, of Anthem Inc., the ultimate parent company of **Amerigroup Florida, Inc.**, hereby affirm that the listings, summaries and analyses relating to the Unearned Premium Reserve balance (Underwriting and Investment Exhibit, Part 2D, Column 1, Line 1), prepared for and submitted to Mark Justus, Director & Actuary III, in support of the actuarial opinion for **Amerigroup Florida, Inc.**, as of December 31, 2014, were prepared in accordance with generally accepted accounting principles and, to the best of my knowledge and belief, are substantially accurate and complete and the same as, or derived from, the records and other data which form the basis of the annual statement for the year ended December 31, 2014.

A handwritten signature in blue ink, appearing to read "R. David Kretschmer", written over a horizontal line.

R. David Kretschmer
Senior Vice President, Treasurer and Chief Investment Officer
February 2, 2015

Anthem, Inc.
120 Monument Circle
Indianapolis, IN 46204
317-488-6422

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Pamela C. Williams, Esq.
Vice President & Counsel - Litigation

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Indianapolis, IN 46204

I, Pamela C. Williams, Vice President & Counsel of Anthem Inc., the ultimate parent company of **Amerigroup Florida, Inc.**, hereby affirm that the listings, summaries and analyses relating to the Legal Claim Reserve balance, prepared for and submitted to **Mark Justus** in support of the actuarial opinion for **Amerigroup Florida, Inc.**, as of December 31, 2014, were prepared in accordance with generally accepted accounting principles and, to the best of my knowledge and belief, are substantially accurate and complete and the same as, or derived from, the records and other data which form the basis of the annual statement for the year ended December 31, 2014.

A handwritten signature in blue ink, appearing to read "P. Williams", written over a horizontal line.

Pamela C. Williams
Vice President & Counsel
Anthem, Inc.
120 Monument Circle
Indianapolis, IN 46204
317-488-6295
February 2, 2015

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Indianapolis, IN 46204

Reliance Statement

Amerigroup Florida, Inc.
For 2014 Actuarial Opinion

I, Kevin T. Geurtsen, Staff VP Medicaid Actuarial, hereby affirm that the rates being charged or to be charged for Amerigroup Florida, Inc. are not adequate to the end of the period for which rates have been guaranteed to the best of my knowledge and belief. A Premium Deficiency Reserve of \$1,535,613 has been recommended for Amerigroup of Florida, Inc. to reflect the inadequacy as of December 31, 2014. This reliance statement is prepared for and submitted to Mark D. Justus, Director & Actuary III in support of the actuarial opinion for December 31, 2014.

A handwritten signature in blue ink that reads "Kevin T. Geurtsen".

Signed, February 20, 2015

Kevin T. Geurtsen
Staff VP Medicaid Actuarial
Amerigroup
4425 Corporation Lane
Virginia Beach, VA 23462
757-473-2737 x33557

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

ASSETS

	Current Year			Prior Year
	1 Assets	2 Nonadmitted Assets	3 Net Admitted Assets (Cols. 1 - 2)	4 Net Admitted Assets
1. Bonds (Schedule D)	115,840,845		115,840,845	121,259,874
2. Stocks (Schedule D):				
2.1 Preferred stocks			0	0
2.2 Common stocks	13,943,531		13,943,531	12,697,829
3. Mortgage loans on real estate (Schedule B):				
3.1 First liens			0	0
3.2 Other than first liens			0	0
4. Real estate (Schedule A):				
4.1 Properties occupied by the company (less \$ encumbrances)			0	0
4.2 Properties held for the production of income (less \$ encumbrances)			0	0
4.3 Properties held for sale (less \$ encumbrances)			0	0
5. Cash (\$ 22,736,649 , Schedule E - Part 1), cash equivalents (\$, Schedule E - Part 2) and short-term investments (\$ 36,754,439 , Schedule DA)	59,491,088		59,491,088	11,531,286
6. Contract loans, (including \$ premium notes)			0	0
7. Derivatives (Schedule DB)			0	0
8. Other invested assets (Schedule BA)			0	0
9. Receivables for securities			0	0
10. Securities lending reinvested collateral assets (Schedule DL)	5,497,979		5,497,979	3,112,884
11. Aggregate write-ins for invested assets	0	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	194,773,443	0	194,773,443	148,601,873
13. Title plants less \$ charged off (for Title insurers only)			0	0
14. Investment income due and accrued	778,265		778,265	862,835
15. Premiums and considerations:				
15.1 Uncollected premiums and agents' balances in the course of collection	7,127,849		7,127,849	1,323,299
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due (including \$ earned but unbilled premiums)			0	0
15.3 Accrued retrospective premiums			0	0
16. Reinsurance:				
16.1 Amounts recoverable from reinsurers			0	0
16.2 Funds held by or deposited with reinsured companies			0	0
16.3 Other amounts receivable under reinsurance contracts			0	0
17. Amounts receivable relating to uninsured plans	1,701,632		1,701,632	629,358
18.1 Current federal and foreign income tax recoverable and interest thereon	7,333,579		7,333,579	0
18.2 Net deferred tax asset	4,901,804		4,901,804	3,477,807
19. Guaranty funds receivable or on deposit			0	0
20. Electronic data processing equipment and software	40,149		40,149	67,865
21. Furniture and equipment, including health care delivery assets (\$)	1,158,001	1,158,001	0	0
22. Net adjustment in assets and liabilities due to foreign exchange rates			0	0
23. Receivables from parent, subsidiaries and affiliates	22,146		22,146	0
24. Health care (\$ 1,121,489) and other amounts receivable	6,371,420	5,249,931	1,121,489	0
25. Aggregate write-ins for other than invested assets	9,910,614	8,277,540	1,633,074	771,111
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	234,118,902	14,685,472	219,433,430	155,734,148
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts			0	0
28. Total (Lines 26 and 27)	234,118,902	14,685,472	219,433,430	155,734,148
DETAILS OF WRITE-INS				
1101.				
1102.				
1103.				
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0	0
1199. Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	0	0	0	0
2501. Goodwill, Intangibles, and Covenant not to Compete	8,069,210	8,069,210	0	0
2502. Prepaids	208,330	208,330	0	1,727
2503. State Income Taxes Receivable	1,633,074		1,633,074	769,384
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	9,910,614	8,277,540	1,633,074	771,111

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

LIABILITIES, CAPITAL AND SURPLUS

	Current Year			Prior Year
	1	2	3	4
	Covered	Uncovered	Total	Total
1. Claims unpaid (less \$0 reinsurance ceded)	81,781,184		81,781,184	49,125,604
2. Accrued medical incentive pool and bonus amounts	2,285,913		2,285,913	1,120,279
3. Unpaid claims adjustment expenses.....	2,649,718		2,649,718	1,713,488
4. Aggregate health policy reserves, including the liability of \$0 for medical loss ratio rebate per the Public Health Service Act	2,062,033		2,062,033	331,405
5. Aggregate life policy reserves.....			0	0
6. Property/casualty unearned premium reserves.....			0	0
7. Aggregate health claim reserves.....	214,727		214,727	1,255,165
8. Premiums received in advance.....	24,029,523		24,029,523	3,112,908
9. General expenses due or accrued.....	866,371		866,371	27,758
10.1 Current federal and foreign income tax payable and interest thereon (including \$ on realized capital gains (losses))			0	345,189
10.2 Net deferred tax liability.....			0	0
11. Ceded reinsurance premiums payable.....			0	0
12. Amounts withheld or retained for the account of others.....			0	0
13. Remittances and items not allocated.....	8,656,218		8,656,218	6,261,339
14. Borrowed money (including \$ current) and interest thereon \$ (including \$ current).....			0	0
15. Amounts due to parent, subsidiaries and affiliates.....	4,708,161		4,708,161	2,059,258
16. Derivatives.....			0	0
17. Payable for securities.....			0	0
18. Payable for securities lending	5,497,979		5,497,979	3,112,884
19. Funds held under reinsurance treaties (with \$ authorized reinsurers, \$0 unauthorized reinsurers and \$ certified reinsurers).....			0	0
20. Reinsurance in unauthorized and certified (\$) companies			0	0
21. Net adjustments in assets and liabilities due to foreign exchange rates			0	0
22. Liability for amounts held under uninsured plans.....	12,899		12,899	12,360
23. Aggregate write-ins for other liabilities (including \$ current).....	3,062,776	0	3,062,776	13,835,357
24. Total liabilities (Lines 1 to 23).....	135,827,502	0	135,827,502	82,312,994
25. Aggregate write-ins for special surplus funds.....	XXX	XXX	21,492,886	0
26. Common capital stock.....	XXX	XXX	100	100
27. Preferred capital stock.....	XXX	XXX		
28. Gross paid in and contributed surplus.....	XXX	XXX	70,184,970	35,184,970
29. Surplus notes.....	XXX	XXX	0	0
30. Aggregate write-ins for other than special surplus funds.....	XXX	XXX	0	0
31. Unassigned funds (surplus).....	XXX	XXX	(8,072,028)	38,236,084
32. Less treasury stock, at cost:				
32.1 shares common (value included in Line 26 \$).....	XXX	XXX		
32.2 shares preferred (value included in Line 27 \$).....	XXX	XXX		
33. Total capital and surplus (Lines 25 to 31 minus Line 32).....	XXX	XXX	83,605,928	73,421,154
34. Total liabilities, capital and surplus (Lines 24 and 33).....	XXX	XXX	219,433,430	155,734,148
DETAILS OF WRITE-INS				
2301. Escheat Liability	487,486		487,486	325,377
2302. ACA PCP Fee Increase	2,575,290		2,575,290	2,006,845
2303. Other Accruals			0	3,135
2398. Summary of remaining write-ins for Line 23 from overflow page.....	0	0	0	11,500,000
2399. Totals (Lines 2301 thru 2303 plus 2398)(Line 23 above).....	3,062,776	0	3,062,776	13,835,357
2501. Estimated 2015 ACA Health Insurer Fee	XXX	XXX	21,492,886	
2502.	XXX	XXX		
2503.	XXX	XXX		
2598. Summary of remaining write-ins for Line 25 from overflow page.....	XXX	XXX	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above).....	XXX	XXX	21,492,886	0
3001.	XXX	XXX		
3002.	XXX	XXX		
3003.	XXX	XXX		
3098. Summary of remaining write-ins for Line 30 from overflow page.....	XXX	XXX	0	0
3099. Totals (Lines 3001 thru 3003 plus 3098)(Line 30 above).....	XXX	XXX	0	0

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

STATEMENT OF REVENUE AND EXPENSES

	Current Year		Prior Year
	1 Uncovered	2 Total	3 Total
1. Member Months.....	XXX	3,613,410	2,947,017
2. Net premium income (including \$ non-health premium income)	XXX	938,450,419	599,620,381
3. Change in unearned premium reserves and reserve for rate credits	XXX	(195,015)	(157,422)
4. Fee-for-service (net of \$ medical expenses)	XXX	0	0
5. Risk revenue	XXX	0	0
6. Aggregate write-ins for other health care related revenues	XXX	0	0
7. Aggregate write-ins for other non-health revenues	XXX	0	0
8. Total revenues (Lines 2 to 7)	XXX	938,255,404	599,462,959
Hospital and Medical:			
9. Hospital/medical benefits		523,973,795	344,364,656
10. Other professional services		43,817,297	13,625,704
11. Outside referrals		0	0
12. Emergency room and out-of-area		107,381,436	79,348,853
13. Prescription drugs		133,591,837	77,092,027
14. Aggregate write-ins for other hospital and medical	0	52,391,401	9,627,868
15. Incentive pool, withhold adjustments and bonus amounts		3,317,530	(688,387)
16. Subtotal (Lines 9 to 15)	0	864,473,296	523,370,721
Less:			
17. Net reinsurance recoveries		0	0
18. Total hospital and medical (Lines 16 minus 17)	0	864,473,296	523,370,721
19. Non-health claims (net)		0	0
20. Claims adjustment expenses, including \$37,503,504 cost containment expenses		51,537,238	41,192,030
21. General administrative expenses		56,823,350	25,603,756
22. Increase in reserves for life and accident and health contracts (including \$ increase in reserves for life only)		1,535,613	0
23. Total underwriting deductions (Lines 18 through 22).....	0	974,369,497	590,166,507
24. Net underwriting gain or (loss) (Lines 8 minus 23)	XXX	(36,114,093)	9,296,452
25. Net investment income earned (Exhibit of Net Investment Income, Line 17)		3,032,598	1,764,853
26. Net realized capital gains (losses) less capital gains tax of \$79,772		150,646	5,363
27. Net investment gains (losses) (Lines 25 plus 26)	0	3,183,244	1,770,216
28. Net gain or (loss) from agents' or premium balances charged off [(amount recovered \$) (amount charged off \$)]			
29. Aggregate write-ins for other income or expenses	0	0	23,500
30. Net income or (loss) after capital gains tax and before all other federal income taxes (Lines 24 plus 27 plus 28 plus 29)	XXX	(32,930,849)	11,090,168
31. Federal and foreign income taxes incurred	XXX	(6,279,326)	4,331,065
32. Net income (loss) (Lines 30 minus 31)	XXX	(26,651,523)	6,759,103
DETAILS OF WRITE-INS			
0601.	XXX		
0602.	XXX		
0603.	XXX		
0698. Summary of remaining write-ins for Line 6 from overflow page	XXX	0	0
0699. Totals (Lines 0601 thru 0603 plus 0698)(Line 6 above)	XXX	0	0
0701.	XXX		
0702.	XXX		
0703.	XXX		
0798. Summary of remaining write-ins for Line 7 from overflow page	XXX	0	0
0799. Totals (Lines 0701 thru 0703 plus 0798)(Line 7 above)	XXX	0	0
1401. Ambulance, DME, Home Health Care, Other LTSS		52,391,401	9,627,868
1402.			
1403.			
1498. Summary of remaining write-ins for Line 14 from overflow page	0	0	0
1499. Totals (Lines 1401 thru 1403 plus 1498)(Line 14 above)	0	52,391,401	9,627,868
2901. Tax Penalties and Fines			23,500
2902.			
2903.			
2998. Summary of remaining write-ins for Line 29 from overflow page	0	0	0
2999. Totals (Lines 2901 thru 2903 plus 2998)(Line 29 above)	0	0	23,500

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

STATEMENT OF REVENUE AND EXPENSES (Continued)

	1 Current Year	2 Prior Year
CAPITAL AND SURPLUS ACCOUNT		
33. Capital and surplus prior reporting year.....	73,421,154	77,520,202
34. Net income or (loss) from Line 32	(26,651,523)	6,759,103
35. Change in valuation basis of aggregate policy and claim reserves		
36. Change in net unrealized capital gains (losses) less capital gains tax of \$368,770	684,857	1,691,171
37. Change in net unrealized foreign exchange capital gain or (loss)		
38. Change in net deferred income tax	1,792,767	1,643,307
39. Change in nonadmitted assets	(641,327)	(2,692,629)
40. Change in unauthorized and certified reinsurance	0	0
41. Change in treasury stock	0	0
42. Change in surplus notes	0	0
43. Cumulative effect of changes in accounting principles.....		
44. Capital Changes:		
44.1 Paid in	0	0
44.2 Transferred from surplus (Stock Dividend)	0	0
44.3 Transferred to surplus.....		
45. Surplus adjustments:		
45.1 Paid in	35,000,000	0
45.2 Transferred to capital (Stock Dividend)		
45.3 Transferred from capital		
46. Dividends to stockholders		(11,500,000)
47. Aggregate write-ins for gains or (losses) in surplus	0	0
48. Net change in capital and surplus (Lines 34 to 47)	10,184,774	(4,099,048)
49. Capital and surplus end of reporting period (Line 33 plus 48)	83,605,928	73,421,154
DETAILS OF WRITE-INS		
4701.		0
4702.		0
4703.		0
4798. Summary of remaining write-ins for Line 47 from overflow page.....	0	0
4799. Totals (Lines 4701 thru 4703 plus 4798)(Line 47 above)	0	0

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

CASH FLOW

	1	2
	Current Year	Prior Year
Cash from Operations		
1. Premiums collected net of reinsurance	953,562,484	603,474,012
2. Net investment income	4,441,223	2,472,714
3. Miscellaneous income	0	0
4. Total (Lines 1 through 3)	958,003,707	605,946,726
5. Benefit and loss related payments	832,599,999	509,524,701
6. Net transfers to Separate Accounts, Segregated Accounts and Protected Cell Accounts		
7. Commissions, expenses paid and aggregate write-ins for deductions	107,410,495	66,494,642
8. Dividends paid to policyholders		
9. Federal and foreign income taxes paid (recovered) net of \$ tax on capital gains (losses)	1,479,214	4,991,376
10. Total (Lines 5 through 9)	941,489,708	581,010,719
11. Net cash from operations (Line 4 minus Line 10)	16,513,999	24,936,007
Cash from Investments		
12. Proceeds from investments sold, matured or repaid:		
12.1 Bonds	25,144,745	33,095,926
12.2 Stocks	0	0
12.3 Mortgage loans	0	0
12.4 Real estate	0	0
12.5 Other invested assets	0	0
12.6 Net gains or (losses) on cash, cash equivalents and short-term investments	864	(30)
12.7 Miscellaneous proceeds	0	0
12.8 Total investment proceeds (Lines 12.1 to 12.7)	25,145,609	33,095,896
13. Cost of investments acquired (long-term only):		
13.1 Bonds	21,009,563	106,187,138
13.2 Stocks	0	531,275
13.3 Mortgage loans	0	0
13.4 Real estate	0	0
13.5 Other invested assets	0	0
13.6 Miscellaneous applications	2,385,095	3,112,884
13.7 Total investments acquired (Lines 13.1 to 13.6)	23,394,658	109,831,297
14. Net increase (decrease) in contract loans and premium notes	0	0
15. Net cash from investments (Line 12.8 minus Line 13.7 minus Line 14)	1,750,951	(76,735,401)
Cash from Financing and Miscellaneous Sources		
16. Cash provided (applied):		
16.1 Surplus notes, capital notes	0	0
16.2 Capital and paid in surplus, less treasury stock	35,000,000	0
16.3 Borrowed funds	0	0
16.4 Net deposits on deposit-type contracts and other insurance liabilities	0	0
16.5 Dividends to stockholders	11,500,000	0
16.6 Other cash provided (applied)	6,194,852	8,832,980
17. Net cash from financing and miscellaneous sources (Lines 16.1 to 16.4 minus Line 16.5 plus Line 16.6)	29,694,852	8,832,980
RECONCILIATION OF CASH, CASH EQUIVALENTS AND SHORT-TERM INVESTMENTS		
18. Net change in cash, cash equivalents and short-term investments (Line 11, plus Lines 15 and 17)	47,959,802	(42,966,414)
19. Cash, cash equivalents and short-term investments:		
19.1 Beginning of year	11,531,286	54,497,700
19.2 End of year (Line 18 plus Line 19.1)	59,491,088	11,531,286
Note: Supplemental disclosures of cash flow information for non-cash transactions:		
20.0001. Depreciation	249,714	240,503

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.
ANALYSIS OF OPERATIONS BY LINES OF BUSINESS

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Net premium income	938,450,419	73,417,615					31,796,451	697,605,562	135,630,791	
2. Change in unearned premium reserves and reserve for rate credit	(195,015)						(195,015)			
3. Fee-for-service (net of \$ medical expenses)	0									XXX
4. Risk revenue	0									XXX
5. Aggregate write-ins for other health care related revenues	0	0	0	0	0	0	0	0	0	XXX
6. Aggregate write-ins for other non-health care related revenues	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
7. Total revenues (Lines 1 to 6)	938,255,404	73,417,615	0	0	0	0	31,601,436	697,605,562	135,630,791	0
8. Hospital/medical benefits	523,973,795	39,035,435					19,555,893	363,141,879	102,240,588	XXX
9. Other professional services	43,817,297	2,981,317					1,194,816	39,365,475	275,689	XXX
10. Outside referrals	0									XXX
11. Emergency room and out-of-area	107,381,436	7,904,437					4,966,682	93,813,410	696,907	XXX
12. Prescription drugs	133,591,837	14,007,400					3,247,990	116,019,914	316,533	XXX
13. Aggregate write-ins for other hospital and medical	52,391,401	1,704,073	0	0	0	0	1,689,286	23,791,495	25,206,547	XXX
14. Incentive pool, withhold adjustments and bonus amounts	3,317,530						34,319	1,376,661	1,906,550	XXX
15. Subtotal (Lines 8 to 14)	864,473,296	65,632,662	0	0	0	0	30,688,986	637,508,834	130,642,814	XXX
16. Net reinsurance recoveries	0									XXX
17. Total medical and hospital (Lines 15 minus 16)	864,473,296	65,632,662	0	0	0	0	30,688,986	637,508,834	130,642,814	XXX
18. Non-health claims (net)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
19. Claims adjustment expenses including \$ 37,503,504 cost containment expenses	51,537,238	7,297,877					2,279,262	38,368,175	3,591,924	
20. General administrative expenses	56,823,350	8,046,411					2,513,043	42,303,553	3,960,343	
21. Increase in reserves for accident and health contracts	1,535,613	64,411						1,154,567	316,635	XXX
22. Increase in reserves for life contracts	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
23. Total underwriting deductions (Lines 17 to 22)	974,369,497	81,041,361	0	0	0	0	35,481,291	719,335,129	138,511,716	0
24. Total underwriting gain or (loss) (Line 7 minus Line 23)	(36,114,093)	(7,623,746)	0	0	0	0	(3,679,855)	(21,729,567)	(2,880,925)	0
DETAILS OF WRITE-INS										
0501.										XXX
0502.										XXX
0503.										XXX
0598. Summary of remaining write-ins for Line 5 from overflow page	0	0	0	0	0	0	0	0	0	XXX
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above)	0	0	0	0	0	0	0	0	0	XXX
0601.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0602.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0603.		XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	
0698. Summary of remaining write-ins for Line 6 from overflow page	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	0
1301. Ambulance, DME, Home Health Care, Other LTSS	52,391,401	1,704,073					1,689,286	23,791,495	25,206,547	XXX
1302.										XXX
1303.										XXX
1398. Summary of remaining write-ins for Line 13 from overflow page	0	0	0	0	0	0	0	0	0	XXX
1399. Totals (Lines 1301 thru 1303 plus 1398) (Line 13 above)	52,391,401	1,704,073	0	0	0	0	1,689,286	23,791,495	25,206,547	XXX

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 1 - PREMIUMS

Line of Business	1 Direct Business	2 Reinsurance Assumed	3 Reinsurance Ceded	4 Net Premium Income (Cols. 1 + 2 - 3)
1. Comprehensive (hospital and medical)	73,417,615			73,417,615
2. Medicare Supplement .....				.0
3. Dental only .....				.0
4. Vision only .....				.0
5. Federal Employees Health Benefits Plan .....	.0			.0
6. Title XVIII - Medicare	31,796,451			31,796,451
7. Title XIX - Medicaid	833,236,353			833,236,353
8. Other health .....				.0
9. Health subtotal (Lines 1 through 8)	938,450,419	.0	.0	938,450,419
10. Life0			.0
11. Property/casualty0			.0
12. Totals (Lines 9 to 11)	938,450,419	0	0	938,450,419

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2 - CLAIMS INCURRED DURING THE YEAR

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Payments during the year:										
1.1 Direct	830,448,103	68,506,659					29,873,454	602,152,299	129,915,691	
1.2 Reinsurance assumed	0	0								
1.3 Reinsurance ceded	0	0								
1.4 Net	830,448,103	68,506,659	0	0	0	0	29,873,454	602,152,299	129,915,691	0
2. Paid medical incentive pools and bonuses	2,151,896						35,543	1,717,199	399,154	
3. Claim liability December 31, current year from Part 2A:										
3.1 Direct	81,781,184	8,179,146	0	0	0	0	4,092,105	57,598,495	11,911,438	0
3.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
3.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
3.4 Net	81,781,184	8,179,146	0	0	0	0	4,092,105	57,598,495	11,911,438	0
4. Claim reserve December 31, current year from Part 2D:										
4.1 Direct	214,727							214,727		
4.2 Reinsurance assumed	0									
4.3 Reinsurance ceded	0									
4.4 Net	214,727	0	0	0	0	0	0	214,727	0	0
5. Accrued medical incentive pools and bonuses, current year	2,285,913									
6. Net healthcare receivables (a)	907,479	56,665					(1,224)	779,741	1,507,396	
7. Amounts recoverable from reinsurers December 31, current year	0						321,352	528,119	1,343	
8. Claim liability December 31, prior year from Part 2A:										
8.1 Direct	49,125,604	10,996,478	0	0	0	0	2,989,540	22,050,064	13,089,522	0
8.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
8.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
8.4 Net	49,125,604	10,996,478	0	0	0	0	2,989,540	22,050,064	13,089,522	0
9. Claim reserve December 31, prior year from Part 2D:										
9.1 Direct	1,255,165							1,255,165		
9.2 Reinsurance assumed	0									
9.3 Reinsurance ceded	0									
9.4 Net	1,255,165	0	0	0	0	0	0	1,255,165	0	0
10. Accrued medical incentive pools and bonuses, prior year	1,120,279	0	0	0	0	0	0	1,120,279	0	0
11. Amounts recoverable from reinsurers December 31, prior year	0	0	0	0	0	0	0	0	0	0
12. Incurred Benefits:										
12.1 Direct	861,155,766	65,632,662	0	0	0	0	30,654,667	636,132,173	128,736,264	0
12.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
12.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
12.4 Net	861,155,766	65,632,662	0	0	0	0	30,654,667	636,132,173	128,736,264	0
13. Incurred medical incentive pools and bonuses	3,317,530	0	0	0	0	0	34,319	1,376,661	1,906,550	0

(a) Excludes \$ loans or advances to providers not yet expensed.

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2A - CLAIMS LIABILITY END OF CURRENT YEAR

	1	2	3	4	5	6	7	8	9	10
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other Health	Other Non-Health
1. Reported in Process of Adjustment:										
1.1 Direct	7,290,339	317,340					290,079	6,310,755	372,165	
1.2 Reinsurance assumed	0									
1.3 Reinsurance ceded	0									
1.4 Net	7,290,339	317,340	0	0	0	0	290,079	6,310,755	372,165	0
2. Incurred but Unreported:										
2.1 Direct	74,490,845	7,861,806					3,802,026	51,287,740	11,539,273	
2.2 Reinsurance assumed	0									
2.3 Reinsurance ceded	0									
2.4 Net	74,490,845	7,861,806	0	0	0	0	3,802,026	51,287,740	11,539,273	0
3. Amounts Withheld from Paid Claims and Capitations:										
3.1 Direct	0									
3.2 Reinsurance assumed	0									
3.3 Reinsurance ceded	0									
3.4 Net	0	0	0	0	0	0	0	0	0	0
4. TOTALS:										
4.1 Direct	81,781,184	8,179,146	0	0	0	0	4,092,105	57,598,495	11,911,438	0
4.2 Reinsurance assumed	0	0	0	0	0	0	0	0	0	0
4.3 Reinsurance ceded	0	0	0	0	0	0	0	0	0	0
4.4 Net	81,781,184	8,179,146	0	0	0	0	4,092,105	57,598,495	11,911,438	0

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2B - ANALYSIS OF CLAIMS UNPAID - PRIOR YEAR - NET OF REINSURANCE

Line of Business	Claims Paid During the Year		Claim Reserve and Claim Liability December 31 of Current Year		5 Claims Incurred In Prior Years (Columns 1 + 3)	6 Estimated Claim Reserve and Claim Liability December 31 of Prior Year
	1 On Claims Incurred Prior to January 1 of Current Year	2 On Claims Incurred During the Year	3 On Claims Unpaid December 31 of Prior Year	4 On Claims Incurred During the Year		
1. Comprehensive (hospital and medical)	9,410,126	59,096,532	139,930	8,039,216	9,550,056	10,996,478
2. Medicare Supplement					0	0
3. Dental Only					0	0
4. Vision Only					0	0
5. Federal Employees Health Benefits Plan					0	0
6. Title XVIII - Medicare	2,563,920	29,152,567	16,428	4,075,677	2,580,348	2,989,540
7. Title XIX - Medicaid	26,716,864	579,056,344	253,158	57,560,064	26,970,022	23,305,229
8. Other health	10,649,447	119,266,244	(12,318)	11,923,756	10,637,129	13,089,522
9. Health subtotal (Lines 1 to 8)	49,340,357	786,571,687	397,198	81,598,713	49,737,555	50,380,769
10. Healthcare receivables (a)	1,957,858	4,413,562			1,957,858	0
11. Other non-health					0	0
12. Medical incentive pools and bonus amounts	1,686,591	465,305	(61,410)	2,347,323	1,625,181	1,120,279
13. Totals (Lines 9 - 10 + 11 + 12)	49,069,090	782,623,430	335,788	83,946,036	49,404,878	51,501,048

(a) Excludes \$ loans or advances to providers not yet expensed.

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Comprehensive (Hospital & Medical)

Year in Which Losses Were Incurred		Cumulative Net Amounts Paid				
		1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	.....	3,028	8,063	9,870	10,101	10,084
2. 2010	.....	74,039	79,627	80,514	80,527	80,510
3. 2011	.....	XXX	79,107	83,411	83,406	83,402
4. 2012	.....	XXX	XXX	77,150	79,931	79,812
5. 2013	.....	XXX	XXX	XXX	61,962	71,529
6. 2014	.....	XXX	XXX	XXX	XXX	59,040

Section B - Incurred Health Claims - Comprehensive (Hospital & Medical)

Year in Which Losses Were Incurred		Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
		1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	.....	8,389	10,059	10,195	10,101	10,084
2. 2010	.....	80,252	80,531	80,606	80,528	80,510
3. 2011	.....	XXX	84,192	83,439	83,436	83,403
4. 2012	.....	XXX	XXX	80,905	80,104	79,799
5. 2013	.....	XXX	XXX	XXX	72,755	71,681
6. 2014	.....	XXX	XXX	XXX	XXX	67,079

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Comprehensive (Hospital & Medical)

Years in which Premiums were Earned and Claims were Incurred		1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2010	.....	96,145	80,510	2,576	3.2	83,086	86.4			83,086	86.4
2. 2011	.....	95,015	83,402	2,636	3.2	86,038	90.6	1		86,039	90.6
3. 2012	.....	87,705	79,812	2,735	3.4	82,547	94.1	(13)		82,534	94.1
4. 2013	80,098	71,529	6,524	9.1	78,053	97.4	152	5	78,210	97.6
5. 2014	73,418	59,040	6,251	10.6	65,291	88.9	8,039	270	73,600	100.2

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Title XVIII

Year in Which Losses Were Incurred		Cumulative Net Amounts Paid				
		1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	.....	2,991	2,990	2,872	2,848	2,848
2. 2010	.....	19,565	21,809	21,569	21,486	21,475
3. 2011	.....	XXX	23,875	26,002	26,006	25,990
4. 2012	.....	XXX	XXX	20,682	23,901	23,871
5. 2013	.....	XXX	XXX	XXX	21,838	24,489
6. 2014	.....	XXX	XXX	XXX	XXX	26,994

Section B - Incurred Health Claims - Title XVIII

Year in Which Losses Were Incurred		Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
		1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	.....	3,027	2,990	2,872	2,848	2,848
2. 2010	.....	22,537	21,812	21,572	21,486	21,475
3. 2011	.....	XXX	27,328	25,901	25,986	25,988
4. 2012	.....	XXX	XXX	23,887	23,860	23,859
5. 2013	.....	XXX	XXX	XXX	24,888	24,519
6. 2014	.....	XXX	XXX	XXX	XXX	31,069

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Title XVIII

Years in which Premiums were Earned and Claims were Incurred		1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2010	.....	24,576	21,475	454	2.1	21,929	89.2			21,929	89.2
2. 2011	.....	28,566	25,990	483	1.9	26,473	92.7	(2)		26,471	92.7
3. 2012	.....	25,029	23,871	595	2.5	24,466	97.8	(12)		24,454	97.7
4. 2013	29,447	24,489	1,627	6.6	26,116	88.7	30	1	26,147	88.8
5. 2014	31,601	26,994	1,946	7.2	28,940	91.6	4,075	137	33,152	104.9

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Title XIX

Year in Which Losses Were Incurred		Cumulative Net Amounts Paid				
		1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior		24,691	26,159	26,193	27,165	27,271
2. 2010		311,621	329,322	329,094	330,533	330,595
3. 2011		XXX	351,540	369,190	370,905	371,052
4. 2012		XXX	XXX	366,536	386,081	386,555
5. 2013		XXX	XXX	XXX	357,222	382,849
6. 2014		XXX	XXX	XXX	XXX	576,925

Section B - Incurred Health Claims - Title XIX

Year in Which Losses Were Incurred		Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
		1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior		28,212	26,558	26,911	27,165	27,271
2. 2010		335,379	330,111	330,012	330,635	330,595
3. 2011		XXX	378,354	370,182	370,751	371,056
4. 2012		XXX	XXX	388,916	385,361	386,491
5. 2013		XXX	XXX	XXX	382,420	383,101
6. 2014		XXX	XXX	XXX	XXX	635,326

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Title XIX

Years in which Premiums were Earned and Claims were Incurred		1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2010		388,418	330,595	10,244	3.1	340,839	87.8			340,839	87.8
2. 2011		408,399	371,052	11,847	3.2	382,899	93.8	4		382,903	93.8
3. 2012		440,991	386,555	13,860	3.6	400,415	90.8	(64)	(3)	400,348	90.8
4. 2013		436,265	382,849	29,309	7.7	412,158	94.5		10	412,420	94.5
5. 2014		697,605	576,925	32,935	5.7	609,860	87.4	58,401	1,827	670,088	96.1

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Other

Year in Which Losses Were Incurred		Cumulative Net Amounts Paid				
		1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	.....	1,266	130	130	123	123
2. 2010	.....	36,598	39,021	38,996	39,000	39,002
3. 2011	.....	XXX	32,938	34,319	34,314	34,309
4. 2012	.....	XXX	XXX	34,955	36,506	36,516
5. 2013	.....	XXX	XXX	XXX	33,773	44,415
6. 2014	.....	XXX	XXX	XXX	XXX	119,664

Section B - Incurred Health Claims - Other

Year in Which Losses Were Incurred		Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
		1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	.....	1,336	130	133	123	123
2. 2010	.....	38,091	39,022	38,997	39,000	39,002
3. 2011	.....	XXX	34,582	34,462	34,284	34,310
4. 2012	.....	XXX	XXX	36,767	36,408	36,515
5. 2013	.....	XXX	XXX	XXX	46,990	44,403
6. 2014	.....	XXX	XXX	XXX	XXX	133,095

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Other

Years in which Premiums were Earned and Claims were Incurred		1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2010	.....	53,704	39,002	1,401	3.6	40,403	75.2			40,403	75.2
2. 2011	.....	46,015	34,309	1,331	3.9	35,640	77.5	1		35,641	77.5
3. 2012	.....	47,955	36,516	1,588	4.3	38,104	79.5	(1)		38,103	79.5
4. 2013	53,653	44,415	3,515	7.9	47,930	89.3	(12)		47,918	89.3
5. 2014	135,631	119,664	423	0.4	120,087	88.5	13,431	403	133,921	98.7

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2C - DEVELOPMENT OF PAID AND INCURRED HEALTH CLAIMS
(000 Omitted)

Section A - Paid Health Claims - Grand Total

Year in Which Losses Were Incurred		Cumulative Net Amounts Paid				
		1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	.....	31,976	37,342	39,065	40,237	40,326
2. 2010	.....	441,823	469,779	470,173	471,546	471,582
3. 2011	.....	XXX	487,460	512,922	514,631	514,753
4. 2012	.....	XXX	XXX	499,323	526,419	526,754
5. 2013	.....	XXX	XXX	XXX	474,795	523,282
6. 2014	.....	XXX	XXX	XXX	XXX	782,623

Section B - Incurred Health Claims - Grand Total

Year in Which Losses Were Incurred		Sum of Cumulative Net Amount Paid and Claim Liability, Claim Reserve and Medical Incentive Pool and Bonuses Outstanding at End of Year				
		1 2010	2 2011	3 2012	4 2013	5 2014
1. Prior	.....	40,964	39,737	40,111	40,237	40,326
2. 2010	.....	476,259	471,476	471,187	471,649	471,582
3. 2011	.....	XXX	524,456	513,984	514,457	514,757
4. 2012	.....	XXX	XXX	530,475	525,733	526,664
5. 2013	.....	XXX	XXX	XXX	527,053	523,704
6. 2014	.....	XXX	XXX	XXX	XXX	866,569

Section C - Incurred Year Health Claims and Claims Adjustment Expense Ratio - Grand Total

Years in which Premiums were Earned and Claims were Incurred		1 Premiums Earned	2 Claims Payment	3 Claim Adjustment Expense Payments	4 (Col. 3/2) Percent	5 Claim and Claim Adjustment Expense Payments (Col. 2 + 3)	6 (Col. 5/1) Percent	7 Claims Unpaid	8 Unpaid Claims Adjustment Expenses	9 Total Claims and Claims Adjustment Expense Incurred (Col. 5+7+8)	10 (Col. 9/1) Percent
1. 2010	.....	562,843	471,582	14,675	3.1	486,257	86.4	0	0	486,257	86.4
2. 2011	.....	577,995	514,753	16,297	3.2	531,050	91.9	4	0	531,054	91.9
3. 2012	.....	601,680	526,754	18,778	3.6	545,532	90.7	(90)	(3)	545,439	90.7
4. 2013	599,463	523,282	40,975	7.8	564,257	94.1	422	16	564,695	94.2
5. 2014	938,255	782,623	41,555	5.3	824,178	87.8	83,946	2,637	910,761	97.1

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 2D - AGGREGATE RESERVE FOR ACCIDENT AND HEALTH CONTRACTS ONLY

	1	2	3	4	5	6	7	8	9
	Total	Comprehensive (Hospital & Medical)	Medicare Supplement	Dental Only	Vision Only	Federal Employees Health Benefits Plan	Title XVIII Medicare	Title XIX Medicaid	Other
1. Unearned premium reserves .....	.0								
2. Additional policy reserves (a)	1,535,613	64,411						1,154,567	316,635
3. Reserve for future contingent benefits .....	.0								
4. Reserve for rate credits or experience rating refunds (including \$) for investment income	526,420						526,420		
5. Aggregate write-ins for other policy reserves .....	.0	.0	.0	.0	.0	.0	.0	.0	.0
6. Totals (gross)	2,062,033	64,411	.0	.0	.0	.0	526,420	1,154,567	316,635
7. Reinsurance ceded .....	.0								
8. Totals (Net)(Page 3, Line 4)	2,062,033	64,411	.0	.0	.0	.0	526,420	1,154,567	316,635
9. Present value of amounts not yet due on claims .....	.0								
10. Reserve for future contingent benefits	214,727							214,727	
11. Aggregate write-ins for other claim reserves .....	.0	.0	.0	.0	.0	.0	.0	.0	.0
12. Totals (gross)	214,727	.0	.0	.0	.0	.0	.0	214,727	.0
13. Reinsurance ceded .....	.0								
14. Totals (Net)(Page 3, Line 7)	214,727	0	0	0	0	0	0	214,727	0
DETAILS OF WRITE-INS									
0501.									
0502.									
0503.									
0598. Summary of remaining write-ins for Line 5 from overflow page.....	.0	.0	.0	.0	.0	.0	.0	.0	.0
0599. Totals (Lines 0501 thru 0503 plus 0598) (Line 5 above)	0	0	0	0	0	0	0	0	0
1101.									
1102.									
1103.									
1198. Summary of remaining write-ins for Line 11 from overflow page .....	.0	.0	.0	.0	.0	.0	.0	.0	.0
1199. Totals (Lines 1101 thru 1103 plus 1198) (Line 11 above)	0	0	0	0	0	0	0	0	0

(a) Includes \$1,535,613 premium deficiency reserve.

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

UNDERWRITING AND INVESTMENT EXHIBIT

PART 3 - ANALYSIS OF EXPENSES

	Claim Adjustment Expenses		3 General Administrative Expenses	4 Investment Expenses	5 Total
	1 Cost Containment Expenses	2 Other Claim Adjustment Expenses			
1. Rent (\$ for occupancy of own building)	979,621	474,675	237,031		1,691,327
2. Salary, wages and other benefits	28,711,258	8,761,385	18,378,194		55,850,837
3. Commissions (less \$ ceded plus \$ assumed)			24,236		24,236
4. Legal fees and expenses	268	1,757	479,855		481,880
5. Certifications and accreditation fees					0
6. Auditing, actuarial and other consulting services	2,097,763	292,921	6,896,456		9,287,140
7. Traveling expenses	596,524	46,289	679,767		1,322,580
8. Marketing and advertising	540,197	19,204	3,424,844		3,984,245
9. Postage, express and telephone	995,775	134,927	2,100,377		3,231,079
10. Printing and office supplies	61,428	5,953	97,217		164,598
11. Occupancy, depreciation and amortization					0
12. Equipment	15,392	2,721	661,001		679,114
13. Cost or depreciation of EDP equipment and software	(41,185)	99,511	5,111,084		5,169,410
14. Outsourced services including EDP, claims, and other services	1,663,814	3,192,777	1,050,513		5,907,104
15. Boards, bureaus and association fees	24,066	4	204,366		228,436
16. Insurance, except on real estate			284,584		284,584
17. Collection and bank service charges	3	104	94,987		95,094
18. Group service and administration fees					0
19. Reimbursements by uninsured plans					0
20. Reimbursements from fiscal intermediaries					0
21. Real estate expenses	9,180	414	890,636		900,230
22. Real estate taxes			(8,912)		(8,912)
23. Taxes, licenses and fees:					
23.1 State and local insurance taxes	155		(910,793)		(910,638)
23.2 State premium taxes					0
23.3 Regulatory authority licenses and fees	10,876	65	36,571		47,512
23.4 Payroll taxes	1,831,110	573,880	1,121,848		3,526,838
23.5 Other (excluding federal income and real estate taxes)			11,491,542		11,491,542
24. Investment expenses not included elsewhere				152,854	152,854
25. Aggregate write-ins for expenses	7,259	427,147	4,477,946	0	4,912,352
26. Total expenses incurred (Lines 1 to 25)	37,503,504	14,033,734	56,823,350	152,854	(a) 108,513,442
27. Less expenses unpaid December 31, current year .	2,649,718		866,371		3,516,089
28. Add expenses unpaid December 31, prior year	1,713,488	0	27,758	0	1,741,246
29. Amounts receivable relating to uninsured plans, prior year	0	0	0	0	0
30. Amounts receivable relating to uninsured plans, current year					0
31. Total expenses paid (Lines 26 minus 27 plus 28 minus 29 plus 30)	36,567,274	14,033,734	55,984,737	152,854	106,738,599
DETAILS OF WRITE-INS					
2501. Capitation Administrative Fee			2,601,528		2,601,528
2502. Pharmacy Administrative Fee			1,232,726		1,232,726
2503. IT Projects			783,080		783,080
2598. Summary of remaining write-ins for Line 25 from overflow page	7,259	427,147	(139,388)	0	295,018
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	7,259	427,147	4,477,946	0	4,912,352

(a) Includes management fees of \$ 96,344,305 to affiliates and \$ to non-affiliates.

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

EXHIBIT OF NET INVESTMENT INCOME

	1 Collected During Year	2 Earned During Year
1. U.S. government bonds	(a)	
1.1 Bonds exempt from U.S. tax	(a)	
1.2 Other bonds (unaffiliated)	(a)	
1.3 Bonds of affiliates	(a) 2,769,627	2,684,425
2.1 Preferred stocks (unaffiliated)	(b)	
2.11 Preferred stocks of affiliates	(b)	
2.2 Common stocks (unaffiliated)	.451,842	.451,842
2.21 Common stocks of affiliates		
3. Mortgage loans	(c)	
4. Real estate	(d)	
5. Contract Loans		
6. Cash, cash equivalents and short-term investments	(e) 13,461	13,461
7. Derivative instruments	(f)	
8. Other invested assets		
9. Aggregate write-ins for investment income	35,093	35,724
10. Total gross investment income	3,270,023	3,185,452
11. Investment expenses		(g) 152,854
12. Investment taxes, licenses and fees, excluding federal income taxes		(g) 0
13. Interest expense		(h) 0
14. Depreciation on real estate and other invested assets		(i) 0
15. Aggregate write-ins for deductions from investment income		0
16. Total deductions (Lines 11 through 15)		152,854
17. Net investment income (Line 10 minus Line 16)		3,032,598
DETAILS OF WRITE-INS		
0901. Securities Lending	35,093	35,724
0902.		
0903.		
0998. Summary of remaining write-ins for Line 9 from overflow page	0	0
0999. Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)	35,093	35,724
1501.		
1502.		
1503.		
1598. Summary of remaining write-ins for Line 15 from overflow page		0
1599. Totals (Lines 1501 thru 1503 plus 1598) (Line 15, above)		0

- (a) Includes \$ 9,837 accrual of discount less \$ 1,331,163 amortization of premium and less \$ 35,844 paid for accrued interest on purchases.
- (b) Includes \$ accrual of discount less \$ amortization of premium and less \$ paid for accrued dividends on purchases.
- (c) Includes \$ accrual of discount less \$ amortization of premium and less \$ paid for accrued interest on purchases.
- (d) Includes \$ for company's occupancy of its own buildings; and excludes \$ interest on encumbrances.
- (e) Includes \$ accrual of discount less \$ 26,257 amortization of premium and less \$ paid for accrued interest on purchases.
- (f) Includes \$ accrual of discount less \$ amortization of premium.
- (g) Includes \$ investment expenses and \$ investment taxes, licenses and fees, excluding federal income taxes, attributable to segregated and Separate Accounts.
- (h) Includes \$ interest on surplus notes and \$ interest on capital notes.
- (i) Includes \$ depreciation on real estate and \$ depreciation on other invested assets.

EXHIBIT OF CAPITAL GAINS (LOSSES)

	1 Realized Gain (Loss) On Sales or Maturity	2 Other Realized Adjustments	3 Total Realized Capital Gain (Loss) (Columns 1 + 2)	4 Change in Unrealized Capital Gain (Loss)	5 Change in Unrealized Foreign Exchange Capital Gain (Loss)
1. U.S. Government bonds	0	0	0	0	0
1.1 Bonds exempt from U.S. tax			0		
1.2 Other bonds (unaffiliated)	229,554	0	229,554	(192,075)	0
1.3 Bonds of affiliates	0	0	0	0	0
2.1 Preferred stocks (unaffiliated)	0	0	0	0	0
2.11 Preferred stocks of affiliates	0	0	0	0	0
2.2 Common stocks (unaffiliated)	0	0	0	1,245,702	0
2.21 Common stocks of affiliates	0	0	0	0	0
3. Mortgage loans	0	0	0	0	0
4. Real estate	0	0	0	0	0
5. Contract loans	0	0	0	0	0
6. Cash, cash equivalents and short-term investments	864	0	864	0	0
7. Derivative instruments	0	0	0	0	0
8. Other invested assets	0	0	0	0	0
9. Aggregate write-ins for capital gains (losses)	0	0	0	0	0
10. Total capital gains (losses)	230,418	0	230,418	1,053,627	0
DETAILS OF WRITE-INS					
0901.					
0902.					
0903.					
0998. Summary of remaining write-ins for Line 9 from overflow page	0	0	0	0	0
0999. Totals (Lines 0901 thru 0903 plus 0998) (Line 9, above)	0	0	0	0	0

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EXHIBIT OF NON-ADMITTED ASSETS

	1 Current Year Total Nonadmitted Assets	2 Prior Year Total Nonadmitted Assets	3 Change in Total Nonadmitted Assets (Col. 2 - Col. 1)
1. Bonds (Schedule D)		0	0
2. Stocks (Schedule D):			
2.1 Preferred stocks		0	0
2.2 Common stocks		0	0
3. Mortgage loans on real estate (Schedule B):			
3.1 First liens		0	0
3.2 Other than first liens		0	0
4. Real estate (Schedule A):			
4.1 Properties occupied by the company		0	0
4.2 Properties held for the production of income		0	0
4.3 Properties held for sale		0	0
5. Cash (Schedule E - Part 1), cash equivalents (Schedule E - Part 2) and short-term investments (Schedule DA)		0	0
6. Contract loans		0	0
7. Derivatives (Schedule DB)		0	0
8. Other invested assets (Schedule BA)		0	0
9. Receivables for securities		0	0
10. Securities lending reinvested collateral assets (Schedule DL)		0	0
11. Aggregate write-ins for invested assets	0	0	0
12. Subtotals, cash and invested assets (Lines 1 to 11)	0	0	0
13. Title plants (for Title insurers only)		0	0
14. Investment income due and accrued		0	0
15. Premiums and considerations:			
15.1 Uncollected premiums and agents' balances in the course of collection		0	0
15.2 Deferred premiums, agents' balances and installments booked but deferred and not yet due		0	0
15.3 Accrued retrospective premiums		0	0
16. Reinsurance:			
16.1 Amounts recoverable from reinsurers		0	0
16.2 Funds held by or deposited with reinsured companies		0	0
16.3 Other amounts receivable under reinsurance contracts		0	0
17. Amounts receivable relating to uninsured plans		0	0
18.1 Current federal and foreign income tax recoverable and interest thereon		0	0
18.2 Net deferred tax asset		0	0
19. Guaranty funds receivable or on deposit		0	0
20. Electronic data processing equipment and software		0	0
21. Furniture and equipment, including health care delivery assets	1,158,001	455,180	(702,821)
22. Net adjustment in assets and liabilities due to foreign exchange rates		0	0
23. Receivable from parent, subsidiaries and affiliates		0	0
24. Health care and other amounts receivable	5,249,931	5,463,941	214,010
25. Aggregate write-ins for other than invested assets	8,277,540	8,125,024	(152,516)
26. Total assets excluding Separate Accounts, Segregated Accounts and Protected Cell Accounts (Lines 12 to 25)	14,685,472	14,044,145	(641,327)
27. From Separate Accounts, Segregated Accounts and Protected Cell Accounts		0	0
28. Total (Lines 26 and 27)	14,685,472	14,044,145	(641,327)
DETAILS OF WRITE-INS			
1101.			
1102.			
1103.			
1198. Summary of remaining write-ins for Line 11 from overflow page	0	0	0
1199. Totals (Lines 1101 thru 1103 plus 1198)(Line 11 above)	0	0	0
2501. Goodwill, Intangibles, and Covenant not to Compete	8,069,210	8,069,210	0
2502. Prepaids	208,330	55,814	(152,516)
2503.			
2598. Summary of remaining write-ins for Line 25 from overflow page	0	0	0
2599. Totals (Lines 2501 thru 2503 plus 2598)(Line 25 above)	8,277,540	8,125,024	(152,516)

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

EXHIBIT 1 - ENROLLMENT BY PRODUCT TYPE FOR HEALTH BUSINESS ONLY

Source of Enrollment	Total Members at End of					6 Current Year Member Months
	1 Prior Year	2 First Quarter	3 Second Quarter	4 Third Quarter	5 Current Year	
1. Health Maintenance Organizations	239,177	241,963	293,912	359,595	364,108	3,613,410
2. Provider Service Organizations						
3. Preferred Provider Organizations						
4. Point of Service						
5. Indemnity Only						
6. Aggregate write-ins for other lines of business	0	0	0	0	0	0
7. Total	239,177	241,963	293,912	359,595	364,108	3,613,410
DETAILS OF WRITE-INS						
0601.						
0602.						
0603.						
0698. Summary of remaining write-ins for Line 6 from overflow page	0	0	0	0	0	0
0699. Totals (Lines 0601 thru 0603 plus 0698) (Line 6 above)	0	0	0	0	0	0

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

EXHIBIT 3 - HEALTH CARE RECEIVABLES

1 Name of Debtor	2 1 - 30 Days	3 31 - 60 Days	4 61 - 90 Days	5 Over 90 Days	6 Nonadmitted	7 Admitted
CVS Caremark	1,691,460	570,417	303,407	83,782	1,527,577	1,121,489
0199998. Aggregate Pharmaceutical Rebate Receivables Not Individually Listed						
0199999. Total Pharmaceutical Rebate Receivables	1,691,460	570,417	303,407	83,782	1,527,577	1,121,489
0299998. Aggregate Claim Overpayment Receivables Not Individually Listed	159,787	217,698	59,358	1,437,106	1,873,949	
0299999. Total Claim Overpayment Receivables	159,787	217,698	59,358	1,437,106	1,873,949	0
0399998. Aggregate Loans and Advances to Providers Not Individually Listed						
0399999. Total Loans and Advances to Providers	0	0	0	0	0	0
0499998. Aggregate Capitation Arrangement Receivables Not Individually Listed				998,588	998,588	
0499999. Total Capitation Arrangement Receivables	0	0	0	998,588	998,588	0
0599998. Aggregate Risk Sharing Receivables Not Individually Listed						
0599999. Total Risk Sharing Receivables	0	0	0	0	0	0
0699998. Aggregate Other Receivables Not Individually Listed	848,050			1,767	849,817	
0699999. Total Other Receivables	848,050	0	0	1,767	849,817	0
0799999 Gross health care receivables	2,699,297	788,115	362,765	2,521,243	5,249,931	1,121,489

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

EXHIBIT 3A - ANALYSIS OF HEALTH CARE RECEIVABLES COLLECTED AND ACCRUED

Type of Health Care Receivable	Health Care Receivables Collected During the Year		Health Care Receivables Accrued as of December 31 of Current Year		5	6
	1 On Amounts Accrued Prior to January 1 of Current Year	2 On Amounts Accrued During the Year	3 On Amounts Accrued December 31 of Prior Year	4 On Amounts Accrued During the Year	Health Care Receivables in Prior Years (Columns 1 + 3)	Estimated Health Care Receivables Accrued as of December 31 of Prior Year
1. Pharmaceutical rebate receivables	1,989,074	1,583,839	4,743	2,644,323	1,993,817	1,876,971
2. Claim overpayment receivables	1,290,506	943,088	1,097,351	776,598	2,387,857	1,786,970
3. Loans and advances to providers					0	0
4. Capitation arrangement receivables	801,412		855,764	142,824	1,657,176	1,800,000
5. Risk sharing receivables					0	0
6. Other health care receivables.....		2,381		849,817	0	0
7. Totals (Lines 1 through 6)	4,080,992	2,529,308	1,957,858	4,413,562	6,038,850	5,463,941

Note that the accrued amounts in Columns 3, 4, and 6 are the total health care receivables, not just the admitted portion.

EXHIBIT 4 - CLAIMS UNPAID AND INCENTIVE POOL, WITHHOLD AND BONUS (Reported and Unreported)

[illegible]

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

[illegible]

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

EXHIBIT 7 PART 1- SUMMARY OF TRANSACTIONS WITH PROVIDERS

	1	2	3	4	5	6
Payment Method	Direct Medical Expense Payment	Column 1 as a % of Total Payments	Total Members Covered	Column 3 as a % of Total Members	Column 1 Expenses Paid to Affiliated Providers	Column 1 Expenses Paid to Non-Affiliated Providers
Capitation Payments:						
1. Medical groups	69,859,338	8.4	364,108	100.0		69,859,338
2. Intermediaries .....	.0	0.0		0.0		
3. All other providers	14,311,339	1.7	364,108	100.0		14,311,339
4. Total capitation payments	84,170,677	10.1	728,216	200.0	0	84,170,677
Other Payments:						
5. Fee-for-service	25,864,186	3.1	XXX	XXX		25,864,186
6. Contractual fee payments	719,505,761	86.5	XXX	XXX		719,505,761
7. Bonus/withhold arrangements - fee-for-service .....	.0	0.0	XXX	XXX		
8. Bonus/withhold arrangements - contractual fee payments	2,151,896	0.3	XXX	XXX		2,151,896
9. Non-contingent salaries .....	.0	0.0	XXX	XXX		
10. Aggregate cost arrangements .....	.0	0.0	XXX	XXX		
11. All other payments .....	.0	0.0	XXX	XXX		
12. Total other payments	747,521,843	89.9	XXX	XXX	0	747,521,843
13. TOTAL (Line 4 plus Line 12)	831,692,520	100%	XXX	XXX	0	831,692,520

EXHIBIT 7 - PART 2 - SUMMARY OF TRANSACTIONS WITH INTERMEDIARIES

1	2	3	4	5	6
NAIC Code	Name of Intermediary	Capitation Paid	Average Monthly Capitation	Intermediary's Total Adjusted Capital	Intermediary's Authorized Control Level RBC
	NONE				
9999999 Totals			XXX	XXX	XXX

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

EXHIBIT 8 - FURNITURE, EQUIPMENT AND SUPPLIES OWNED

	1	2	3	4	5	6
Description	Cost	Improvements	Accumulated Depreciation	Book Value Less Encumbrances	Assets Not Admitted	Net Admitted Assets
1. Administrative furniture and equipment	4,454,477		(3,296,476)	1,158,001	1,158,001	
2. Medical furniture, equipment and fixtures						
3. Pharmaceuticals and surgical supplies						
4. Durable medical equipment						
5. Other property and equipment						
6. Total	4,454,477	0	(3,296,476)	1,158,001	1,158,001	0

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

NOTES TO FINANCIAL STATEMENTS

1. Summary of Significant Accounting Policies

A. Accounting Practices

The accompanying financial statements of AMERIGROUP Florida, Inc. (the "Company") have been prepared in conformity with the National Association of Insurance Commissioners' ("NAIC") *Annual Statement Instructions* and in accordance with accounting practices prescribed by the NAIC *Accounting Practice and Procedures Manual* ("NAIC SAP"), subject to any deviations prescribed or permitted by the Florida Department of Financial Services ("Florida DFS").

For the years ended December 31, 2014 and the year ended December 31, 2013, there were no differences between the Company's statutory basis capital and surplus and net income under NAIC SAP and practices prescribed and permitted by the state of Florida.

	State of Domicile	2014	2013
Net Income			
(1) AMERIGROUP Florida Inc. (Page 4, Line 32, Columns 2 & 4)	Florida	\$ (26,651,523)	\$ 6,759,103
(2) States Prescribed Practices that increase(decrease) NAIC SAP:	Florida	-	-
(3) State Permitted Practices that increase(decrease) NAIC SAP:	Florida	-	-
(4) NAIC SAP (1 - 2 - 3 = 4)	Florida	\$ (26,651,523)	\$ 6,759,103
Surplus			
(5) AMERIGROUP Florida Inc. (Page 3, Line 33, Columns 3 & 4)	Florida	\$ 83,605,928	\$ 73,421,154
(6) States Prescribed Practices that increase(decrease) NAIC SAP:	Florida	-	-
(7) State Permitted Practices that increase(decrease) NAIC SAP:	Florida	-	-
(8) NAIC SAP (5 - 6 - 7 = 8)	Florida	\$ 83,605,928	\$ 73,421,154

B. Use of Estimates in the Preparation of the Financial Statements

Preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

C. Accounting Policies

Health premium revenues, based on membership records and premiums rates for each membership category within each county, are recognized as revenue during the period in which the Company is obligated to provide service to members. Premiums are reported net of excess loss reinsurance ceded and experience rating refunds. Premiums paid before the effective service month are recorded on the balance sheet as premiums received in advance and are subsequently credited to income as earned during the coverage period. Premium rates are subject to approval by Centers for Medicare, Medicaid Services, and CMS. Costs, such as premium taxes and other underwriting expenses are charged to operations as incurred.

In addition, the Company uses the following accounting policies:

1. Short-term investments with maturities of less than one year at the date of acquisition are reported at amortized cost, which approximates fair value. Non-investment grade short-term investments are stated at the lower of amortized cost or fair value.
2. Investment grade bonds not backed by other loans are stated at amortized cost, with amortization calculated based on the modified scientific method, using lower of yield to call or yield to maturity. Non-investment grade bonds are stated at the lower of amortized cost or fair value as determined by various third-party pricing sources.
3. Common stocks of unaffiliated companies are stated at fair value based upon security ratings prescribed by various third-party pricing sources.
4. The Company has no investments in preferred stock.
5. The Company has no mortgage loans.
6. Loan-backed securities are stated at amortized cost. Pre-payment assumptions for loan-backed securities and structured securities were obtained from broker-dealer survey values or internal estimates. These assumptions are consistent with the current interest rate and economic environment. The retrospective adjustment method is used to value all loan-backed securities. Non-investment grade loan-backed securities are stated at the lower of amortized cost or fair value.
7. The Company has no investments in subsidiaries, controlled and affiliated companies.
8. The Company has no investments in joint ventures, partnerships and limited liability companies.
9. The Company has no investments in derivatives.
10. The Company does not utilize anticipated investment income as a factor in the premium deficiency calculations.
11. Unpaid claims and claims adjustment expenses include management's best estimate of amounts based on historical claim development patterns and certain individual case estimates. The established

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

liability considers health benefit provisions, business practices, economic conditions and other factors that may materially affect the cost, frequency and severity of claims. Reserves for unpaid claims and claims adjustment expenses are based on assumptions and estimates, and while management believes such estimates are reasonable, the ultimate liability may be in excess or less than the amount provided. The methods for making such estimates and for establishing the resulting liabilities are continually reviewed and changes in estimates are incorporated into current period estimates.

12. The Company has not modified its capitalization policy from the prior period.
13. Pharmacy rebates receivable are recorded when earned based upon actual rebate receivables billed and an estimate of receivables based upon current utilization of specific pharmaceuticals and provider contract terms. All pharmaceutical rebates receivables are considered non-admitted due to their collectability beyond 90 days.

2. **Accounting Changes and Corrections of Errors**

There were no significant accounting changes or corrections during the years ended December 31, 2014 and 2013.

3. **Business Combinations and Goodwill**

A. Statutory Purchase Method	Not applicable
B. Statutory Merger	Not applicable
C. Assumption Reinsurance	Not applicable
D. Impairment Loss	Not applicable

4. **Discontinued Operations**

The Company had no operations that were discontinued during 2014 or 2013.

5. **Investments**

A. Mortgage Loans, including Mezzanine Real Estate Loans

The Company did not have investments in mortgage loans at December 31, 2014 or 2013.

B. Debt Restructuring

The Company did not have invested assets that were restructured debt at December 31, 2014 or 2013.

C. Reverse Mortgages

The Company did not have investments in reverse mortgages at December 31, 2014 or 2013.

D. Loan-Backed Securities

1. Prepayment assumptions for single-class and multi-class mortgage-backed and asset-backed securities were obtained from broker-dealer survey values or internal estimates. The Company used various third-party pricing sources in determining the market value of its loan-backed securities.
2. The Company did not recognize other-than-temporary impairments on its loan-backed securities during years ended December 31, 2014 and 2013.
3. The Company did not hold other-than-temporarily impaired loan-backed securities at December 31, 2014 and 2013.
4. The Company had no impaired securities for which an other-than-temporary impairment had not been recognized in earnings as a realized loss at December 31, 2014 and 2013.
5. The Company had no impaired loan-backed securities at December 31, 2014 and 2013.

E. Repurchase Agreements and/or Securities Lending Transactions

1. The Company did not enter into repurchase agreements at December 31, 2014 or 2013.
2. The Company participates in a securities lending program whereby marketable securities in its investment portfolio are transferred to independent brokers or dealers based on, among other things, their creditworthiness in exchange for collateral initially equal to at least 102% of the market value of the loaned securities. The Company receives the collateral in cash or securities, and if cash is received the cash collateral is thereafter invested according to guidelines of the Company's Investment Policy.

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3. Collateral Received

a. Aggregate amount collateral received

1. Repurchase agreement – Not applicable.

	Fair Value
2. Securities Lending	
a. Open	5,498,223
b. 30 days or less	-
c. 31 to 60 days	-
d. 61 to 90 days	-
e. Greater than 90 days	-
f. Subtotal	5,498,223
g. Securities received	-
h. Total collateral received	5,498,223

3. Dollar repurchase agreement – Not applicable.

b. The fair value of that collateral and of the portion of that collateral that it has sold or repledged \$5,498,223

c. The Company receives cash collateral in an amount in excess of the fair value of the securities lent. The Company reinvests the cash collateral into short-term investments.

4. Not applicable.

5. Collateral Reinvestment

a. Aggregate amount collateral reinvested

1. Repurchase agreement – Not applicable.

	Amortized Cost	Fair Value
2. Securities Lending		
a. Open	\$ -	\$ -
b. 30 days or less	4,330,935	4,331,197
c. 31 to 60 days	-	-
d. 61 to 90 days	-	-
e. 91 to 120 days	150,000	149,989
f. 121 to 180 days	100,060	100,060
g. 181 to 365 days	451,807	451,928
h. 1 to 2 years	465,177	465,049
i. 2 to 3 years	-	-
j. Greater than 3 years	-	-
k. Subtotal	\$ 5,497,979	\$ 5,498,223
l. Securities received	-	-
m. Total collateral reinvested	\$ 5,497,979	\$ 5,498,223

3. Dollar repurchase agreement – Not applicable.

b. Not applicable.

6. Not applicable.

7. Not applicable.

F. Real Estate

The Company did not have investments in real estate and did not engage in retail land sales operations during 2014 or 2013.

G. Investments in Low-Income Housing Tax Credits

The Company did not invest in properties generating low-income housing tax credits during 2014 or 2013.

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H. Restricted Assets

1. Restricted assets (including pledged)

	1	2	3	4	5	6
Restricted Asset Category	Total Gross Restricted From Current Year	Total Gross Restricted From Prior Year	Increase/ (Decrease) (Col. 1 minus Col. 2)	Total Current Year Admitted Restricted	Percentage Gross Restricted to Total Assets	Percentage Admitted Restricted to Total Admitted Assets
a. Subject to contractual obligation for which liability is not shown	\$ -	\$ -	\$ -	\$ -	-	-
b. Collateral held under security lending agreements	5,497,979	3,112,884	2,385,095	5,497,979	2.348%	2.506%
c. Subject to repurchase agreements	-	-	-	-	-	-
d. Subject to reverse repurchase agreements	-	-	-	-	-	-
e. Subject to dollar repurchase agreements	-	-	-	-	-	-
f. Subject to dollar reverse repurchase agreements	-	-	-	-	-	-
g. Placed under option contracts	-	-	-	-	-	-
h. Letter stock or securities restricted as to sale - excluding FHLB capital stock	-	-	-	-	-	-
i. FHLB capital stock	-	-	-	-	-	-
j. On deposit with states	40,084,373	23,756,174	16,328,199	40,084,373	17.121%	18.267%
k. On deposit with other regulatory bodies	-	-	-	-	-	-
l. Pledged collateral to FHLB (including assets backing funding agreements)	-	-	-	-	-	-
m. Pledged as collateral not captured in other categories	-	-	-	-	-	-
n. Other restricted assets	-	-	-	-	-	-
o. Total Restricted Assets	<u>\$ 45,582,352</u>	<u>\$ 26,869,058</u>	<u>\$ 18,713,294</u>	<u>\$ 45,582,352</u>	19.470%	20.773%

2. Not applicable.

3. Not applicable.

I. Working Capital Finance Investments

The Company did not have any working capital finance investments as December 31, 2014 and 2013.

J. Offsetting and Netting of Assets and Liabilities

The Company did not have any offsetting and netting of assets and liabilities at December 31, 2014.

K. Structured Notes

The Company did not have any structured notes at December 31, 2014 and 2013.

6. Joint Ventures, Partnerships and Limited Liability Companies

A. The Company has no investments in joint ventures, partnerships, or limited liability companies that exceeded 10% of its admitted assets at December 31, 2014 or 2013.

B. The Company did not recognize impairment write downs for its investments in joint ventures, partnerships or limited liability companies during 2014 or 2013.

7. Investment Income

A. All investment income due and accrued with amounts that are over 90 days past due is non-admitted.

B. At December 31, 2014 and 2013, there was no non-admitted accrued investment interest income.

8. Derivative Instruments

The Company has no derivative instruments at December 31, 2014 and 2013.

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9. Income Taxes

A. The components of net deferred tax assets (liabilities):

1. The components of net deferred tax asset (liabilities) at December 31 are as follows:

12/31/2014			
(1)	(2)	(3)	
Ordinary	Capital	(Col 1+2) Total	
(a) Gross deferred tax assets	\$ 6,521,620	\$ -	\$ 6,521,620
(b) Statutory valuation allowance adjustments	-	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	6,521,620	-	6,521,620
(d) Deferred tax assets nonadmitted	-	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	6,521,620	-	6,521,620
(f) Deferred tax liabilities	3,045	1,616,771	1,619,816
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	\$ 6,518,575	\$ (1,616,771)	\$ 4,901,804

12/31/2013			
(4)	(5)	(6)	
Ordinary	Capital	(Col 4+5) Total	
(a) Gross deferred tax assets	\$ 4,735,783	\$ -	\$ 4,735,783
(b) Statutory valuation allowance adjustments	-	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	4,735,783	-	4,735,783
(d) Deferred tax assets nonadmitted	-	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	4,735,783	-	4,735,783
(f) Deferred tax liabilities	-	1,257,976	1,257,976
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	\$ 4,735,783	\$ (1,257,976)	\$ 3,477,807

Change			
(7)	(8)	(9)	
(Col 1-4) Ordinary	(Col 2-5) Capital	(Col 7+8) Total	
(a) Gross deferred tax assets	\$ 1,785,837	\$ -	\$ 1,785,837
(b) Statutory valuation allowance adjustments	-	-	-
(c) Adjusted gross deferred tax assets (1a - 1b)	1,785,837	-	1,785,837
(d) Deferred tax assets nonadmitted	-	-	-
(e) Subtotal net admitted deferred tax asset (1c - 1d)	1,785,837	-	1,785,837
(f) Deferred tax liabilities	3,045	358,795	361,840
(g) Net admitted deferred tax asset/(net deferred tax liability) (1e - 1f)	\$ 1,782,792	\$ (358,795)	\$ 1,423,997

2. The amount of admitted adjusted gross deferred tax assets under each component of SSAP 101 as of December 31 is as follows:

12/31/2014			
(1)	(2)	(3)	
Ordinary	Capital	(Col 1+2) Total	
(a) Federal income taxes paid in prior years recoverable through loss carrybacks	\$ 4,237,403	\$ -	\$ 4,237,403
(b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation (the lesser of 2(b)1 and 2(b)2 below)	1,620,174	-	1,620,174
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	1,620,174	-	1,620,174
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	11,799,596
(c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	664,043	-	664,043
(d) Deferred tax assets admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	\$ 6,521,620	\$ -	\$ 6,521,620

Admission Calculation Components SSAP No. 101

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12/31/2013		
(4)	(5)	(6)
Ordinary	Capital	(Col 4+5) Total

Admission Calculation Components SSAP No. 101

(a) Federal income taxes paid in prior years recoverable through loss carrybacks	\$ 3,860,192	\$ -	\$ 3,860,192
(b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation (the lesser of 2(b)1 and 2(b)2 below)	264,061	-	264,061
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	264,061	-	264,061
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	10,481,322
(c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	611,530	-	611,530
(d) Deferred tax assets admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	\$ 4,735,783	\$ -	\$ 4,735,783

Change		
(7)	(8)	(9)
(Col 1-4) Ordinary	(Col 2-5) Capital	(Col 7+8) Total

Admission Calculation Components SSAP No. 101

(a) Federal income taxes paid in prior years recoverable through loss carrybacks	\$ 377,211	\$ -	\$ 377,211
(b) Adjusted gross deferred tax assets expected to be realized (excluding the amount of deferred tax assets from 2(a) above) after application of the threshold limitation (the lesser of 2(b)1 and 2(b)2 below)	1,356,113	-	1,356,113
1. Adjusted gross deferred tax assets expected to be realized following the balance sheet date	1,356,113	-	1,356,113
2. Adjusted gross deferred tax assets allowed per limitation threshold	XXX	XXX	1,318,274
(c) Adjusted gross deferred tax assets (excluding the amount of deferred tax assets from 2(a) and 2(b) above) offset by gross deferred tax liabilities	52,513	-	52,513
(d) Deferred tax assets admitted as the result of application of SSAP No. 101. Total (2(a) + 2(b) + 2(c))	\$ 1,785,837	\$ -	\$ 1,785,837

3.	2014	2013
(a) Ratio percentage used to determine recovery period and threshold limitation amount	2.90%	1.00%
(b) Amount of adjusted capital and surplus used to determine recovery period and threshold limitation in 2(b)2 above	\$ 78,663,972	\$ 69,875,481

4. Impact of tax planning strategies

12/31/2014		12/31/2013		Change	
(1)	(2)	(3)	(4)	(5)	(6)
Ordinary	Capital	Ordinary	Capital	(Col 1-3) Ordinary	(Col 2-4) Capital

(a) Determination of adjusted gross deferred tax assets and net admitted deferred tax assets by tax character as a percentage					
1 Adjusted gross DTAs amount from Note 9A1(c)	\$ 6,521,620	\$ -	\$ 4,735,783	\$ -	\$ 1,785,837
2 Percentage of adjusted gross DTAs by tax character attributable to the impact of tax planning strategies	0.00%	0.00%	0.00%	0.00%	0.00%
3 Net admitted adjusted gross DTAs amount from Note 9A1(e)	\$ 6,521,620	\$ -	\$ 4,735,783	\$ -	\$ 1,785,837
4 Percentage of net admitted adjusted gross DTAs by tax character admitted because of the impact of tax planning strategies	0.00%	0.00%	0.00%	0.00%	0.00%
(b) Does the Company's tax-planning strategies include the use of reinsurance?	Yes		No	X	

B. The Company has no unrecognized deferred tax liabilities at December 31, 2014 and 2013.

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C. Current income taxes incurred consist of the following major components:

	(1)	(2)	(3)
	12/31/2014	12/31/2013	(Col 1-2) Change
1. Current Income Tax			
(a) Federal	\$ (6,279,326)	\$ 4,331,065	\$ (10,610,391)
(b) Foreign	-	-	-
(c) Subtotal	(6,279,326)	4,331,065	(10,610,391)
(d) Federal income tax expense on net capital gains	79,772	3,079	76,693
(e) Utilization of capital loss carry-forwards	-	-	-
(f) Other	-	-	-
(g) Federal and foreign income taxes incurred	\$ (6,199,554)	\$ 4,334,144	\$ (10,533,698)
2. Deferred Tax Assets:			
(a) Ordinary			
(1) Discounting of unpaid losses	\$ 260,705	\$ 181,242	\$ 79,463
(2) Unearned premium reserve	1,682,067	217,904	1,464,163
(3) Policyholder reserves	903,086	1,042,160	(139,074)
(4) Investments	-	-	-
(5) Deferred acquisition costs	-	-	-
(6) Policyholder dividends accrual	-	-	-
(7) Fixed assets	559,505	429,721	129,784
(8) Compensation and benefits accrual	-	-	-
(9) Pension accrual	-	-	-
(10) Receivables - nonadmitted	1,839,781	1,912,379	(72,598)
(11) Net operating loss carryforward	-	-	-
(12) Tax credit carry-forward	-	-	-
(13) Other (including items <5% of total ordinary tax assets)	-	-	-
(14) Accrued future expenses	-	65	(65)
(15) Amortization	724,801	932,777	(207,976)
(16) Partnership income	-	-	-
(17) Premium deficiency reserves	537,465	-	537,465
(18) Prepaid expenses	14,210	19,535	(5,325)
(99) Subtotal	6,521,620	4,735,783	1,785,837
(b) Statutory valuation allowance adjustment	-	-	-
(c) Nonadmitted	-	-	-
(d) Admitted ordinary deferred tax assets (2a99 - 2b - 2c)	\$ 6,521,620	\$ 4,735,783	\$ 1,785,837
(e) Capital:			
(1) Investments	\$ -	\$ -	\$ -
(2) Net capital loss carryforward	-	-	-
(3) Real estate	-	-	-
(4) Other (including items <5% of total capital tax assets)	-	-	-
(5) Investment Partnership	-	-	-
(99) Subtotal	-	-	-
(f) Statutory valuation allowance adjustment	-	-	-
(g) Nonadmitted	-	-	-
(h) Admitted capital deferred tax assets (2e99 - 2f - 2g)	-	-	-
(i) Admitted deferred tax assets (2d + 2h)	\$ 6,521,620	\$ 4,735,783	\$ 1,785,837
3. Tax Liabilities:			
(a) Ordinary:			
(1) Investments	\$ -	\$ -	\$ -
(2) Fixed assets	-	-	-
(3) Deferred and uncollected premium	-	-	-
(4) Policyholder reserves	-	-	-
(5) Other (including items <5% of total ordinary tax liabilities)	-	-	-
(6) Amortization	-	-	-
(7) Discount of coordination of benefits	3,045	-	3,045
(99) Subtotal	3,045	-	3,045
(b) Capital:			
(1) Investments	1,616,771	1,257,976	358,795
(2) Real estate	-	-	-
(3) Other (including items <5% of total capital tax liabilities)	-	-	-
(99) Subtotal	1,616,771	1,257,976	358,795
(c) Deferred tax liabilities (3a99 + 3b99)	1,619,816	1,257,976	361,840
4. Net deferred tax assets/liabilities (2i - 3C)	\$ 4,901,804	\$ 3,477,807	\$ 1,423,997

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- D. The Company's income tax expense and change in deferred income taxes differs from the amount obtained by applying the federal statutory income tax rate of 35% for the year ended December 31 as follows:

	2014	2013
Tax expense computed using federal statutory rate	\$ (11,497,877)	\$ 3,882,636
Change in nonadmitted assets	(224,464)	(1,134,513)
Tax exempt income and dividend received	(363,795)	(254,315)
Prior year true-ups and adjustments	62,149	22,224
Revenue agent report settlements and FIN48	(94,120)	-
ACA health insurer fee	3,969,042	-
Contributions	-	113,610
Non-lobbying	95,386	-
Other	61,358	61,195
Total	<u>\$ (7,992,321)</u>	<u>\$ 2,690,837</u>
Federal income taxes incurred	\$ (6,199,554)	\$ 4,334,144
Change in net deferred income taxes	(1,792,767)	(1,643,307)
Total statutory income taxes	<u>\$ (7,992,321)</u>	<u>\$ 2,690,837</u>

E. Operating loss carryforwards:

- The Company has no operating loss carryforwards and no tax credit carryforwards as of December 31, 2014.
- The following are income taxes incurred in the current and prior year(s) that will be available for recoupment in the event of future net losses:

	Ordinary	Capital	Total
2014	\$ -	\$ -	\$ -
2013	4,496,893	8,798	4,505,691
2012	N/A	-	-

- The Company has no protective tax deposits reported as admitted assets under Section 6603 of the Internal Revenue Code as of December 31, 2014 and 2013.

- F. The following companies will be included in the consolidated federal income tax return with their parent Anthem, Inc. as of December 31, 2014, and either are current members of the consolidated tax sharing agreement or are in the process of being added to the tax sharing agreement. Allocation of federal income taxes with affiliates subject to the tax sharing agreement is based upon separate income tax return calculations with credit for net losses that can be used on a consolidated basis. Pursuant to this agreement, the Company has the enforceable right to recoup federal income taxes paid in prior years in the event of future net losses, which it may incur, or to recoup its net losses carried forward as an offset to future net income subject to federal income taxes. Intercompany income tax balances are settled based on the Internal Revenue Service due dates.

1-800 CONTACTS PARENT CORP.	CareMore Health Plan of Texas, Inc.
1-800 CONTACTS PARENT HOLDINGS CORP.	CareMore Health System
1-800 CONTACTS, INC.	CareMore Holdings, Inc.
American Imaging Management, Inc.	Cerulean Companies, Inc.
AMERIGROUP Arizona, Inc.	Claim Management Services, Inc.
AMERIGROUP California, Inc.	Community Insurance Company
AMERIGROUP Colorado, Inc.	CompCare Health Services Insurance Corporation
AMERIGROUP Community Care of Arizona, Inc.	Crossroads Acquisition Corp
AMERIGROUP Community Care of Mississippi, Inc.	DeCare Analytics, LLC
AMERIGROUP Community Care of New Mexico, Inc.	DeCare Dental Health International, LLC
AMERIGROUP Connecticut, Inc.	DeCare Dental Networks, LLC
AMERIGROUP Corporation	DeCare Dental, LLC
AMERIGROUP Delaware, Inc.	Designated Agent Company, Inc.
AMERIGROUP Florida, Inc.	EHC Benefits Agency, Inc.
AMERIGROUP Hawaii, Inc.	Empire HealthChoice Assurance, Inc.
AMERIGROUP Health Solutions, Inc.	Empire HealthChoice HMO, Inc.
AMERIGROUP Indiana, Inc.	EVISION, INC.
Amerigroup Insurance Company	Forty-Four Forty-Four Forest Park Redevelopment Corp
Amerigroup Kansas, Inc.	Golden West Health Plan, Inc.
AMERIGROUP Louisiana, Inc.	Government Health Services, LLC
AMERIGROUP Maine, Inc.	Health Core, Inc.
AMERIGROUP Maryland, Inc.	Health Management Corporation
AMERIGROUP Massachusetts, Inc.	HealthKeepers, Inc.
AMERIGROUP Michigan, Inc.	HealthLink HMO, Inc.

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AMERIGROUP Michigan, Inc.	HealthLink HMO, Inc.
AMERIGROUP Nevada, Inc.	HealthLink, Inc.
AMERIGROUP New Jersey, Inc.	Healthy Alliance Life Insurance Company
AMERIGROUP New York, LLC	HMO Colorado, Inc.
AMERIGROUP Ohio, Inc.	HMO Missouri, Inc.
AMERIGROUP Pennsylvania, Inc.	Imaging Management Holdings, LLC
AMERIGROUP Puerto Rico, Inc.	Imaging Providers of Texas
Amerigroup Services, Inc.	Matthew Thornton Health Plan, Inc.
AMERIGROUP Tennessee, Inc.	National Government Services, Inc.
AMERIGROUP Texas, Inc.	OneNation Insurance Company
AMERIGROUP Washington, Inc.	Park Square Holdings, Inc.
AMERIGROUP Wisconsin, Inc.	Park Square I, Inc.
AMGP Georgia Managed Care Company, Inc.	Park Square II, Inc.
AMGP Georgia, Inc.	PHP Holdings, Inc.
Anthem Blue Cross Life and Health Insurance Company	R&P Realty, Inc.
Anthem Financial, Inc.	Resolution Health, Inc.
Anthem Health Insurance Company of Nevada	RightCHOICE Insurance Company
Anthem Health Plans of Kentucky, Inc.	RightCHOICE Managed Care, Inc.
Anthem Health Plans of Maine, Inc.	Rocky Mountain Hospital and Medical Service, Inc.
Anthem Health Plans of New Hampshire, Inc.	SellCore, Inc.
Anthem Health Plans of Virginia, Inc.	Southeast Services, Inc.
Anthem Health Plans, Inc.	State Sponsored Business UM Services, Inc.
Anthem Holding Corp.	The Anthem Companies of California, Inc.
Anthem Insurance Companies, Inc.	The Anthem Companies, Inc.
Anthem Kentucky Managed Care Plan, Inc.	TrustSolutions, LLC
Anthem Life & Disability Insurance Company	UNICARE Health Insurance Company of the Midwest
Anthem Southeast, Inc.	UNICARE Health Plan of Kansas, Inc.
Anthem UM Services, Inc.	UNICARE Health Plan of West Virginia, Inc.
Anthem, Inc.	UNICARE Health Plans of Texas, Inc.
Arcus Enterprises, Inc.	UNICARE Health Plans of the Midwest, Inc.
ARCUS HealthyLiving Services, Inc.	UNICARE Illinois Services, Inc.
Associated Group, Inc.	UNICARE Life & Health Insurance Company
Blue Cross and Blue Shield of Georgia, Inc.	UNICARE National Services, Inc.
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	UNICARE Specialty Services, Inc.
Blue Cross Blue Shield of Wisconsin	UtiliMed IPA, Inc.
Blue Cross of California	WellPoint Behavioral Health, Inc.
Blue Cross of California Partnership Plan, Inc.	WellPoint California Services, Inc.
CareMore Health Group, Inc.	WellPoint Dental Services, Inc.
CareMore Health Plan	WellPoint Holding Corporation
CareMore Health Plan of Arizona, Inc.	WellPoint Information Technology Services, Inc.
CareMore Health Plan of Colorado, Inc.	WellPoint Insurance Services, Inc.
CareMore Health Plan of Georgia, Inc.	WellPoint Military Care Corporation
CareMore Health Plan of Nevada	

G. Not applicable.

10. Information Concerning Parent, Subsidiaries, Affiliates, and Other Related Parties

A. Nature of the relationship

The Company is a Florida domiciled stock insurance company and is a wholly-owned subsidiary of PHP Holding, Inc. which is own by AMERIGROUP Corporation ("AGP"). AGP is a wholly-own subsidiary of ATH Holding Company, LLC ("ATH Holding"), which is an indirect wholly-owned subsidiary of Anthem, Inc. ("Anthem"), a publicly traded company owning 100% of the outstanding shares of the Physicians Healthcare Plan Holding, Inc. (PHP Holdings, Inc.). The shareholders of Anthem approved a proposal to amend its articles of incorporation to change the name to Anthem, Inc. from WellPoint, Inc. The name change was effective December 2, 2014.

B. Significant Transactions for Each Period

The following significant transactions took place between the Company and its affiliates:

The Company received a \$35,000,000 on December 31, 2014 of capital contributions from its parent. The Company received no capital contributions from its parent for the year ended December 31, 2013.

The Board of Directors of the Company declared an ordinary dividend in the amount of \$11,500,000 on December 4, 2013. The Company paid the dividend to its parent company, AGP, on February 6, 2014. The Company paid no dividends for the year ended December 31, 2014.

C. Intercompany Management and Service Arrangements

See note F below for changes to intercompany management and service arrangements. The amounts of transactions under such agreements are presented in Schedule Y, Part 2.

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D. Amounts Due to or from Related Parties

At December 31, 2014 and 2013, the Company reported \$22,146 and zero due from affiliates and \$4,708,161 and \$2,059,258 due to affiliates, respectively. The receivable and payable balances represent intercompany transactions that will be settled in accordance with the settlement terms of the intercompany agreement.

E. Guarantees or Contingencies for Related Parties

The Company did not enter into guarantees or undertakings for the benefit of an affiliate which would result in a material contingent exposure of the Company's or any affiliated insurer's assets or liabilities.

F. Management, Service Contracts, Cost Sharing Arrangements

Effective January 1, 2014, the Company has entered into an administrative services agreement with its affiliated companies, which the Department approved on January 22, 2014. Pursuant to these agreements, various administrative, management and support services are provided to or provided by the Company. The costs and expenses related to these administrative management and support services are allocated to or allocated by the Company in an amount equal to the direct and indirect costs and expenses incurred in providing these services. Direct costs include expenses such as salaries, employee benefits, communications, advertising, consulting services, maintenance, rent utilities, and supplies which are directly attributable to the Company's operations. Allocated costs include expenses such as salaries, benefit claims and enrollment processing, billings, accounting, underwriting, product development and budgeting, which support the Company's operations. These costs are allocated based on various utilization statistics.

G. Nature of Control Relationships that Could Affect Operations or Financial Position

AGP owns all the outstanding shares of the Company. The Company's ultimate parent is Anthem, Inc.

H. Amount deducted for Investment in Upstream Company

The Company does not own shares of upstream intermediate entities or Anthem, Inc.

I. Detail of Investments in Affiliates Greater than 10% of Admitted Assets

The Company does not have investment in affiliates greater than 10% of admitted assets.

J. Write-down for Impairments of Investments in Subsidiaries, Controlled or Affiliated Companies

The Company did not write-down any investments in subsidiaries, controlled or affiliated companies as of December 31, 2014.

K. Investment in a Foreign Insurance Subsidiary

The Company does not have investments in foreign insurance subsidiaries.

L. Investment in Downstream Non-insurance Holding Companies

The Company does not have investments in downstream non-insurance holding companies.

11. Debt

A. Capital Notes

The Company had no capital notes outstanding at December 31, 2014 and 2013.

B. All Other Debt

The Company had no other debt outstanding at December 31, 2014 and 2013.

12. Retirement Plans, Deferred Compensation, Postemployment Benefits and Compensated Absences and Other Postretirement Benefits Plans

A. Defined Benefit Plan

Not applicable – See Note 12G.

B. Not applicable – See Note 12G.

C. Not applicable – See Note 12G.

D. Not applicable – See Note 12G.

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E. Defined Contribution Plan

Not applicable – See Note 12G.

F. Multiemployer Plan

The Company does not participate in a multiemployer plan.

G. Consolidated/Holding Company Plans

Beginning on January 1, 2014, the Company participates in a deferred compensation plan sponsored by Anthem which covers certain employees. The deferred amounts are payable according to the terms and subject to the conditions of said deferred compensation agreements. Anthem allocates a share of the total accumulated costs of this plan to the Company based on the number of allocated employees subject to the deferred compensation agreements. During 2014 and 2013, these costs totaled \$14,830 and \$0. The Company has no legal obligation for benefits under this plan.

Prior to January 1, 2014, the Company participated in a defined contribution plan sponsored by AGP and covering substantially all employees in which a portion of the total accumulated costs of the Plan were allocated to the Company based on the number of allocated employees. During 2013, those costs totaled \$324,787. Starting January 1, 2014, the Company participated in a defined contribution plan sponsored by ATH Holding Company LLC (“ATH Holding”) and covering substantially all employees. Voluntary employee contributions are matched by ATH Holding subject to certain limitations. ATH Holding allocates a share of the total accumulated costs of this plan to the Company based on the number of allocated employees. During 2014 these costs totaled \$1,466,394. The Company has no legal obligation for benefits under these plans.

H. Post Employment Benefits and Compensated Absences

Liabilities for earned not yet taken vacation and severance benefits have been accrued as of December 31, 2014 and 2013.

I. Impact of Medicare Modernization Act on Postretirement Benefits (INT 04-17)

Not applicable.

13. Capital and Surplus, Shareholder's Dividend Restrictions and Quasi-Reorganizations

1. Outstanding Shares

As of December 31, 2014, the Company has 1,000 shares of \$1 par value common stock authorized. The number of shares issued and outstanding is 100.

2. Preferred Stock

The Company has no preferred stock outstanding.

3. Dividend Restrictions

Per the *Florida Statute 641.365*, there are certain limitations exist on the Company's ability to pay dividends to its parent. The Company may pay funds only from accumulated surplus funds that were derived from realized net operating profits on its business and net realized capital gains. Prior written approval by the Florida DFS is required for payment of any dividend which would result in these accumulated surplus funds being less than zero. Florida DFS approval is not required if the dividend to be paid is less than the greater of 1) ten percent of the Company's accumulated surplus or 2) the Company's entire net operating profit, including realized capital gains, for the immediately preceding calendar year.

4. Dividends Paid

See Footnote 10B.

5. Maximum Ordinary Dividends During 2015

Within the limitations of (3) above, the Company may pay \$8,360,592 in dividends during 2015 without prior approval.

6. Unassigned Surplus Restrictions

Unassigned surplus funds are not restricted at December 31, 2014.

7. Mutual Surplus Advances

Not applicable.

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8. Company Stock Held for Special Purpose

There are no shares of stock held for special purposes at December 31, 2014.

9. Changes in Special Surplus Funds

The changes in balances of special surplus funds from the prior year are due to amounts segregated for the estimated 2015 ACA health insurer fee.

10. Changes in Unassigned Funds

The portion of unassigned funds represented by cumulative unrealized gains were \$4,653,124 at December 31, 2014.

11. Surplus Notes

The Company has not issued any surplus notes or debentures of similar obligations.

12. Restatement due to Prior Quasi-reorganization

The Company has no restatements due to prior quasi-reorganizations.

13. Quasi-reorganization over Prior 10 years

The Company has not been involved in a quasi-reorganization during the past 10 years.

14. Liabilities, Contingencies and Assessments

A. Contingent Commitments

The Company has no contingent commitments at December 31, 2014.

B. Assessments

1. The Company is subject to guaranty fund and other assessments by the state in which it writes business. Guaranty fund assessments are accrued at the time of insolvencies. Other assessments are accrued either at the time of the assessment or at the time the losses are incurred.

The State of Florida has not issued a guaranty fund assessment, and the Company has not recorded a liability for an assessment as of December 31, 2014.

2. Not applicable.

C. Gain Contingencies

The Company has no gain contingencies at December 31, 2014.

D. Claims-Related Extra Contractual Obligations and Bad Faith Losses Stemming from Lawsuits

Not applicable.

E. Joint and Several Liabilities

Not applicable.

F. All Other Contingencies

In February 2015, Anthem reported that it was the target of a sophisticated external cyber-attack. The attackers gained unauthorized access to certain of Anthem's information technology systems and obtained personal information related to many of Anthem's current and former members and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that Anthem will not identify additional information that was accessed or obtained.

Currently, Anthem is in the process of determining the extent of this cyber-attack and supporting federal law enforcement efforts to identify the responsible parties. Upon discovery of the cyber-attack, Anthem took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate the systems and identify solutions based on the evolving landscape. Anthem will provide credit monitoring and identity protection services to those who have been affected by this cyber-attack. Anthem has incurred expenses subsequent to the cyber-attack to investigate and remediate this matter and expects to continue to incur expenses of this nature in the foreseeable future. Although Anthem is

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

unable to quantify the ultimate magnitude of such expenses at this time, they may be significant. Anthem will recognize these expenses in the periods in which they are incurred.

Actions have been filed in courts in many states and other claims have been or may be asserted against Anthem on behalf of current or former members, current or former employees, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber-attack. State and federal agencies, including state insurance regulators, state attorneys general, and the Federal Bureau of Investigations, are investigating events related to the cyber-attack, including how it occurred, its consequences and our responses. Although Anthem is cooperating in these investigations, Anthem may be subject to fines or other obligations, which may have an adverse effect on how we operate our business and our results of operations. Anthem has contingency plans and insurance coverage for potential liabilities of this nature, however, the coverage may not be sufficient to cover all claims and liabilities. While a loss from these matters is reasonably possible, the Company cannot reasonably estimate a range of possible losses because our investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

The Company is involved in other pending and threatened litigation of the character incidental to the business transacted, arising out of its operations and is from time to time involved as a party in various governmental and administrative proceedings. These investigations, audits and reviews include routine and special investigations by state insurance departments, state attorneys general, the U.S. Attorney General and Federal Agencies. Such investigations could result in the imposition of civil or criminal fines, penalties and other sanctions. The Company believes that any liability that may result from any one of these actions is unlikely to have a material adverse effect on the Company's financial position or results of operations.

15. Leases

A. Lessee Leasing Arrangements

1. The Company leases office space and equipment under various non-cancelable and cancelable operating lease that expire through August 2020. Rental expense related to these leases totaled \$426,215 and \$577,625 for the years ended December 31, 2014 and 2013.
2. At January 1, 2015, the minimum aggregate rental commitments are as follows:

Year Ending December 31	Operating Leases
2015	\$ 2,297,573
2016	2,121,975
2017	2,148,424
2018	2,200,744
2019	2,007,660
Total	\$ 10,776,376

3. The Company has not entered into any material sale-leaseback transactions.

B. Lessor Leasing Arrangements

1. The Company has not entered into any operating leases.
2. The Company has not entered into any leverage leases.

16. Information about Financial Instruments with Off-Balance Sheet Risk and Financial Instruments with Concentrations of Credit Risk

The Company has no significant financial instruments with off-balance sheet risk.

Financial instruments that potentially subject the Company to concentration of credit risk consist primarily of investment securities. All investment securities are managed by professional investment managers with policies authorized by the board of directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. As of December 31, 2014, there were no significant concentrations.

17. Sale, Transfer and Servicing of Financial Assets and Extinguishments of Liabilities

A. Transfers of Receivables Reported as Sales

Not applicable at December 31, 2014 and 2013.

B. Transfer and Servicing of Financial Assets

1. The Company participates in a securities lending program whereby marketable securities in its investment portfolio are transferred to independent brokers or dealers. At December 31, 2014, the

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fair value of securities loaned was \$5,362,973 and the carrying value of securities loaned was \$5,339,862.

2. – 7. Not applicable.

C. Wash Sales

1. In the course of the Company's asset management, securities may be sold and reacquired within 30 days of the sale date to enhance the yield on the investments.
2. At December 31, 2014 and 2013, there were no wash sales involving securities with an NAIC designation of 3 or below or unrated.

18. Gain or Loss to the Reporting Entity from Uninsured A&H Plans and the Uninsured Portion of Partially Insured Plans

A. Administrative Services Only Plans

Not applicable in December 31, 2014 and 2013.

B. Administrative Services Contract Plans

Not applicable in December 31, 2014 and 2013.

C. Medicare or Other Similarly Structured Cost-Based Reimbursement Contract

CMS pays a catastrophic reinsurance subsidy, a low-income member cost sharing subsidy, and a coverage gap discount subsidy which represent cost reimbursements under the Part D program. The Company is fully reimbursed for costs incurred for these contract elements, and accordingly, there is no insurance risk to the Company. Amounts received for these subsidies are not reflected as premium revenue, but rather are accounted for as deposits. Receivables from CMS of \$1,701,632 and \$629,358 at December 31, 2014 and 2013, respectively, are recorded as receivables for amounts held under uninsured plans in the accompanying statutory statements. Liabilities to CMS of \$12,899 and \$12,360 at December 31, 2014 and 2013, respectively, are recorded as liabilities for amounts held under uninsured plans in the accompanying statutory statements.

19. Direct Premium Written/Produced by Managing General Agents/Third Party Administrators

No premiums were written by managing general agents or third party administrators during the years ended December 31, 2014 and 2013.

20. Fair Value

A. Fair Value Measurements

1. Fair Value Measurements at Reporting Date

Description for each class of asset or liability	(Level 1)	(Level 2)	(Level 3)	Total
a. Assets at fair value				
Bonds				
Industrial and Misc	\$ -	\$ 3,803,085	\$ -	\$ 3,803,085
Total bonds	\$ -	\$ 3,803,085	\$ -	\$ 3,803,085
Common stock				
Industrial and Misc	\$ 13,943,531	\$ -	\$ -	\$ 13,943,531
Total common stocks	\$ 13,943,531	\$ -	\$ -	\$ 13,943,531
Total assets at fair value	\$ 13,943,531	\$ 3,803,085	\$ -	\$ 17,746,616

2. As of December 31, 2014, there were no investments in Level 3 carried at fair value.
3. The Company's policy is to recognize transfers between Levels, if any, at the beginning of the reporting period.
4. Fair values of fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level 1 or Level 2 inputs, for the determination of fair value to facilitate fair value measurements and disclosures. United States Government securities represent Level 1 securities, while Level 2 securities primarily include corporate securities, securities from states, municipalities and political subdivisions and residential mortgage-backed securities. For securities not actively traded, the third party pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds.

Fair values of equity securities are generally designated as Level 1 and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always

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available and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level 2.

There have been no significant changes in the valuation techniques during the current period.

B. Fair Value Measurements Under Other Accounting Pronouncements

Not applicable.

C. Financial Instruments

Type of Financial Instrument	Aggregated Fair Value	Admitted Assets	(Level 1)	(Level 2)	(Level 3)	Not Practicable (Carrying Value)
Bonds	\$ 117,623,942	\$ 115,840,845	\$ -	\$ 117,623,942	\$ -	\$ -
Common Stock	13,943,531	13,943,531	13,943,531	-	-	-
Short Term Inv & MMFs	36,754,439	36,754,439	36,754,439	-	-	-
	<u>\$ 168,321,912</u>	<u>\$ 166,538,815</u>	<u>\$ 50,697,970</u>	<u>\$ 117,623,942</u>	<u>\$ -</u>	<u>\$ -</u>

D. Not Practicable to Estimate Fair Value

There are no financial instruments that were not practicable to estimate fair value.

21. Other Items

A. Extraordinary Items

Not applicable at December 31, 2014 and 2013.

B. Troubled Debt Restructuring: Debtors

Not applicable at December 31, 2014 and 2013.

C. Other Disclosures and Unusual items

Not applicable at December 31, 2014 and 2013.

D. Business Interruption Insurance Recoveries

The Company has reported no recoveries for business interruption for the years ended December 31, 2014 and 2013.

E. State Transferable Tax Credits

The Company did not have state transferable tax credits at December 31, 2014 and 2013.

F. Subprime Mortgage-Related Risk Exposure

1. The Company's investment strategy of providing safety and preservation of capital, sufficient liquidity to meet cash flow requirements and the attainment of a competitive after-tax investment return is supported by a well diversified portfolio consisting of many different types of investments. The portion of the Company's investment portfolio with subprime mortgage-related risk exposure is relatively small in comparison to the overall investment portfolio, and consists of investment grade securities with no exposure to collateralized debt obligations. All mortgage related investments are monitored closely as part of the quarterly investment review performed by the Anthem Investment Review Committee.
2. At December 31, 2014, the Company did not have carry investments in subprime mortgage loans in its portfolio.
3. At December 31, 2014, the Company's investment portfolio did not contain investments with subprime mortgage-related risk exposure.
4. The Company did not underwrite Mortgage Guaranty or Financial Guaranty insurance coverage at December 31, 2014.

G. Retained Assets

The Company did not have any retained assets at December 31, 2014 and 2013.

22. Events Subsequent

The Company is subject to an annual fee under section 9010 of the Affordable Care Act("ACA"). A health insurance company's portion of the annual fee becomes payable once the entity provides health insurance for

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

any U.S. health risk for each calendar year beginning on or after January 1 of the year the fee is due. The Company has written health insurance subject to the ACA assessment and expects to conduct health insurance business in 2015. The Company reflected its estimated portion of the fee payable on September 30, 2015 in special surplus.

	Current Year	Prior Year
A. ACA fee assessment payable for the upcoming year	\$ 21,492,886	\$ 12,405,000
B. ACA fee assessment paid	\$ 11,340,119	\$ -
C. Premium written subject to ACA 9010 assessment	\$ 805,328,358	\$ 548,510,356
D. Total Adjusted Capital before surplus adjustment	\$ 83,605,928	
E. Authorized Control Level before surplus adjustment	\$ 36,144,939	
F. Total Adjusted Capital after surplus adjustment	\$ 62,113,042	
G. Authorized Control Level after surplus adjustment	\$ 36,144,939	
H. Would reporting the ACA assessment as of December 31, 2014 have triggered an RBC action level (YES/NO)?	NO	

There were no other events occurring subsequent to December 31, 2014 requiring disclosure. Subsequent events have been considered through March 31, 2015 for the statutory statement issued on March 31, 2015.

23. Reinsurance

A. Ceded Reinsurance Report

Section 1 – General Interrogatories

- Are any of the reinsurers that are listed in Schedule S as non-affiliated owned in excess of 10% or controlled, either directly or indirectly, by the Company or by any representative, officer, trustee, or director of the Company?
Yes () No(X)

If yes, give full details.

- Have any policies issued by the Company been reinsured with a company chartered in a country other than the United States (excluding U.S. Branches of such companies) that is owned in excess of 10% or controlled, directly or indirectly, by an insured, a beneficiary, a creditor or an insured or any other person not primarily engaged in the insurance business?

Yes () No(X)

If yes, give full details

Section 2 – Ceded Reinsurance Report – Part A

- Does the Company have any reinsurance agreements in effect under which the reinsurer may unilaterally cancel any reinsurance for reasons other than for nonpayment of premium or other similar credits?

Yes () No(X)

- Does the reporting entity have any reinsurance agreements in effect such that the amount of losses paid or accrued through the statement date may result in a payment to the reinsurer of amounts that, in aggregate and allowing for offset of mutual credits from other reinsurance agreements with the same insurer, exceed the total direct premium collected under reinsured policies?

Yes () No(X)

If yes, give full details.

Section 3 – Ceded Reinsurance Report – Part B

- What is the estimated amount of the aggregate reduction in surplus, (for agreements other than those under which the reinsurer may unilaterally cancel for reasons other than for nonpayment of premium or other similar credits that are reflected in Section 2) above of termination of ALL reinsurance agreements, by either party, as of the date of this statement? Where necessary, the Company may consider the current or anticipated experience of the business reinsured in making this estimate.

N/A

- Have any new agreements been executed or existing agreements amended, since January 1 of the year of this statement include policies or contract that were in force or which had existing reserves established by the Company as of the effective date of the agreement?

Yes () No(X)

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B. Uncollectible Reinsurance

The Company has no uncollectible reinsurance at December 31, 2014 and 2013.

C. Commutation of Ceded Reinsurance

The Company has not commuted ceded reinsurance during 2014 and 2013.

D. Certified Reinsurer Rating Downgraded or Status Subject Revocation

The Company has no downgraded certified reinsurer ratings or status subject revocations during 2014 and 2013.

24. Retrospectively Rated Contracts and Contracts Subject to Redetermination

A. The Company sells accident and health policies for which the premiums vary based on loss experience. The Company estimates retrospective premium adjustments through the review of each retrospectively rate account, comparing the claim development with that anticipated in the policy contracts.

B. The Company records accrued retrospective premium through written premium.

C. The amount of net premiums written by the Company at December 31, 2014 and 2013 that are subject to retrospective rating features was \$105,214,066 and \$109,545,372 respectively, which represents 11.2% and 18.3% of the total net premiums written. No other net premiums written by the Company are subject to retrospective rating features.

D. The Company participates only in Medicaid and Medicare business and is not currently subject to the medical loss rebates required by the Federal 2010 Patient Protection and Affordable Care and Public Health Service Acts.

E. Risk-Sharing Provisions of ACA

1. Did the reporting entity write accident and health insurance premium which is subject to the Affordable Care Act risk sharing provisions (YES/NO)? No

2. Not applicable.

3. Not applicable.

25. Change in Incurred Claims and Claim Adjustment Expenses

The estimated cost of claims and claim adjustment expense attributable to insured events of prior years increased by \$2,102,072 during 2014. This is approximately 4.0% of unpaid claims and claim adjustment expense of \$53,214,536 as of December 31, 2013. The deficiency reflects the increases in estimated claims expenses as a result of claim payments during the year, and as additional information is received regarding claims incurred prior to 2014. Recent claim development trends are also taken into account in evaluating the overall adequacy of unpaid claims and claim adjustment expense.

26. Intercompany Pooling Arrangements

Not applicable at December 31, 2014 and 2013.

27. Structured Settlements

Not applicable at December 31, 2014 and 2013.

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28. Health Care Receivables

A. Pharmaceutical Rebate Receivables

Quarter	Estimated Pharmacy Rebates as Reported on Financial Statements	Pharmacy Rebates as Billed or Otherwise Confirmed	Actual Rebates Received Within 90 Days of Billing	Actual Rebates Received Within 91 to 180 Days of Billing	Actual Rebates Received More Than 180 Days After Billing
4Q14	569,971	569,971	—	—	—
3Q14	705,786	701,447	—	—	—
2Q14	922,876	854,241	—	606,291	—
1Q14	915,677	981,014	—	732,360	245,188
4Q13	789,305	903,461	—	689,608	213,853
3Q13	759,526	896,705	—	697,907	197,543
2Q13	748,724	812,203	—	645,464	166,740
1Q13	724,048	803,849	—	626,998	176,519
4Q12	726,800	747,735	—	597,172	150,563
3Q12	750,977	720,239	—	576,496	143,743
2Q12	630,249	791,872	—	613,390	178,482
1Q12	619,522	812,747	—	654,251	156,200
4Q11	579,975	768,296	—	620,102	148,194
3Q11	552,794	757,248	—	599,697	157,552
2Q11	567,999	712,195	—	—	712,177
1Q11	653,684	790,331	—	—	789,489

B. Risk Sharing Receivables

Not applicable at December 31, 2014 and 2013.

29. Participating Policies

Not applicable at December 31, 2014 and 2013.

30. Premium Deficiency Reserves

- Liability carried for premium deficiency reserves \$ 1,535,613
- Date of the most recent evaluation of this liability December 31, 2014
- Was anticipated investment income utilized in the calculation? Yes [] No [X]

The Company recorded premium deficiency reserves of \$1,535,613 at December 31, 2014.

31. Anticipated Subrogation and Other Recoveries

The Company took into account estimated anticipated subrogation and other recoveries in its determination of the liability for unpaid claims and reduced the liability by \$554,000 and \$985,000 at December 31, 2014 and 2013, respectively.

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GENERAL INTERROGATORIES

**PART 1 - COMMON INTERROGATORIES
GENERAL**

- 1.1 Is the reporting entity a member of an Insurance Holding Company System consisting of two or more affiliated persons, one or more of which is an insurer? Yes [X] No []
If yes, complete Schedule Y, Parts 1, 1A and 2
- 1.2 If yes, did the reporting entity register and file with its domiciliary State Insurance Commissioner, Director or Superintendent, or with such regulatory official of the state of domicile of the principal insurer in the Holding Company System, a registration statement providing disclosure substantially similar to the standards adopted by the National Association of Insurance Commissioners (NAIC) in its Model Insurance Holding Company System Regulatory Act and model regulations pertaining thereto, or is the reporting entity subject to standards and disclosure requirements substantially similar to those required by such Act and regulations? Yes [X] No [] N/A []
- 1.3 State Regulating? Florida
- 2.1 Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation, or deed of settlement of the reporting entity? Yes [] No [X]
- 2.2 If yes, date of change:
- 3.1 State as of what date the latest financial examination of the reporting entity was made or is being made. 12/31/2012
- 3.2 State the as of date that the latest financial examination report became available from either the state of domicile or the reporting entity. This date should be the date of the examined balance sheet and not the date the report was completed or released. 12/31/2012
- 3.3 State as of what date the latest financial examination report became available to other states or the public from either the state of domicile or the reporting entity. This is the release date or completion date of the examination report and not the date of the examination (balance sheet date). 03/01/2014
- 3.4 By what department or departments?
State of Florida Office of Insurance Regulation
- 3.5 Have all financial statement adjustments within the latest financial examination report been accounted for in a subsequent financial statement filed with Departments? Yes [X] No [] N/A []
- 3.6 Have all of the recommendations within the latest financial examination report been complied with? Yes [X] No [] N/A []
- 4.1 During the period covered by this statement, did any agent, broker, sales representative, non-affiliated sales/service organization or any combination thereof under common control (other than salaried employees of the reporting entity), receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.11 sales of new business? Yes [] No [X]
4.12 renewals? Yes [] No [X]
- 4.2 During the period covered by this statement, did any sales/service organization owned in whole or in part by the reporting entity or an affiliate, receive credit or commissions for or control a substantial part (more than 20 percent of any major line of business measured on direct premiums) of:
4.21 sales of new business? Yes [] No [X]
4.22 renewals? Yes [] No [X]
- 5.1 Has the reporting entity been a party to a merger or consolidation during the period covered by this statement? Yes [] No [X]
- 5.2 If yes, provide the name of the entity, NAIC Company Code, and state of domicile (use two letter state abbreviation) for any entity that has ceased to exist as a result of the merger or consolidation.
- | 1
Name of Entity | 2
NAIC Company Code | 3
State of Domicile |
|---------------------|------------------------|------------------------|
| | | |
- 6.1 Has the reporting entity had any Certificates of Authority, licenses or registrations (including corporate registration, if applicable) suspended or revoked by any governmental entity during the reporting period? Yes [] No [X]
- 6.2 If yes, give full information:
- 7.1 Does any foreign (non-United States) person or entity directly or indirectly control 10% or more of the reporting entity? Yes [] No [X]
- 7.2 If yes,
7.21 State the percentage of foreign control; %
7.22 State the nationality(s) of the foreign person(s) or entity(s) or if the entity is a mutual or reciprocal, the nationality of its manager or attorney-in-fact; and identify the type of entity(s) (e.g., individual, corporation or government, manager or attorney in fact).
- | 1
Nationality | 2
Type of Entity |
|------------------|---------------------|
| | |

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GENERAL INTERROGATORIES

8.1 Is the company a subsidiary of a bank holding company regulated by the Federal Reserve Board? Yes [] No [X]

8.2 If response to 8.1 is yes, please identify the name of the bank holding company.

8.3 Is the company affiliated with one or more banks, thrifts or securities firms? Yes [] No [X]

8.4 If response to 8.3 is yes, please provide below the names and location (city and state of the main office) of any affiliates regulated by a federal regulatory services agency [i.e. the Federal Reserve Board (FRB), the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Securities Exchange Commission (SEC)] and identify the affiliate's primary federal regulator.

1 Affiliate Name	2 Location (City, State)	3 FRB	4 OCC	5 FDIC	6 SEC

9. What is the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit?
Ernst & Young LLP, 111 Monument Circle, Suite 2600, Indianapolis, IN 46204

10.1 Has the insurer been granted any exemptions to the prohibited non-audit services provided by the certified independent public accountant requirements as allowed in Section 7H of the Annual Financial Reporting Model Regulation (Model Audit Rule), or substantially similar state law or regulation? Yes [] No [X]

10.2 If the response to 10.1 is yes, provide information related to this exemption:

10.3 Has the insurer been granted any exemptions related to the other requirements of the Annual Financial Reporting Model Regulation as allowed for in Section 17A of the Model Regulation, or substantially similar state law or regulation? Yes [] No [X]

10.4 If the response to 10.3 is yes, provide information related to this exemption:

10.5 Has the reporting entity established an Audit Committee in compliance with the domiciliary state insurance laws? Yes [X] No [] N/A []

10.6 If the response to 10.5 is no or n/a, please explain

11. What is the name, address and affiliation (officer/employee of the reporting entity or actuary/consultant associated with an actuarial consulting firm) of the individual providing the statement of actuarial opinion/certification?
Mark Justus, FSA, MAAA, Director and Actuary III (employee); 3350 Peachtree Road, Atlanta, GA 30326

12.1 Does the reporting entity own any securities of a real estate holding company or otherwise hold real estate indirectly? Yes [] No [X]

12.11 Name of real estate holding company
12.12 Number of parcels involved
12.13 Total book/adjusted carrying value \$

12.2 If, yes provide explanation:

13. **FOR UNITED STATES BRANCHES OF ALIEN REPORTING ENTITIES ONLY:**

13.1 What changes have been made during the year in the United States manager or the United States trustees of the reporting entity?

13.2 Does this statement contain all business transacted for the reporting entity through its United States Branch on risks wherever located? Yes [] No []

13.3 Have there been any changes made to any of the trust indentures during the year? Yes [] No []

13.4 If answer to (13.3) is yes, has the domiciliary or entry state approved the changes? Yes [] No [] N/A []

14.1 Are the senior officers (principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions) of the reporting entity subject to a code of ethics, which includes the following standards? Yes [X] No []

(a) Honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships;
(b) Full, fair, accurate, timely and understandable disclosure in the periodic reports required to be filed by the reporting entity;
(c) Compliance with applicable governmental laws, rules and regulations;
(d) The prompt internal reporting of violations to an appropriate person or persons identified in the code; and
(e) Accountability for adherence to the code.

14.11 If the response to 14.1 is No, please explain:

14.2 Has the code of ethics for senior managers been amended? Yes [X] No []

14.21 If the response to 14.2 is yes, provide information related to amendment(s).
Effective January 2014, the Company adopted Anthem's Standards of Ethical Business Conduct as approved by the Board of Directors.

14.3 Have any provisions of the code of ethics been waived for any of the specified officers? Yes [] No [X]

14.31 If the response to 14.3 is yes, provide the nature of any waiver(s).

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

- 15.1 Is the reporting entity the beneficiary of a Letter of Credit that is unrelated to reinsurance where the issuing or confirming bank is not on the SVO Bank List? Yes [] No [X]
- 15.2 If the response to 15.1 is yes, indicate the American Bankers Association (ABA) Routing Number and the name of the issuing or confirming bank of the Letter of Credit and describe the circumstances in which the Letter of Credit is triggered.

1 American Bankers Association (ABA) Routing Number	2 Issuing or Confirming Bank Name	3 Circumstances That Can Trigger the Letter of Credit	4 Amount

BOARD OF DIRECTORS

16. Is the purchase or sale of all investments of the reporting entity passed upon either by the board of directors or a subordinate committee thereof? Yes [X] No []
17. Does the reporting entity keep a complete permanent record of the proceedings of its board of directors and all subordinate committees thereof? Yes [X] No []
18. Has the reporting entity an established procedure for disclosure to its board of directors or trustees of any material interest or affiliation on the part of any of its officers, directors, trustees or responsible employees that is in conflict with the official duties of such person? Yes [X] No []

FINANCIAL

19. Has this statement been prepared using a basis of accounting other than Statutory Accounting Principles (e.g., Generally Accepted Accounting Principles)? Yes [] No [X]
- 20.1 Total amount loaned during the year (inclusive of Separate Accounts, exclusive of policy loans):
- | | |
|---|----|
| 20.11 To directors or other officers | \$ |
| 20.12 To stockholders not officers | \$ |
| 20.13 Trustees, supreme or grand (Fraternal Only) | \$ |
- 20.2 Total amount of loans outstanding at the end of year (inclusive of Separate Accounts, exclusive of policy loans):
- | | |
|---|----|
| 20.21 To directors or other officers | \$ |
| 20.22 To stockholders not officers | \$ |
| 20.23 Trustees, supreme or grand (Fraternal Only) | \$ |
- 21.1 Were any assets reported in this statement subject to a contractual obligation to transfer to another party without the liability for such obligation being reported in the statement? Yes [] No [X]
- 21.2 If yes, state the amount thereof at December 31 of the current year:
- | | |
|----------------------------|----|
| 21.21 Rented from others | \$ |
| 21.22 Borrowed from others | \$ |
| 21.23 Leased from others | \$ |
| 21.24 Other | \$ |
- 22.1 Does this statement include payments for assessments as described in the Annual Statement Instructions other than guaranty fund or guaranty association assessments? Yes [] No [X]
- 22.2 If answer is yes:
- | | |
|--|----|
| 22.21 Amount paid as losses or risk adjustment | \$ |
| 22.22 Amount paid as expenses | \$ |
| 22.23 Other amounts paid | \$ |
- 23.1 Does the reporting entity report any amounts due from parent, subsidiaries or affiliates on Page 2 of this statement? Yes [X] No []
- 23.2 If yes, indicate any amounts receivable from parent included in the Page 2 amount: \$ 0

INVESTMENT

- 24.01 Were all the stocks, bonds and other securities owned December 31 of current year, over which the reporting entity has exclusive control, in the actual possession of the reporting entity on said date? (other than securities lending programs addressed in 24.03) Yes [X] No []
- 24.02 If no, give full and complete information relating thereto
- 24.03 For security lending programs, provide a description of the program including value for collateral and amount of loaned securities, and whether collateral is carried on or off-balance sheet, (an alternative is to reference Note 17 where this information is also provided) The company's securities lending program authorizes lending agents to loan securities to approved borrowers for a negotiated fee. These loans are collateralized with 102% cash and the collateral is invested according to guidelines of the company's Investment Policy. For Statutory reporting, the collateral is carried off-balance sheet.
FMV of invested collateral - \$5,498,223
FMV of loaned securities - \$5,362,973
- 24.04 Does the Company's security lending program meet the requirements for a conforming program as outlined in the Risk-Based Capital Instructions? Yes [X] No [] N/A []
- 24.05 If answer to 24.04 is yes, report amount of collateral for conforming programs. \$ 5,497,979
- 24.06 If answer to 24.04 is no, report amount of collateral for other programs. \$
- 24.07 Does your securities lending program require 102% (domestic securities) and 105% (foreign securities) from the counterparty at the outset of the contract? Yes [X] No [] N/A []
- 24.08 Does the reporting entity non-admit when the collateral received from the counterparty falls below 100%? Yes [X] No [] N/A []
- 24.09 Does the reporting entity or the reporting entity's securities lending agent utilize the Master Securities lending Agreement (MSLA) to conduct securities lending? Yes [X] No [] N/A []

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

24.10 For the reporting entity's security lending program state the amount of the following as December 31 of the current year:

24.101	Total fair value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2	\$	5,496,223
24.102	Total book adjusted/carrying value of reinvested collateral assets reported on Schedule DL, Parts 1 and 2	\$	5,497,979
24.103	Total payable for securities lending reported on the liability page	\$	5,497,979

25.1 Were any of the stocks, bonds or other assets of the reporting entity owned at December 31 of the current year not exclusively under the control of the reporting entity, or has the reporting entity sold or transferred any assets subject to a put option contract that is currently in force? (Exclude securities subject to Interrogatory 21.1 and 24.03). Yes [☒] No [☐]

25.2 If yes, state the amount thereof at December 31 of the current year:

25.21	Subject to repurchase agreements	\$
25.22	Subject to reverse repurchase agreements	\$
25.23	Subject to dollar repurchase agreements	\$
25.24	Subject to reverse dollar repurchase agreements	\$
25.25	Placed under option agreements	\$
25.26	Letter stock or securities restricted as to sale - excluding FHLB Capital Stock	\$
25.27	FHLB Capital Stock	\$
25.28	On deposit with states	\$
25.29	On deposit with other regulatory bodies	\$
25.30	Pledged as collateral - excluding collateral pledged to an FHLB	\$
25.31	Pledged as collateral to FHLB - including assets backing funding agreements	\$
25.32	Other	\$

25.3 For category (25.26) provide the following:

1 Nature of Restriction	2 Description	3 Amount

26.1 Does the reporting entity have any hedging transactions reported on Schedule DB? Yes [☐] No [☒]26.2 If yes, has a comprehensive description of the hedging program been made available to the domiciliary state? Yes [☐] No [☐] N/A [☒]
If no, attach a description with this statement.27.1 Were any preferred stocks or bonds owned as of December 31 of the current year mandatorily convertible into equity, or, at the option of the issuer, convertible into equity? Yes [☐] No [☒]

27.2 If yes, state the amount thereof at December 31 of the current year: \$

28. Excluding items in Schedule E - Part 3 - Special Deposits, real estate, mortgage loans and investments held physically in the reporting entity's offices, vaults or safety deposit boxes, were all stocks, bonds and other securities, owned throughout the current year held pursuant to a custodial agreement with a qualified bank or trust company in accordance with Section 1, III - General Examination Considerations, F. Outsourcing of Critical Functions, Custodial or Safekeeping Agreements of the NAIC Financial Condition Examiners Handbook? Yes [☒] No [☐]

28.01 For agreements that comply with the requirements of the NAIC Financial Condition Examiners Handbook, complete the following:

1 Name of Custodian(s)	2 Custodian's Address
Bank of New York Mellon Corporation	One BNY Mellon Center Room 151-1035 Pittsburgh, PA 15258

28.02 For all agreements that do not comply with the requirements of the NAIC Financial Condition Examiners Handbook, provide the name, location and a complete explanation:

1 Name(s)	2 Location(s)	3 Complete Explanation(s)

28.03 Have there been any changes, including name changes, in the custodian(s) identified in 28.01 during the current year? Yes [☐] No [☒]

28.04 If yes, give full and complete information relating thereto:

1 Old Custodian	2 New Custodian	3 Date of Change	4 Reason

28.05 Identify all investment advisors, brokers/dealers or individuals acting on behalf of brokers/dealers that have access to the investment accounts, handle securities and have authority to make investments on behalf of the reporting entity:

1 Central Registration Depository Number(s)	2 Name	3 Address
105006	Deutsche Asset Management	New York, NY
113878	McDonnell Investment Management, LLC	Oak Brook, IL

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

- 29.1 Does the reporting entity have any diversified mutual funds reported in Schedule D, Part 2 (diversified according to the Securities and Exchange Commission (SEC) in the Investment Company Act of 1940 [Section 5(b)(1)])? Yes [] No [X]
- 29.2 If yes, complete the following schedule:

1 CUSIP #	2 Name of Mutual Fund	3 Book/Adjusted Carrying Value
29.2999 - Total		0

- 29.3 For each mutual fund listed in the table above, complete the following schedule:

1 Name of Mutual Fund (from above table)	2 Name of Significant Holding of the Mutual Fund	3 Amount of Mutual Fund's Book/Adjusted Carrying Value Attributable to the Holding	4 Date of Valuation

30. Provide the following information for all short-term and long-term bonds and all preferred stocks. Do not substitute amortized value or statement value for fair value.

	1 Statement (Admitted) Value	2 Fair Value	3 Excess of Statement over Fair Value (-), or Fair Value over Statement (+)
30.1 Bonds	152,595,284	154,378,381	1,783,097
30.2 Preferred stocks	0		0
30.3 Totals	152,595,284	154,378,381	1,783,097

- 30.4 Describe the sources or methods utilized in determining the fair values:
Fair values were obtained from third-party pricing sources. If a security was not priced by a third-party pricing source, internal analytical systems or broker quotes were utilized.

- 31.1 Was the rate used to calculate fair value determined by a broker or custodian for any of the securities in Schedule D? Yes [] No [X]

- 31.2 If the answer to 31.1 is yes, does the reporting entity have a copy of the broker's or custodian's pricing policy (hard copy or electronic copy) for all brokers or custodians used as a pricing source? Yes [] No []

- 31.3 If the answer to 31.2 is no, describe the reporting entity's process for determining a reliable pricing source for purposes of disclosure of fair value for Schedule D:

- 32.1 Have all the filing requirements of the Purposes and Procedures Manual of the NAIC Securities Valuation Office been followed? Yes [X] No []

- 32.2 If no, list exceptions:

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

OTHER

33.1 Amount of payments to trade associations, service organizations and statistical or rating bureaus, if any?\$

33.2 List the name of the organization and the amount paid if any such payment represented 25% or more of the total payments to trade associations, service organizations and statistical or rating bureaus during the period covered by this statement.

1 Name	2 Amount Paid

34.1 Amount of payments for legal expenses, if any?\$461,462

34.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payments for legal expenses during the period covered by this statement.

1 Name	2 Amount Paid
Hogan Lovells	125,451

35.1 Amount of payments for expenditures in connection with matters before legislative bodies, officers or departments of government, if any?\$246,000

35.2 List the name of the firm and the amount paid if any such payment represented 25% or more of the total payment expenditures in connection with matters before legislative bodies, officers or departments of government during the period covered by this statement.

1 Name	2 Amount Paid
Cocoran Johnston & Blair	120,000
Larry J. Overton & Associates	96,000
Lobbying expenses disclosed reflect amounts reported in the Lobbyist Disclosure Reports filed with the Secretary of State as well as the cost of external contractors who provided lobbying services to the Company. The amount may include expenses that may have been paid by an affiliate on behalf of the Company and, as a result, may not be included in the Underwriting Gain reported on page 4 of the 2014 Annual Statement.	

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

PART 2 - HEALTH INTERROGATORIES

1.1 Does the reporting entity have any direct Medicare Supplement Insurance in force? Yes [] No [X]

1.2 If yes, indicate premium earned on U.S. business only. \$

1.3 What portion of Item (1.2) is not reported on the Medicare Supplement Insurance Experience Exhibit? \$

1.31 Reason for excluding

1.4 Indicate amount of earned premium attributable to Canadian and/or Other Alien not included in Item (1.2) above \$

1.5 Indicate total incurred claims on all Medicare Supplement Insurance. \$ 0

1.6 Individual policies:

Most current three years:

1.61 Total premium earned \$ 0

1.62 Total incurred claims \$ 0

1.63 Number of covered lives 0

All years prior to most current three years:

1.64 Total premium earned \$ 0

1.65 Total incurred claims \$ 0

1.66 Number of covered lives 0

1.7 Group policies:

Most current three years:

1.71 Total premium earned \$ 0

1.72 Total incurred claims \$ 0

1.73 Number of covered lives 0

All years prior to most current three years:

1.74 Total premium earned \$ 0

1.75 Total incurred claims \$ 0

1.76 Number of covered lives 0

2. Health Test:

	1 Current Year	2 Prior Year
2.1 Premium Numerator	938,450,419	599,620,381
2.2 Premium Denominator	938,450,419	599,620,381
2.3 Premium Ratio (2.1/2.2)	1.000	1.000
2.4 Reserve Numerator	86,343,857	51,832,453
2.5 Reserve Denominator	86,343,857	51,832,453
2.6 Reserve Ratio (2.4/2.5)	1.000	1.000

3.1 Has the reporting entity received any endowment or gift from contracting hospitals, physicians, dentists, or others that is agreed will be returned when, as and if the earnings of the reporting entity permits? Yes [] No [X]

3.2 If yes, give particulars:

4.1 Have copies of all agreements stating the period and nature of hospitals', physicians', and dentists' care offered to subscribers and dependents been filed with the appropriate regulatory agency? Yes [X] No []

4.2 If not previously filed, furnish herewith a copy(ies) of such agreement(s). Do these agreements include additional benefits offered? Yes [] No []

5.1 Does the reporting entity have stop-loss reinsurance? Yes [] No [X]

5.2 If no, explain:

5.3 Maximum retained risk (see instructions)

5.31 Comprehensive Medical \$

5.32 Medical Only \$

5.33 Medicare Supplement \$

5.34 Dental & Vision \$

5.35 Other Limited Benefit Plan \$

5.36 Other \$

6. Describe arrangement which the reporting entity may have to protect subscribers and their dependents against the risk of insolvency including hold harmless provisions, conversion privileges with other carriers, agreements with providers to continue rendering services, and any other agreements:
Physician and hospital contracts contain provisions, including hold harmless agreements, to protect members and dependents against insolvency.

7.1 Does the reporting entity set up its claim liability for provider services on a service date basis? Yes [X] No []

7.2 If no, give details

8. Provide the following information regarding participating providers:

8.1 Number of providers at start of reporting year 13,323

8.2 Number of providers at end of reporting year 14,256

9.1 Does the reporting entity have business subject to premium rate guarantees? Yes [] No [X]

9.2 If yes, direct premium earned:

9.21 Business with rate guarantees between 15-36 months \$

9.22 Business with rate guarantees over 36 months \$

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

GENERAL INTERROGATORIES

- 10.1 Does the reporting entity have Incentive Pool, Withhold or Bonus Arrangements in its provider contracts? Yes [☒] No [☐]
- 10.2 If yes:
- 10.21 Maximum amount payable bonuses.....\$
10.22 Amount actually paid for year bonuses.....\$2,151,896
10.23 Maximum amount payable withholds.....\$
10.24 Amount actually paid for year withholds.....\$
- 11.1 Is the reporting entity organized as:
- 11.12 A Medical Group/Staff Model..... Yes [☐] No [☒]
11.13 An Individual Practice Association (IPA), or, .. Yes [☐] No [☒]
11.14 A Mixed Model (combination of above)? Yes [☒] No [☐]
- 11.2 Is the reporting entity subject to Minimum Net Worth Requirements? Yes [☒] No [☐]
- 11.3 If yes, show the name of the state requiring such net worth. Florida
- 11.4 If yes, show the amount required.\$21,769,008
- 11.5 Is this amount included as part of a contingency reserve in stockholder's equity? Yes [☐] No [☒]
- 11.6 If the amount is calculated, show the calculation
2% December 31, 2014 annualized premiums from Income Statement = 2% * \$938,450,419 + \$3,000,000 (PHP consent order) = 21,769,008
12. List service areas in which reporting entity is licensed to operate:

1 Name of Service Area
Brevard
Broward
Hardee
Highlands
Hillsborough
Lake
Manatee
Miami-Dade
Monroe
Pasco
Palm Beach
Pinellas
Polk
Orange
Osceola
Sarasota
Seminole
Volusia

- 13.1 Do you act as a custodian for health savings accounts? Yes [☐] No [☒]
- 13.2 If yes, please provide the amount of custodial funds held as of the reporting date.\$
- 13.3 Do you act as an administrator for health savings accounts? Yes [☐] No [☒]
- 13.4 If yes, please provide the balance of funds administered as of the reporting date.\$
- 14.1 Are any of the captive affiliates reported on Schedule S, Part 3, authorized reinsurers? Yes [☐] No [☐] N/A [☒]
- 14.2 If the answer to 14.1 is yes, please provide the following:

1 Company Name	2 NAIC Company Code	3 Domiciliary Jurisdiction	4 Reserve Credit	Assets Supporting Reserve Credit		
				5 Letters of Credit	6 Trust Agreements	7 Other

15. Provide the following for individual ordinary life insurance* policies (U.S. business only) for the current year (prior to reinsurance assumed or ceded):

- 15.1 Direct Premium Written\$
15.2 Total Incurred Claims\$
15.3 Number of Covered Lives

*Ordinary Life Insurance Includes
Term (whether full underwriting, limited underwriting, jet issue, "short form app")
Whole Life (whether full underwriting, limited underwriting, jet issue, "short form app")
Variable Life (with or without secondary guarantee)
Universal Life (with or without secondary guarantee)
Variable Universal Life (with or without secondary guarantee)

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

FIVE-YEAR HISTORICAL DATA

	1 2014	2 2013	3 2012	4 2011	5 2010
Balance Sheet (Pages 2 and 3)					
1. Total admitted assets (Page 2, Line 28)	219,433,430	155,734,148	118,391,216	113,143,698	154,020,622
2. Total liabilities (Page 3, Line 24)	135,827,502	82,312,994	40,871,014	49,265,033	88,951,546
3. Statutory surplus	21,769,008	14,993,600	15,033,596	14,559,899	14,256,855
4. Total capital and surplus (Page 3, Line 33)	83,605,928	73,421,154	77,520,202	63,878,665	65,069,076
Income Statement (Page 4)					
5. Total revenues (Line 8)	938,255,404	599,462,959	601,679,818	577,994,950	562,842,742
6. Total medical and hospital expenses (Line 18)	864,473,296	523,370,721	520,920,122	519,282,832	471,167,432
7. Claims adjustment expenses (Line 20)	51,537,238	41,192,030	15,818,014	16,472,571	14,271,241
8. Total administrative expenses (Line 21)	56,823,350	25,603,756	49,470,432	52,744,276	54,271,993
9. Net underwriting gain (loss) (Line 24)	(36,114,093)	9,296,452	15,471,250	(10,504,729)	23,132,076
10. Net investment gain (loss) (Line 27)	3,183,244	1,770,216	991,278	1,201,482	1,249,279
11. Total other income (Lines 28 plus 29)	0	23,500	23,263	0	0
12. Net income or (loss) (Line 32)	(26,651,523)	6,759,103	11,541,636	(3,064,292)	15,663,462
Cash Flow (Page 6)					
13. Net cash from operations (Line 11)	16,513,999	24,936,007	6,930,116	(45,805,968)	19,107,487
Risk-Based Capital Analysis					
14. Total adjusted capital	83,605,928	73,421,154	77,520,202	63,878,665	65,069,076
15. Authorized control level risk-based capital	36,144,939	18,641,375	18,862,444	18,936,640	16,857,790
Enrollment (Exhibit 1)					
16. Total members at end of period (Column 5, Line 7)	364,108	239,177	256,002	256,580	263,127
17. Total members months (Column 6, Line 7)	3,613,410	2,947,017	3,146,682	3,101,235	3,089,226
Operating Percentage (Page 4) (Item divided by Page 4, sum of Lines 2, 3 and 5) x 100.0					
18. Premiums earned plus risk revenue (Line 2 plus Lines 3 and 5)	100.0	100.0	100.0	100.0	100.0
19. Total hospital and medical plus other non-health (Lines 18 plus Line 19)	92.1	87.3	86.6	89.8	83.7
20. Cost containment expenses	4.0	5.0	2.0	2.2	1.9
21. Other claims adjustment expenses	1.5	1.9	0.6	0.6	0.6
22. Total underwriting deductions (Line 23)	103.8	98.4	97.4	101.8	95.9
23. Total underwriting gain (loss) (Line 24)	(3.8)	1.6	2.6	(1.8)	4.1
Unpaid Claims Analysis (U&I Exhibit, Part 2B)					
24. Total claims incurred for prior years (Line 13, Col. 5)	49,404,878	30,593,009	30,287,092	35,952,720	39,714,615
25. Estimated liability of unpaid claims-[prior year (Line 13, Col. 6)]	51,501,048	34,275,305	38,174,388	39,673,717	42,804,694
Investments in Parent, Subsidiaries and Affiliates					
26. Affiliated bonds (Sch. D Summary, Line 12, Col. 1)	0	0	0	0	0
27. Affiliated preferred stocks (Sch. D Summary, Line 18, Col. 1)	0	0	0	0	0
28. Affiliated common stocks (Sch. D Summary, Line 24, Col. 1)	0	0	0	0	0
29. Affiliated short-term investments (subtotal included in Schedule DA Verification, Col. 5, Line 10)	0	0	0	0	0
30. Affiliated mortgage loans on real estate					
31. All other affiliated					
32. Total of above Lines 26 to 31	0	0	0	0	0
33. Total investment in parent included in Lines 26 to 31 above					

NOTE: If a party to a merger, have the two most recent years of this exhibit been restated due to a merger in compliance with the disclosure requirements of SSAP No. 3, Accounting Changes and Correction of Errors?

Yes [] No []

If no, please explain:



ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION AMERIGROUP Florida, Inc.

2. Tampa, FL

NAIC Group Code	0671	BUSINESS IN THE STATE OF		(LOCATION)							95093	
				Florida		DURING THE YEAR		2014		NAIC Company Code		
				1	2	3	4	5	6	7		8	9	10
			Comprehensive (Hospital & Medical)									
		Total	Individual	Group	Medicare Supplement	Vision Only	Dental Only	Federal Employees Health Benefit Plan	Title XVIII Medicare	Title XIX Medicaid	Other	
Total Members at end of:												
1.	Prior Year	239,177	54,827	0	0	0	0	0	2,339	176,270	5,741	
2.	First Quarter	241,963	55,576						2,228	179,294	4,865	
3.	Second Quarter	293,912	52,569						2,313	234,438	4,592	
4.	Third Quarter	359,595	48,767						2,542	302,757	5,529	
5.	Current Year	364,108	42,395						2,831	314,695	4,187	
6.	Current Year Member Months	3,613,410	614,386						29,234	2,912,993	56,797	
Total Member Ambulatory Encounters for Year:												
7.	Physician	1,683,528	221,858						35,024	1,425,688	958	
8.	Non-Physician	1,744,961	72,716						27,529	1,253,894	390,822	
9.	Total	3,428,489	294,574	0	0	0	0	0	62,553	2,679,582	391,780	
10.	Hospital Patient Days Incurred	160,753	5,181						7,363	110,191	38,018	
11.	Number of Inpatient Admissions	24,890	1,105						897	22,810	78	
12.	Health Premiums Written (b)	938,450,419	73,417,615						31,796,451	697,605,562	135,630,791	
13.	Life Premiums Direct	0										
14.	Property/Casualty Premiums Written	0										
15.	Health Premiums Earned.....	938,255,404	73,417,615						31,601,436	697,605,562	135,630,791	
16.	Property/Casualty Premiums Earned	0										
17.	Amount Paid for Provision of Health Care Services.....	831,692,520	68,449,994						29,587,645	603,341,379	130,313,502	
18.	Amount Incurred for Provision of Health Care Services	864,473,296	65,632,662						30,688,986	637,508,834	130,642,814	

(a) For health business: number of persons insured under PPO managed care products and number of persons insured under indemnity only products
(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$31,796,451



ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

EXHIBIT OF PREMIUMS, ENROLLMENT AND UTILIZATION (a)

REPORT FOR: 1. CORPORATION AMERIGROUP Florida, Inc.

2. Tampa, FL

NAIC Group Code	0671	BUSINESS IN THE STATE OF	Grand Total		4	5	DURING THE YEAR		2014	(LOCATION)		NAIC Company Code	95093	
			Comprehensive (Hospital & Medical)				6	7		8	9			10
			2	3										
		Total	Individual	Group										
Total Members at end of:														
1. Prior Year		239,177	54,827	0	0	0	0	0	0	2,339	176,270		5,741	
2. First Quarter		241,963	55,576	0	0	0	0	0	0	2,228	179,294		4,865	
3. Second Quarter		293,912	52,569	0	0	0	0	0	0	2,313	234,438		4,592	
4. Third Quarter		359,595	48,767	0	0	0	0	0	0	2,542	302,757		5,529	
5. Current Year		364,108	42,395	0	0	0	0	0	0	2,831	314,695		4,187	
6. Current Year Member Months		3,613,410	614,386	0	0	0	0	0	0	29,234	2,912,993		56,797	
Total Member Ambulatory Encounters for Year:														
7. Physician		1,683,528	221,858	0	0	0	0	0	0	35,024	1,425,688		958	
8. Non-Physician		1,744,961	72,716	0	0	0	0	0	0	27,529	1,253,894		390,822	
9. Total		3,428,489	294,574	0	0	0	0	0	0	62,553	2,679,582		391,780	
10. Hospital Patient Days Incurred		160,753	5,181	0	0	0	0	0	0	7,363	110,191		38,018	
11. Number of Inpatient Admissions		24,890	1,105	0	0	0	0	0	0	897	22,810		78	
12. Health Premiums Written (b)		938,450,419	73,417,615	0	0	0	0	0	0	31,796,451	697,605,562		135,630,791	
13. Life Premiums Direct		0	0	0	0	0	0	0	0	0	0		0	
14. Property/Casualty Premiums Written		0	0	0	0	0	0	0	0	0	0		0	
15. Health Premiums Earned		938,255,404	73,417,615	0	0	0	0	0	0	31,601,436	697,605,562		135,630,791	
16. Property/Casualty Premiums Earned		0	0	0	0	0	0	0	0	0	0		0	
17. Amount Paid for Provision of Health Care Services		831,692,520	68,449,994	0	0	0	0	0	0	29,587,645	603,341,379		130,313,502	
18. Amount Incurred for Provision of Health Care Services		864,473,296	65,632,662	0	0	0	0	0	0	30,688,986	637,508,834		130,642,814	

(a) For health business: number of persons insured under PPO managed care products0 and number of persons insured under indemnity only products0

(b) For health premiums written: amount of Medicare Title XVIII exempt from state taxes or fees \$31,796,451

30.GT

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

Schedule S - Part 1 - Section 2

NONE

Schedule S - Part 2

NONE

Schedule S - Part 3 - Section 2

NONE

Schedule S - Part 4

NONE

Schedule S - Part 4 - Bank Footnote

NONE

Schedule S - Part 5

NONE

Schedule S - Part 5 - Bank Footnote

NONE

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE S - PART 6

Five Year Exhibit of Reinsurance Ceded Business (000 Omitted)

	1 2014	2 2013	3 2012	4 2011	5 2010
A. OPERATIONS ITEMS					
1. Premiums	0	0	0	0	0
2. Title XVIII - Medicare	0	1	4	3	3
3. Title XIX - Medicaid	0	59	142	148	138
4. Commissions and reinsurance expense allowance					
5. Total hospital and medical expenses					
B. BALANCE SHEET ITEMS					
6. Premiums receivable					
7. Claims payable	0	0	0	0	0
8. Reinsurance recoverable on paid losses	0	0	0	0	0
9. Experience rating refunds due or unpaid					
10. Commissions and reinsurance expense allowances due					
11. Unauthorized reinsurance offset					
12. Offset for reinsurance with Certified Reinsurers				XXX	XXX
C. UNAUTHORIZED REINSURANCE (DEPOSITS BY AND FUNDS WITHHELD FROM)					
13. Funds deposited by and withheld from (F)	0	0	0	0	0
14. Letters of credit (L)	0	0	0	0	0
15. Trust agreements (T)	0	0	0	0	0
16. Other (O)	0	0	0	0	0
D. REINSURANCE WITH CERTIFIED REINSURERS (DEPOSITS BY AND FUNDS WITHHELD FROM)					
17. Multiple Beneficiary Trust	0	0	0	XXX	XXX
18. Funds deposited by and withheld from (F)	0	0	0	XXX	XXX
19. Letters of credit (L)	0	0	0	XXX	XXX
20. Trust agreements (T)	0	0	0	XXX	XXX
21. Other (O)	0	0	0	XXX	XXX

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE S - PART 7

Restatement of Balance Sheet to Identify Net Credit For Ceded Reinsurance

	1 As Reported (net of ceded)	2 Restatement Adjustments	3 Restated (gross of ceded)
ASSETS (Page 2, Col. 3)			
1. Cash and invested assets (Line 12)	194,773,443		194,773,443
2. Accident and health premiums due and unpaid (Line 15)	7,127,849		7,127,849
3. Amounts recoverable from reinsurers (Line 16.1)	0		0
4. Net credit for ceded reinsurance	XXX	0	0
5. All other admitted assets (Balance)	17,532,138		17,532,138
6. Total assets (Line 28)	219,433,430	0	219,433,430
LIABILITIES, CAPITAL AND SURPLUS (Page 3)			
7. Claims unpaid (Line 1)	81,781,184		81,781,184
8. Accrued medical incentive pool and bonus payments (Line 2)	2,285,913		2,285,913
9. Premiums received in advance (Line 8)	24,029,523		24,029,523
10. Funds held under reinsurance treaties with authorized and unauthorized reinsurers (Line 19 first inset amount plus second inset amount)	0		0
11. Reinsurance in unauthorized companies (Line 20 minus inset amount)	0		0
12. Reinsurance with Certified Reinsurers (Line 20 inset amount)			0
13. Funds held under reinsurance treaties with Certified Reinsurers (Line 19 third inset amount)	0		0
14. All other liabilities (Balance)	27,730,882		27,730,882
15. Total liabilities (Line 24)	135,827,502	0	135,827,502
16. Total capital and surplus (Line 33)	83,605,928	XXX	83,605,928
17. Total liabilities, capital and surplus (Line 34)	219,433,430	0	219,433,430
NET CREDIT FOR CEDED REINSURANCE			
18. Claims unpaid	0		
19. Accrued medical incentive pool	0		
20. Premiums received in advance	0		
21. Reinsurance recoverable on paid losses	0		
22. Other ceded reinsurance recoverables	0		
23. Total ceded reinsurance recoverables	0		
24. Premiums receivable	0		
25. Funds held under reinsurance treaties with authorized and unauthorized reinsurers	0		
26. Unauthorized reinsurance	0		
27. Reinsurance with Certified Reinsurers	0		
28. Funds held under reinsurance treaties with Certified Reinsurers	0		
29. Other ceded reinsurance payables/offsets	0		
30. Total ceded reinsurance payables/offsets	0		
31. Total net credit for ceded reinsurance	0		

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.
SCHEDULE T PREMIUMS AND OTHER CONSIDERATIONS

Allocated by States and Territories									
States, etc.	1	Direct Business Only							
		2	3	4	5	6	7	8	9
	Active Status	Accident & Health Premiums	Medicare Title XVIII	Medicaid Title XIX	Federal Employees Health Benefits Plan Premiums	Life & Annuity Premiums & Other Considerations	Property/Casualty Premiums	Total Columns 2 Through 7	Deposit-Type Contracts
1. Alabama	AL	N						.0	
2. Alaska	AK	N						.0	
3. Arizona	AZ	N						.0	
4. Arkansas	AR	N						.0	
5. California	CA	N						.0	
6. Colorado	CO	N						.0	
7. Connecticut	CT	N						.0	
8. Delaware	DE	N						.0	
9. District of Columbia	DC	N						.0	
10. Florida	FL	73,417,615	31,796,451	833,236,353				938,450,419	
11. Georgia	GA	N						.0	
12. Hawaii	HI	N						.0	
13. Idaho	ID	N						.0	
14. Illinois	IL	N						.0	
15. Indiana	IN	N						.0	
16. Iowa	IA	N						.0	
17. Kansas	KS	N						.0	
18. Kentucky	KY	N						.0	
19. Louisiana	LA	N						.0	
20. Maine	ME	N						.0	
21. Maryland	MD	N						.0	
22. Massachusetts	MA	N						.0	
23. Michigan	MI	N						.0	
24. Minnesota	MN	N						.0	
25. Mississippi	MS	N						.0	
26. Missouri	MO	N						.0	
27. Montana	MT	N						.0	
28. Nebraska	NE	N						.0	
29. Nevada	NV	N						.0	
30. New Hampshire	NH	N						.0	
31. New Jersey	NJ	N						.0	
32. New Mexico	NM	N						.0	
33. New York	NY	N						.0	
34. North Carolina	NC	N						.0	
35. North Dakota	ND	N						.0	
36. Ohio	OH	N						.0	
37. Oklahoma	OK	N						.0	
38. Oregon	OR	N						.0	
39. Pennsylvania	PA	N						.0	
40. Rhode Island	RI	N						.0	
41. South Carolina	SC	N						.0	
42. South Dakota	SD	N						.0	
43. Tennessee	TN	N						.0	
44. Texas	TX	N						.0	
45. Utah	UT	N						.0	
46. Vermont	VT	N						.0	
47. Virginia	VA	N						.0	
48. Washington	WA	N						.0	
49. West Virginia	WV	N						.0	
50. Wisconsin	WI	N						.0	
51. Wyoming	WY	N						.0	
52. American Samoa	AS	N						.0	
53. Guam	GU	N						.0	
54. Puerto Rico	PR	N						.0	
55. U.S. Virgin Islands	VI	N						.0	
56. Northern Mariana Islands	MP	N						.0	
57. Canada	CAN	N						.0	
58. Aggregate other alien	OT	XXX	.0	.0	.0	.0	.0	.0	.0
59. Subtotal	XXX	73,417,615	31,796,451	833,236,353	.0	.0	.0	938,450,419	.0
60. Reporting entity contributions for Employee Benefit Plans	XXX							.0	
61. Total (Direct Business)	(a) 1	73,417,615	31,796,451	833,236,353	0	0	0	938,450,419	0
DETAILS OF WRITE-INS									
58001.	XXX								
58002.	XXX								
58003.	XXX								
58998. Summary of remaining write-ins for Line 58 from overflow page	XXX	.0	.0	.0	.0	.0	.0	.0	.0
58999. Totals (Lines 58001 through 58003 plus 58998)(Line 58 above)	XXX	0	0	0	0	0	0	0	0

(L) Licensed or Chartered - Licensed Insurance Carrier or Domiciled RRG; (R) Registered - Non-domiciled RRGs; (Q) Qualified - Qualified or Accredited Reinsurer; (E) Eligible - Reporting Entities eligible or approved to write Surplus Lines in the state; (N) None of the above - Not allowed to write business in the state.
Explanation of basis of allocation by states, premiums by state, etc.

No allocation used as only licensed in one state.
(a) Insert the number of L responses except for Canada and Other Alien.

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE T - PART 2
INTERSTATE COMPACT - EXHIBIT OF PREMIUMS WRITTEN

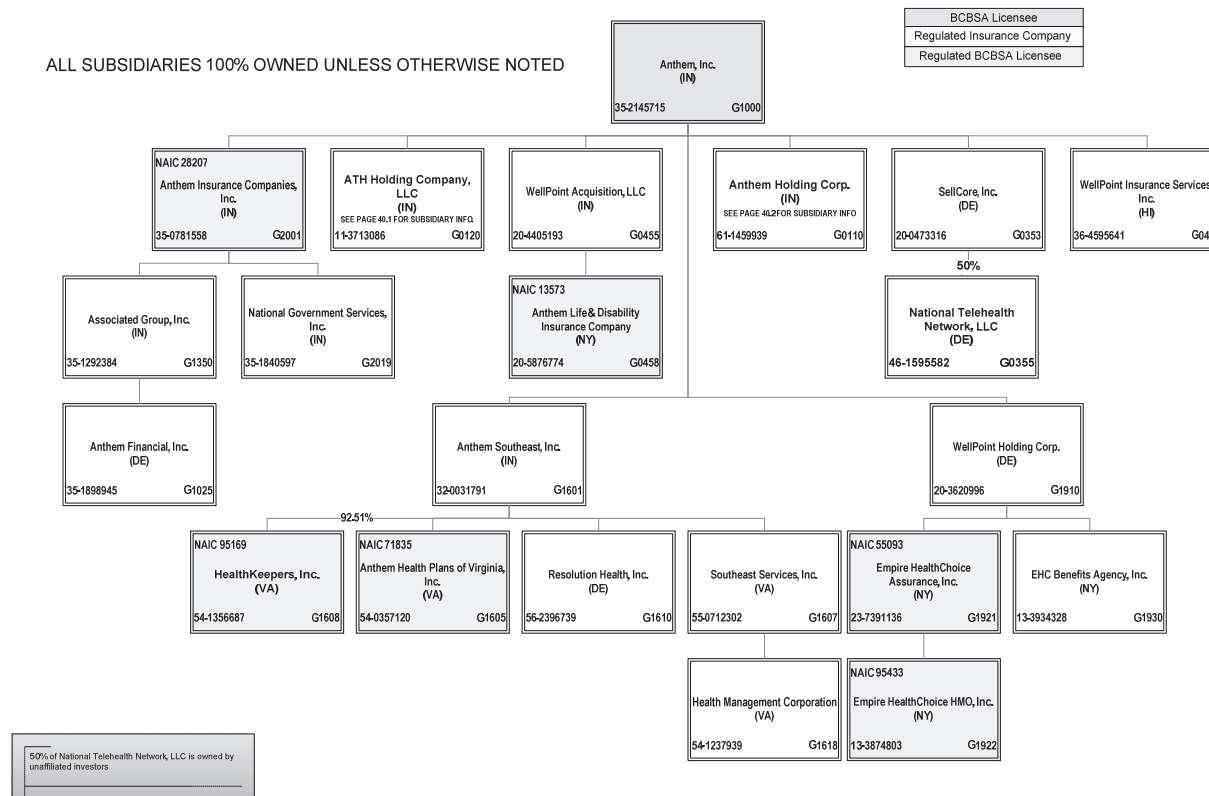
Allocated by States and Territories

States, Etc.	Direct Business Only					
	1 Life (Group and Individual)	2 Annuities (Group and Individual)	3 Disability Income (Group and Individual)	4 Long-Term Care (Group and Individual)	5 Deposit-Type Contracts	6 Totals
1. Alabama AL						
2. Alaska AK						
3. Arizona AZ						
4. Arkansas AR						
5. California CA						
6. Colorado CO						
7. Connecticut CT						
8. Delaware DE						
9. District of Columbia DC						
10. Florida FL						
11. Georgia GA						
12. Hawaii HI						
13. Idaho ID						
14. Illinois IL						
15. Indiana IN						
16. Iowa IA						
17. Kansas KS						
18. Kentucky KY						
19. Louisiana LA						
20. Maine ME						
21. Maryland MD						
22. Massachusetts MA						
23. Michigan MI						
24. Minnesota MN						
25. Mississippi MS						
26. Missouri MO						
27. Montana MT						
28. Nebraska NE						
29. Nevada NV						
30. New Hampshire NH						
31. New Jersey NJ						
32. New Mexico NM						
33. New York NY						
34. North Carolina NC						
35. North Dakota ND						
36. Ohio OH						
37. Oklahoma OK						
38. Oregon OR						
39. Pennsylvania PA						
40. Rhode Island RI						
41. South Carolina SC						
42. South Dakota SD						
43. Tennessee TN						
44. Texas TX						
45. Utah UT						
46. Vermont VT						
47. Virginia VA						
48. Washington WA						
49. West Virginia WV						
50. Wisconsin WI						
51. Wyoming WY						
52. American Samoa AS						
53. Guam GU						
54. Puerto Rico PR						
55. U.S. Virgin Islands VI						
56. Northern Mariana Islands MP						
57. Canada CAN						
58. Aggregate Other Alien OT						
59. Total						

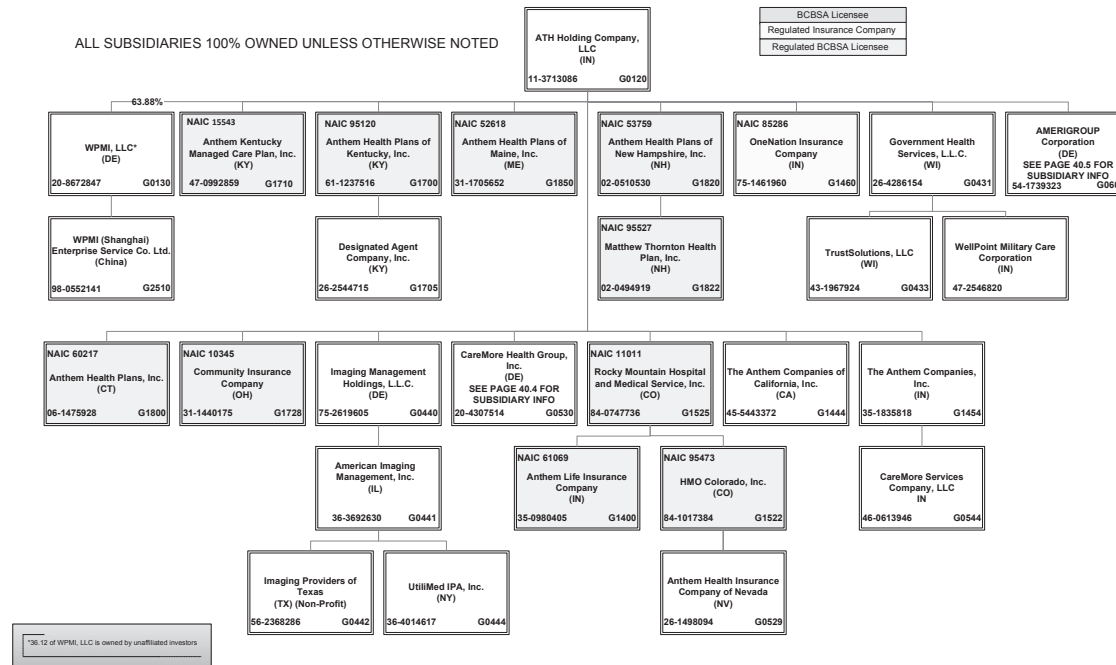
NONE

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.
SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART

40

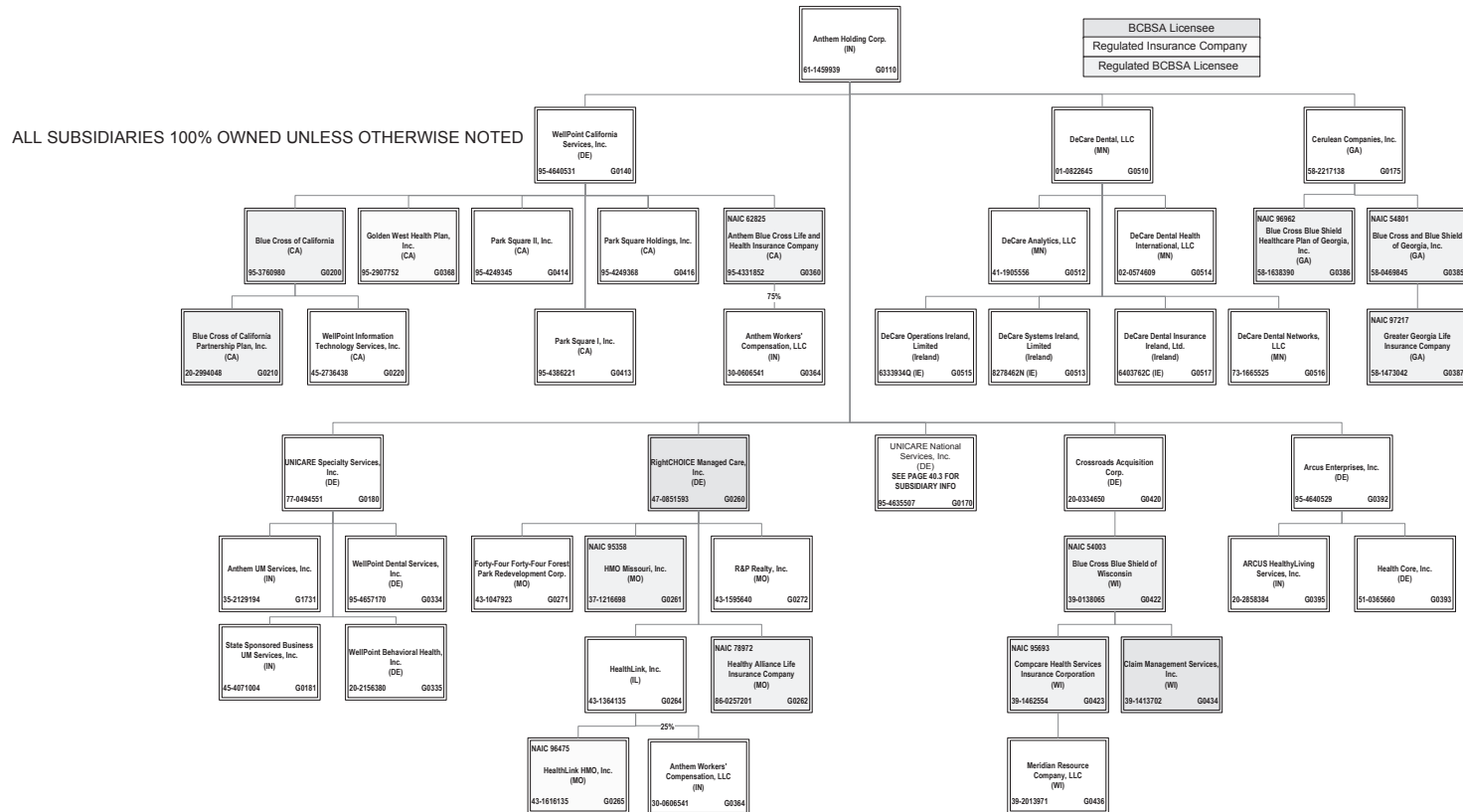


ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.
SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



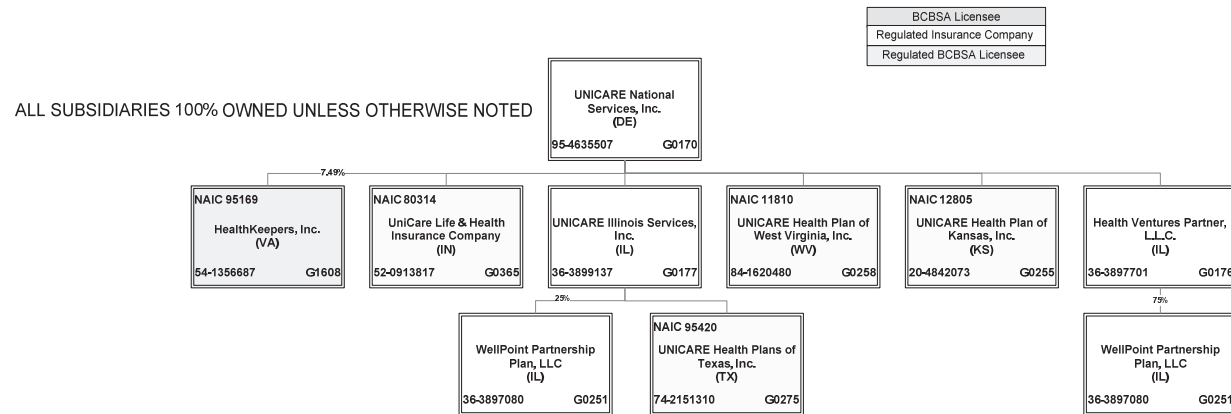
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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.
SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



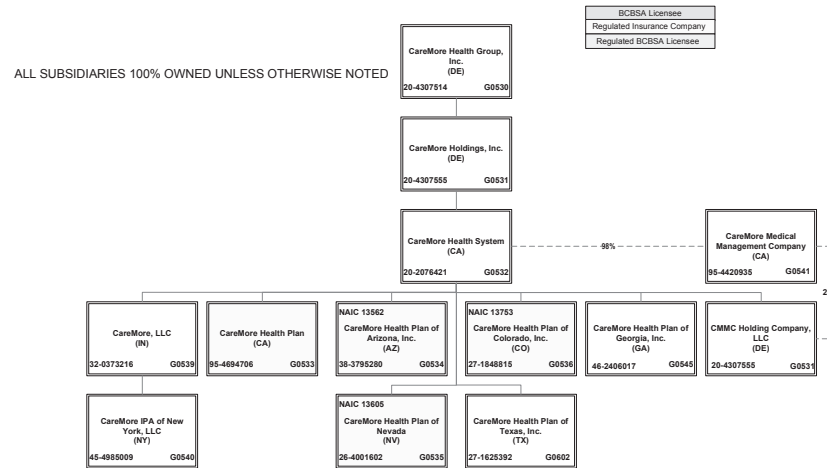
402

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.
SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



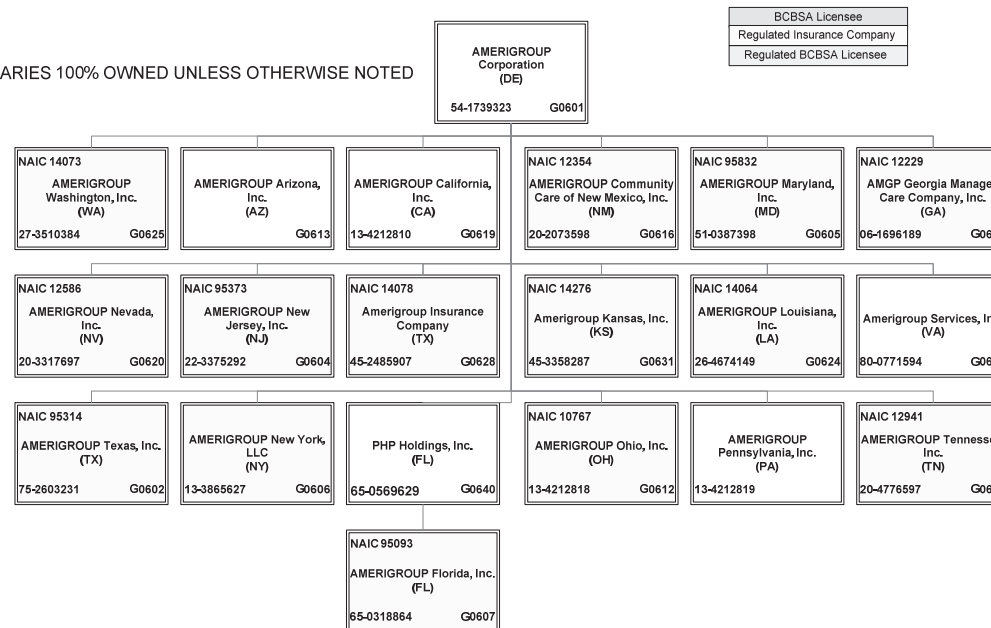
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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.
SCHEDULE Y – INFORMATION CONCERNING ACTIVITIES OF INSURER MEMBERS OF A HOLDING COMPANY GROUP
PART 1 – ORGANIZATIONAL CHART



40.4

ALL SUBSIDIARIES 100% OWNED UNLESS OTHERWISE NOTED



ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE Y
PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	*
..671	Anthem, Inc.		36-3692630				American Imaging Management, Inc.	..IL	..NIA	Imaging Management Holdings, L.L.C.	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.						AMERIGROUP Arizona, Inc.	..AZ	..NIA	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.		13-4212810				AMERIGROUP California, Inc.	..CA	..NIA	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..12354	20-2073598				AMERIGROUP Community Care of New Mexico, Inc.	..NM	..IA	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.		54-1739323				AMERIGROUP Corporation	..DE	..UIP	ATH Holding Company, LLC	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..95093	65-0318864				AMERIGROUP Florida, Inc.	..FL		PHP Holdings, Inc.	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..14078	45-2485907				Amerigroup Insurance Company	..TX	..IA	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..14276	45-336287				Amerigroup Kansas, Inc.	..KS	..IA	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..14064	26-4674149				AMERIGROUP Louisiana, Inc.	..LA	..IA	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..95832	51-0387398				AMERIGROUP Maryland, Inc.	..MD	..IA	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..12586	20-3317897				AMERIGROUP Nevada, Inc.	..NV	..IA	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..95373	22-3375292				AMERIGROUP New Jersey, Inc.	..NJ	..IA	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.		13-3865627				AMERIGROUP New York, LLC	..NY	..IA	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	..0100
..671	Anthem, Inc.	..10767	13-4212818				AMERIGROUP Ohio, Inc.	..OH	..IA	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.		13-4212819				AMERIGROUP Pennsylvania, Inc.	..PA	..NIA	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.		80-0771594				Amerigroup Services, Inc.	..VA	..NIA	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..12941	20-4776397				AMERIGROUP Tennessee, Inc.	..TN	..IA	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..95314	75-2603231				AMERIGROUP Texas, Inc.	..TX	..IA	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..14073	27-3510384				AMERIGROUP Washington, Inc.	..WA	..IA	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..12229	06-1696189				AMGP Georgia Managed Care Company, Inc.	..GA	..IA	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..62825	95-4331852				Anthem Blue Cross Life and Health Insurance Company	..CA	..IA	WellPoint California Services, Inc.	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..35-1898945					Anthem Financial, Inc.	..DE	..NIA	Associated Group, Inc.	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..26-1498094					Anthem Health Insurance Company of Nevada	..NV	..NIA	HMO Colorado, Inc.	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..95120	61-1237516				Anthem Health Plans of Kentucky, Inc.	..KY	..IA	ATH Holding Company, LLC	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..52616	31-1705652				Anthem Health Plans of Maine, Inc.	..ME	..IA	ATH Holding Company, LLC	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..53759	02-0510530				Anthem Health Plans of New Hampshire, Inc.	..NH	..IA	ATH Holding Company, LLC	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..71835	54-0357120	40003317			Anthem Health Plans of Virginia, Inc.	..VA	..IA	Anthem Southeast, Inc.	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..60217	06-1475928				Anthem Health Plans, Inc.	..CT	..IA	ATH Holding Company, LLC	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.		61-1459939				Anthem Holding Corp.	..IN	..NIA	Anthem, Inc.	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..35-2145715			6324	New York Stock Exchange -NYSE	Anthem, Inc.	..IN	..UIP				Anthem, Inc.	
..671	Anthem, Inc.	..28207	35-0781558				Anthem Insurance Companies, Inc.	..IN	..IA	Anthem, Inc.	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..15543	47-0992859				Anthem Kentucky Managed Care Plan, Inc.	..KY	..IA	ATH Holding Company, LLC	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..13573	20-5876774				Anthem Life & Disability Insurance Company	..NY	..IA	WellPoint Acquisition, LLC	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..61089	35-0980405				Anthem Life Insurance Company	..IN	..IA	Rocky Mountain Hospital and Medical Service, Inc.	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..32-0031791					Anthem Southeast, Inc.	..IN	..NIA	Anthem, Inc.	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..35-2129194					Anthem UM Services, Inc.	..IN	..NIA	AMCORE Specialty Services, Inc.	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..30-0606541					Anthem Workers' Compensation, LLC	..IN	..NIA	Insurance Company	Ownership	..75.000	Anthem, Inc.	
..671	Anthem, Inc.	..30-0606541					Anthem Workers' Compensation, LLC	..IN	..NIA	HealthLink, Inc.	Ownership	..25.000	Anthem, Inc.	
..671	Anthem, Inc.	..95-4640529					Arcus Enterprises, Inc.	..DE	..NIA	Anthem Holding Corp.	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..20-2636384					ARCUS HealthLiving Services, Inc.	..IN	..NIA	Arcus Enterprises, Inc.	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..35-1292384					Associated Group, Inc.	..IN	..NIA	Anthem Insurance Companies, Inc.	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..11-3713066					ATH Holding Company, LLC	..IN	..UIP	Anthem, Inc.	Ownership	..100.000	Anthem, Inc.	
..671	Anthem, Inc.	..54801	58-0469845				Blue Cross and Blue Shield of Georgia, Inc.	..GA	..IA	Cerulean Companies, Inc.	Ownership	..100.000	Anthem, Inc.	

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE Y
PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	*
..671	Anthem, Inc.	..96962	58-1638390	.....	.....	.....	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	..GA	..IA	Cerulean Companies, Inc.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	..54003	39-0138065	.....	.....	.....	Blue Cross Blue Shield of Wisconsin	..WI	..IA	Crossroads Acquisition Corp.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	95-3768990	.....	.....	.....	Blue Cross of California	..CA	..IA	WellPoint California Services, Inc.	Ownership	..100.000	Anthem, Inc.	..0101
..671	Anthem, Inc.	.....	20-2994048	.....	.....	.....	Blue Cross of California Partnership Plan, Inc.	..CA	..IA	Blue Cross of California	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	20-4307514	.....	.....	.....	Caremore Health Group, Inc.	..DE	..NIA	ATH Holding Company, LLC	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	95-4694706	.....	.....	.....	Caremore Health Plan	..CA	..IA	Caremore Health System	Ownership	..100.000	Anthem, Inc.	..0103
..671	Anthem, Inc.	..13562	38-3795280	.....	.....	.....	Caremore Health Plan of Arizona, Inc.	..AZ	..IA	Caremore Health System	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	27-1848815	.....	.....	.....	Caremore Health Plan of Colorado, Inc.	..CO	..IA	Caremore Health System	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	46-2408017	.....	.....	.....	Caremore Health Plan of Georgia, Inc.	..GA	..IA	Caremore Health System	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	..13605	29-4001602	.....	.....	.....	Caremore Health Plan of Nevada	..NV	..IA	Caremore Health System	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	27-1625392	.....	.....	.....	Caremore Health Plan of Texas, Inc.	..TX	..NIA	Caremore Health System	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	20-4307555	.....	.....	.....	Caremore Holdings, Inc.	..DE	..NIA	Caremore Health Group, Inc.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	45-4985009	.....	.....	.....	Caremore IPA of New York, LLC	..NY	..NIA	Caremore, LLC	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	32-0373216	.....	.....	.....	Caremore, LLC	..IN	..NIA	Caremore Health System	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	20-2076421	.....	.....	.....	Caremore Health System	..CA	..NIA	Caremore Holdings, Inc.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	95-4420935	.....	.....	.....	Caremore Medical Management Company	..CA	..NIA	Caremore Health System	Ownership	..98.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	95-4420935	.....	.....	.....	Caremore Medical Management Company	..CA	..NIA	OMC Holding Company, LLC	Ownership	..2.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	58-2217138	.....	.....	.....	Cerulean Companies, Inc.	..GA	..NIA	Anthem Holding Corp.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	39-1431702	.....	.....	.....	Claim Management Services, Inc.	..WI	..NIA	Blue Cross Blue Shield of Wisconsin	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	20-4307555	.....	.....	.....	OMC Holding Company, LLC	..DE	..NIA	Caremore Health System	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	..10345	31-1440175	.....	.....	.....	Community Insurance Company	..OH	..IA	ATH Holding Company, LLC	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	39-1462554	.....	.....	.....	Comcare Health Services Insurance Corporation	..WI	..IA	Blue Cross Blue Shield of Wisconsin	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	20-0334650	.....	.....	.....	Crossroads Acquisition Corp.	..DE	..NIA	Anthem Holding Corp.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	41-1905556	.....	.....	.....	DeCare Analytics, LLC	..MN	..NIA	DeCare Dental, LLC	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	02-0574609	.....	.....	.....	DeCare Dental Health International, LLC	..MN	..NIA	DeCare Dental, LLC	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	73-1665525	.....	.....	.....	DeCare Dental Insurance Ireland, Ltd.	..JRL	..NIA	DeCare Dental, LLC	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	01-0822645	.....	.....	.....	DeCare Dental Networks, LLC	..MN	..NIA	DeCare Dental, LLC	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	01-0822645	.....	.....	.....	DeCare Dental, LLC	..MN	..NIA	Anthem Holding Corp.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	73-1665525	.....	.....	.....	DeCare Operations Ireland, Limited	..JRL	..NIA	DeCare Dental, LLC	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	26-2544715	.....	.....	.....	DeCare Systems Ireland, Limited	..JRL	..NIA	DeCare Dental, LLC	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	13-3834328	.....	.....	.....	Designated Agent Company, Inc.	..NY	..NIA	Anthem Health Plans of Kentucky, Inc.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	..55083	23-7391136	.....	.....	.....	EHG Benefits Agency, Inc.	..NY	..NIA	WellPoint Holding Corp.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	13-3874803	.....	.....	.....	Empire HealthChoice Assurance, Inc.	..NY	..IA	WellPoint Holding Corp.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	..95433	13-3874803	.....	.....	.....	Empire HealthChoice HMO, Inc.	..NY	..IA	Empire HealthChoice Assurance, Inc.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	43-1047923	.....	.....	.....	Forty-Four Forty-Four Forest Park Redevelopment Corp.	..MD	..NIA	RightCHOICE Managed Care, Inc.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	95-2907752	.....	.....	.....	Golden West Health Plan, Inc.	..CA	..IA	WellPoint California Services, Inc.	Ownership	..100.000	Anthem, Inc.	..0104
..671	Anthem, Inc.	.....	26-4286154	.....	.....	.....	Government Health Services, LLC	..WI	..NIA	ATH Holding Company, LLC	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	..97217	58-1473042	.....	.....	.....	Greater Georgia Life Insurance Company	..GA	..IA	Blue Cross and Blue Shield of Georgia, Inc.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	51-0365660	.....	.....	.....	Health Core, Inc.	..DE	..NIA	Acus Enterprises, Inc.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	54-1237939	.....	.....	.....	Health Management Corporation	..VA	..NIA	Southeast Services, Inc.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	36-3897701	.....	.....	.....	Health Ventures Partner, L.L.C.	..IL	..NIA	UNICARE National Services, Inc.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	..95169	54-1356687	.....	.....	.....	HealthKeepers, Inc.	..VA	..IA	Anthem Southeast, Inc.	Ownership	..92.510	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	54-1356687	.....	.....	.....	HealthKeepers, Inc.	..VA	..IA	UNICARE National Services, Inc.	Ownership	..7.490	Anthem, Inc.	.....
..671	Anthem, Inc.	..96475	43-1616135	.....	.....	.....	HealthLink, Inc.	..MD	..NIA	HealthLink, Inc.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	.....	43-1841135	.....	.....	.....	HealthLink, Inc.	..IL	..NIA	RightCHOICE Managed Care, Inc.	Ownership	..100.000	Anthem, Inc.	.....
..671	Anthem, Inc.	..78972	86-0257201	.....	.....	.....	Healthy Alliance Life Insurance Company	..MD	..IA	RightCHOICE Managed Care, Inc.	Ownership	..100.000	Anthem, Inc.	.....

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE Y
PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	*
..671	Anthem, Inc.	..95473	84-1017384	..	..	..	HMO Colorado, Inc.	..CO	..IA	Rocky Mountain Hospital and Medical Service, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..95358	37-1216698	..	..	..	HMO Missouri, Inc.	..MO	..IA	RightCHOICE Managed Care, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	75-2619005	..	..	..	Imaging Management Holdings, L.L.C.	..DE	..NIA	ATH Holding Company, LLC	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	98-2388286	..	..	..	Imaging Providers of Texas -non-profit)	..TX	..NIA	American Imaging Management, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..95527	02-0494919	..	..	..	Matthew Thornton Health Plan, Inc.	..NH	..IA	Anthem Health Plans of New Hampshire, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	39-2013971	..	..	..	Meridian Resource Company, LLC	..WI	..NIA	CompCare Health Services Insurance Corporation	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	35-1840597	..	..	..	National Government Services, Inc.	..IN	..NIA	Anthem Insurance Companies, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	46-1595392	..	..	..	National Telehealth Network, LLC	..DE	..NIA	SellCore, Inc.	Ownership	..50.000	Anthem, Inc.	..0105
..671	Anthem, Inc.	..85286	75-1461960	..	..	..	OreNation Insurance Company	..IN	..IA	ATH Holding Company, LLC	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	95-4349368	..	..	..	Park Square Holdings, Inc.	..CA	..NIA	WellPoint California Services, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	95-4386221	..	..	..	Park Square I, Inc.	..CA	..NIA	WellPoint California Services, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	95-4249345	..	..	..	Park Square II, Inc.	..CA	..NIA	WellPoint California Services, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	65-0569629	..	..	..	PHP Holdings, Inc.	..FL	..UDP	AMERIGROUP Corporation	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	43-1595640	..	..	..	R & P Realty, Inc.	..MO	..NIA	RightCHOICE Managed Care, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	96-2396739	..	..	..	Resolution Health, Inc.	..DE	..NIA	Anthem Southeast, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	47-0851593	..	..	..	RightCHOICE Managed Care, Inc.	..DE	..NIA	Anthem Holding Corp.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..11011	84-0747736	..	..	..	Rocky Mountain Hospital and Medical Service, Inc.	..CO	..IA	ATH Holding Company, LLC	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	20-0473316	..	..	..	SellCore, Inc.	..DE	..NIA	Anthem, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	55-0712302	..	..	..	Southeast Services, Inc.	..VA	..NIA	Anthem Southeast, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	45-4071004	..	..	..	State Sponsored Business UM Services, Inc.	..IN	..NIA	UNICARE Specialty Services, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	35-1835818	..	..	..	The Anthem Companies, Inc.	..IN	..NIA	ATH Holding Company, LLC	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	45-5443372	..	..	..	The Anthem Companies of California, Inc.	..CA	..NIA	ATH Holding Company, LLC	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	43-1967324	..	..	..	TrustSolutions, LLC	..WI	..NIA	Government Health Services, LLC	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..12805	20-4842073	..	..	..	UNICARE Health Plan of Kansas, Inc.	..KS	..IA	UNICARE National Services, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..11810	84-1620480	..	..	..	UNICARE Health Plan of West Virginia, Inc.	..WV	..IA	UNICARE National Services, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..95420	74-2151310	..	..	..	UNICARE Health Plans of Texas, Inc.	..TX	..IA	UNICARE Illinois Services, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	36-3899137	..	..	..	UNICARE Illinois Services, Inc.	..IL	..NIA	UNICARE National Services, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..80314	32-0913817	..	..	..	UNICARE Life & Health Insurance Company	..IN	..IA	UNICARE National Services, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	95-4633507	..	..	..	UNICARE National Services, Inc.	..DE	..NIA	Anthem Holding Corp.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	77-0494551	..	..	..	UNICARE Specialty Services, Inc.	..DE	..NIA	Anthem Holding Corp.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	36-0414617	..	..	..	Utilimed IPA, Inc.	..NY	..NIA	American Imaging Management, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	20-4405193	..	..	..	WellPoint Acquisition, LLC	..IN	..NIA	Anthem, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	20-2156380	..	..	..	WellPoint Behavioral Health, Inc.	..DE	..NIA	UNICARE Specialty Services, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	95-4640531	..	..	..	WellPoint California Services, Inc.	..DE	..NIA	Anthem Holding Corp.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	95-4657170	..	..	..	WellPoint Dental Services, Inc.	..DE	..NIA	UNICARE Specialty Services, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	20-3620996	..	..	..	WellPoint Holding Corp.	..DE	..NIA	Anthem, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	45-2736438	..	..	..	WellPoint Information Technology Services, Inc.	..CA	..NIA	Blue Cross of California	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	36-4595641	..	..	..	WellPoint Insurance Services, Inc.	..HI	..NIA	Anthem, Inc.	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	47-2546820	..	..	..	WellPoint Military Care Corporation	..IN	..NIA	Government Health Services, LLC	Ownership	..100.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	36-3897080	..	..	..	WellPoint Partnership Plan, LLC	..IL	..NIA	Health Ventures Partner, L.L.C.	Ownership	..75.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	36-3897080	..	..	..	WellPoint Partnership Plan, LLC	..IL	..NIA	UNICARE Illinois Services, Inc.	Ownership	..25.000	Anthem, Inc.	..
..671	Anthem, Inc.	..	98-0552141	..	..	..	WPHI -Shanghai) Enterprise Service Co. Ltd.	..CN	..NIA	WPHI, LLC	Ownership	..100.000	Anthem, Inc.	..

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE Y

PART 1A - DETAIL OF INSURANCE HOLDING COMPANY SYSTEM

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Group Code	Group Name	NAIC Company Code	ID Number	Federal RSSD	CIK	Name of Securities Exchange if Publicly Traded (U.S. or International)	Names of Parent, Subsidiaries Or Affiliates	Domiciliary Location	Relationship to Reporting Entity	Directly Controlled by (Name of Entity/Person)	Type of Control (Ownership, Board, Management, Attorney-in-Fact, Influence, Other)	If Control is Ownership Provide Percentage	Ultimate Controlling Entity(ies)/Person(s)	*
0671	Anthem, Inc.		20-8672847				IPWII, LLC	DE	NIA	ATH Holding Company, LLC	Ownership	63.880	Anthem, Inc.	0106

Asterisk	Explanation
0100	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the New York State Department of Health.
0101	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0102	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0103	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0104	Insurer is deemed to be an insurance affiliate in column 10, but does not have an NAIC Company Code in column 3 because it is regulated by the California Department of Managed Health Care.
0105	50% owned by American Well Corporation
0106	36.12% owned by unaffiliated investors

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE Y

PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1	2	3	4	5	6	7	8	9	10	11	12	13
NAIC Company Code	ID Number	Names of Insurers and Parent, Subsidiaries or Affiliates	Shareholder Dividends	Capital Contributions	Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	Management Agreements and Service Contracts	Income/ (Disbursements) Incurred Under Reinsurance Agreements	*	Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	Totals	Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
11069	36-4384128	American Imaging Management East, LLC					(57)				(57)	
	36-3692630	American Imaging Management, Inc.					(32,965,115)				(32,965,115)	
12354	20-2073598	AMERIGROUP Community Care of New Mexico, Inc.	(6,900,000)				(4,726,970)				(11,626,970)	
	54-1739323	AMERIGROUP Corporation					75,831,451				75,831,451	
95093	65-0318864	AMERIGROUP Florida, Inc.	(11,500,000)	35,000,000			(97,912,463)				(74,412,463)	
14078	45-2485907	AMERIGROUP Insurance Company					(38,322,979)				(38,322,979)	
14276	45-3358287	AMERIGROUP Kansas, Inc.		70,000,000			(40,007,538)				29,992,462	
14064	26-4674149	AMERIGROUP Louisiana, Inc.					(47,086,624)				(47,086,624)	
95832	51-0387398	AMERIGROUP Maryland, Inc.	(30,000,000)				(125,481,176)				(155,481,176)	
12586	20-3317697	AMERIGROUP Nevada, Inc.					(51,133,020)				(51,133,020)	
95373	22-3375292	AMERIGROUP New Jersey, Inc.	(12,900,000)				(126,270,441)				(139,170,441)	
	13-3865627	AMERIGROUP New York, LLC					(242,723,580)				(242,723,580)	
10767	13-4212818	AMERIGROUP Ohio Inc	(25,000,000)				(260,846)				(25,260,846)	
12941	20-4776597	AMERIGROUP Tennessee, Inc.		15,000,000			(126,351,038)				(111,351,038)	
95314	75-2603231	AMERIGROUP Texas, Inc.	(69,300,000)				(284,588,752)				(353,888,752)	
14073	27-3510384	AMERIGROUP Washington, Inc.		70,000,000			(48,187,741)				21,812,259	
12229	06-1696189	AMGP Georgia Managed Care Company, Inc.	(10,900,000)				(133,337,540)				(144,237,540)	
62825	95-4331852	Anthem Blue Cross Life and Health Insurance Company, Inc.	(148,600,000)				(1,046,586,041)	(7,006,001)			(1,202,192,042)	5,591,789
60217	06-1475928	Anthem Health Plans, Inc.	(117,200,000)				(326,809,281)				(444,009,281)	
95120	61-1237516	Anthem Health Plans of Kentucky, Inc.	(162,100,000)				(346,884,303)				(508,984,303)	
52618	31-1705652	Anthem Health Plans of Maine, Inc.	(43,000,000)				(103,697,336)				(146,697,336)	
53759	02-0510530	Anthem Health Plans of New Hampshire, Inc.	(15,000,000)				(47,481,323)	39,532			(62,441,791)	
71835	54-0357120	Anthem Health Plans of Virginia, Inc.	(335,000,000)				(585,833,600)	4,612,685			(926,220,915)	(1,187,401)
28207	35-0781558	Anthem Insurance Companies, Inc.	(570,000,000)	(5,000,000)			(1,108,125,855)	985,079			(1,682,140,776)	(2,934,642)
15543	47-0992859	Anthem Kentucky Managed Care Plan, Inc.		18,000,000			(8,098,434)				9,901,566	
13573	20-5876774	Anthem Life and Disability Insurance Company					(1,413,232)				(1,413,232)	
61069	35-0980405	Anthem Life Insurance Company	(48,100,000)				(37,535,543)	19,404,273			(66,231,270)	(23,519,753)
	35-2145715	Anthem, Inc.	3,234,500,000	(308,500,000)			5,509,313,931				8,435,313,931	
	11-3713086	ATH Holding Company, LLC					10,960,079				10,960,079	
54801	58-0469845	Blue Cross and Blue Shield of Georgia, Inc.		95,000,000			(414,865,223)				(319,865,223)	
96962	58-1638390	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	(25,200,000)				(326,803,963)				(352,003,963)	
54003	39-0138065	Blue Cross Blue Shield of Wisconsin	(86,716,552)	16,716,552			(122,943,372)	(90,061)			(193,033,433)	
	95-3760980	Blue Cross of California	(150,000,000)	(100,000,000)			(1,178,605,644)	265,269			(1,428,340,375)	
	20-2994048	Blue Cross of California Partnership Plan, Inc.					(203,844,260)				(203,844,260)	
	95-4694706	Caremore Health Plan	(40,000,000)				(120,547,913)				(160,547,913)	
13562	38-3975280	Caremore Health Plan of Arizona, Inc.					(52,977,527)				(52,977,527)	
13753	27-1848815	Caremore Health Plan of Colorado, Inc.					(13,740)				(13,740)	

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE Y








PART 2 - SUMMARY OF INSURER'S TRANSACTIONS WITH ANY AFFILIATES

1	2	3	4	5	6	7	8	9	10	11	12	13
NAIC Company Code	ID Number	Names of Insurers and Parent, Subsidiaries or Affiliates	Shareholder Dividends	Capital Contributions	Purchases, Sales or Exchanges of Loans, Securities, Real Estate, Mortgage Loans or Other Investments	Income/ (Disbursements) Incurred in Connection with Guarantees or Undertakings for the Benefit of any Affiliate(s)	Management Agreements and Service Contracts	Income/ (Disbursements) Incurred Under Reinsurance Agreements	*	Any Other Material Activity Not in the Ordinary Course of the Insurer's Business	Totals	Reinsurance Recoverable/ (Payable) on Losses and/or Reserve Credit Taken/(Liability)
13605	26-4001602	Caremore Health Plan of Nevada		5,000,000			(15,511,443)				(10,511,443)	
	20-2076421	Caremore Health System					23,656,158				23,656,158	
10345	31-1440175	Community Insurance Company	(250,000,000)				(874,137,775)				(1,124,137,775)	
95693	39-1462554	Compcare Health Services Insurance Corporation	(8,283,448)	(16,716,552)			(87,061,403)				(112,061,403)	
	01-0822645	DeCare Dental, LLC					(39,644,429)				(39,644,429)	
55093	23-7391136	Empire HealthChoice Assurance, Inc.	(555,000,000)				(564,042,093)				(1,119,042,093)	
95433	13-3874803	Empire HealthChoice HMO, Inc.	(165,000,000)				(162,137,659)				(327,137,659)	
	95-2907752	Golden West Health Plan, Inc.					(694,447)				(694,447)	
97217	58-1473042	Greater Georgia Life Insurance Company					(5,280,019)				(5,280,019)	
	51-0365660	Health Core, Inc.					(22,690,893)				(22,690,893)	
95169	54-1356687	HealthKeepers, Inc.	(25,000,000)				(267,589,751)	(4,612,685)			(297,202,436)	1,187,401
96475	43-1616135	HealthLink HMO, Inc.	(12,000,000)				7,412,537	(4,798)			(4,592,261)	
	43-1364135	HealthLink, Inc.					(63,716,858)				(63,716,858)	
78972	86-0257201	Healthy Alliance Life Insurance Company	(100,000,000)				(293,572,691)				(393,572,691)	
95473	84-1017384	HMO Colorado, Inc.	(7,584,931)	(815,069)			(39,046,518)				(47,446,518)	
95358	37-1216698	HMO Missouri, Inc.	(20,000,000)				(16,071,285)				(36,071,285)	
	98-0408753	HTH Re, LTD						7,006,001			7,006,001	(5,591,789)
95527	02-0494919	Matthew Thornton Health Plan, Inc.	(25,000,000)				(95,464,883)				(120,464,883)	
	35-1840597	National Government Services, Inc.		5,000,000			(19,972,264)				(14,972,264)	
85286	75-1461960	OneNation Insurance Company					(81,761)	106,489			24,728	218,560
83640	36-3506910	RightCHOICE Insurance Company		500,000			(41,851)				458,149	
	47-0851593	RightCHOICE Managed Care, Inc.					(19,447,446)				(19,447,446)	
11011	84-0747736	Rocky Mountain Hospital and Medical Service, Inc.	(55,215,069)	815,069			(262,964,956)	(1,078,645)			(318,443,601)	
	35-1835818	The Anthem Companies, Inc.					4,362,969,140				4,362,969,140	
	45-5443372	The Anthem Companies of California, Inc.					173,944,762				173,944,762	
70700	36-3304416	UNICARE Health Insurance Company of the Midwest					(369,181)				(369,181)	
12805	20-4842073	UNICARE Health Plan of Kansas, Inc.					652,394				652,394	
11810	84-1620480	UNICARE Health Plan of West Virginia, Inc.	(4,000,000)				(38,926,296)				(42,926,296)	
95420	74-2151310	UNICARE Health Plans of Texas, Inc.					238,470				238,470	
95505	36-3897076	UNICARE Health Plans of the Midwest, Inc.					7,442				7,442	
80314	52-0913817	UNICARE Life & Health Insurance Company	(100,000,000)				(57,129,445)	(19,627,138)			(176,756,583)	26,235,835
	20-3620996	WellPoint Holding Corp					16,858,680				16,858,680	
	45-2736438	WellPoint Information Technology Services		100,000,000			225,930,818				325,930,818	
	36-3897080	WellPoint Partnership Plan, LLC					(19,758,045)				(19,758,045)	
9999999 Control Totals			0	0	0	0	0	0	XXX	0	0	0

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.
SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

The following supplemental reports are required to be filed as part of your statement filing unless specifically waived by the domiciliary state. However, in the event that your domiciliary state waives the filing requirement, your response of WAIVED to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.

	Responses
MARCH FILING	
1. Will the Supplemental Compensation Exhibit be filed with the state of domicile by March 1?	SEE EXPLANATION
2. Will an actuarial opinion be filed by March 1?	SEE EXPLANATION
3. Will the confidential Risk-based Capital Report be filed with the NAIC by March 1?	SEE EXPLANATION
4. Will the confidential Risk-based Capital Report be filed with the state of domicile, if required, by March 1?	SEE EXPLANATION
APRIL FILING	
5. Will Management's Discussion and Analysis be filed by April 1?	YES
6. Will the Supplemental Investment Risks Interrogatories be filed by April 1?	YES
7. Will the Accident and Health Policy Experience Exhibit be filed by April 1?	YES
JUNE FILING	
8. Will an audited financial report be filed by June 1?	YES
9. Will Accountant's Letter of Qualifications be filed with the state of domicile and electronically with the NAIC by June 1?	YES
AUGUST FILING	
10. Will Communication of Internal Control Related Matters Noted in Audit be filed with the state of domicile by August 1?	YES
The following supplemental reports are required to be filed as part of your annual statement filing. However, in the event that your company does not transact the type of business for which the special report must be filed, your response of NO to the specific interrogatory will be accepted in lieu of filing a "NONE" report and a bar code will be printed below. If the supplement is required of your company but is not being filed for whatever reason enter SEE EXPLANATION and provide an explanation following the interrogatory questions.	
MARCH FILING	
11. Will the Medicare Supplement Insurance Experience Exhibit be filed with the state of domicile and the NAIC by March 1?	NO
12. Will the Supplemental Life data due March 1 be filed with the state of domicile and the NAIC?	NO
13. Will the Supplemental Property/Casualty data due March 1 be filed with the state of domicile and the NAIC?	NO
14. Will Schedule SIS (Stockholder Information Supplement) be filed with the state of domicile by March 1?	NO
15. Will the actuarial opinion on participating and non-participating policies as required in Interrogatories 1 and 2 on Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
16. Will the actuarial opinion on non-guaranteed elements as required in Interrogatory 3 to Exhibit 5 to Life Supplement be filed with the state of domicile and electronically with the NAIC by March 1?	NO
17. Will the Medicare Part D Coverage Supplement be filed with the state of domicile and the NAIC by March 1?	NO
18. Will an approval from the reporting entity's state of domicile for relief related to the five-year rotation requirement for lead audit partner be filed electronically with the NAIC by March 1?	NO
19. Will an approval from the reporting entity's state of domicile for relief related to the one-year cooling off period for independent CPA be filed electronically with the NAIC by March 1?	NO
20. Will an approval from the reporting entity's state of domicile for relief related to the Requirements for Audit Committees be filed electronically with the NAIC by March 1?	NO
APRIL FILING	
21. Will the Long-Term Care Experience Reporting Forms be filed with the state of domicile and the NAIC by April 1?	NO
22. Will the Supplemental Life data due April 1 be filed with the state of domicile and the NAIC?	NO
23. Will the Supplemental Property/Casualty Insurance Expense Exhibit due April 1 be filed with any state that requires it, and, if so, the NAIC?	NO
24. Will the Supplemental Health Care Exhibit (Parts 1, 2 and 3) be filed with the state of domicile and the NAIC by April 1?	NO
25. Will the regulator only (non-public) Supplemental Health Care Exhibit's Expense Allocation Report be filed with the state of domicile and the NAIC by April 1?	NO
AUGUST FILING	
26. Will Management's Report of Internal Control Over Financial Reporting be filed with the state of domicile by August 1?	YES
Explanations:	
1. The annual filing for Florida isn't due until April 1, 2014.	
2. The annual filing for Florida isn't due until April 1, 2014.	
3. The RBC isn't required by the state of Florida.	
4. The RBC isn't required by the state of Florida.	
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Bar Codes:	
11. Medicare Supplement Insurance Experience Exhibit [Document Identifier 360]	
12. Life Supplement [Document Identifier 205]	
13. Property/Casualty Supplement [Document Identifier 207]	
14. SIS Stockholder Information Supplement [Document Identifier 420]	
15. Participating Opinion for Exhibit 5 [Document Identifier 371]	
16. Non-Guaranteed Opinion for Exhibit 5 [Document Identifier 370]	
17. Medicare Part D Coverage Supplement [Document Identifier 365]	

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES

18. Relief from the five-year rotation requirement for lead audit partner [Document Identifier 224]



19. Relief from the one-year cooling off period for independent CPA [Document Identifier 225]



20. Relief from the Requirements for Audit Committees [Document Identifier 226]



21. Long-Term Care Experience Reporting Forms [Document Identifier 306]



22. Life Supplement [Document Identifier 211]



23. Property/Casualty Supplement Insurance Expense Exhibit [Document Identifier 213]



24. Supplemental Health Care Exhibit (Parts 1, 2 and 3) [Document Identifier 216]



25. Supplemental Health Care Exhibit's Expense Allocation Report [Document Identifier 217]



ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

OVERFLOW PAGE FOR WRITE-INS

Additional Write-ins for Liabilities Line 23

	Current Year			Prior Year
	1 Covered	2 Uncovered	3 Total	4 Total
2304. Dividends Payable to AMERIGROUP Corporation			0	11,500,000
2397. Summary of remaining write-ins for Line 23 from overflow page	0	0	0	11,500,000

Additional Write-ins for Underwriting and Investment Exhibit Part 3 Line 25

	Claim Adjustment Expenses		3	4	5
	1 Cost Containment Expenses	2 Other Claim Adjustment Expenses	General Administrative Expenses	Investment Expenses	Total
2504. Miscellaneous	7,259	427,147	(139,388)		295,018
2597. Summary of remaining write-ins for Line 25 from overflow page	7,259	427,147	(139,388)	0	295,018

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SUMMARY INVESTMENT SCHEDULE

Investment Categories	Gross Investment Holdings		Admitted Assets as Reported in the Annual Statement			
	1 Amount	2 Percentage	3 Amount	4 Securities Lending Reinvested Collateral Amount	5 Total (Col. 3 + 4) Amount	6 Percentage
1. Bonds:						
1.1 U.S. treasury securities		0.000			0	0.000
1.2 U.S. government agency obligations (excluding mortgage-backed securities):						
1.21 Issued by U.S. government agencies		0.000			0	0.000
1.22 Issued by U.S. government sponsored agencies		0.000			0	0.000
1.3 Non-U.S. government (including Canada, excluding mortgaged-backed securities)		0.000			0	0.000
1.4 Securities issued by states, territories, and possessions and political subdivisions in the U.S.:						
1.41 States, territories and possessions general obligations	6,747,130	3.464	6,747,130	0	6,747,130	3.464
1.42 Political subdivisions of states, territories and possessions and political subdivisions general obligations	7,373,188	3.786	7,373,188	0	7,373,188	3.786
1.43 Revenue and assessment obligations	15,742,572	8.083	15,742,572	0	15,742,572	8.083
1.44 Industrial development and similar obligations		0.000			0	0.000
1.5 Mortgage-backed securities (includes residential and commercial MBS):						
1.51 Pass-through securities:						
1.511 Issued or guaranteed by GNMA	1,133,104	0.582	1,133,104	0	1,133,104	0.582
1.512 Issued or guaranteed by FNMA and FHLMC	19,484,400	10.004	19,484,400	0	19,484,400	10.004
1.513 All other		0.000		4,331,145	4,331,145	2.224
1.52 CMOs and REMICs:						
1.521 Issued or guaranteed by GNMA, FNMA, FHLMC or VA	1,283,246	0.659	1,283,246	0	1,283,246	0.659
1.522 Issued by non-U.S. Government issuers and collateralized by mortgage-backed securities issued or guaranteed by agencies shown in Line 1.521	7,622,696	3.914	7,622,696	0	7,622,696	3.914
1.523 All other		0.000			0	0.000
2. Other debt and other fixed income securities (excluding short-term):						
2.1 Unaffiliated domestic securities (includes credit tenant loans and hybrid securities)	56,454,509	28.985	56,454,509	1,166,834	57,621,343	29.584
2.2 Unaffiliated non-U.S. securities (including Canada)		0.000			0	0.000
2.3 Affiliated securities		0.000			0	0.000
3. Equity interests:						
3.1 Investments in mutual funds		0.000			0	0.000
3.2 Preferred stocks:						
3.21 Affiliated		0.000			0	0.000
3.22 Unaffiliated		0.000			0	0.000
3.3 Publicly traded equity securities (excluding preferred stocks):						
3.31 Affiliated		0.000			0	0.000
3.32 Unaffiliated	13,943,531	7.159	13,943,531	0	13,943,531	7.159
3.4 Other equity securities:						
3.41 Affiliated		0.000			0	0.000
3.42 Unaffiliated		0.000			0	0.000
3.5 Other equity interests including tangible personal property under lease:						
3.51 Affiliated		0.000			0	0.000
3.52 Unaffiliated		0.000			0	0.000
4. Mortgage loans:						
4.1 Construction and land development		0.000			0	0.000
4.2 Agricultural		0.000			0	0.000
4.3 Single family residential properties		0.000			0	0.000
4.4 Multifamily residential properties		0.000			0	0.000
4.5 Commercial loans		0.000			0	0.000
4.6 Mezzanine real estate loans		0.000			0	0.000
5. Real estate investments:						
5.1 Property occupied by company		0.000	0		0	0.000
5.2 Property held for production of income (including \$ of property acquired in satisfaction of debt)		0.000	0		0	0.000
5.3 Property held for sale (including \$ of property acquired in satisfaction of debt)		0.000	0		0	0.000
6. Contract loans		0.000	0		0	0.000
7. Derivatives		0.000	0		0	0.000
8. Receivables for securities		0.000	0		0	0.000
9. Securities Lending (Line 10, Asset Page reinvested collateral)	5,497,979	2.823	5,497,979	XXX	XXX	XXX
10. Cash, cash equivalents and short-term investments	59,491,088	30.544	59,491,088	0	59,491,088	30.544
11. Other invested assets		0.000			0	0.000
12. Total invested assets	194,773,443	100.000	194,773,443	5,497,979	194,773,443	100.000

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

Schedule A - Verification - Real Estate

NONE

Schedule B - Verification - Mortgage Loans

NONE

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.
SCHEDULE BA - VERIFICATION BETWEEN YEARS
Other Long-Term Invested Assets

1.	Book/adjusted carrying value, December 31 of prior year	
2.	Cost of acquired:	
2.1	Actual cost at time of acquisition (Part 2, Column 8)	
2.2	Additional investment made after acquisition (Part 2, Column 9)	
3.	Capitalized deferred interest and other:	
3.1	Totals, Part 1, Column 16	
3.2	Totals, Part 3, Column 12	
4.	Accrual of discount	
5.	Unrealized valuation increase (decrease):	
5.1	Totals, Part 1, Column 13	
5.2	Totals, Part 3, Column 9	
6.	Total gain (loss) on disposals, Part 3, Column 19	
7.	Deduct amounts received on disposals, Part 3, Column 18	
8.	Deduct amortization of premium and depreciation	
9.	Total foreign exchange change in book/adjusted carrying value:	
9.1	Totals, Part 1, Column 17	
9.2	Totals, Part 3, Column 14	
10.	Deduct current year's other than temporary impairment recognized:	
10.1	Totals, Part 1, Column 15	
10.2	Totals, Part 3, Column 11	
11.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5+6-7-8+9-10)	
12.	Deduct total nonadmitted amounts	
13.	Statement value at end of current period (Line 11 minus Line 12)	

NONE

SCHEDULE D - VERIFICATION BETWEEN YEARS
Bonds and Stocks

1.	Book/adjusted carrying value, December 31 of prior year	133,957,703
2.	Cost of bonds and stocks acquired, Part 3, Column 7	21,009,563
3.	Accrual of discount	9,837
4.	Unrealized valuation increase (decrease):	
4.1.	Part 1, Column 12	(192,075)
4.2.	Part 2, Section 1, Column 15	
4.3.	Part 2, Section 2, Column 13	1,245,702
4.4.	Part 4, Column 11	0
5.	Total gain (loss) on disposals, Part 4, Column 19	1,053,627
6.	Deduction consideration for bonds and stocks disposed of, Part 4, Column 7	229,554
7.	Deduct amortization of premium	25,144,745
8.	Total foreign exchange change in book/adjusted carrying value:	
8.1.	Part 1, Column 15	0
8.2.	Part 2, Section 1, Column 19	
8.3.	Part 2, Section 2, Column 16	0
8.4.	Part 4, Column 15	0
9.	Deduct current year's other than temporary impairment recognized:	
9.1.	Part 1, Column 14	0
9.2.	Part 2, Section 1, Column 17	
9.3.	Part 2, Section 2, Column 14	0
9.4.	Part 4, Column 13	0
10.	Book/adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	129,784,376
11.	Deduct total nonadmitted amounts	0
12.	Statement value at end of current period (Line 10 minus Line 11)	129,784,376

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE D - SUMMARY BY COUNTRY

Long-Term Bonds and Stocks OWNED December 31 of Current Year

Description		1 Book/Adjusted Carrying Value	2 Fair Value	3 Actual Cost	4 Par Value of Bonds
BONDS					
Governments (Including all obligations guaranteed by governments)	1. United States	1,133,104	1,116,472	1,136,095	1,048,889
	2. Canada				
	3. Other Countries				
	4. Totals	1,133,104	1,116,472	1,136,095	1,048,889
U.S. States, Territories and Possessions (Direct and guaranteed)					
	5. Totals	6,747,130	7,146,027	6,970,954	6,325,000
U.S. Political Subdivisions of States, Territories and Possessions (Direct and guaranteed)					
	6. Totals	7,373,188	7,720,875	7,683,485	6,645,000
U.S. Special revenue and special assessment obligations and all non-guaranteed obligations of agencies and authorities of governments and their political subdivisions					
	7. Totals	36,510,218	37,528,557	36,968,466	33,574,411
Industrial and Miscellaneous and Hybrid Securities (unaffiliated)	8. United States	64,077,205	64,112,011	65,317,797	59,092,421
	9. Canada				
	10. Other Countries				
	11. Totals	64,077,205	64,112,011	65,317,797	59,092,421
Parent, Subsidiaries and Affiliates	12. Totals	0	0	0	0
	13. Total Bonds	115,840,845	117,623,942	118,076,797	106,685,721
PREFERRED STOCKS					
Industrial and Miscellaneous (unaffiliated)	14. United States				
	15. Canada				
	16. Other Countries				
	17. Totals	0	0	0	
Parent, Subsidiaries and Affiliates	18. Totals				
	19. Total Preferred Stocks	0	0	0	
COMMON STOCKS					
Industrial and Miscellaneous (unaffiliated)	20. United States	13,943,531	13,943,531	9,093,502	
	21. Canada				
	22. Other Countries				
	23. Totals	13,943,531	13,943,531	9,093,502	
Parent, Subsidiaries and Affiliates	24. Totals	0	0	0	
	25. Total Common Stocks	13,943,531	13,943,531	9,093,502	
	26. Total Stocks	13,943,531	13,943,531	9,093,502	
	27. Total Bonds and Stocks	129,784,376	131,567,473	127,170,299	

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1A - SECTION 1

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 9.7	8 Total from Col. 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed (a)
1. U.S. Governments											
1.1 NAIC 1	1,645,819	295,826	244,665	318,462	174,461	2,679,233	1.8	2,794,465	2.1	2,679,233	0
1.2 NAIC 2						0	0.0	0	0.0		0
1.3 NAIC 3						0	0.0	0	0.0		0
1.4 NAIC 4						0	0.0	0	0.0		0
1.5 NAIC 5						0	0.0	0	0.0		0
1.6 NAIC 6						0	0.0	0	0.0		0
1.7 Totals	1,645,819	295,826	244,665	318,462	174,461	2,679,233	1.8	2,794,465	2.1	2,679,233	0
2. All Other Governments											
2.1 NAIC 1						0	0.0	0	0.0		0
2.2 NAIC 2						0	0.0	0	0.0		0
2.3 NAIC 3						0	0.0	0	0.0		0
2.4 NAIC 4						0	0.0	0	0.0		0
2.5 NAIC 5						0	0.0	0	0.0		0
2.6 NAIC 6						0	0.0	0	0.0		0
2.7 Totals	0	0	0	0	0	0	0.0	0	0.0	0	0
3. U.S. States, Territories and Possessions etc., Guaranteed											
3.1 NAIC 1	0	3,706,196	3,040,934	0	0	6,747,130	4.4	14,746,580	11.0	6,747,130	0
3.2 NAIC 2						0	0.0	0	0.0		0
3.3 NAIC 3						0	0.0	0	0.0		0
3.4 NAIC 4						0	0.0	0	0.0		0
3.5 NAIC 5						0	0.0	0	0.0		0
3.6 NAIC 6						0	0.0	0	0.0		0
3.7 Totals	0	3,706,196	3,040,934	0	0	6,747,130	4.4	14,746,580	11.0	6,747,130	0
4. U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed											
4.1 NAIC 1	0	2,228,682	5,144,506	0	0	7,373,188	4.8	7,507,546	5.6	7,373,188	0
4.2 NAIC 2						0	0.0	0	0.0		0
4.3 NAIC 3						0	0.0	0	0.0		0
4.4 NAIC 4						0	0.0	0	0.0		0
4.5 NAIC 5						0	0.0	0	0.0		0
4.6 NAIC 6						0	0.0	0	0.0		0
4.7 Totals	0	2,228,682	5,144,506	0	0	7,373,188	4.8	7,507,546	5.6	7,373,188	0
5. U.S. Special Revenue & Special Assessment Obligations, etc., Non-Guaranteed											
5.1 NAIC 1	2,798,931	9,339,919	18,823,999	3,927,139	1,620,230	36,510,218	23.9	38,365,593	28.7	36,510,218	0
5.2 NAIC 2						0	0.0	0	0.0		0
5.3 NAIC 3						0	0.0	0	0.0		0
5.4 NAIC 4						0	0.0	0	0.0		0
5.5 NAIC 5						0	0.0	0	0.0		0
5.6 NAIC 6						0	0.0	0	0.0		0
5.7 Totals	2,798,931	9,339,919	18,823,999	3,927,139	1,620,230	36,510,218	23.9	38,365,593	28.7	36,510,218	0

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 9.7	8 Total from Col. 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed (a)
6. Industrial & Miscellaneous (Unaffiliated)											
6.1 NAIC 1	40,734,898	36,422,994	1,602,283	0	0	78,760,175	51.6	50,916,936	38.1	77,166,073	1,594,102
6.2 NAIC 2	665,280	11,335,879	4,721,096	0	0	16,722,255	11.0	15,309,154	11.5	14,866,320	1,855,935
6.3 NAIC 3						0	0.0	0	0.0	0	0
6.4 NAIC 4	0	0	0	0	3,803,085	3,803,085	2.5	3,995,160	3.0	3,803,085	0
6.5 NAIC 5						0	0.0	0	0.0	0	0
6.6 NAIC 6						0	0.0	0	0.0	0	0
6.7 Totals	41,400,178	47,758,873	6,323,379	0	3,803,085	99,285,515	65.1	70,221,250	52.5	95,835,478	3,450,037
7. Hybrid Securities											
7.1 NAIC 1						0	0.0	0	0.0	0	0
7.2 NAIC 2						0	0.0	0	0.0	0	0
7.3 NAIC 3						0	0.0	0	0.0	0	0
7.4 NAIC 4						0	0.0	0	0.0	0	0
7.5 NAIC 5						0	0.0	0	0.0	0	0
7.6 NAIC 6						0	0.0	0	0.0	0	0
7.7 Totals	0	0	0	0	0	0	0.0	0	0.0	0	0
8. Parent, Subsidiaries and Affiliates											
8.1 NAIC 1						0	0.0	0	0.0	0	0
8.2 NAIC 2						0	0.0	0	0.0	0	0
8.3 NAIC 3						0	0.0	0	0.0	0	0
8.4 NAIC 4						0	0.0	0	0.0	0	0
8.5 NAIC 5						0	0.0	0	0.0	0	0
8.6 NAIC 6						0	0.0	0	0.0	0	0
8.7 Totals	0	0	0	0	0	0	0.0	0	0.0	0	0

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1A - SECTION 1 (Continued)

Quality and Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Types of Issues and NAIC Designations

NAIC Designation	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 9.7	8 Total from Col. 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed (a)
9. Total Bonds Current Year											
9.1 NAIC 1	(d) 45,179,648	51,993,617	28,856,387	4,245,601	1,794,691	132,069,944	86.5	XXX	XXX	130,475,842	1,594,102
9.2 NAIC 2	(d) 665,280	11,335,879	4,721,096	.0	.0	16,722,255	11.0	XXX	XXX	14,866,320	1,855,935
9.3 NAIC 3	(d) .0	.0	.0	.0	.0	.0	0.0	XXX	XXX	.0	.0
9.4 NAIC 4	(d) .0	.0	.0	.0	3,803,085	3,803,085	2.5	XXX	XXX	3,803,085	.0
9.5 NAIC 5	(d) .0	.0	.0	.0	.0	.0	0.0	XXX	XXX	.0	.0
9.6 NAIC 6	(d) .0	.0	.0	.0	.0	.0	0.0	XXX	XXX	.0	.0
9.7 Totals	45,844,928	63,329,496	33,577,483	4,245,601	5,597,776	152,595,284	100.0	XXX	XXX	149,145,247	3,450,037
9.8 Line 9.7 as a % of Col. 6	30.0	41.5	22.0	2.8	3.7	100.0	XXX	XXX	XXX	97.7	2.3
10. Total Bonds Prior Year											
10.1 NAIC 1	21,017,190	54,895,934	33,771,069	3,093,514	1,553,413	XXX	XXX	114,331,120	85.6	113,012,269	1,318,851
10.2 NAIC 2	256,922	5,309,254	4,743,487	.0	4,999,491	XXX	XXX	15,309,154	11.5	13,454,162	1,854,992
10.3 NAIC 3	.0	.0	.0	.0	.0	XXX	XXX	.0	0.0	.0	.0
10.4 NAIC 4	.0	.0	.0	.0	3,995,160	XXX	XXX	3,995,160	3.0	3,995,160	.0
10.5 NAIC 5	.0	.0	.0	.0	.0	XXX	XXX	.0	0.0	.0	.0
10.6 NAIC 6	.0	.0	.0	.0	.0	XXX	XXX	.0	0.0	.0	.0
10.7 Totals	21,274,112	60,205,188	38,514,556	3,093,514	10,548,064	XXX	XXX	133,635,434	100.0	130,461,591	3,173,843
10.8 Line 10.7 as a % of Col. 8	15.9	45.1	28.8	2.3	7.9	XXX	XXX	100.0	XXX	97.6	2.4
11. Total Publicly Traded Bonds											
11.1 NAIC 1	45,179,648	50,399,515	28,856,387	4,245,601	1,794,691	130,475,842	85.5	113,012,269	84.6	130,475,842	XXX
11.2 NAIC 2	665,280	10,229,941	3,971,099	.0	.0	14,866,320	9.7	13,454,162	10.1	14,866,320	XXX
11.3 NAIC 3	.0	.0	.0	.0	.0	.0	0.0	.0	0.0	.0	XXX
11.4 NAIC 4	.0	.0	.0	.0	3,803,085	3,803,085	2.5	3,995,160	3.0	3,803,085	XXX
11.5 NAIC 5	.0	.0	.0	.0	.0	.0	0.0	.0	0.0	.0	XXX
11.6 NAIC 6	.0	.0	.0	.0	.0	.0	0.0	.0	0.0	.0	XXX
11.7 Totals	45,844,928	60,629,456	32,827,486	4,245,601	5,597,776	149,145,247	97.7	130,461,591	97.6	149,145,247	XXX
11.8 Line 11.7 as a % of Col. 6	30.7	40.7	22.0	2.8	3.8	100.0	XXX	XXX	XXX	100.0	XXX
11.9 Line 11.7 as a % of Line 9.7, Col. 6, Section 9	30.0	39.7	21.5	2.8	3.7	97.7	XXX	XXX	XXX	97.7	XXX
12. Total Privately Placed Bonds											
12.1 NAIC 1	.0	1,594,102	.0	.0	.0	1,594,102	1.0	1,318,851	1.0	XXX	1,594,102
12.2 NAIC 2	.0	1,105,938	749,997	.0	.0	1,855,935	1.2	1,854,992	1.4	XXX	1,855,935
12.3 NAIC 3	.0	.0	.0	.0	.0	.0	0.0	.0	0.0	XXX	.0
12.4 NAIC 4	.0	.0	.0	.0	.0	.0	0.0	.0	0.0	XXX	.0
12.5 NAIC 5	.0	.0	.0	.0	.0	.0	0.0	.0	0.0	XXX	.0
12.6 NAIC 6	.0	.0	.0	.0	.0	.0	0.0	.0	0.0	XXX	.0
12.7 Totals	.0	2,700,040	749,997	.0	.0	3,450,037	2.3	3,173,843	2.4	XXX	3,450,037
12.8 Line 12.7 as a % of Col. 6	.0	78.3	21.7	.0	.0	100.0	XXX	XXX	XXX	XXX	100.0
12.9 Line 12.7 as a % of Line 9.7, Col. 6, Section 9	0.0	1.8	0.5	0.0	0.0	2.3	XXX	XXX	XXX	XXX	2.3

(a) Includes \$ 3,450,038 freely tradable under SEC Rule 144 or qualified for resale under SEC Rule 144A.

(b) Includes \$.0 current year, \$.0 prior year of bonds with Z designations and \$.0 current year, \$.0 prior year of bonds with Z designations. The letter "Z" means the NAIC designation was not assigned by the Securities Valuation Office (SVO) at the date of the statement. "Z" means the SVO could not evaluate the obligation because valuation procedures for the security class are under regulatory review.

(c) Includes \$.0 current year, \$.0 prior year of bonds with 5 designations and \$.0 current year, \$.0 prior year of bonds with 6 designations. "5" means the NAIC designation was assigned by the (SVO) in reliance on the insurer's certification that the issuer is current in all principal and interest payments. "6" means the NAIC designation was assigned by the SVO due to inadequate certification of principal and interest payments.

(d) Includes the following amount of non-rated short-term and cash equivalent bonds by NAIC designation: NAIC 1 \$.0 ; NAIC 2 \$.0 ; NAIC 3 \$.0 ; NAIC 4 \$.0 ; NAIC 5 \$.0 ; NAIC 6 \$.0

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1A - SECTION 2

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 9.5	8 Total from Col. 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed
1. U.S. Governments											
1.1 Issuer Obligations	1,546,129	0	0	0	0	1,546,129	1.0	1,545,980	1.2	1,546,129	0
1.2 Residential Mortgage-Backed Securities	99,690	295,826	244,665	318,462	174,461	1,133,104	0.7	1,248,485	0.9	1,133,104	0
1.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
1.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
1.5 Totals	1,645,819	295,826	244,665	318,462	174,461	2,679,233	1.8	2,794,465	2.1	2,679,233	0
2. All Other Governments											
2.1 Issuer Obligations	0	0	0	0	0	0	0.0	0	0.0	0	0
2.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
2.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
2.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
2.5 Totals	0	0	0	0	0	0	0.0	0	0.0	0	0
3. U.S. States, Territories and Possessions, Guaranteed											
3.1 Issuer Obligations	0	3,706,196	3,040,934	0	0	6,747,130	4.4	14,746,580	11.0	6,747,130	0
3.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
3.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
3.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
3.5 Totals	0	3,706,196	3,040,934	0	0	6,747,130	4.4	14,746,580	11.0	6,747,130	0
4. U.S. Political Subdivisions of States, Territories and Possessions, Guaranteed											
4.1 Issuer Obligations	0	2,228,682	5,144,506	0	0	7,373,188	4.8	7,507,546	5.6	7,373,188	0
4.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
4.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
4.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
4.5 Totals	0	2,228,682	5,144,506	0	0	7,373,188	4.8	7,507,546	5.6	7,373,188	0
5. U.S. Special Revenue & Special Assessment Obligations etc., Non-Guaranteed											
5.1 Issuer Obligations	0	1,820,724	13,921,848	0	0	15,742,572	10.3	17,539,233	13.1	15,742,572	0
5.2 Residential Mortgage-Backed Securities	2,798,931	7,519,195	4,902,151	3,927,139	1,620,230	20,767,646	13.6	20,826,360	15.6	20,767,646	0
5.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
5.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
5.5 Totals	2,798,931	9,339,919	18,823,999	3,927,139	1,620,230	36,510,218	23.9	38,365,593	28.7	36,510,218	0
6. Industrial and Miscellaneous											
6.1 Issuer Obligations	40,037,036	43,101,602	4,721,096	0	3,803,085	91,662,819	60.1	63,276,129	47.3	88,212,782	3,450,037
6.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
6.3 Commercial Mortgage-Backed Securities	1,363,142	4,657,271	1,602,283	0	0	7,622,696	5.0	6,945,121	5.2	7,622,696	0
6.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
6.5 Totals	41,400,178	47,758,873	6,323,379	0	3,803,085	99,285,515	65.1	70,221,250	52.5	95,835,478	3,450,037
7. Hybrid Securities											
7.1 Issuer Obligations	0	0	0	0	0	0	0.0	0	0.0	0	0
7.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
7.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
7.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
7.5 Totals	0	0	0	0	0	0	0.0	0	0.0	0	0
8. Parent, Subsidiaries and Affiliates											
8.1 Issuer Obligations	0	0	0	0	0	0	0.0	0	0.0	0	0
8.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
8.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
8.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
8.5 Totals	0	0	0	0	0	0	0.0	0	0.0	0	0

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1A - SECTION 2 (Continued)

Maturity Distribution of All Bonds Owned December 31, at Book/Adjusted Carrying Values by Major Type and Subtype of Issues

Distribution by Type	1 1 Year or Less	2 Over 1 Year Through 5 Years	3 Over 5 Years Through 10 Years	4 Over 10 Years Through 20 Years	5 Over 20 Years	6 Total Current Year	7 Col. 6 as a % of Line 9.5	8 Total from Col. 6 Prior Year	9 % From Col. 7 Prior Year	10 Total Publicly Traded	11 Total Privately Placed
9. Total Bonds Current Year											
9.1 Issuer Obligations	41,583,165	50,857,204	26,828,384	0	3,803,085	123,071,838	80.7	XXX	XXX	119,621,801	3,450,037
9.2 Residential Mortgage-Backed Securities	2,898,621	7,815,021	5,146,816	4,245,601	1,794,691	21,900,750	14.4	XXX	XXX	21,900,750	0
9.3 Commercial Mortgage-Backed Securities	1,363,142	4,657,271	1,602,283	0	0	7,622,696	5.0	XXX	XXX	7,622,696	0
9.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	XXX	XXX	0	0
9.5 Totals	45,844,928	63,329,496	33,577,483	4,245,601	5,597,776	152,595,284	100.0	XXX	XXX	149,145,247	3,450,037
9.6 Line 9.5 as a % of Col. 6	30.0	41.5	22.0	2.8	3.7	100.0	XXX	XXX	XXX	97.7	2.3
10. Total Bonds Prior Year											
10.1 Issuer Obligations	16,765,600	46,245,422	32,609,795	0	8,994,651	XXX	XXX	104,615,468	78.3	101,441,624	3,173,844
10.2 Residential Mortgage-Backed Securities	4,508,512	8,882,883	4,036,523	3,093,514	1,553,413	XXX	XXX	22,074,845	16.5	22,074,845	0
10.3 Commercial Mortgage-Backed Securities	0	5,076,883	1,868,238	0	0	XXX	XXX	6,945,121	5.2	6,945,121	(1)
10.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	XXX	XXX	0	0.0	0	0
10.5 Totals	21,274,112	60,205,188	38,514,556	3,093,514	10,548,064	XXX	XXX	133,635,434	100.0	130,461,591	3,173,843
10.6 Line 10.5 as a % of Col. 8	15.9	45.1	28.8	2.3	7.9	XXX	XXX	100.0	XXX	97.6	2.4
11. Total Publicly Traded Bonds											
11.1 Issuer Obligations	41,583,165	48,157,164	26,078,387	0	3,803,085	119,621,801	78.4	101,441,624	75.9	119,621,801	XXX
11.2 Residential Mortgage-Backed Securities	2,898,621	7,815,021	5,146,816	4,245,601	1,794,691	21,900,750	14.4	22,074,845	16.5	21,900,750	XXX
11.3 Commercial Mortgage-Backed Securities	1,363,142	4,657,271	1,602,283	0	0	7,622,696	5.0	6,945,121	5.2	7,622,696	XXX
11.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	0	0.0	0	0
11.5 Totals	45,844,928	60,629,456	32,827,486	4,245,601	5,597,776	149,145,247	97.7	130,461,591	97.6	149,145,247	XXX
11.6 Line 11.5 as a % of Col. 6	30.7	40.7	22.0	2.8	3.8	100.0	XXX	XXX	XXX	100.0	XXX
11.7 Line 11.5 as a % of Line 9.5, Col. 6, Section 9	30.0	39.7	21.5	2.8	3.7	97.7	XXX	XXX	XXX	97.7	XXX
12. Total Privately Placed Bonds											
12.1 Issuer Obligations	0	2,700,040	749,997	0	0	3,450,037	2.3	3,173,844	2.4	XXX	3,450,037
12.2 Residential Mortgage-Backed Securities	0	0	0	0	0	0	0.0	0	0.0	XXX	0
12.3 Commercial Mortgage-Backed Securities	0	0	0	0	0	0	0.0	(1)	0.0	XXX	0
12.4 Other Loan-Backed and Structured Securities	0	0	0	0	0	0	0.0	0	0.0	XXX	0
12.5 Totals	0	2,700,040	749,997	0	0	3,450,037	2.3	3,173,843	2.4	XXX	3,450,037
12.6 Line 12.5 as a % of Col. 6	0.0	78.3	21.7	0.0	0.0	100.0	XXX	XXX	XXX	XXX	100.0
12.7 Line 12.5 as a % of Line 9.5, Col. 6, Section 9	0.0	1.8	0.5	0.0	0.0	2.3	XXX	XXX	XXX	XXX	2.3

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.
SCHEDULE DA - VERIFICATION BETWEEN YEARS

Short-Term Investments

	1 Total	2 Bonds	3 Mortgage Loans	4 Other Short-term Investment Assets (a)	5 Investments in Parent, Subsidiaries and Affiliates
1. Book/adjusted carrying value, December 31 of prior year	12,375,560	12,375,560	0	0	0
2. Cost of short-term investments acquired	84,274,910	84,274,910	0	0	0
3. Accrual of discount	0				
4. Unrealized valuation increase (decrease)	0				
5. Total gain (loss) on disposals	864	864	0	0	0
6. Deduct consideration received on disposals	59,870,638	59,870,638	0	0	0
7. Deduct amortization of premium	26,257	26,257	0	0	0
8. Total foreign exchange change in book/adjusted carrying value	0				
9. Deduct current year's other than temporary impairment recognized	0				
10. Book adjusted carrying value at end of current period (Lines 1+2+3+4+5-6-7+8-9)	36,754,439	36,754,439	0	0	0
11. Deduct total nonadmitted amounts	0				
12. Statement value at end of current period (Line 10 minus Line 11)	36,754,439	36,754,439	0	0	0

(a) Indicate the category of such assets, for example, joint ventures, transportation equipment:

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

Schedule DB - Part A - Verification - Options, Caps, Floors, Collars, Swaps and Forwards

NONE

Schedule DB - Part B - Verification - Futures Contracts

NONE

Schedule DB - Part C - Section 1 - Replication (Synthetic Asset) Transactions (RSATs) Open

NONE

Schedule DB-Part C-Section 2-Reconciliation of Replication (Synthetic Asset) Transactions Open

NONE

Schedule DB - Verification - Book/Adjusted Carrying Value, Fair Value and Potential Exposure of
Derivatives

NONE

Schedule E - Verification - Cash Equivalents

NONE

Schedule A - Part 1 - Real Estate Owned

NONE

Schedule A - Part 2 - Real Estate Acquired and Additions Made

NONE

Schedule A - Part 3 - Real Estate Disposed

NONE

Schedule B - Part 1 - Mortgage Loans Owned

NONE

Schedule B - Part 2 - Mortgage Loans Acquired and Additions Made

NONE

Schedule B - Part 3 - Mortgage Loans Disposed, Transferred or Repaid

NONE

Schedule BA - Part 1 - Other Long-Term Invested Assets Owned

NONE

Schedule BA - Part 2 - Other Long-Term Invested Assets Acquired and Additions Made

NONE

SI11, SI12, SI13, SI14, SI15, E01, E02, E03, E04, E05, E06, E07, E08

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

Schedule BA - Part 3 - Other Long-Term Invested Assets Disposed, Transferred or Repaid

NONE

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
CUSIP Identification	Description	Code	For	Foreign	NAIC Des.	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization) Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date
36180J-V6-8	GNMA POOL AD9507		2		1	544,109	105.6090	531,141	502,692	542,558	0	(1,969)	0	0	3.500	2.656	MON	1,467	17,683	04/08/2013	03/20/2043
36180J-V2-6	GNMA POOL AD7257		2		1	388,964	105.3850	391,167	370,453	397,896	0	(1,616)	0	0	3.500	2.692	MON	1,081	12,987	03/15/2013	03/15/2043
3620AC-V3-1	GNMA POOL 726382		2		1	193,022	110.6510	194,164	175,474	192,660	0	(1,122)	0	0	5.000	2.064	MON	731	8,774	03/15/2013	09/15/2039
02999999	Subtotal - Bonds - U.S. Governments - Residential Mortgage-Backed Securities					1,136,095	XXX	1,116,472	1,048,889	1,133,104	0	(1,507)	0	0	XXX	XXX	XXX	3,279	39,344	XXX	XXX
05999999	Total - U.S. Government Bonds					1,136,095	XXX	1,116,472	1,048,889	1,133,104	0	(1,507)	0	0	XXX	XXX	XXX	3,279	39,344	XXX	XXX
10999999	Total - All Other Government Bonds					0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0	XXX	XXX
31383J-V4-7	BERGIA ST		1		JFE	258,260	111.0690	249,505	225,000	236,482	0	(4,369)	0	0	5.000	2.870	JU	5,625	11,250	08/14/2009	07/01/2019
419791-V2-4	HANNA ST				JFE	459,660	114.9730	459,660	444,823	444,823	0	(7,156)	0	0	5.000	2.940	FA	8,333	20,000	01/14/2011	02/01/2019
604129-V5-2	MINNESOTA ST				JFE	182,859	114.0180	171,027	150,000	165,645	0	(4,174)	0	0	5.000	1.971	FA	3,125	7,500	09/29/2010	08/01/2018
677521-V3-6	OHIO STATE		SD		JFE	3,069,192	114.4310	3,204,068	2,800,000	3,040,490	0	(27,210)	0	0	4.000	2.770	IN	18,667	104,222	12/12/2013	11/01/2022
70194P-VB-5	PENNSYLVANIA ST		1		JFE	2,128,200	110.2840	2,205,680	2,000,000	2,055,034	0	(19,888)	0	0	5.000	3.870	FA	41,667	100,000	02/11/2011	08/01/2022
97705J-LA-8	WISCONSIN ST		1		JFE	569,837	105.4530	569,716	550,000	560,716	0	(13,276)	0	0	5.000	1.633	IN	1,750	27,500	03/13/2011	11/01/2019
97705J-RL-3	WISCONSIN ST		1		JFE	323,886	113.1730	339,525	300,000	311,835	0	(3,276)	0	0	5.000	3.730	IN	2,500	15,000	02/14/2011	05/01/2021
11999999	Subtotal - Bonds - U.S. States, Territories and Possessions - Issuer Obligations					6,970,954	XXX	7,146,027	6,325,000	6,747,130	0	(80,040)	0	0	XXX	XXX	XXX	83,667	280,472	XXX	XXX
17999999	Total - U.S. States, Territories and Possessions Bonds					6,970,954	XXX	7,146,027	6,325,000	6,747,130	0	(80,040)	0	0	XXX	XXX	XXX	83,667	280,472	XXX	XXX
181059-VX-7	CLARK COUNTY NEW SCH DIST				JFE	3,835,295	118.2590	1,773,885	1,500,000	1,755,331	0	(36,480)	0	0	5.000	2.161	JU	3,333	75,000	10/12/2012	06/15/2021
190491-V3-3	COLUMBUS OHIO				JFE	474,109	116.4070	465,628	400,000	444,823	0	(9,334)	0	0	5.000	2.361	JU	10,000	20,000	10/12/2011	07/01/2019
235219-V0-9	DALLAS TEXAS				JFE	460,425	109.2250	453,284	415,000	442,159	0	(12,439)	0	0	5.000	1.841	FA	7,838	20,750	07/10/2013	02/15/2017
34133P-V2-3	FLORIDA ST BRD ED		SD		JFE	1,638,112	119.5660	1,673,924	1,400,000	1,596,493	0	(27,785)	0	0	5.000	2.610	JU	5,833	70,000	06/26/2013	06/01/2023
34133P-V3-5	FLORIDA ST BRD ED SERIES C				JFE	820,088	119.9200	829,360	825,000	804,038	0	(11,244)	0	0	5.000	2.450	JU	2,188	28,250	07/19/2013	06/01/2021
442331-TN-4	HOUSTON TEX				JFE	1,144,050	109.3520	1,093,520	1,000,000	1,052,580	0	(23,340)	0	0	5.000	2.491	IN	16,667	30,000	12/07/2010	03/01/2017
75844B-VX-6	REDDY CREEK IMPT DIST FLA		1		JFE	1,194,811	117.2730	1,336,912	1,140,000	1,188,645	0	(4,631)	0	0	5.250	4.632	JU	4,988	39,800	08/15/2013	06/01/2030
788237-VG-5	SAN ANTONIO TEXAS				JFE	319,596	110.9970	294,142	265,000	289,119	0	(9,106)	0	0	5.000	1.400	FA	5,521	13,250	12/09/2011	08/01/2017
18999999	Subtotal - Bonds - U.S. Political Subdivisions - Issuer Obligations					7,683,485	XXX	7,720,875	6,645,000	7,373,188	0	(134,359)	0	0	XXX	XXX	XXX	96,369	335,100	XXX	XXX
24999999	Total - U.S. Political Subdivisions Bonds					7,683,485	XXX	7,720,875	6,645,000	7,373,188	0	(134,359)	0	0	XXX	XXX	XXX	96,369	335,100	XXX	XXX
10071C-V5-3	CALIFORNIA ST UNITY SERIES A		1		JFE	300,380	122.5130	360,104	300,000	368,136	0	(6,468)	0	0	5.000	3.521	IN	6,667	40,000	07/23/2013	11/01/2023
140345-V0-3	HOUSTON TEL UTIL SYS REV SER C		1		JFE	307,103	119.8700	323,649	270,000	304,885	0	(2,218)	0	0	5.000	3.380	IN	1,725	7,875	03/13/2014	05/15/2028
49151F-E0-9	KENTUCKY ST PROPERTY & BLDGS C SERIES A		1		JFE	1,071,682	115.8710	1,106,568	955,000	1,056,739	0	(9,749)	0	0	5.000	3.571	AO	11,938	47,750	06/05/2013	10/01/2029
53645C-BH-2	LOS ANGELES CA INSTNTR SYS REV SERIES B		1		JFE	2,033,046	119.2860	2,099,434	1,760,000	1,996,237	0	(24,136)	0	0	5.000	3.170	JU	7,333	88,000	06/05/2013	06/01/2029
574204-WN-9	HAWAIIAN ST DEPT TRANS CONS				JFE	974,977	110.1150	968,449	825,000	890,167	0	(27,228)	0	0	5.000	1.540	IN	6,875	41,250	10/31/2011	05/01/2017
582591-PN-5	METROPOLITAN TRANS AUTH NY				JFE	2,436,240	119.5120	2,390,240	2,000,000	2,342,798	0	(29,044)	0	0	5.000	2.570	IN	16,667	100,000	07/23/2012	11/01/2022
582646-65-7	METROPOLITAN WASHINGTON D C AR SERIES A		1		JFE	217,694	117.1630	222,610	190,000	216,549	0	(1,145)	0	0	5.000	3.311	AO	2,375	2,322	05/30/2014	10/01/2028
604146-AP-1	MINNESOTA ST GEN FUND REVENUE				JFE	2,169,390	117.9360	2,358,720	2,000,000	2,145,426	0	(17,330)	0	0	5.000	3.630	IN	33,333	100,000	08/06/2013	03/01/2028
646139-V2-5	NEW JERSEY ST TURNPIKE AUTH SERIES A		1		JFE	1,189,776	116.9670	1,228,154	1,050,000	1,182,709	0	(17,967)	0	0	5.000	3.430	JU	31,938	27,750	05/14/2014	01/01/2030
67769P-JR-3	OHIO ST TRK COMMA TRN REV				JFE	1,182,248	118.2430	1,300,673	1,100,000	1,154,838	0	(5,478)	0	0	5.000	4.510	FA	21,817	47,750	08/15/2013	02/15/2029
684517-VB-4	GRANDE OITY FL SCH BRD OPS SERIES A		1		JFE	3,428,869	117.0020	1,521,026	1,300,000	1,421,978	0	(6,891)	0	0	5.000	3.821	FA	27,083	15,347	03/19/2014	08/01/2029
71883P-JU-2	PHOENIX ARIZ CIVIC IMPT CORP		1		JFE	383,699	119.8080	401,527	335,000	380,795	0	(2,904)	0	0	5.000	3.111	JU	8,375	3,536	03/19/2014	07/01/2029
73573D-PS-3	SALT RIVER PROJ AZ AGRIC IMPT				JFE	428,472	114.9160	402,206	350,000	380,006	0	(10,521)	0	0	5.000	1.741	JU	1,458	17,500	10/04/2011	12/01/2018
813643-GT-5	SEATTLE WASH MUN LIGHT & POWER				JFE	867,280	119.4030	835,821	700,000	820,737	0	(15,860)	0	0	5.000	2.700	JU	2,917	15,000	08/01/2012	06/01/2025
88258E-V2-6	TEXAS ST PUB FIN AUTH REV		1		JFE	344,491	104.7720	324,793	310,000	317,204	0	(7,019)	0	0	5.000	2.630	JU	7,750	15,500	12/15/2010	07/01/2017
89602N-ZH-7	TRIBOROUGH BRD & TUNL AUTH NY				JFE	234,213	117.1030	222,496	190,000	220,347	0	(5,945)	0	0	5.000	1.581	IN	1,214	9,500	08/23/2012	11/15/2019
25999999	Subtotal - Bonds - U.S. Special Revenues - Issuer Obligations					16,148,144	XXX	16,626,300	14,135,000	15,742,572	0	(191,024)	0	0	XXX	XXX	XXX	189,465	581,330	XXX	XXX
31288B-V2-7	PHILIC GOLD POOL 007213		2		1	444,881	104.3860	437,387	419,122	444,137	0	(402)	0	0	3.500	2.709	MON	1,222	14,688	03/27/2013	11/01/2042
313840-3F-4	FNMA SERIES 2013-A5 CLASS CR		2		1	862,704	105.4550	836,452	800,000	854,565	0	(2,829)	0	0	4.000	1.748	MON	1,702	29,422	04/10/2013	12/25/2046
313780-V3-3	PHILIC MULTIFAMILY STRUCTURED SERIES 4182 CLASS KT		2		1	734,496	104.2600	707,527	678,618	728,680	0	(1,873)	0	0	3.500	1.269	MON	1,979	23,751	05/01/2013	05/15/2041
31384X-VX-8	FNMA POOL AJ0091		2		1	424,932	106.8520	424,190	396,988	424,260	0	(488)	0	0	4.000	2.856	MON	1,323	15,880	03/27/2013	12/31/2041
31384X-VX-8	FNMA POOL AJ0094		2		1	508,689	106.8520	508,144	475,559	507,737	0	(369)	0	0	4.000	2.858	MON	1,365	19,022	03/15/2013	12/01/2041
313853-HX-9	FNMA POOL AJ0544		2		1	475,221	104.2190	460,158	450,158	475,421	0	(1,561)	0	0	4.000	1.802	MON	1,125	15,585	04/08/2013	04/01/2022
313853-HT-4	FNMA POOL AL0241		2		1	434,813	106.8520	432,506	404,771	433,833	0	(1,412)	0	0	4.000	2.900	MON	1,349	16,191	04/08/2013	04/01/2041
31385X-JH-0	FNMA POOL AL2071		2		1	668,511	112.2940	668,058	610,948	667,155	0	288	0	0	5.500	2.481	MON	2,800	33,602	05/06/2013	03/01/2046
31385X-SH-1	FNMA POOL AL2080		2		1	1,094,199	106.8520	1,094,199	970,309	1,094,199	0	(2,892)	0	0	5.500	2.482	MON	2,430	29,291	05/03/2013	03/01/2046
31385X-WK-7	FNMA POOL AL2093		2		1	641,200	104.7250	633,920	605,319	640,165	0	(453)	0	0	3.500	2.658	MON	1,766	21,186	03/15/2013	02/01/2045

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes		6	7	Fair Value		10	11	Change in Book/Adjusted Carrying Value				16	17	18	19	20	Dates		
3	4	5				8	9			12	13	14	15					21	22		
CUSIP	Description	Bond Char	NAIC Des.	Actual Cost	Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization) Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date		
3138EX-UB-4	FNMA POOL AL3307	2		1,230,315	107,490	1,271,032	1,182,818	1,229,404	0	(,613)	0	0	4.000	3.320	MON	3,943	47,313	06/25/2013	11/01/2042		
3138EX-HE-1	FNMA POOL AL3344	2		1,030,442	110,780	1,126,887	1,126,687	1,017,616	1,088,963	0	(,100)	0	4.500	3.461	MON	3,816	45,793	09/29/2013	10/01/2042		
3138EX-BR-3	FNMA POOL AL3647	2		769,867	106,820	761,817	760,786	760,786	0	(,80)	0	0	4.000	3.453	MON	2,377	0	12/18/2014	12/01/2042		
3138H3-FO-2	FNMA POOL AR5562	2		1,265,089	104,620	1,255,537	1,200,089	1,263,058	0	(,1,295)	0	0	3.500	2.889	MON	3,500	42,002	05/24/2013	02/01/2043		
3138H1-GJ-9	FNMA POOL AT5600	2		1,287,300	104,720	1,278,020	1,220,416	1,285,801	0	(,560)	0	0	3.500	2.782	MON	3,560	42,714	05/24/2013	05/01/2043		
3138H3-HIT-5	FNMA POOL AT2169	2		851,191	108,190	863,743	798,889	850,950	0	(,241)	0	0	4.000	3.501	MON	2,683	2,683	11/04/2014	11/01/2044		
314020-C7-3	FNMA POOL 725594	2		347,573	112,530	358,017	318,144	346,661	0	(,131)	0	0	5.500	2.691	MON	1,458	17,496	06/05/2013	07/01/2034		
314020-2V-2	FNMA POOL 735288	2		222,382	110,760	226,834	204,783	221,794	0	(,31)	0	0	5.000	2.536	MON	853	10,239	03/26/2013	03/01/2035		
314168-LD-8	FNMA POOL 955024	2		1,271,655	112,270	1,306,842	1,163,886	1,268,882	0	(,12)	0	0	5.500	2.611	MON	5,335	64,019	06/05/2013	08/01/2037		
314168-HS-3	FNMA POOL 956112	2		761,341	112,380	753,195	696,680	759,584	0	(,80)	0	0	5.500	2.627	MON	3,194	38,338	06/05/2013	07/01/2038		
314168-TA-6	FNMA POOL 956345	2		305,902	110,400	308,778	279,682	305,338	0	(,564)	0	0	5.000	1.605	MON	1,165	8,157	04/16/2014	01/01/2039		
314162-C3-7	FNMA POOL 956722	2		352,279	110,710	359,582	324,588	351,513	0	75	0	0	5.000	2.441	MON	1,352	16,229	03/15/2013	05/01/2038		
314170-CE-4	FNMA POOL AR8068	2		487,359	104,350	459,091	439,915	466,566	0	(,370)	0	0	3.500	2.568	MON	1,283	15,397	04/04/2013	04/01/2043		
314170-CP-1	FNMA POOL AR8069	2		494,230	104,350	464,472	450,441	480,441	0	(,286)	0	0	3.500	2.390	MON	1,354	16,246	04/04/2013	04/01/2043		
31418A-6G-8	FNMA POOL BA1770	2		999,190	108,710	1,012,716	930,967	998,071	0	(,1,119)	0	0	4.500	3.422	MON	3,491	34,911	01/30/2014	02/01/2044		
31418A-JL-3	FNMA POOL BA1166	2		550,482	105,510	547,595	518,998	548,645	0	(,975)	0	0	3.500	2.411	MON	1,514	18,165	03/15/2013	09/01/2032		
314180-HG-6	FNMA POOL BA3894	2		779,709	107,800	783,773	727,001	777,094	0	(,1,323)	0	0	4.000	2.558	MON	2,423	29,080	05/02/2013	09/01/2037		
31418A-6K-7	FNMA POOL AE0201	2		653,553	112,470	672,833	598,218	692,126	0	15	0	0	5.500	2.701	MON	2,742	32,902	06/05/2013	08/01/2037		
314190-4K-4	FNMA POOL AE3525	2		311,750	106,860	309,804	289,916	311,054	0	(,321)	0	0	4.000	2.840	MON	966	11,597	04/03/2013	03/01/2041		
314190-IL-5	FNMA POOL AE8750	2		887,251	106,820	880,367	823,912	885,359	0	(,701)	0	0	4.000	2.779	MON	2,746	32,957	05/03/2013	12/01/2040		
2699999. Subtotal - Bonds - U.S. Special Revenues - Residential Mortgage-Backed Securities						20,820,322	XXX	20,902,257	19,439,411	20,767,646	0	(20,748)	0	0	XXX	XXX	XXX	67,019	733,641	XXX	XXX
3199999. Total - U.S. Special Revenues Bonds						38,968,486	XXX	37,528,557	33,574,411	36,510,218	0	(211,772)	0	0	XXX	XXX	XXX	256,484	1,314,971	XXX	XXX
002680-BR-6	AT&T INC.		JFE	401,376	100,3870	401,588	400,000	400,689	0	(,277)	0	0	1.700	1.627	JJ	567	8,800	06/28/2012	06/01/2017		
003460-AJ-0	AGILENT TECHNOLOGIES INC.	1	JFE	696,808	99,3620	696,534	700,000	697,233	0	271	0	0	3.875	3.930	JJ	12,508	28,933	07/14/2013	07/15/2023		
023135-AH-9	AMAZON.COM INC.		JFE	149,270	98,9300	148,409	150,000	149,569	0	144	0	0	1.200	1.301	IN	160	1,800	11/29/2012	11/29/2017		
025890-DE-6	AMERICAN EXPRESS CREDIT SERIES MTN		JFE	306,936	100,5500	301,650	300,000	301,127	0	(2,505)	0	0	1.750	0.906	JJ	277	5,250	08/31/2012	06/12/2019		
026874-CZ-8	AMERICAN INTERNATIONAL GROUP		JFE	334,323	100,1020	335,342	335,000	334,382	0	59	0	0	2.300	2.343	JJ	3,531	0	07/08/2014	07/16/2019		
031162-BR-0	AUGEN INC.		JFE	1,048,856	99,2110	1,041,716	1,050,000	1,040,084	0	229	0	0	1.250	1.287	IN	1,422	6,563	05/19/2014	05/22/2017		
032095-AD-3	AMPHENOL CORP.		JFE	454,536	99,7220	453,735	455,000	454,582	0	46	0	0	1.550	1.585	MS	2,135	0	09/09/2014	09/15/2017		
037833-AJ-9	APPLE COMPUTER INC.		JFE	866,790	98,5160	857,089	870,000	867,837	0	833	0	0	1.000	1.076	IN	1,402	8,700	04/30/2013	05/03/2019		
053319-AK-9	BBAT CORPORATION SERIES MTN		JFE	407,338	101,4430	405,772	400,000	402,451	0	(1,567)	0	0	2.150	1.738	MS	2,365	8,600	06/28/2012	03/22/2017		
053319-AN-3	BBAT CORPORATION	1	JFE	49,527	100,6500	50,330	50,000	49,949	0	14	0	0	2.050	2.081	JJ	34	1,025	06/14/2013	06/19/2018		
060505-DH-4	BANK OF AMERICA CORP.		JFE	977,592	110,2650	926,226	840,000	927,505	0	(31,659)	0	0	6.000	1.970	MS	16,800	50,400	05/22/2013	09/01/2017		
060507-LR-1	BANK OF AMERICA NA SERIES FIO		JFE	324,760	99,6390	323,827	325,000	324,849	0	79	0	0	1.125	1.150	IN	477	3,656	11/06/2013	11/14/2018		
060510-EX-3	BANK OF AMERICA CORP.		JFE	1,289,450	100,7780	1,259,725	1,250,000	1,267,042	0	(2,488)	0	0	2.800	2.245	JJ	4,778	26,250	05/29/2014	01/15/2019		
06406H-BX-6	BANK OF NEW YORK MELLON SERIES MTN		JFE	155,279	102,8620	153,279	150,000	152,072	0	(1,292)	0	0	2.300	1.410	JJ	1,466	3,450	06/28/2012	07/28/2016		
075887-BB-4	BECTON DICKINSON AND CO		JFE	411,940	100,7380	402,952	400,000	405,174	0	(2,752)	0	0	1.750	1.043	IN	1,031	7,000	07/09/2012	11/08/2016		
075887-BD-0	BECTON DICKINSON AND CO		JFE	225,000	100,3690	225,800	225,000	225,000	0	0	0	0	1.800	1.800	JJ	180	0	12/04/2014	12/15/2017		
075889-AA-8	BEO BATH AND BEYOND INC.		JFE	344,987	101,3730	340,738	345,000	345,001	0	4	0	0	3.749	3.749	FA	5,892	0	07/14/2014	09/01/2026		
08247X-AK-7	BLACKROCK INC.		JFE	506,333	100,4500	502,295	500,000	500,927	0	(2,211)	0	0	1.375	0.928	JJ	573	6,875	08/07/2012	06/01/2015		
090714-AK-4	BOEING CAPITAL CORP.	1	JFE	420,008	101,8950	400,000	407,799	407,799	0	(5,014)	0	0	2.125	0.847	FA	3,211	8,500	07/19/2012	08/15/2016		
090723-BE-4	BOEING CO		JFE	168,128	97,7810	166,228	170,000	168,734	0	366	0	0	0.950	1.176	IN	206	1,615	04/30/2013	05/15/2019		
110123-AJ-7	BRISTOL-MYERS SQUIBB CO		JFE	495,885	99,1020	495,510	500,000	497,840	0	821	0	0	0.875	1.040	FA	1,623	4,375	08/07/2012	08/01/2017		
133429-AN-5	CAMERON INTERNATIONAL CORP.		JFE	349,829	98,4820	344,722	350,000	349,858	0	30	0	0	1.400	1.417	JJ	2,382	0	06/17/2014	06/15/2017		
134429-AV-1	CAMPBELL SOUP CO		JFE	432,744	103,3960	413,584	416,732	416,732	0	(6,411)	0	0	3.050	1.366	JJ	5,626	12,200	06/28/2012	07/15/2017		
140420-AL-0	CAPITAL ONE BANK USA	1	JFE	249,970	99,1400	247,850	250,000	249,976	0	5	0	0	1.300	1.304	JJ	225	1,625	06/03/2014	06/05/2017		
140425-QZ-1	CAPITAL ONE NA SERIES BONT		JFE	673,266	98,1940	674,519	680,000	679,340	0	1,500	0	0	1.500	1.500	MS	3,297	0	09/02/2014	09/05/2017		
149123-BZ-3	CATERPILLAR INC.		JFE	349,580	100,6170	352,160	350,000	349,787	0	83	0	0	1.500	1.525	JJ	73	5,250	06/26/2012	06/26/2017		
151020-AN-4	CELEBRE CORP.		JFE	284,290	99,2940	282,968	285,000	284,375	0	85	0	0	2.250	2.303	IN	819	3,206	05/06/2014	05/15/2019		
160764-AA-8	CHEVRONTERRACORP	1	JFE	115,000	99,3620	114,289	115,000	115,000	0	0	0	0	1.104	1.104	JJ	32	1,270	12/05/2012	12/05/2017		
172729-AK-8	CISCO SYSTEMS INC.		JFE	435,100	104,5300	416,872	400,000	416,872	0	(7,228)	0	0	3.150	1.228	MS	3,745	2,680	05/28/2012	03/14/2017		
172967-EH-9	CITIGROUP INC.		JFE	2,128,268	111,5080	2,107,144	1,800,000	2,013,473	0	(17,247)	0	0	6.125	1.887	IN	12,250	110,250	05/22/2013	11/21/2017		
191216-AJ-8	COCA-COLA COMPANY		JFE	401,672	100,1010	400,404	400,000	400,125	0	(825)	0	0	0.750	0.593	MS	900	3,000	07/06/2012	03/13/2015		
194160-DX-5	COLGATE-PALMOLIVE CO SERIES MTN		JFE																		

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 1

Showing All Long-Term BONDS Owned December 31 of Current Year

1	2	Codes			6	7	Fair Value				10	11	Change in Book/Adjusted Carrying Value				Interest			Dates			
		3	4	5			8	9	12	13			14	15	16	17	18	19	20	21	22		
CUSIP Identification	Description	C o d e	F o r e i g n	Bond Char	NAIC Des.	Actual Cost	Rate Used to Obtain Fair Value	Fair Value	Fair Value	Par Value	Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ (Decrease)	Current Year's (Amortization) Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Rate of	Effective Rate of	When Paid	Admitted Amount Due and Accrued	Amount Received During Year	Acquired	Stated Contractual Maturity Date	
882508-AA-5	TEXAS INSTRUMENTS INC				JFE	421,584	102.2860	409,184	400,000	407,733	0	(5,962)	0	0	2.375	0.956	IN		1,188	9,500	06/28/2012	05/16/2016	
882508-AI-1	TEXAS INSTRUMENTS INC				JFE	99,669	100.1100	100,110	100,000	99,934	0	111	0	0	0.450	0.562	FA		185	459	08/01/2012	06/03/2015	
883558-BA-9	THE THERMO FISHER SCIENTIFIC				ZFE	415,904	101.5500	406,236	400,000	406,345	0	(3,848)	0	0	2.250	1.259	FA		3,400	9,000	06/26/2012	08/15/2016	
885791-AE-1	3M COMPANY				JFE	946,357	99.8150	948,243	950,000	948,164	0	725	0	0	1.000	1.079	JD		132	9,500	06/26/2012	06/26/2017	
882631-AL-9	TOYOTA MOTOR CREDIT CORP				JFE	669,725	100.1580	671,059	670,000	668,873	0	91	0	0	0.800	0.814	IN		655	5,380	05/14/2013	05/17/2016	
920484-HH-3	TYSON FOODS INC				ZFE	159,894	100.9110	161,458	160,000	159,903	0	9	0	0	2.650	2.664	FA		1,684	0	08/05/2014	08/15/2019	
91159H-HB-9	US BANCORP SERIES MTN	1			JFE	104,937	102.0460	102,046	100,000	102,178	0	(1,203)	0	0	2.200	0.967	IN		281	2,200	09/10/2012	11/15/2016	
91159H-HD-5	US BANCORP SERIES MTN	1			JFE	402,488	100.7400	402,984	400,000	401,202	0	(512)	0	0	1.650	1.516	IN		843	6,600	06/28/2012	05/15/2017	
913017-BH-1	UNITED TECHNOLOGIES CORP				JFE	175,670	101.4000	162,240	160,000	162,209	0	(6,600)	0	0	4.875	0.718	IN		1,300	7,800	12/14/2012	05/01/2015	
913017-BU-2	UNITED TECHNOLOGIES CORP				JFE	201,249	101.3070	202,614	200,000	200,616	0	(248)	0	0	1.900	1.669	JD		300	3,600	06/01/2012	06/01/2017	
922775-AC-1	VENTAS REALTY LP/CAP CORP				ZFE	44,917	99.0600	44,581	45,000	44,936	0	19	0	0	1.250	1.313	AO		116	281	04/10/2014	04/17/2017	
923431-BD-5	VERIZON COMMUNICATIONS				ZFE	415,472	101.4660	405,864	400,000	406,684	0	(3,591)	0	0	2.000	1.077	IN		1,333	8,000	07/13/2012	11/01/2016	
923431-BN-3	VERIZON COMMUNICATIONS				ZFE	307,763	102.2170	314,828	308,000	307,862	0	78	0	0	2.500	2.527	IS		2,267	7,636	08/11/2013	08/15/2016	
923431-CN-2	VERIZON COMMUNICATIONS	1			ZFE	184,443	98.6230	182,453	185,000	184,435	0	12	0	0	3.000	3.048	IN		566	0	10/22/2014	11/01/2021	
931142-CX-9	WAL-MART STORES INC				JFE	770,475	100.9280	756,945	750,000	755,133	0	(6,250)	0	0	1.500	0.658	AO		2,063	11,250	07/13/2012	10/25/2015	
931422-AG-4	WALGREEN CO				ZFE	249,923	100.0930	250,233	250,000	249,994	0	31	0	0	1.000	1.013	IS		750	2,500	09/13/2012	03/13/2015	
948748-FD-7	WELLS FARGO & COMPANY MTN				JFE	400,436	101.0950	406,780	400,000	400,219	0	(90)	0	0	2.100	2.076	IN		1,237	8,400	06/28/2012	05/08/2017	
948748-FE-5	WELLS FARGO & COMPANY				JFE	101,253	100.5370	100,537	100,000	100,219	0	(434)	0	0	1.500	1.060	JD		750	1,500	08/07/2012	07/01/2015	
963320-AS-5	WHIRLPOOL CORP SERIES 31R				ZFE	444,973	99.6680	443,523	445,000	444,975	0	1	0	0	1.650	1.652	IN		1,163	0	10/30/2014	11/01/2017	
983919-AS-6	XILINX CORP				JFE	318,326	99.3570	317,942	320,000	318,583	0	258	0	0	2.125	2.238	IS		2,002	3,457	03/05/2014	03/15/2019	
3299999	Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations					57,338,021	XXX	56,446,967	51,843,500	56,454,509	(192,075)	(379,860)	0	0	XXX	XXX	XXX		351,848	1,324,007	XXX	XXX	
073880-AE-9	BEAR STEARNS COMMERCIAL MORTG SERIES 2007-PH17			2	JPL	1,505,055	108.4660	1,410,058	1,300,000	1,417,533	0	(55,388)	0	0	0	5.694	1.289	MON		6,169	74,022	05/24/2013	06/11/2050
073881-AE-8	BEAR STEARNS COMMERCIAL MORTG SERIES 2007-T26			2	JPL	1,469,261	107.1090	1,369,840	1,278,921	1,358,824	0	(79,627)	0	0	0	5.471	0.160	MON		5,831	69,988	05/17/2013	01/12/2045
126288-AD-6	COMB MORTGAGE TRUST SERIES 2013-GRD CLASS A4			2	JPL	659,167	109.0920	698,189	640,000	656,851	0	(1,686)	0	0	4.210	3.867	MON		2,245	26,944	08/01/2013	08/10/2046	
468251-NE-9	JP MORGAN CHASE COMMERCIAL MTO SERIES 2005-LDP2			2	JPL	569,996	100.7790	534,129	530,000	537,960	0	(19,484)	0	0	4.780	1.067	MON		2,111	25,334	05/02/2013	07/15/2042	
46842E-AV-8	JPM88 COMMERCIAL MORTGAGE SECU SERIES 2014-C21			2	JPL	926,998	102.8730	925,857	900,000	924,571	0	(2,428)	0	0	2.892	2.225	MON		2,169	10,844	07/01/2014	08/15/2047	
50177A-AS-8	LB COMMERCIAL CONDUIT MORTGAGE SERIES 2007-C3			2	JPL	1,490,328	107.6610	1,399,593	1,300,000	1,395,795	0	(62,096)	0	0	5.517	0.831	MON		3,985	71,721	05/28/2013	07/15/2044	
82890P-JF-1	HF-RBS COMMERCIAL MORTGAGE TRU SERIES 2013-C14			2	JPL	1,338,969	102.1060	1,327,378	1,300,000	1,331,162	0	(5,008)	0	0	2.977	2.536	MON		3,222	36,701	05/22/2013	06/15/2046	
3499999	Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Commercial Mortgage-Backed Securities					7,959,776	XXX	7,665,044	7,248,921	7,622,696	0	(225,717)	0	0	XXX	XXX	XXX		25,732	317,554	XXX	XXX	
3899999	Total - Industrial and Miscellaneous (Unaffiliated) Bonds					65,317,797	XXX	64,112,011	59,092,421	64,077,205	(192,075)	(605,577)	0	0	XXX	XXX	XXX		377,580	1,641,561	XXX	XXX	
4899999	Total - Hybrid Securities					0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX		0	0	XXX	XXX	
5599999	Total - Parent, Subsidiaries and Affiliates Bonds					0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX		0	0	XXX	XXX	
7799999	Total - Issuer Obligations					88,160,604	XXX	87,940,169	78,948,500	86,317,399	(192,075)	(785,283)	0	0	XXX	XXX	XXX		681,349	2,520,909	XXX	XXX	
7899999	Total - Residential Mortgage-Backed Securities					21,956,417	XXX	22,018,729	20,488,300	21,900,750	0	(22,255)	0	0	XXX	XXX	XXX		70,298	772,985	XXX	XXX	
7999999	Total - Commercial Mortgage-Backed Securities					7,959,776	XXX	7,665,044	7,248,921	7,622,696	0	(225,717)	0	0	XXX	XXX	XXX		25,732	317,554	XXX	XXX	
8099999	Total - Other Loan-Backed and Structured Securities					0	XXX	0	0	0	0	0	0	0	XXX	XXX	XXX		0	0	XXX	XXX	
8399999	Total Bonds					118,076,797	XXX	117,623,942	106,685,721	115,840,845	(192,075)	(1,033,255)	0	0	XXX	XXX	XXX		777,379	3,611,448	XXX	XXX	

SCHEDULE D - PART 2 - SECTION 1[illegible]

SCHEDULE D - PART 2 - SECTION 2

1	2	3 Codes		5	6	Fair Value		9	Dividends			Change in Book/Adjusted Carrying Value				17	18					
		3	4			7	8		10	11	12	13	14	15	16							
CUSIP Identification	Description	Code	For- eign	Number of Shares	Book/ Adjusted Carrying Value	Rate Per Share Used to Obtain Fair Value	Fair Value	Actual Cost	Declared but Unpaid	Amount Received During Year	Nonadmitted Declared But Unpaid	Unrealized Valuation Increase/ (Decrease)	Current Year's Other-Than- Temporary Impairment Recognized	Total Change in Book/Adjusted Carrying Value (13 - 14)	Total Foreign Exchange Change in Book/Adjusted Carrying Value	NAIC Market Indicator (a)	Date Acquired					
784844-78-3	SPDR BARCLAYS INTERMEDIATE ETF			57,780,000	\$ 4,551,488	78.800	\$ 551,488	3,046,848	0	215,828	0	356,957	0	356,957	0		10/11/2013					
921946-40-6	VANGUARD HIGH DIV YIELD ETF			72,436,000	\$ 4,979,975	68.750	\$ 979,975	3,963,210	0	338,208	0	465,763	0	465,763	0		10/11/2013					
922908-74-4	VANGUARD LARGE-CAP			52,220,000	\$ 4,412,068	84.490	\$ 412,068	2,683,444	0	57,808	0	422,982	0	422,982	0		10/11/2013					
9099999	Subtotal - Common Stock - Industrial and Miscellaneous (Unaffiliated)				13,943,531	XXX	13,943,531	9,093,502	0	451,842	0	1,245,702	0	1,245,702	0	XXX	XXX					
9799999	Total Common Stocks				13,943,531	XXX	13,943,531	9,093,502	0	451,842	0	1,245,702	0	1,245,702	0	XXX	XXX					
9899999	Total Preferred and Common Stocks				13,943,531	XXX	13,943,531	9,093,502	0	451,842	0	1,245,702	0	1,245,702	0	XXX	XXX					

0000000 - Total Preferred and Common Stocks	10,940,301	XXXX	10,940,301	0,000,000	0	10,940,301
(a) For all common stock bearing the NAIC market indicator "U" provide: the number of such issues _____, the total \$ value (included in Column 8) of all such issues \$ _____						

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 3

Showing All Long-Term Bonds and Stocks ACQUIRED During Current Year

1	2	3	4	5	6	7	8	9
CUSIP Identification	Description	Foreign	Date Acquired	Name of Vendor	Number of Shares of Stock	Actual Cost	Par Value	Paid for Accrued Interest and Dividends
3138L-9R-3	FMAA POOL AL3647 4.000% 12/01/42		12/16/2014	DBTC AMERICA/PNC BANK		760,867	712,964	1,426
3138Y3-MT-5	FMAA POOL AX2169 4.000% 11/01/44		11/04/2014	DBTC AMERICA/PNC BANK		851,191	798,889	1,065
31416B-TA-6	FMAA POOL 995245 5.000% 01/01/39		04/16/2014	Cantor Fitzgerald & Co		305,902	279,682	427
31418A-6S-8	FMAA POOL WA1770 4.500% 02/01/44		01/30/2014	Nomura Securities		999,190	930,967	1,396
4426S-10-3	KOOSTON TEX UTIL SYS NEW SER C 5.000% 05/15/28		03/13/2014	National Financial Services		307,103	270,000	.0
502646-6S-7	METROPOLITAN WASHINGTON D C AR SERIES A 5.000% 10/01/28		05/30/2014	Merrill Lynch		217,694	190,000	.0
646139-4Z-5	NEW JERSEY ST TURNPIKE AUTH SERIES A 5.000% 01/01/30		05/14/2014	Goldman Sachs & Co		1,189,776	1,050,000	.0
664617-BB-4	ORANGE COUNTY FL SCH BUD CORP SERIES A 5.000% 08/01/29		03/19/2014	Chase		1,428,869	1,300,000	.0
71863R-JA-2	PHOENIX INTL CIVIC IMPRT CORP 5.000% 07/01/29		03/19/2014	Goldman Sachs & Co		363,699	335,000	.0
3199999	Subtotal - Bonds - U.S. Special Revenues					6,444,291	5,867,502	4,314
028674-CZ-8	AMERICAN INTERNATIONAL GROUP 2.300% 07/16/19		07/09/2014	Goldman Sachs & Co		334,323	335,000	.0
03116Z-BB-0	AMGEN INC 1.250% 05/22/17		05/19/2014	Bony/Banclays Capital Inc		1,048,856	1,050,000	.0
030395-AO-3	ARPHENIL CORP 1.550% 09/15/17		09/30/2014	Chase		454,536	455,000	.0
96951G-EL-3	BANK OF AMERICA CORP 2.800% 01/15/19		05/20/2014	RBC Dominion		1,269,430	1,250,000	11,568
075887-BD-0	BECTON DICKINSON AND CO 1.800% 12/15/17		12/04/2014	Goldman Sachs & Co		225,000	225,000	.0
075896-AA-8	BED BATH AND BEYOND INC 3.749% 08/01/24		07/14/2014	J.P. Morgan		344,997	345,000	.0
13342B-AA-5	CAMERON INTERNATIONAL CORP 1.400% 06/15/17		06/17/2014	CS First Boston		249,829	250,000	.0
10402D-L-0	CAPITAL ONE BANK USA 1.300% 06/05/17		06/03/2014	Chase		249,970	250,000	.0
10402E-SZ-1	CAPITAL ONE NA SERIES BKMT 1.500% 09/05/17		09/02/2014	Bony/Banclays Capital Inc		679,266	680,000	.0
15102D-AA-4	CELENE CORP 2.250% 05/15/19		05/06/2014	CS First Boston		284,290	285,000	.0
302190-AJ-7	EXPRESS SCRIPTS HOLDING 1.250% 06/02/17		06/02/2014	Chase		599,787	599,000	.0
38479D-AA-0	GRAIN SPECTRUM PACKING II SERIES 144A 3.290% 10/10/19		09/16/2014	Morgan Stanley		275,000	275,000	.0
42809H-AE-7	HESS CORP 1.300% 06/15/17		06/19/2014	Morgan Stanley		224,732	225,000	.0
428236-BY-8	HEILETT-PACKARD CO 2.750% 01/14/19		01/09/2014	Bank of America		314,855	315,000	.0
446438-RG-0	HARTINGTON NATIONAL BANK 2.200% 04/01/19		02/26/2014	CS First Boston		429,321	430,000	.0
46642E-AA-8	JPMORGAN COMMERCIAL MORTGAGE SECURITIES 2014-221 CLASS A2 2.892% 08/15/47		07/01/2014	Chase		306,998	300,000	1,518
482480-AB-6	KLA-TENCOR CORPORATION 2.375% 11/01/17		10/30/2014	J.P. Morgan		424,745	425,000	.0
61166H-AS-0	MONSANTO CO 2.125% 07/15/19		07/02/2014	Various		934,198	935,000	269
615369-AO-7	MUDOL'S CORPORATION 2.750% 07/15/19		07/07/2014	J.P. Morgan		239,660	210,000	.0
681938-BB-5	ORCA HEALTHCARE INVESTORS 4.500% 04/01/24		10/16/2014	Tax Free Exchange		372,892	380,000	1,196
69353R-DY-1	PNC BANK NA 1.500% 10/18/17		09/15/2014	Citigroup Global Markets		629,880	630,000	.0
842587-OK-1	SOUTHERN CO 1.300% 08/15/17		08/19/2014	Chase		159,949	160,000	.0
867914-BG-7	SUNTRUST BANKS INC 2.500% 05/01/19		04/24/2014	SunTrust Bank		579,484	580,000	.0
87163B-AA-1	SYNCHRON FINANCIAL 1.875% 08/15/17		08/06/2014	J.P. Morgan		36,916	37,000	.0
871829-AB-8	SYSCO CORP 1.450% 10/02/17		09/23/2014	Goldman Sachs & Co		269,897	270,000	.0
902494-AA-3	TYSON FOODS INC 2.650% 08/15/19		08/05/2014	Morgan Stanley		159,894	160,000	.0
92277G-AC-1	VENTAS REALTY LP/OP CORP 1.250% 04/17/17		04/10/2014	Citigroup Global Markets		44,917	45,000	.0
92343V-DA-2	VERIZON COMMUNICATIONS 3.000% 11/01/21		10/22/2014	Nachovia Securities		184,443	185,000	.0
963320-AS-5	WHLRPOOL CORP SERIES 3YR 1.650% 11/01/17		10/30/2014	J.P. Morgan		444,973	445,000	.0
983919-AE-6	XILINX CORP 2.125% 03/15/19		03/05/2014	J.P. Morgan		318,325	320,000	.0
3899999	Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)					13,001,383	12,972,000	14,539
8399997	Total - Bonds - Part 3					19,445,674	18,839,502	18,853
8399996	Total - Bonds - Part 5					1,563,889	1,538,665	16,991
8399999	Total - Bonds					21,009,563	20,388,167	35,844
8999997	Total - Preferred Stocks - Part 3					0	XXX	0
8999998	Total - Preferred Stocks - Part 5					0	XXX	0
8999999	Total - Preferred Stocks					0	XXX	0
9799997	Total - Common Stocks - Part 3					0	XXX	0
9799998	Total - Common Stocks - Part 5					0	XXX	0
9799999	Total - Common Stocks					0	XXX	0
9899999	Total - Preferred and Common Stocks					0	XXX	0
9999999	Totals					21,009,563	XXX	35,844

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 4

Showing All Long-Term Bonds and Stocks SOLD, REDEEMED or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
CUSIP Identification	Description	For- eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Con- sideration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ Decrease	Current Year's (Amor- tization)/ Accretion	Current Year's Other- Than- Temporary Impairment Recognized	Total Change in Book/ Adjusted Carrying Value (11+12-13)	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Con- tractual Maturity Date
36180J-W6-8	RNA POOL A26937 3.500% 03/20/43		12/01/2014	Paydown		30.500	30.500	32.997	32.961	0	(2.462)	0	(2.462)	0	30.500	0	0	0	0.628	03/20/2043
36180K-W6-6	RNA POOL A27257 3.500% 03/15/43		12/01/2014	Paydown		23.339	23.339	25.133	25.092	0	(1.792)	0	(1.792)	0	23.339	0	0	0	0.510	03/15/2043
36203C-Z3-1	RNA POOL 726292 5.000% 09/15/39		12/01/2014	Paydown		50.810	50.810	55.891	55.822	0	(5.072)	0	(5.072)	0	50.810	0	0	0	1.302	09/15/2039
0599999	Subtotal - Bonds - U.S. Governments					104.649	104.649	114.021	113.875	0	(9.226)	0	(9.226)	0	104.649	0	0	0	2.440	XXXX
93074C-WJ-7	WASHINGTON ST 5.000% 07/01/20		01/31/2014	BMO Nesbitt Burns		7,990,889	6,700,000	7,925,698	7,919,410	0	(17,661)	0	(17,661)	0	7,901,750	0	89,139	89,139	201,000	07/01/2020
1799999	Subtotal - Bonds - U.S. States, Territories and Possessions					7,990,889	6,700,000	7,925,698	7,919,410	0	(17,661)	0	(17,661)	0	7,901,750	0	89,139	89,139	201,000	XXXX
20775B-KY-4	CONNECTICUT ST SPL TAX 0816 5.000%		03/13/2014	Paine Webber		230.410	200,000	234,192	219,469	0	(1,041)	0	(1,041)	0	219,469	0	11,982	11,982	3,808	11/01/2017
31286B-K2-7	PHLIC GOLD POOL 007213 3.500% 11/01/42		12/01/2014	Paydown		36.169	36.169	38.393	38.362	0	(2.193)	0	(2.193)	0	36.169	0	0	0	7.733	11/01/2042
31364D-3F-4	RNA SERIES 2013-45 CLASS CB 4.000%		12/01/2014	Paydown		83.754	83.754	70.269	69.603	0	(5.949)	0	(5.949)	0	83.754	0	0	0	1.332	12/25/2042
31378D-XC-3	PHLIC MULTIFAMILY STRUCTURED SERIES 4182		12/01/2014	Paydown		83.661	83.661	90.550	90.064	0	(6.403)	0	(6.403)	0	83.661	0	0	0	1.632	05/15/2041
31378A-CY-9	PHLIC 1.000% 08/27/14		04/24/2014	Morgan Stanley		752.318	750,000	758.625	751.957	0	(945)	0	(945)	0	751,012	1,305	1,305	0	0	08/27/2014
31378A-CY-9	PHLIC 1.000% 08/27/14		08/27/2014	Maturity		250.000	250,000	252.875	250.622	0	(652)	0	(652)	0	250,000	0	0	0	2,500	08/27/2014
31384J-VI-8	RNA POOL A36091 4.000% 12/01/41		12/01/2014	Paydown		57.302	57.302	61.336	61.309	0	(4.007)	0	(4.007)	0	57.302	0	0	0	1.176	12/01/2041
3138E-IH-8	RNA POOL A38345 4.000% 12/01/41		12/01/2014	Paydown		62.427	62.427	66.777	66.699	0	(4.273)	0	(4.273)	0	62.427	0	0	0	1.383	12/01/2041
3138EB-HI-8	RNA POOL A65444 3.000% 04/01/27		12/01/2014	Paydown		60.393	60.393	64.158	63.995	0	(3.602)	0	(3.602)	0	60.393	0	0	0	1.038	04/01/2027
3138EG-HI-4	RNA POOL AL0241 4.000% 04/01/41		12/01/2014	Paydown		56.766	56.766	60.979	60.900	0	(4.194)	0	(4.194)	0	56.766	0	0	0	1.434	04/01/2041
3138EJ-JI-0	RNA POOL AL2071 5.500% 03/01/40		12/01/2014	Paydown		201.441	201,441	220.420	219.895	0	(18.454)	0	(18.454)	0	201.441	0	0	0	5.640	03/01/2040
3138EK-SI-1	RNA POOL AL3560 3.000% 02/01/28		12/01/2014	Paydown		114.821	114,821	121.728	121.476	0	(6.655)	0	(6.655)	0	114.821	0	0	0	1.616	02/01/2028
3138EK-NK-7	RNA POOL AL3093 3.500% 02/01/43		12/01/2014	Paydown		68.002	68,002	72.040	71.968	0	(3.966)	0	(3.966)	0	68.002	0	0	0	1.554	02/01/2043
3138EK-UR-4	RNA POOL AL3307 4.000% 11/01/42		12/01/2014	Paydown		148.464	148,464	154.425	154.388	0	(5.324)	0	(5.324)	0	148.464	0	0	0	3.274	11/01/2042
3138EK-WE-1	RNA POOL AL3344 4.500% 10/01/42		12/01/2014	Paydown		102.054	102,054	109.357	109.319	0	(7.265)	0	(7.265)	0	102.054	0	0	0	2.473	10/01/2042
3138EK-FC-2	RNA POOL AR5562 3.500% 02/01/43		12/01/2014	Paydown		83.674	83,674	88.207	88.156	0	(4.482)	0	(4.482)	0	83.674	0	0	0	1.562	02/01/2043
3138IT-GJ-9	RNA POOL AT5600 3.500% 05/01/43		12/01/2014	Paydown		112.194	112,194	118.343	118.238	0	(6.044)	0	(6.044)	0	112.194	0	0	0	2.607	05/01/2043
3139BA-3G-5	RNA 1.500% 09/08/14		09/08/2014	Maturity		1,000.000	1,000,000	1,023.500	1,007.361	0	(7.361)	0	(7.361)	0	1,000,000	0	0	0	15,000	09/08/2014
3139BA-3K-6	RNA 1.250% 03/14/14		03/07/2014	Morgan Stanley		200.027	200,000	203.656	200.303	0	(287)	0	(287)	0	200,017	10	10	0	1,222	03/14/2014
3139BA-3K-6	RNA 1.250% 03/14/14		03/14/2014	Maturity		800.000	800,000	814.624	801.214	0	(1,214)	0	(1,214)	0	800,000	0	0	0	5,000	03/14/2014
31402D-C7-3	RNA POOL 725594 5.500% 07/01/34		12/01/2014	Paydown		93.019	93,019	101.623	101.395	0	(8.376)	0	(8.376)	0	93.019	0	0	0	2.589	07/01/2034
31402D-VY-2	RNA POOL 735288 5.000% 03/01/35		12/01/2014	Paydown		56.500	56,500	61.355	61.201	0	(4.702)	0	(4.702)	0	56,500	0	0	0	1,436	03/01/2035
31418D-LI-8	RNA POOL 995024 5.500% 08/01/37		12/01/2014	Paydown		367.765	367,765	400.892	397.765	0	(33,199)	0	(33,199)	0	367,765	0	0	0	10,313	08/01/2037
31418B-H5-3	RNA POOL 995112 5.500% 07/01/36		12/01/2014	Paydown		213.981	213,981	233.774	233.259	0	(19,278)	0	(19,278)	0	213,981	0	0	0	6,457	07/01/2036
31418C-03-7	RNA POOL 995722 5.000% 05/01/38		12/01/2014	Paydown		99.533	99,533	106.025	107.767	0	(8.233)	0	(8.233)	0	99,533	0	0	0	2,635	05/01/2038
31417G-CE-4	RNA POOL AB9068 3.500% 04/01/43		12/01/2014	Paydown		50.578	50,578	53.733	53.665	0	(3.107)	0	(3.107)	0	50,578	0	0	0	1,076	04/01/2043
31417G-01-1	RNA POOL AB9069 3.500% 04/01/43		12/01/2014	Paydown		66.880	66,880	71.251	71.129	0	(4.249)	0	(4.249)	0	66,880	0	0	0	1,515	04/01/2043
31418A-LJ-3	RNA POOL WA1166 3.500% 09/01/32		12/01/2014	Paydown		71.210	71,210	75.527	75.412	0	(4.202)	0	(4.202)	0	71,210	0	0	0	1,404	09/01/2032
31418D-KG-6	RNA POOL WA3894 4.000% 09/01/31		12/01/2014	Paydown		146.064	146,064	156.653	156.393	0	(10,330)	0	(10,330)	0	146,064	0	0	0	3,261	09/01/2031
31418A-0K-7	RNA POOL AE0201 5.500% 08/01/37		12/01/2014	Paydown		186.569	186,569	203.827	203.377	0	(16,898)	0	(16,898)	0	186,569	0	0	0	5,344	08/01/2037
31418D-4I-4	RNA POOL AB3525 4.000% 03/01/41		12/01/2014	Paydown		28.506	28,506	30.653	30.616	0	(2.110)	0	(2.110)	0	28,506	0	0	0	530	03/01/2041
31418K-IL-5	RNA POOL AE8750 4.000% 12/01/40		12/01/2014	Paydown		116.805	116,805	125.785	125.676	0	(8.811)	0	(8.811)	0	116,805	0	0	0	2,771	12/01/2040
679111-US-1	OKLAHOMA ST TURNPIKE AUTH 5.000% 01/01/18		03/19/2014	BONY + WINNING SPARKS		480.980	420,000	494.374	468.875	0	(2,722)	0	(2,722)	0	466,153	0	14,827	14,827	15,342	01/01/2018
746189-08-8	PURDUE UNIV ST OLEAN VTR REV 5.000%		03/13/2014	Pershing		309.992	265,000	315.673	296.023	0	(1,409)	0	(1,409)	0	294,614	0	15,378	15,378	9,459	07/01/2018
882756-SF-5	TEXAS ST PUB FIN AUTH REV 5.000% 07/01/19		05/23/2014	Tax Free Exchange		852.054	850,000	916.190	859.729	0	(7,675)	0	(7,675)	0	852,054	0	0	0	38,014	07/01/2019
977092-UR-6	WISCONSIN ST CLEON VTR REV 5.000%		03/19/2014	BONY + WINNING SPARKS		290.280	250,000	294.753	277.194	0	(1,352)	0	(1,352)	0	275,842	0	14,438	14,438	3,924	06/01/2018
3199999	Subtotal - Bonds - U.S. Special Revenues					7,914.613	7,733.552	8,269.405	8,087.892	0	(231.241)	0	(231.241)	0	7,856.672	0	57.940	57,940	165,438	XXXX
035231-BI-9	AMEUSER-BUSCH 0.800% 07/15/15		09/19/2014	UBS Securities Inc		401.364	400,000	399.549	399.767	0	(.110)	0	(.110)	0	399,877	0	1.487	1.487	0	07/15/2015
060516-ED-8	BANK OF AMERICA CORP 3.875% 03/22/17		05/20/2014	RBC Dominion		1,070.140	1,000,000	1,079.570	1,067.577	0	(8,088)	0	(8,088)	0	1,059,509	0	10,631	10,631	25,941	03/22/2017
96408H-B2-1	BANK OF NEW YORK MELLON 1.700% 11/24/14		11/24/2014	Maturity		160.000	160,000	163.446	161.511	0	(1,511)	0	(1,511)	0	160,000	0	0	0	2,729	11/24/2014
07388V-AE-8	BEAR STEARNS COMMERCIAL MORTG SERIES 2007-126 CLASS AA 5.471% 01/12/45		12/01/2014	Paydown		21.079	21,079	24.216	23.708	0	(2,629)	0	(2,629)	0	21,079	0	0	0	1,063	01/12/2045
25459H-AL-9	DIRECTV HOLDINGS/FINANCE 4.750% 10/01/14		04/24/2014	Cal	101.8710	101.871	100,000	106.719	102.818	0	(1.177)	0	(1.177)	0	101.641	0	230	230	2.678	10/01/2014

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 4

Showing All Long-Term Bonds and Stocks SOLD, REDEEMED or Otherwise DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	Change In Book/Adjusted Carrying Value					16	17	18	19	20	21
										11	12	13	14	15						
CUSIP Identification	Description	For- eign	Disposal Date	Name of Purchaser	Number of Shares of Stock	Con- sideration	Par Value	Actual Cost	Prior Year Book/ Adjusted Carrying Value	Unrealized Valuation Increase/ Decrease	Current Year's (Amor- tization)/ Accretion	Current Year's Other- Than- Temporary Impairment Recognized	Total Change in Book/ Adjusted Carrying Value (11+12-13)	Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Book/ Adjusted Carrying Value at Disposal Date	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Bond Interest/ Stock Dividends Received During Year	Stated Con- tractual Maturity Date
293791-AN-9	ENTERPRISE PRODUCTS SERIES B 5.600%		10/15/2014	Maturity		150,000	150,000	165,674	154,104	0	(4,104)	0	(4,104)	0	150,000	0	0	0	8,400	10/15/2014
464288-63-8	SHARES INTERMEDIATE CREDIT 0.000%		05/07/2014	Direct		5,058,793	46,200	4,999,491	4,999,491	0	0	0	0	0	4,999,491	0	59,301	59,301	53,491	01/01/9999
637432-HP-7	NATIONAL RURAL UTILITIES 1.000% 02/02/15		12/01/2014	Call 100,190		100,136	100,000	101,035	100,389	0	(389)	0	(389)	0	100,000	0	136	136	1,331	02/02/2015
82943V-BN-3	VERIZON COMMUNICATIONS 2.500% 09/15/16		11/24/2014	Call 102,972		146,220	142,000	141,891	141,901	0	32	0	32	0	141,933	0	4,287	4,287	4,201	09/15/2016
767204-AH-8	RIO TINTO FIN USA 2.250% 12/14/18	F	03/04/2014	First Union Capital Markets		373,434	370,000	366,618	366,927	0	308	0	308	0	367,035	0	6,403	6,403	1,919	12/14/2018
38999999	Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)					7,583,037	2,489,279	7,548,209	7,518,193	0	(17,628)	0	(17,628)	0	7,500,565	0	82,475	82,475	105,557	XXXX
83999997	Total - Bonds - Part 4					23,593,188	17,027,480	23,857,333	23,639,370	0	(275,739)	0	(275,739)	0	23,363,636	0	229,554	229,554	474,435	XXXX
83999998	Total - Bonds - Part 5					1,551,557	1,558,665	1,563,889	1,563,889	0	(12,332)	0	(12,332)	0	1,551,557	0	0	0	40,913	XXXX
83999999	Total - Bonds					25,144,745	18,586,145	25,421,222	23,639,370	0	(288,071)	0	(288,071)	0	24,915,193	0	229,554	229,554	515,348	XXXX
89999997	Total - Preferred Stocks - Part 4					0	XXXX	0	0	0	0	0	0	0	0	0	0	0	0	XXXX
89999998	Total - Preferred Stocks - Part 5					0	XXXX	0	0	0	0	0	0	0	0	0	0	0	0	XXXX
89999999	Total - Preferred Stocks					0	XXXX	0	0	0	0	0	0	0	0	0	0	0	0	XXXX
97999997	Total - Common Stocks - Part 4					0	XXXX	0	0	0	0	0	0	0	0	0	0	0	0	XXXX
97999998	Total - Common Stocks - Part 5					0	XXXX	0	0	0	0	0	0	0	0	0	0	0	0	XXXX
97999999	Total - Common Stocks					0	XXXX	0	0	0	0	0	0	0	0	0	0	0	0	XXXX
98999999	Total - Preferred and Common Stocks					0	XXXX	0	0	0	0	0	0	0	0	0	0	0	0	XXXX
99999999	Totals					25,144,745	XXXX	25,421,222	23,639,370	0	(288,071)	0	(288,071)	0	24,915,193	0	229,554	229,554	515,348	XXXX

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE D - PART 5

Showing All Long-Term Bonds and Stocks ACQUIRED During Year and Fully DISPOSED OF During Current Year

1	2	3	4	5	6	7	8	9	10	11	Change in Book/Adjusted Carrying Value					17	18	19	20	21
CUSIP Identification	Description	For- eign	Date Acquired	Name of Vendor	Disposal Date	Name of Purchaser	Par Value (Bonds) or Number of Shares (Stock)	Actual Cost	Consid- eration	Book/ Adjusted Carrying Value at Disposal	12 Unrealized Valuation Increase/ (Decrease)	13 Current Year's (Amort- ization)/ Accretion	14 Current Year's Other- Than- Temporary Impairment Recognized	15 Total Change in Book/ Adjusted Carrying Value (12 + 13 - 14)	16 Total Foreign Exchange Change in Book/ Adjusted Carrying Value	Foreign Exchange Gain (Loss) on Disposal	Realized Gain (Loss) on Disposal	Total Gain (Loss) on Disposal	Interest and Dividends Received During Year	Paid for Accrued Interest and Dividends
313813-WT-5	FNMA POOL AZ2169 4.000% 11/01/44		11/04/2014	BFC AMERICA/PNC BANK	12/01/2014	Paydown	1,111	1,184	1,111	1,111	0	(73)	0	(73)	0	0	0	0	0	0
314169-1A-6	FNMA POOL 952845 5.000% 01/01/39		04/16/2014	Centor Fitzgerald & Co	12/01/2014	Paydown	59,840	65,430	59,840	59,840	0	(5,610)	0	(5,610)	0	0	0	0	0	0
314184-6S-6	FNMA POOL MA1770 4.500% 02/01/44		01/30/2014	Nomura Securities	12/01/2014	Paydown	67,714	72,676	67,714	67,714	0	(4,962)	0	(4,962)	0	0	0	0	0	0
882756-2H-8	TEXAS ST PUB F IN AUTH REV 5.000%		07/01/19		07/01/2014	Call	100,000	465,000	465,000	465,000	0	(1,145)	0	(1,145)	0	0	0	0	11,625	9,171
882756-2P-3	TEXAS ST PUB F IN AUTH REV 5.000%		07/01/19		07/01/2014	Call	100,000	385,000	385,000	385,000	0	(909)	0	(909)	0	0	0	0	9,625	7,593
31999999	Subtotal - Bonds - U.S. Special Revenues							978,665	991,364	978,665	0	(12,699)	0	(12,699)	0	0	0	0	23,767	16,958
681936-BA-7	OMEGA HEALTHCARE INVESTORS SERIES 144A 4.950% 04/01/24		03/07/2014	Various	10/16/2014	Tax Free Exchange	580,000	572,525	572,892	572,892	0	367	0	367	0	0	0	0	17,148	33
38999999	Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated)							580,000	572,525	572,892	0	367	0	367	0	0	0	0	17,148	33
83999998	Total - Bonds							1,558,665	1,563,889	1,551,557	0	(12,332)	0	(12,332)	0	0	0	0	40,913	16,991
89999998	Total - Preferred Stocks							0	0	0	0	0	0	0	0	0	0	0	0	0
97999998	Total - Common Stocks							0	0	0	0	0	0	0	0	0	0	0	0	0
98999999	Total - Preferred and Common Stocks							0	0	0	0	0	0	0	0	0	0	0	0	0
99999999	Totals							1,563,889	1,551,557	1,551,557	0	(12,332)	0	(12,332)	0	0	0	0	40,913	16,991

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

Schedule D-Part 6-Section 1-Valuation of Shares of Subsidiary, Controlled or Affiliated Companies

NONE

Schedule D - Part 6 - Section 2

NONE

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE DA - PART 1

Showing All SHORT-TERM INVESTMENTS Owned December 31 of Current Year

1	2	Codes		5	6	7	8	Change in Book/Adjusted Carrying Value				13	14	Interest						21
		3	4					9	10	11	12			15	16	17	18	19	20	
CUSIP Identification	Description	Code	Foreign	Date Acquired	Name of Vendor	Maturity Date	Book/Adjusted Carrying Value	Unrealized Valuation Increase/(Decrease)	Current Year's (Amortization)/Accretion	Current Year's Other-Than-Temporary Impairment Recognized	Total Foreign Exchange Change in Book/Adjusted Carrying Value	Par Value	Actual Cost	Amount Due and Accrued Dec. 31 of Current Year on Bonds not in Default	Non-Admitted Due and Accrued	Rate of	Effective Rate of	When Paid	Amount Received During Year	Paid for Accrued Interest
0599999	Total - U.S. Government Bonds						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
1099999	Total - All Other Government Bonds						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
1799999	Total - U.S. States, Territories and Possessions Bonds						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
2499999	Total - U.S. Political Subdivisions Bonds						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
3199999	Total - U.S. Special Revenues Bonds						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
3899999	Total - Industrial and Miscellaneous (Unaffiliated) Bonds						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
4899999	Total - Hybrid Securities						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
5599999	Total - Parent, Subsidiaries and Affiliates Bonds						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
7799999	Total - Issuer Obligations						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
7899999	Total - Residential Mortgage-Backed Securities						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
7999999	Total - Commercial Mortgage-Backed Securities						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
8099999	Total - Other Loan-Backed and Structured Securities						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
8399999	Total Bonds						0	0	0	0	0	0	0	0	0	XXX	XXX	XXX	0	0
8699999	Total - Parent, Subsidiaries and Affiliates						0	0	0	0	0	XXX	0	0	0	XXX	XXX	XXX	0	0
94675H-29-6	WELLS FARGO ADV TR PL MM-INS TAXABLE TREASURY	SD		12/02/2014	Various		XXX 1,245,896	0	0	0	0	0	1,245,896	0	0	0.000	0.000		150	0
94675H-29-6	WELLS FARGO ADV TR PL MM-INS TAXABLE TREASURY			12/02/2014	Various		XXX 233	0	0	0	0	0	233	0	0	0.000	0.000		0	0
	State of Florida Cash Deposit			01/01/2014	Various		XXX 300,000	0	0	0	0	0	0	0	0	0.000	0.000		0	0
8899999	Subtotal - Exempt Money Market Mutual Funds						1,546,129	0	0	0	0	XXX	1,246,129	0	0	XXX	XXX	XXX	150	0
26188J-20-6	DREYFUS CASH MANAGEMENT ADMIN			12/09/2014	Direct		XXX 211,386	0	0	0	0	0	211,386	0	0	0.000	0.000		0	0
26200V-10-4	DREYFUS INSTL CASH ADVANTAGE	SD		12/30/2014	Direct		XXX 717,760	0	0	0	0	0	717,760	0	0	0.000	0.000		199	0
26200V-10-4	DREYFUS INSTL CASH ADVANTAGE			12/30/2014	Direct		XXX 441,270	0	0	0	0	0	441,270	0	0	0.000	0.000		0	0
946917-39-7	WELLS FARGO ADVANTAGE HERITAGE INSTL CLASS	SD		12/02/2014	Direct		XXX 33,837,894	0	0	0	0	0	33,837,894	0	0	0.000	0.000		2,596	0
8999999	Subtotal - Class One Money Market Mutual Funds						35,296,316	0	0	0	0	XXX	35,298,359	0	0	XXX	XXX	XXX	2,771	0
9199999	- Totals						36,754,438	0	0	0	0	XXX	36,464,438	0	0	XXX	XXX	XXX	2,921	0

E 17

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

Schedule DB - Part A - Section 1 - Options, Caps, Floors, Collars, Swaps and Forwards Open

NONE

Schedule DB - Part A - Section 2 - Options, Caps, Floors, Collars, Swaps and Forwards Terminated

NONE

Schedule DB - Part B - Section 1 - Futures Contracts Open

NONE

Schedule DB - Part B - Section 1B - Brokers with whom cash deposits have been made

NONE

Schedule DB - Part B - Section 2 - Futures Contracts Terminated

NONE

Schedule DB - Part D - Section 1 - Counterparty Exposure for Derivative Instruments Open

NONE

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged By

NONE

Schedule DB - Part D-Section 2 - Collateral for Derivative Instruments Open - Pledged To

NONE

E18, E19, E20, E21, E22, E23

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE DL - PART 1
SECURITIES LENDING COLLATERAL ASSETS

Reinvested Collateral Assets Owned December 31 Current Year

1 CUSIP Identification	2 Description	3 Code	4 NAIC Designation/ Market Indicator	5 Fair Value	6 Book/Adjusted Carrying Value	7 Maturity Date
0599999999	Total - U.S. Government Bonds			0	0	XXX
1099999999	Total - All Other Government Bonds			0	0	XXX
1799999999	Total - U.S. States, Territories and Possessions Bonds			0	0	XXX
2499999999	Total - U.S. Political Subdivisions Bonds			0	0	XXX
3199999999	Total - U.S. Special Revenues Bonds			0	0	XXX
000000-00-0	PAYABLE/RECEIVABLE		1	52	(210)	01/02/2015
06417F-BG-4	BANK OF NOVA SCOTIA (HOUSTON)		1	100,269	100,221	09/11/2015
06417H-HL-3	BANK OF NOVA SCOTIA (HOUSTON)		1	124,963	124,965	03/22/2016
161453-AD-7	CHASE BANK USA NA		1	149,989	150,000	04/24/2015
24422E-SJ-8	JOHN DEERE CAPITAL CORP		1	140,042	140,022	02/25/2016
24422E-SB-2	JOHN DEERE CAPITAL CORP		1	59,932	100,000	04/12/2016
63254A-JD-0	NATIONAL AUSTRALIA BANK LTD (NEW YORK)		1	251,644	251,586	08/07/2015
69371R-L3-8	PACCAR FINANCIAL CORP		1	100,112	100,170	02/08/2016
881140-AJ-7	TORONTO-DOMINION BANK		1	100,060	100,060	05/01/2015
903310-HE-0	US BANK NA CINCINNATI		1	100,016	100,000	10/01/2015
3299999999	Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Issuer Obligations			1,167,078	1,166,834	XXX
000000-00-0	CITIGROUP GLOBAL MARKETS INC REPO		1	1,279,911	1,279,911	
000000-00-0	CREDIT AGRICOLE CIB REPO		1	946,461	946,461	
000000-00-0	JP MORGAN SECURITIES LLC		1	824,862	824,862	
000000-00-0	WIZARD SECURITIES USA, INC. REPO		1	1,279,911	1,279,911	
3399999999	Subtotal - Bonds - Industrial and Miscellaneous (Unaffiliated) - Residential Mortgage-Backed Securities			4,331,145	4,331,145	XXX
3899999999	Total - Industrial and Miscellaneous (Unaffiliated) Bonds			5,498,223	5,497,979	XXX
4899999999	Total - Hybrid Securities			0	0	XXX
5599999999	Total - Parent, Subsidiaries and Affiliates Bonds			0	0	XXX
6199999999	Total - Issuer Obligations			1,167,078	1,166,834	XXX
6299999999	Total - Residential Mortgage-Backed Securities			4,331,145	4,331,145	XXX
6399999999	Total - Commercial Mortgage-Backed Securities			0	0	XXX
6499999999	Total - Other Loan-Backed and Structured Securities			0	0	XXX
6599999999	Total Bonds			5,498,223	5,497,979	XXX
7099999999	Total - Preferred Stocks			0	0	XXX
7599999999	Total - Common Stocks			0	0	XXX
7699999999	Total - Preferred and Common Stocks			0	0	XXX
9999999999	Totals			5,498,223	5,497,979	XXX

General Interrogatories:

1. Total activity for the year Fair Value \$ 2,385,339 Book/Adjusted Carrying Value \$ 2,385,095
2. Average balance for the year Fair Value \$ 10,383,458 Book/Adjusted Carrying Value \$ 10,383,363
3. Reinvested securities lending collateral assets book/adjusted carrying value included in this schedule by NAIC designation:
NAIC 1 \$ 5,497,979 NAIC 2 \$ NAIC 3 \$ NAIC 4 \$ NAIC 5 \$ NAIC 6 \$

SCHEDULE DL - PART 2
SECURITIES LENDING COLLATERAL ASSETS

NONE

Fair Value \$	Book/Adjusted Carrying Value \$
Fair Value \$	Book/Adjusted Carrying Value \$

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE E - PART 1 - CASH

1	2	3	4	5	6	7
Depository	Code	Rate of Interest	Amount of Interest Received During Year	Amount of Interest Accrued December 31 of Current Year	Balance	*
Wells Fargo					(14,544,820)	XXX
J.P. Morgan					14,132	XXX
Bank of America					37,267,337	XXX
0199998 Deposits in ... depositories which do not exceed the allowable limit in any one depository (See instructions) - open depositories	XXX	XXX				XXX
0199999 Totals - Open Depositories	XXX	XXX	0	0	22,736,649	XXX
0299998 Deposits in ... depositories which do not exceed the allowable limit in any one depository (See instructions) - suspended depositories	XXX	XXX				XXX
0299999 Totals - Suspended Depositories	XXX	XXX	0	0	0	XXX
0399999 Total Cash on Deposit	XXX	XXX	0	0	22,736,649	XXX
0499999 Cash in Company's Office	XXX	XXX	XXX	XXX		XXX
.....						
.....						
.....						
.....						
.....						
.....						
.....						
.....						
0599999 Total - Cash	XXX	XXX	0	0	22,736,649	XXX

TOTALS OF DEPOSITORY BALANCES ON THE LAST DAY OF EACH MONTH DURING THE CURRENT YEAR

1. January.....	54,457,535	4. April.....	(21,091,887)	7. July.....	(11,713,755)	10. October.....	(24,368,140)
2. February.....	13,738,322	5. May.....	(26,218,690)	8. August.....	(31,208,755)	11. November.....	(35,133,483)
3. March.....	(38,340,154)	6. June.....	(34,085,691)	9. September.....	(28,868,051)	12. December.....	22,736,649

SCHEDULE E - PART 2 - CASH EQUIVALENTS

1 Description	2 Code	3 Date Acquired	4 Rate of Interest	5 Maturity Date	6 Book/Adjusted Carrying Value	7 Amount of Interest Due and Accrued	8 Amount Received During Year
NONE							
8699999 - Total Cash Equivalents							

Attachment 2014 Amerigroup Florida
Annual Health Statement — Page 114

ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

SCHEDULE E - PART 3 - SPECIAL DEPOSITS

States, Etc.	1 Type of Deposit	2 Purpose of Deposit	Deposits For the Benefit of All Policyholders		All Other Special Deposits	
			3 Book/Adjusted Carrying Value	4 Fair Value	5 Book/Adjusted Carrying Value	6 Fair Value
1. Alabama	AL					
2. Alaska	AK					
3. Arizona	AZ					
4. Arkansas	AR					
5. California	CA					
6. Colorado	CO					
7. Connecticut	CT					
8. Delaware	DE					
9. District of Columbia	DC					
10. Florida	FL	0 FL ACHA 100, DOE 100, Surplus Deposit	40,084,373	40,324,938		
11. Georgia	GA					
12. Hawaii	HI					
13. Idaho	ID					
14. Illinois	IL					
15. Indiana	IN					
16. Iowa	IA					
17. Kansas	KS					
18. Kentucky	KY					
19. Louisiana	LA					
20. Maine	ME					
21. Maryland	MD					
22. Massachusetts	MA					
23. Michigan	MI					
24. Minnesota	MN					
25. Mississippi	MS					
26. Missouri	MO					
27. Montana	MT					
28. Nebraska	NE					
29. Nevada	NV					
30. New Hampshire	NH					
31. New Jersey	NJ					
32. New Mexico	NM					
33. New York	NY					
34. North Carolina	NC					
35. North Dakota	ND					
36. Ohio	OH					
37. Oklahoma	OK					
38. Oregon	OR					
39. Pennsylvania	PA					
40. Rhode Island	RI					
41. South Carolina	SC					
42. South Dakota	SD					
43. Tennessee	TN					
44. Texas	TX					
45. Utah	UT					
46. Vermont	VT					
47. Virginia	VA					
48. Washington	WA					
49. West Virginia	WV					
50. Wisconsin	WI					
51. Wyoming	WY					
52. American Samoa	AS					
53. Guam	GU					
54. Puerto Rico	PR					
55. U.S. Virgin Islands	VI					
56. Northern Mariana Islands	MP					
57. Canada	CAN					
58. Aggregate Alien and Other	OT	XXX	0	0	0	0
59. Subtotal	XXX	XXX	40,084,373	40,324,938	0	0
DETAILS OF WRITE-INS						
5801.						
5802.						
5803.						
5898. Summary of remaining write-ins for Line 58 from overflow page	XXX	XXX	0	0	0	0
5899. Totals (Lines 5801 thru 5803 plus 5898)(Line 58 above)	XXX	XXX	0	0	0	0



Relief from the five-year rotation requirement for lead audit partner



Relief from the one-year cooling off period for independent CPA



Relief from the Requirements for Audit Committees



SUPPLEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.
MEDICARE SUPPLEMENT INSURANCE EXPERIENCE EXHIBIT

For The Year Ended December 31, 2014
(To Be Filed by March 1)

FOR THE STATE OF Florida
NAIC Group Code
ADDRESS (City, State and Zip Code)
Person Completing This Exhibit
Title
Telephone Number
NAIC Company Code

1	2	3	4	5	6	7	8	9	10	Policies Issued Through 2011		14	15	Policies Issued in 2012; 2013; 2014		
										11	12			16	17	18
Compliance with OBRA	Policy Form Number	Standardized Medicare Supplement Benefit Plan	Medicare Select	Plan Characteristics	Date Approved	Date Approval Withdrawn	Date Last Amended	Date Closed	Policy Marketing Trade Name	Premiums Earned	Amount	Number of Covered Lives	Premiums Earned	Amount	Percent of Premiums Earned	Number of Covered Lives

GENERAL INTERROGATORIES

1. If response in Column 1 is no, give full and complete details

2. Claims address and contact person provided to the Secretary of Health and Human Services as required by 42 U.S.C. 1395u(h)(3)(B) for this state.

2.1 Address:

2.2 Contact Person and Phone Number:

3. Billing address and contact person for user fees established under 41 U.S.C. 1395u(h)(3)(B).

3.1 Address:

3.2 Contact Person and Phone Number:

4. Explain any policies identified above as policy type "O".

360 FL



SUPPLEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.
MEDICARE PART D COVERAGE SUPPLEMENT
(Net of Reinsurance)

NAIC Group Code 0671		(To Be Filed by March 1)		NAIC Company Code 95093	
	Individual Coverage		Group Coverage		5 Total Cash
	1 Insured	2 Uninsured	3 Insured	4 Uninsured	
1. Premiums Collected					
1.1 Standard Coverage					
1.11 With Reinsurance Coverage .....		.XXX		.XXX	
1.12 Without Reinsurance Coverage .....		.XXX		.XXX	
1.13 Risk-Corridor Payment Adjustments .....		.XXX		.XXX	
1.2 Supplemental Benefits .....		.XXX		.XXX	
2. Premiums Due and Uncollected-change					
2.1 Standard Coverage					
2.11 With Reinsurance Coverage .....		.XXX		.XXX	.XXX
2.12 Without Reinsurance Coverage .....		.XXX		.XXX	.XXX
2.2 Supplemental Benefits .....		.XXX		.XXX	.XXX
3. Unearned Premium and Advance Premium-change					
3.1 Standard Coverage					
3.11 With Reinsurance Coverage .....		.XXX		.XXX	.XXX
3.12 Without Reinsurance Coverage .....		.XXX		.XXX	.XXX
3.2 Supplemental Benefits .....		.XXX		.XXX	.XXX
4. Risk-Corridor Payment Adjustments-change					
4.1 Receivable .....		.XXX		.XXX	.XXX
4.2 Payable .....		.XXX		.XXX	.XXX
5. Earned Premiums					
5.1 Standard Coverage					
5.11 With Reinsurance Coverage .....		.XXX		.XXX	.XXX
5.12 Without Reinsurance Coverage .....		.XXX		.XXX	.XXX
5.13 Risk-Corridor Payment Adjustments .....		.XXX		.XXX	.XXX
5.2 Supplemental Benefits .....		.XXX		.XXX	.XXX
6. Total Premiums .....		.XXX		.XXX	
7. Claims Paid					
7.1 Standard Coverage					
7.11 With Reinsurance Coverage .....		.XXX		.XXX	
7.12 Without Reinsurance Coverage .....		.XXX		.XXX	
7.2 Supplemental Benefits .....		.XXX		.XXX	
8. Claim Reserves and Liabilities-change					
8.1 Standard Coverage					
8.11 With Reinsurance Coverage .....		.XXX		.XXX	.XXX
8.12 Without Reinsurance Coverage .....		.XXX		.XXX	.XXX
8.2 Supplemental Benefits .....		.XXX		.XXX	.XXX
9. Health Care Receivables-change					
9.1 Standard Coverage					
9.11 With Reinsurance Coverage .....		.XXX		.XXX	.XXX
9.12 Without Reinsurance Coverage .....		.XXX		.XXX	.XXX
9.2 Supplemental Benefits .....		.XXX		.XXX	.XXX
10. Claims Incurred					
10.1 Standard Coverage					
10.11 With Reinsurance Coverage .....		.XXX		.XXX	.XXX
10.12 Without Reinsurance Coverage .....		.XXX		.XXX	.XXX
10.2 Supplemental Benefits .....		.XXX		.XXX	.XXX
11. Total Claims .....		.XXX		.XXX	
12. Reinsurance Coverage and Low Income Cost Sharing					
12.1 Claims Paid - Net of Reimbursements Applied .....	.XXX		.XXX		
12.2 Reimbursements Received but Not Applied-change .....	.XXX		.XXX		
12.3 Reimbursements Receivable-change .....	.XXX		.XXX		.XXX
12.4 Health Care Receivables-change .....	.XXX		.XXX		.XXX
13. Aggregate Policy Reserves-change					.XXX
14. Expenses Paid .....		.XXX		.XXX	
15. Expenses Incurred .....		.XXX		.XXX	.XXX
16. Underwriting Gain/Loss .....		.XXX		.XXX	.XXX
17. Cash Flow Results	.XXX	.XXX	.XXX	.XXX	

NONE



Non-Guaranteed Opinion for Exhibit 5



NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

SCHEDULES SIS

STOCKHOLDER INFORMATION SUPPLEMENT

For The Year Ended December 31, 2014
(To Be Filed by March 1)

REQUIRED BY THE APPLICABLE QUESTION ON THE SUPPLEMENTAL EXHIBITS AND SCHEDULES INTERROGATORIES
FOR THE PROPERTY/CASUALTY, LIFE ACCIDENT AND HEALTH, TITLE AND HEALTH INSURANCE BLANKS

TO THE ANNUAL STATEMENT OF THE

Amerigroup Florida, Inc.

COMPANY

SUPPLEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

Schedule SIS II

NONE

Schedule SIS III

NONE

Schedule SIS IV

NONE



Participating Opinion for Exhibit 5

SUPPLEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

Life Supplement Cover

NONE

Life Supplement - Exhibit 5 - Aggregate Reserve for Life Contracts

NONE

Life Supplement - Exhibit 5 - Interrogatories

NONE

Life Supplement - Exhibit 7 - Deposit-Type Contracts

NONE

Life Supplement - Schedule S - Part 1 - Section 1

NONE

Life Supplement - Schedule S - Part 3 - Section 1

NONE

LS01, LS02, LS03, LS04, LS05, LS06



SUPPLEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

DIRECT BUSINESS IN THE STATE OF
NAIC Group Code 0671

LIFE INSURANCE

DURING THE YEAR 2014
NAIC Company Code 95093

DIRECT PREMIUMS AND ANNUITY CONSIDERATIONS		1 Ordinary	2 Credit Life (Group and Individual)	3 Group	4 Industrial	5 Total
1.	Life insurance					
2.	Annuity considerations					
3.	Deposit-type contract funds		XXX		XXX	
4.	Other considerations					
5.	Totals (Sum of Lines 1 to 4)					
DIRECT DIVIDENDS TO POLICYHOLDERS						
Life insurance:						
6.1	Paid in cash or left on deposit					
6.2	Applied to pay renewal premiums					
6.3	Applied to provide paid-up additions or shorten the endowment or premium-paying period					
6.4	Other					
6.5	Totals (sum of Line 6.1 to 6.4)					
Annuities:						
7.1	Paid in cash or left on deposit					
7.2	Applied to provide paid-up annuities					
7.3	Other					
7.4	Totals (sum of Lines 7.1 to 7.3)					
8.	Grand Totals (Lines 6.5 plus 7.4)					
DIRECT CLAIMS AND BENEFITS PAID						
9.	Death benefits					
10.	Matured endowments					
11.	Annuity benefits					
12.	Surrender values and withdrawals for life contracts					
13.	Aggregate write-ins for miscellaneous direct claims and benefits paid					
14.	All other benefits, except accident and health					
15.	Totals					
DETAILS OF WRITE-INS						
1301.	.....				
1302.	.....				
1303.	.....				
1396.	Summary of Line 13 from overflow page					
1399.	Totals (Lines 1301 thru 1303 plus 1398) (Line 13 above)					

NONE

DIRECT DEATH BENEFITS AND MATURED ENDOWMENTS INCURRED	Ordinary		Credit Life (Group and Individual)		Group		Industrial		Total	
	1	2	3	4	5	6	7	8	9	10
	No.	Amount	No. of Ind. Pol. & Gr. Certifs.	Amount	No. of Certifs.	Amount	No.	Amount	No.	Amount
16.	Unpaid December 31, prior year									
17.	Incurred during current year Settled during current year:									
18.1	By payment in full									
18.2	By payment on compromised claims									
18.3	Totals paid									
18.4	Reduction by compromise									
18.5	Amount rejected									
18.6	Total settlements									
19.	Unpaid Dec. 31, current year (16+17-18.6)									
POLICY EXHIBIT										
20.	In force December 31, prior year			(a)	No. of Policies					
21.	Issued during year									
22.	Other changes to in force (Net)									
23.	In force December 31 of current year			(a)						

(a) Includes Individual Credit Life Insurance prior year \$, current year \$
Includes Group Credit Life Insurance Loans less than or equal to 60 months at issue, prior year \$, current year \$
Loans greater than 60 months at issue BUT NOT GREATER THAN 120 MONTHS, prior year \$, current year \$

ACCIDENT AND HEALTH INSURANCE

	1 Direct Premiums	2 Direct Premiums Earned	3 Dividends Paid Or Credited On Direct Business	4 Direct Losses Paid	5 Direct Losses Incurred
24.	Group Policies (b)				
24.1	Federal Employees Health Benefits Plan premium (b)				
24.2	Credit (Group and Individual)				
24.3	Collectively renewable policies (b)				
24.4	Medicare Title XVIII exempt from state taxes or fees Other Individual Policies:				
25.1	Non-cancelable (b)				
25.2	Guaranteed renewable (b)				
25.3	Non-renewable for stated reasons only (b)				
25.4	Other accident only				
25.5	All other (b)				
25.6	Totals (sum of Lines 25.1 to 25.5)				
26.	Totals (Lines 24 + 24.1 + 24.2 + 24.3 + 24.4 + 25.6)				

(b) For health business on indicated lines report: Number of persons insured under PPO managed care products0 and number of persons
insured under indemnity only products0 .

LS206

SUPPLEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

P&C Supplement Cover

NONE

P&C Supplement - Schedule F - Part 1

NONE

P&C Supplement - Schedule F - Part 3

NONE

P&C Supplement - Schedule P - Part 1 - Summary

NONE

P&C Supplement - Schedule P - Part 1A - Homeowners/Farmowners

NONE

P&C Supplement - Schedule P - Part 1B - Private Passenger Auto Liability/Medical

NONE

P&C Supplement - Schedule P - Part 1C - Commercial Auto/Truck Liability/Medical

NONE

P&C Supplement - Schedule P - Part 1D - Workers' Compensation (Excluding Excess Workers' Compensation)

NONE

P&C Supplement - Schedule P - Part 1E - Commercial Multiple Peril

NONE

P&C Supplement - Schedule P - Part 1F - Section 1 - Medical Professional Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 1F - Section 2 - Medical Professional Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 1G - Special Liability (Ocean Marine, Aircraft (all perils), Boiler and Machinery)

NONE

P&C Supplement - Schedule P - Part 1H - Section 1 - Other Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 1H - Section 2 - Other Liability - Claims-Made

NONE

PS01, PS02, PS03, PS04, PS05, PS06, PS07, PS08, PS09, PS10, PS11, PS12, PS13, PS14

SUPPLEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

P&C Supplement - Schedule P - Part 1I - Special Property (Fire, Allied Lines...)

NONE

P&C Supplement - Schedule P - Part 1J - Auto Physical Damage

NONE

P&C Supplement - Schedule P - Part 1K - Fidelity/Surety

NONE

P&C Supplement - Schedule P - Part 1L - Other (Including Credit, Accident and Health)

NONE

P&C Supplement - Schedule P - Part 1M - International

NONE

P&C Supplement - Schedule P - Part 1N - Reinsurance - Nonproportional Assumed Property

NONE

P&C Supplement - Schedule P - Part 1O - Reinsurance - Nonproportional Assumed Liability

NONE

P&C Supplement - Schedule P - Part 1P - Reinsurance - Nonproportional Assumed Financial Lines

NONE

P&C Supplement - Schedule P - Part 1R - Section 1 - Products Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 1R - Section 2 - Products Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 1S - Financial Guaranty/Mortgage Guaranty

NONE

P&C Supplement - Schedule P - Part 1T - Warranty

NONE

P&C Supplement - Schedule P - Part 2 - Summary

NONE

P&C Supplement - Schedule P - Part 2A - Homeowners/Farmowners

NONE

PS15, PS16, PS17, PS18, PS19, PS20, PS21, PS22, PS23, PS24, PS25, PS26, PS27, PS28

SUPPLEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

P&C Supplement - Schedule P - Part 2B - Private Passenger Auto Liability/Medical

NONE

P&C Supplement - Schedule P - Part 2C - Commercial Auto/Truck Liability/Medical

NONE

P&C Supplement - Schedule P - Part 2D - Workers' Compensation (Excluding Excess Workers' Compensation)

NONE

P&C Supplement - Schedule P - Part 2E - Commercial Multiple Peril

NONE

P&C Supplement - Schedule P - Part 2F - Section 1 - Medical Professional Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 2F - Section 2 - Medical Professional Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 2G - Special Liability (Ocean Marine, Aircraft (all perils), Boiler and Machinery)

NONE

P&C Supplement - Schedule P - Part 2H - Section 1 - Other Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 2H - Section 2- Other Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 2I - Special Property

NONE

P&C Supplement - Schedule P - Part 2J - Auto Physical Damage

NONE

P&C Supplement - Schedule P - Part 2K - Fidelity/Surety

NONE

P&C Supplement - Schedule P - Part 2L - Other (Including Credit, Accident and Health)

NONE

P&C Supplement - Schedule P - Part 2M - International

NONE

PS28, PS29, PS30

SUPPLEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.

P&C Supplement - Schedule P - Part 2N - Reinsurance - Nonproportional Assumed Property

NONE

P&C Supplement - Schedule P - Part 2O - Reinsurance - Nonproportional Assumed Liability

NONE

P&C Supplement - Schedule P - Part 2P - Reinsurance - Nonproportional Assumed Financial Lines

NONE

P&C Supplement - Schedule P - Part 2R - Section 1 - Products Liability - Occurrence

NONE

P&C Supplement - Schedule P - Part 2R - Section 2 - Products Liability - Claims-Made

NONE

P&C Supplement - Schedule P - Part 2S - Financial Guaranty/Mortgage Guaranty

NONE

P&C Supplement - Schedule P - Part 2T - Warranty

NONE



SUPPLEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.
EXHIBIT OF PREMIUMS AND LOSSES (Statutory Page 14)

NAIC Group Code 0671

BUSINESS IN THE STATE OF

DURING THE YEAR 2014

NAIC Company Code 95093

Line of Business	Gross Premiums, Including Policy and Membership Fees, Less Return Premiums and Premiums on Policies not Taken		3 Dividends Paid or Credited to Policyholders on Direct Business	4 Direct Unearned Premium Reserves	5 Direct Losses Paid (deducting salvage)	6 Direct Losses Incurred	7 Direct Losses Unpaid	8 Direct Defense and Cost Containment Expense Paid	9 Direct Defense and Cost Containment Expense Incurred	10 Direct Defense and Cost Containment Expense Unpaid	11 Commissions and Brokerage Expenses	12 Taxes, Licenses and Fees
	1 Direct Premiums Written	2 Direct Premiums Earned										
1. Fire												
2.1 Allied lines												
2.2 Multiple peril crop												
2.3 Federal flood												
2.4 Private crop												
3. Farmowners multiple peril												
4. Homeowners multiple peril												
5.1 Commercial multiple peril (non-liability portion)												
5.2 Commercial multiple peril (liability portion)												
6. Mortgage guaranty												
8. Ocean marine												
9. Inland marine												
10. Financial guaranty												
11. Medical professional liability												
12. Earthquake												
13. Group accident and health (b)												
14. Credit accident and health (group and individual)												
15.1 Collectively renewable accident and health (b)												
15.2 Non-cancelable accident and health(b)												
15.3 Guaranteed renewable accident and health(b)												
15.4 Non-renewable for stated reasons only (b)												
15.5 Other accident only												
15.6 Medicare Title XVIII exempt from state taxes or fees												
15.7 All other accident and health (b)												
15.8 Federal employees health benefits plan premium (b)												
16. Workers' compensation												
17.1 Other Liability - occurrence												
17.2 Other Liability - claims made												
17.3 Excess workers' compensation												
18. Products liability												
19.1 Private passenger auto no-fault (personal injury protection)												
19.2 Other private passenger auto liability												
19.3 Commercial auto no-fault (personal injury protection)												
19.4 Other commercial auto liability												
21.1 Private passenger auto physical damage												
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NONE

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ANNUAL STATEMENT FOR THE YEAR 2014 OF THE Amerigroup Florida, Inc.
ANNUAL DISKETTE TRANSMITTAL FORM AND CERTIFICATION (HEALTH)

Name of Insurer AMERIGROUP Florida, Inc.
Date 03/30/2015 FEIN 65-0318864
NAIC Group # 0671 NAIC Company # 95093

THIS FORM IS REQUIRED FOR ALL DISKETTE TRANSMITTALS. PLEASE PROVIDE ANY ADDITIONAL COMMENTS THAT MAY HELP TO IDENTIFY DISKETTE CONTENT.

A.		MARCH	APRIL	JUNE
	1. Is this the first time you've submitted this filing? (Y/N)	YES		
	2. Is this being re-filed at the request of the NAIC or a state insurance department? (Y/N)	NO		
	3. Is this being re-filed due to changes to the data originally filed? (Y/N) (IF "YES", ENCLOSE HARD COPY PAGES FOR THE CHANGES.)	NO		
	4. Other? (Y/N) (If "yes", attach an explanation.)	NO		

B. Additional comments if necessary for clarification:

C. Diskette Contact Person:

Bette Lou Gronseth

Phone: 757-518-3638

Address: 4425 Corporation Lane Virginia Beach VA 23462

D. Software Vendor: Eagle Technology Management

Version: 2014

E. Have material validation failures been addressed in the explanation file?

Yes ☒ No ☐

The undersigned hereby certifies, according to the best of his/her knowledge and belief: that the diskettes submitted with this form were prepared in compliance with the NAIC specifications, that the diskettes have been tested against the validations included with these specifications, and that annual statement information required to be contained on diskette is identical to the information in the 2014 Annual Statement blank filed with the Insurer's domiciliary state insurance department. In addition, the diskettes submitted have been scanned through a virus detection software package, and no viruses are present on the diskettes. The virus detection software used was (name)

Symantec Endpoint Protection (version number) 11.0.7300.1294

Signed

Bette L. Gronseth

Type Name and Title:

Bette L. Gronseth, Director II Regulatory Reporting

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE
SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2016
OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE
SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____
Commission file number: 001-16751

ANTHEM, INC.

(Exact name of registrant as specified in its charter)

INDIANA

(State or other jurisdiction of
incorporation or organization)

35-2145715

(I.R.S. Employer Identification Number)

**120 MONUMENT CIRCLE
INDIANAPOLIS, INDIANA**
(Address of principal executive offices)

46204
(Zip Code)

Registrant's telephone number, including area code: **(317) 488-6000**
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock, Par Value \$0.01	New York Stock Exchange
Securities registered pursuant to Section 12(g) of the Act: NONE	
Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. <input type="checkbox"/>	
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer", and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one): Large accelerated filer <input checked="" type="checkbox"/> Accelerated filer <input type="checkbox"/> Non-accelerated filer <input type="checkbox"/> (Do not check if a smaller reporting company) Smaller reporting company <input type="checkbox"/>	
Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all Directors and executive officers of the registrant are "affiliates") as of June 30, 2016 was approximately \$34,510,272,302.	
As of February 10, 2017, 264,378,577 shares of the Registrant's Common Stock were outstanding.	

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10-K incorporates by reference information from the registrant's Definitive Proxy Statement for the Annual Meeting of Shareholders to be held May 18, 2017.

Anthem, Inc.

Annual Report on Form 10-K
For the Year Ended December 31, 2016

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This Annual Report on Form 10-K, including Management's Discussion and Analysis of Financial Condition and Results of Operations, contains forward-looking statements, within the meaning of the Private Securities Litigation Reform Act of 1995, that reflect our views about future events and financial performance. When used in this report, the words "expect," "feel," "believe," "will," "may," "should," "anticipate," "intend," "estimate," "project," "forecast," "plan," and similar expressions are intended to identify forward-looking statements, which are generally not historical in nature. Forward-looking statements include, but are not limited to, financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Forward-looking statements are subject to known and unknown risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. You are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. You are also urged to carefully review and consider the various disclosures made by us, which attempt to advise interested parties of the factors that affect our business, including "Risk Factors" set forth in Part I, Item 1A hereof and our reports filed with the U.S. Securities and Exchange Commission, or SEC, from time to time. Except to the extent otherwise required by federal securities laws, we do not undertake any obligation to republish revised forward-looking statements to reflect events or circumstances after the date hereof or to reflect the occurrence of unanticipated events.

References in this Annual Report on Form 10-K to the terms "we," "our," "us," "Anthem" or the "Company" refer to Anthem, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries.

PART I

ITEM 1. BUSINESS.

General

We are one of the largest health benefits companies in the United States in terms of medical membership, serving 39.9 million medical members through our affiliated health plans as of December 31, 2016. We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as BCBS in 10 New York City metropolitan and surrounding counties, and as Blue Cross or BCBS in selected upstate counties), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield or Empire Blue Cross (in our New York service areas). We also conduct business through arrangements with other BCBS licensees in South Carolina and Western New York. Through our AMERIGROUP Corporation, or Amerigroup, subsidiary, we conduct business in Florida, Georgia, Iowa, Kansas, Louisiana, Maryland, Nevada, New Jersey, New Mexico, New York, Tennessee, Texas, and Washington. In addition, we conduct business through our Simply Healthcare Holdings, Inc., or Simply Healthcare, subsidiary in Florida. We also serve customers throughout the country as HealthLink, UniCare (including a non-risk arrangement with Massachusetts), and in certain Arizona, California, Nevada and Virginia markets through our CareMore Health Group, Inc., or CareMore, subsidiary. We are licensed to conduct insurance operations in all 50 states through our subsidiaries.

In March 2016, we filed a lawsuit against our vendor for pharmacy benefit management services, Express Scripts, Inc., or Express Scripts, seeking to recover damages for pharmacy pricing that is higher than competitive benchmark pricing and damages related to operational breaches, and seeking various declarations under the agreement between the parties. In April 2016, Express Scripts filed an answer to the lawsuit disputing our contractual claims and alleging various defenses and counterclaims. For additional information regarding this lawsuit, see Note 13, "Commitments and Contingencies - *Litigation*," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

On July 24, 2015, we and Cigna Corporation, or Cigna, announced that we entered into an Agreement and Plan of Merger, or Merger Agreement, dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and our direct wholly-owned subsidiary, pursuant to which we will acquire all outstanding shares of Cigna, or the Acquisition. This Acquisition will further our goal of creating a premier health benefits company with critical diversification and scale to lead the transformation of health care delivery for consumers. Cigna is a global health services organization that delivers affordable and personalized products and services to customers through employer-based, government-sponsored and individual coverage arrangements. All of Cigna's products and services are provided exclusively by or through its operating subsidiaries, including Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Life Insurance Company of North America and Cigna Life Insurance Company of New York. Such products and services include an integrated suite of health services, such as medical, dental, behavioral health, pharmacy, vision, supplemental benefits, and other related products including group life, accident and disability insurance. Cigna maintains sales capability in 30 countries and jurisdictions.

Under the terms of the Merger Agreement, Cigna's shareholders will receive \$103.40 in cash and 0.5152 shares of our common stock for each Cigna common share outstanding. The value of the transaction is estimated to be approximately \$53.0 billion based on the closing price of our common stock on the New York Stock Exchange on July 23, 2015. The final purchase price will be determined based on our closing stock price on the date of closing of the Acquisition. The combined company will reflect a pro forma equity ownership comprised of approximately 67% Anthem shareholders and approximately 33% Cigna shareholders. We expect to finance the cash portion of the Acquisition through available cash on hand and the issuance of new debt. The Acquisition is subject to certain state regulatory approvals, other standard closing conditions and customary approvals required under the Hart-Scott-Rodino Antitrust Improvements Act. For additional information, see "Risk Factors" included in Part I, Item 1A; "Management's Discussion and Analysis of Financial Condition and Results of Operations - Overview" included in Part II, Item 7; and Note 3, "Business Acquisitions and Divestiture - *Pending Acquisition of Cigna Corporation*" included in Part II, Item 8 of this Annual Report on Form 10-K.

In July 2016, the U.S. Department of Justice, or DOJ, along with certain state attorneys general, filed a civil antitrust lawsuit in the U.S. District Court for the District of Columbia, or District Court, seeking to block the Acquisition. Trial commenced in November 2016 and concluded in January 2017. On January 18, 2017, we provided notice to Cigna that we had elected to extend the termination date under the Merger Agreement from January 31, 2017 until April 30, 2017. On February 8, 2017, the District Court ruled in favor of the DOJ, and following our motion to expedite the appeal, which was granted on February 17, 2017, we promptly appealed the District Court's ruling to the U.S. Circuit Court of Appeals for the District of Columbia Circuit, or the Appellate Court. On February 14, 2017, Cigna purported to terminate the Merger Agreement and commenced litigation against us in the Delaware Court of Chancery, or Delaware Court, seeking damages and a declaratory judgment that its purported termination of the Merger Agreement was lawful, among other claims. We believe Cigna's allegations are without merit. Also on February 14, 2017, we initiated our own litigation against Cigna in the Delaware Court seeking a temporary restraining order to enjoin Cigna from terminating the Merger Agreement, specific performance compelling Cigna to comply with the Merger Agreement and damages. On February 15, 2017, the Delaware Court granted our motion for a temporary restraining order and issued an order enjoining Cigna from terminating the Merger Agreement. The temporary restraining order became effective immediately and will remain in place pending any further order from the Delaware Court. A hearing will be scheduled the week of April 10, 2017. We intend to vigorously defend the Acquisition in both the Circuit Court and the Delaware Court and remain committed to completing the Acquisition as soon as practicable. If the Merger Agreement is terminated because the required regulatory approvals cannot be obtained, under certain conditions, we could be obligated to pay a \$1.85 billion termination fee to Cigna.

Our vision is to become America's valued health partner. Together we are transforming health care with trusted and caring solutions and as a result, we focus on delivering quality products and services that give members access to the care they need. With an unyielding commitment to meeting the needs of our diverse customers, we are guided by the following values:

- Accountable
- Caring
- Easy to do business with
- Innovative
- Trustworthy

We offer a broad spectrum of network-based managed care plans to large and small employer, individual, Medicaid and Medicare markets. Our managed care plans include: preferred provider organizations, or PPOs; health maintenance organizations, or HMOs; point-of-service, or POS, plans; traditional indemnity plans and other hybrid plans, including consumer-driven health plans, or CDHPs; and hospital only and limited benefit products. In addition, we provide a broad array of managed care services to self-funded customers, including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services. We provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal health care. We also provide services to the federal government in connection with the Federal Employee Program, or FEP.

The increased focus on health care costs by employers, the government and consumers has continued to drive the growth of alternatives to traditional indemnity health insurance. HMO, PPO and hybrid plans, such as POS plans and CDHPs, are among the various forms of managed care products that have been developed. Through these types of products, insurers attempt to contain the cost of health care by negotiating contracts with hospitals, physicians and other providers to deliver high quality health care to members at favorable rates. These products usually feature medical management and other quality and cost optimization measures such as pre-admission review and approval for certain non-emergency services, pre-authorization of outpatient surgical procedures, network credentialing to determine that network doctors and hospitals have the required certifications and expertise, and various levels of care management programs to help members better understand and navigate the health care system. In addition, providers may have incentives to achieve certain quality measures, may share medical cost risk or may have other incentives to deliver quality medical services in a cost-effective manner. Also, certain plans offer members incentives for healthy behaviors, such as smoking cessation and weight management. Members are charged periodic, prepaid premiums and generally pay co-payments, coinsurance and/or deductibles when they receive services. While the distinctions between the various types of plans have lessened over recent years, PPO, POS and CDHP

products generally provide reduced benefits for out-of-network services, while traditional HMO products generally provide little to no reimbursement for non-emergency out-of-network utilization, but often offer more generous benefit coverage. An HMO plan may also require members to select one of the network primary care physicians, or PCPs, to coordinate their care and approve any specialist or other services.

Economic factors, greater consumer and employer sophistication and accountability have resulted in an increased demand for choice in both product/benefit designs and provider network configurations. As a result we continue to offer our broad access PPO networks with multiple benefit designs, but are also focused on leveraging our provider collaboration initiatives with our Accountable Care Organization, or ACO, partnerships to develop both narrow and tiered network offerings. This array of network and product configurations allows both the employer and the employee to design and select the combination of benefit designs (e.g., traditional PPOs, high deductibles, HRAs, HSAs, PCP based products, tiered copays) and networks (e.g., broad, narrow, tiered, closed or exclusive provider, and open) that optimize choice, quality and price at the consumer, employer and market level. We believe we are well-positioned in each of our states to respond to these market preferences.

For our fully-insured products, we charge a premium and assume all of the health care risk. Under self-funded products, we charge a fee for services and the employer or plan sponsor reimburses us for the health care costs. In addition, we charge a premium to underwrite stop loss insurance for Large Group and National Account employers that maintain self-funded health plans.

Our medical membership includes seven different customer types: Local Group, Individual, National Accounts, BlueCard®, Medicare, Medicaid and FEP.

BCBS-branded business generally refers to members in our service areas licensed by the BCBSA. Non-BCBS-branded business refers to members in our non-BCBS-branded Amerigroup, CareMore and Simply Healthcare plans, as well as HealthLink and UniCare members. In addition to the above medical membership, we also serve customers who purchase one or more of our other products or services that are often ancillary to our health business.

Our products are generally developed and marketed with an emphasis on the differing needs of our customers. In particular, our product development and marketing efforts take into account the differing characteristics between the various customers served by us, as well as the unique needs of educational and public entities, labor groups, federal employee health and benefit programs, national employers and state-run programs servicing low-income, high-risk and under-served markets. Overall, we seek to establish pricing and product designs to provide value for our customers while achieving an appropriate level of profitability for each of our customer categories balanced with the competitive objective to grow market share. We believe that one of the keys to our success has been our focus on these distinct customer types, which better enables us to develop benefit plans and services that meet our customers' unique needs.

We market our products through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships for Individual and Medicare customers, and for certain Local Group customers with a smaller employee base. Products for National Accounts and Local Group customers with a larger employee base are generally sold through independent brokers or consultants retained by the customer and working with industry specialists from our in-house sales force. In the Individual and Small Group markets, we offer on-exchange products through state or federally facilitated marketplaces, referred to as public exchanges, and off-exchange products. Federal premium subsidies are available for certain members, subject to income and family size, who purchase public exchange products.

Being a licensee of the BCBS association of companies, of which there were 36 independent primary licensees as of December 31, 2016, provides significant market value, especially when competing for very large multi-state employer groups. For example, each BCBS member company is able to utilize other BCBS licensees' substantial provider networks and discounts when any BCBS member works or travels outside of the state in which their policy is written. This program is referred to as BlueCard® and is a source of revenue when we provide member services in the states where we are the BCBS licensee to individuals who are customers of BCBS plans not affiliated with us. This program also provides a national provider network for our members when they travel to other states.

For additional information describing each of our customer types, detailed marketing efforts and changes in medical membership over the last three years, see "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in Part II, Item 7 of this Annual Report on Form 10-K.

Our results of operations depend in large part on accurately predicting health care costs and our ability to manage future health care costs through adequate product pricing, medical management, product design and negotiation of favorable provider contracts.

Advances in medical technology, increases in specialty drug costs, increases in hospital expenditures and other provider costs, the aging of the population and other demographic characteristics continue to contribute to rising health care costs. Our managed care plans and products are designed to encourage providers and members to participate in quality, cost-effective health benefit programs by using the full range of our innovative medical management services, quality initiatives and financial incentives. Our significant market share and high business retention rates enable us to realize the long-term benefits of investing in preventive and early detection programs. Our ability to provide cost-effective health benefits products and services is enhanced through a disciplined approach to internal cost containment, prudent management of our risk exposure and successful integration of acquired businesses. In addition, our ability to manage selling, general and administrative costs continues to be a driver of our overall profitability.

The future results of our operations will also be impacted by certain external forces and resulting changes in our business model and strategy. In 2010, the Patient Protection and Affordable Care Act, or ACA, as well as the Health Care and Education Reconciliation Act of 2010, or collectively, Health Care Reform, became law, causing significant changes to the U.S. health care system. Since then, significant regulations have been enacted by the U.S. Department of Health and Human Services, or HHS, the Department of Labor and the Department of the Treasury. The legislation and regulations are far-reaching and are intended to expand access to health insurance coverage over time by mandating that most individuals obtain health insurance coverage, increasing the eligibility thresholds for most state Medicaid programs and providing certain individuals and small businesses with tax credits to subsidize a portion of the cost of health insurance coverage. As a result of the complexity of the law, its impact on health care in the United States, the continuing modification and interpretation of Health Care Reform rules and the potential for significant future changes to the law, we continue to analyze and refine our estimates of the ultimate impact of Health Care Reform on our business, cash flows, financial condition and results of operations. Health Care Reform presented us with new growth opportunities, but also introduced new risks, regulatory challenges and uncertainties, and required changes in the way products are designed, underwritten, priced, distributed and administered. Changes to our business are likely to continue for the next several years as elected officials at the national and state level have proposed significant modification to existing laws and regulations, including the potential repeal or replacement of Health Care Reform. For additional discussion, see "Regulation," herein and Part I, Item 1A "Risk Factors" in this Annual Report on Form 10-K.

In addition to the external forces discussed in the preceding paragraph, our results of operations are impacted by levels and mix of membership. In recent years, we have experienced membership growth due to the quality and pricing of our health benefits products and services, improved economic conditions, decreases in unemployment, acquisitions, entry into new markets and expansions in existing markets. In addition, we believe the self-insured portion of our group membership base will continue to increase as a percentage of total group membership. However, these membership trends could be negatively impacted by various factors that could have a material adverse effect on our future results of operations such as general economic downturns that result in business failures, failure to obtain new customers or retain existing customers, premium increases, benefit changes or our exit from a specific market. See Part I, Item 1A "Risk Factors" and Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

Private exchanges have gained visibility in the marketplace based on the promise of helping employers reduce costs, increase consumer engagement and manage the complexities created by the ACA and other market forces. While private exchanges have been a distribution channel in the Medicare and Individual markets for some time, in more recent years the Commercial market has received an increased level of attention from the consulting and broker communities as well as health insurance carriers. In response, we have continued our broad-based strategy of offering Anthem Health Marketplace's consumer experience platform to groups, while also participating in four large national consultant-led exchanges, several regional broker-led exchanges and various Individual, Commercial and Medicare exchanges. To date, adoption levels in the Commercial market overall have been lower than analyst predictions. While the ultimate volume, pace of growth and winning business models remain highly uncertain in this space, we continue to believe we are well positioned to adapt with the market as it evolves.

We believe health care is local and that we have the strong local presence required to understand and meet local customer needs. Further, we believe we are well-positioned to deliver what customers want: innovative, choice-based and affordable products; distinctive service; simplified transactions; and better access to information for quality care. Our local presence, combined with our national expertise, has created opportunities for collaborative programs that reward physicians and hospitals for clinical quality and excellence. We feel that our commitment to health improvement and care management provides added value to customers and health care professionals. Ultimately, we believe that practical and sustainable improvements in health care must focus on improving health care quality while managing costs for total affordability. We have implemented initiatives driving payment innovation and partnering with providers to compel improved cost, quality and health, and we continue to develop new and innovative ways to effectively manage risk and engage our members. In addition, we are focused on achieving efficiencies from our national scale while optimizing service performance for our customers. Finally, we expect to continue to rationalize our portfolio of businesses and products and align our investments to capitalize on new opportunities to drive growth in our existing markets and expand into new markets in the future.

We continue to enhance interactions with customers, providers, brokers, agents, employees and other stakeholders through web-enabled technology and improving internal operations. Our approach includes not only sales and distribution of health benefits products on the Internet, but also implementing advanced capabilities that improve services benefiting customers, agents, brokers, and providers while optimizing administrative costs. These enhancements can also help improve the quality, coordination and safety of health care through increased communications between patients and their physicians.

In pursuing our vision of becoming America's valued health partner, we intend to transform health care by providing trusted and caring solutions and delivering quality products and services that give customers access to the care they need. At the same time, we will focus on earnings per share, or EPS, growth through organic membership growth, improvements in our operating cost structure, strategic acquisitions and the efficient use of capital.

Significant Transactions

While Health Care Reform has caused significant changes to the U.S. health care system in recent years, the significant transactions that have occurred over the last five years that have impacted or will impact our capital structure or that have or will influence how we conduct our business operations include:

- Pending acquisition of Cigna;
- Acquisition of Simply Healthcare (2015);
- Use of Capital—Board of Directors declaration of dividends on common stock (2012 through February 2017); authorization for repurchases of our common stock (2017 and prior); and debt repurchases and new debt issuance (2015 and prior);
- Acquisition of Amerigroup and the related debt issuance (2012); and
- Acquisition of 1-800 CONTACTS (2012) and subsequent divestiture (2014).

For additional information regarding certain of these transactions, see Note 3, "Business Acquisitions and Divestiture," Note 12, "Debt," and Note 14, "Capital Stock," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Competition

The managed care industry is highly competitive, both nationally and in our local markets. Competition continues to be intense due to aggressive marketing and pricing, business consolidations, new competitors in the market, a proliferation of new products, the impact of Health Care Reform, and increased quality awareness and price sensitivity among customers.

We believe that participants in the managed care industry compete for customers based on quality of service, price, access to provider networks, access to care management and wellness programs (including health information), innovation, breadth and flexibility of products and benefits, reputation (including National Committee on Quality Assurance, or NCQA, accreditation status), brand recognition and financial stability. Our ability to attract and retain customers is substantially tied to our ability to distinguish ourselves from our competitors in these areas.

Also, a health plan's ability to interact with employers, customers and other third parties (including health care professionals) via the Internet has become a more important competitive factor, and we have made significant investments in technology to enhance our electronic interaction with providers, employers, customers and third parties.

We believe our exclusive right to market products under the most recognized brand in the industry, BCBS, in our most significant markets provides us with greater brand recognition over competitive product offerings. Our provider networks in our markets enable us to achieve efficiencies and distinctive service levels enabling us to offer a broad range of health benefits to our customers on a more cost-effective basis than many of our competitors. We strive to distinguish our products through provider access, service, care management, product value and brand recognition.

Pricing in our Commercial and Specialty Business segment (defined below), including our Individual and Small Group lines of business, remains competitive and we strive to price our health care benefit products consistent with anticipated underlying medical trends. We believe our pricing strategy, based on predictive modeling, proprietary research and data-driven processes have positioned us to benefit from the potential growth opportunities available in fully-insured commercial products as a result of Health Care Reform and any subsequent changes to the current regulatory scheme. We believe that our pricing strategy, brand name and network quality will provide a strong foundation for commercial risk membership growth opportunities in the future.

To build our provider networks, we compete with other health benefits plans for the best contracts with hospitals, physicians and other providers. We believe that physicians and other providers primarily consider customer volume, reimbursement rates, timeliness of reimbursement and administrative service capabilities along with the reduction of non-value added administrative tasks when deciding whether to contract with a health benefits plan.

At the sales and distribution level, we compete for qualified agents and brokers to recommend and distribute our products. Strong competition exists among insurance companies and health benefits plans for agents and brokers with demonstrated ability to secure new business and maintain existing accounts. We believe that the quality and price of our products, support services, reputation and prior relationships, along with a reasonable commission structure are the factors agents and brokers consider in choosing whether to market our products. We believe that we have good relationships with our agents and brokers, and that our products, support services and commission structure compare favorably to those of our competitors in all of our markets. Typically, we are the largest competitor in each of our Blue-branded markets and, thus, are a closely watched target by other insurance competitors.

Reportable Segments

We manage our operations through three reportable segments: Commercial and Specialty Business, Government Business and Other. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, merger and acquisition activity and changing laws and regulations. As a result, these reportable segments may change in the future.

Our Commercial and Specialty Business and Government Business segments both offer a diversified mix of managed care products, including PPOs, HMOs, traditional indemnity benefits and POS plans, as well as a variety of hybrid benefit plans including CDHPs, hospital only and limited benefit products.

Our Commercial and Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial and Specialty Business segment offer fully-insured health products; provide a broad array of managed care services to self-funded customers including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services; and provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal health care guidance.

Our Government Business segment includes Medicare and Medicaid businesses, National Government Services, or NGS, and services provided to the federal government in connection with FEP. Medicare business includes services such as Medicare Advantage, Medicare Part D, and Medicare Supplement. Medicaid business includes our managed care alternatives through publicly funded health care programs, including Medicaid; Temporary Assistance for Needy Family programs, or TANF; programs for seniors and people with disabilities, or SPD; programs for long-term services and support, or LTSS;

Children's Health Insurance Programs, or CHIP; and ACA-related Medicaid expansion programs. NGS acts as a Medicare contractor for the federal government in several regions across the nation.

Our Other segment includes other businesses that do not individually meet the quantitative thresholds for an operating segment as defined by Financial Accounting Standards Board, or FASB, guidance, as well as corporate expenses not allocated to the other reportable segments.

Through our participation in various federal government programs, we generated approximately 18.2%, 18.8% and 21.0% of our total consolidated revenues from agencies of the U.S. government for the years ended December 31, 2016, 2015 and 2014, respectively. These revenues are contained in the Government Business segment. An immaterial amount of our total consolidated revenues is derived from activities outside of the U.S.

For additional information regarding the operating results of our segments, see Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" and Note 19, "Segment Information," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Products and Services

A general description of our products and services is provided below:

Preferred Provider Organization: PPO products offer the member an option to select any health care provider, with benefits reimbursed by us at a higher level when care is received from a participating network provider. Increasingly, customers are choosing our PPO products offered with an exclusive provider organization which eliminates coverage out of network. Coverage is subject to co-payments or deductibles and coinsurance, with member cost sharing usually limited by out-of-pocket maximums.

Consumer-Driven Health Plans: CDHPs provide consumers with increased financial responsibility, choice and control regarding how their health care dollars are spent. Generally, CDHPs combine a high-deductible PPO plan with an employer-funded and/or employee-funded personal care account, which may result in tax benefits to the employee. Some or all of the dollars remaining in the personal care account at year-end can be rolled over to the next year for future health care needs.

Traditional Indemnity: Indemnity products offer the member an option to select any health care provider for covered services. Coverage is subject to deductibles and coinsurance, with member cost sharing usually limited by out-of-pocket maximums.

Health Maintenance Organization: HMO products include comprehensive managed care benefits, generally through a participating network of physicians, hospitals and other providers. A member in one of our HMOs must typically select a PCP from our network. PCPs generally are family practitioners, internists or pediatricians who provide necessary preventive and primary medical care, and are generally responsible for coordinating other necessary health care services. We offer HMO plans with varying levels of co-payments, which result in different levels of premium rates.

Point-of-Service: POS products blend the characteristics of HMO, PPO and indemnity plans. Members can have comprehensive HMO-style benefits through participating network providers with minimum out-of-pocket expenses (co-payments) and also can go directly, without a referral, to any provider they choose, subject to, among other things, certain deductibles and coinsurance. Member cost sharing is limited by out-of-pocket maximums.

ACA Public Exchange and Off-Exchange Products: The ACA required the modification of existing products and development of new products to meet the requirements of the legislation, subject to certain transitional relief. Individual and Small Group products cover essential health benefits as defined in the ACA along with many other requirements and cost sharing features. Individual and Small Group products offered on and off the public exchanges meet the definition of the "metal" product requirements (bronze, silver, gold and platinum) and each metal product must satisfy a specific actuarial value. Health insurers participating on the public exchanges must offer at least one silver and one gold product.

In our Individual markets we offer bronze, silver and gold products, both on and off the public exchanges, in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. Additionally, we offer platinum products, both on and off the public exchanges, in California and New York.

In our Small Group markets, we offer bronze, silver and gold products, off the public exchanges, in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. We offer platinum products, off the public exchanges, in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, New York, Virginia and Wisconsin. We offer bronze, silver and gold products, on the public exchanges, in Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio and Virginia. Additionally, we offer platinum products on the public exchange in Connecticut.

Administrative Services: In addition to fully-insured products, we provide administrative services to Large Group employers that maintain self-funded health plans. These administrative services include underwriting, actuarial services, medical cost management, disease management, wellness programs, claims processing and other administrative services for self-funded employers. Self-funded health plans are also able to use our provider networks and to realize savings through our negotiated provider arrangements, while allowing employers the ability to design certain health benefit plans in accordance with their own requirements and objectives. We also underwrite stop loss insurance for self-funded plans.

BlueCard®: BlueCard® is a national program that links participating health care providers and independent BCBS plans. BlueCard® host members are generally members who reside in or travel to a state in which an Anthem subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer sponsored health plan serviced by a non-Anthem controlled BCBS licensee, which is the “home” plan. We perform certain administrative functions for BlueCard® host members, for which we receive administrative fees from the BlueCard® members’ home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan.

Medicare Plans: We offer a wide variety of plans, products and options to individuals age 65 and older such as Medicare supplement plans; Medicare Advantage, including special needs plans; Medicare Part D Prescription Drug Plans, or Medicare Part D; and Medicare-Medicaid Plans, or MMPs. Medicare supplement plans typically pay the difference between health care costs incurred by a beneficiary and amounts paid by Medicare. Medicare Advantage plans provide Medicare beneficiaries with a managed care alternative to traditional Medicare and often include a Medicare Part D benefit. In addition, our Medicare Advantage special needs plans provide tailored benefits to Medicare beneficiaries who have chronic diseases and also cover certain dual eligible customers, who are low-income seniors and persons under age 65 with disabilities. Medicare Part D offers a prescription drug plan to Medicare and MMP beneficiaries. MMP is a demonstration program focused on serving members who are dually eligible for Medicaid and Medicare, which was established as a result of the passage of the ACA. We offer these plans to customers through our health benefit subsidiaries throughout the country, including Amerigroup, CareMore and Simply Healthcare.

Individual Plans: We offer a full range of health insurance plans with a variety of options and deductibles for individuals who are not covered by employer-sponsored coverage and are not eligible for government sponsored plans, such as Medicare and/or Medicaid. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the Internet. Individual business is sold on a fully-insured basis. We offer on-exchange products through public exchanges and off-exchange products. Federal premium subsidies are available only for certain public exchange Individual products. Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network, and the efficiency of administration. Some of our products target certain demographic populations such as uninsured younger individuals between the ages of 19 and 29, families, those transitioning between jobs or early retirees.

Medicaid Plans and Other State-Sponsored Programs: We have contracts to serve members enrolled in publicly funded health care programs, including Medicaid, TANF, SPD, LTSS, CHIP, and ACA-related Medicaid expansion programs. The Medicaid program makes federal matching funds available to all states for the delivery of health care benefits for low income and/or high medical risk individuals. These programs are managed by the individual states based on broad federal guidelines. TANF is a state and federally funded program designed for the population consisting primarily of low-income children and their guardians. SPD is a federal income supplement program designed for Supplemental Security Income recipients; however, states can broaden eligibility criteria. This population consists of low-income seniors and people with disabilities. LTSS is a state and federally funded program that offers states a broad and flexible set of program design options and refers to the delivery of long-term services and support for our members who receive home and community- or institution-based services for long-term care. CHIP is a state and federally funded program that provides health care coverage to children not otherwise covered by Medicaid or other insurance programs. Our Medicaid plans also cover certain dual eligible customers, as previously described above, who also receive Medicare benefits. We provide Medicaid and other State-

Sponsored services in California, Florida, Georgia, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Nevada, New Jersey, New York, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia and Wisconsin.

Pharmacy Products: We market and sell an integrated prescription drug product to both fully-insured and self-funded customers through our health benefit subsidiaries throughout the country. This comprehensive product includes features such as drug formularies, a pharmacy network and maintenance of a prescription drug database and mail order capabilities. Since December 1, 2009, we have delegated certain functions and administrative services related to our integrated prescription drug products to Express Scripts under a ten year contract, excluding our CareMore subsidiary and certain self-insured members who have exclusive agreements with different pharmacy benefit management, or PBM, service providers. Express Scripts manages the network of pharmacy providers, operates mail order pharmacies and processes prescription drug claims on our behalf, while we sell and support the product for clients, make formulary decisions and set drug benefit design strategy and provide front line member support. In March 2016, we filed a lawsuit against Express Scripts seeking to recover damages for pharmacy pricing that is higher than competitive benchmark pricing. For additional information, see Note 13, "Commitments and Contingencies - *Litigation*," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Life Insurance: We offer an array of competitive individual and group life insurance benefit products to both Large Group and Small Group customers in conjunction with our health plans. The life products include term life and accidental death and dismemberment.

Disability: We offer short-term and long-term disability products, usually in conjunction with our health plans.

Radiology Benefit Management: We offer outpatient diagnostic imaging management services to health plans. These services include utilization management for advanced diagnostic imaging procedures, network development and optimization, patient safety, claims adjudication and provider payment.

Personal Health Care Guidance: We offer evidence-based and analytics-driven personal health care guidance. These services help improve the quality, coordination and safety of health care, enhance communications between patients and their physicians, and reduce medical costs.

Dental: Our dental plans include networks in certain states in which we operate. Many of the dental benefits are provided to customers enrolled in our health plans and are offered on both a fully-insured and self-funded basis. Our members also have access to additional dental providers through our participation in the National Dental GRID, a national dental network developed by and for BCBS plans. The National Dental GRID includes dentists in all 50 states and provides multi-state customers with a national solution providing in-network discounts across the country. Additionally, we offer managed dental services to other health care plans to assist those plans in providing dental benefits to their customers.

Vision Services and Products: Our vision plans include networks within the states in which we operate. Many of the vision benefits are provided to customers enrolled in our health plans and are offered on both a fully-insured and self-funded basis.

Medicare Administrative Operations: Through our subsidiary, NGS, we serve as a fiscal intermediary, carrier and Medicare administrative contractor for the federal government providing administrative services for the Medicare program, which generally provides coverage for persons who are 65 or older and for persons who are disabled or with end-stage renal disease. Part A of the Medicare program provides coverage for services provided by hospitals, skilled nursing facilities and other health care facilities. Part B of the Medicare program provides coverage for services provided by physicians, physical and occupational therapists and other professional providers, as well as certain durable medical equipment and medical supplies.

Networks and Provider Relations

Our relationships with physicians, hospitals and professionals that render health care services to our members are guided by local, regional and national standards for network development, reimbursement and contract methodologies. While following industry standards, we are simultaneously seeking to lead transformation efforts within our health care system, moving from our current fragmented model premised on episodic intervention to one based on proactive, coordinated care built around the needs of the patient. A key element of this transformation involves a transition from traditional fee-for-

service payment models to models where providers are paid based on the value, both in quality and affordability, of the care they deliver.

We establish “market-based” hospital reimbursement payments that we believe are fair, but aggressive, and among the most competitive in the market. We also seek to ensure that physicians in our network are paid in a timely manner at appropriate rates. In many instances, we deploy multi-year contracting strategies, including case rates or fixed rates, to limit our exposure to medical cost inflation and to increase cost predictability. We maintain both broad and narrow provider networks to ensure member choice, based on both price and access needs, while implementing programs designed to improve the quality of care our members receive. Increasingly, we are supplementing our broad-based networks with smaller or more cost-effective networks that are designed to be attractive to a more price-sensitive customer segment, such as public exchange customers.

Our reimbursement strategies vary across markets and depend on the degree of consolidation and integration of physician groups and hospitals. Fee-for-service is currently our predominant reimbursement methodology for physicians, but as noted above, we are transitioning providers to value-based payment contracts. More traditional physician fee schedules are developed at the state level based on an assessment of several factors and conditions, including the Centers for Medicare & Medicaid Services, or CMS, resource-based relative value system, or RBRVS, medical practice cost inflation and physician supply. We utilize CMS RBRVS fee schedules as a reference point for fee schedule development and analysis. The RBRVS structure was developed, maintained, and updated by CMS and is used by the Medicare program and other major payers. In addition, we have implemented and continue to expand physician incentive contracting, or “pay for performance,” which ties physician payment levels to performance on clinical measures.

While we generally do not delegate full financial responsibility to our physician providers in the form of capitation-based reimbursement, we maintain capitation-based arrangements in certain markets where we determine that market dynamics result in it being a useful method to lower costs and reduce underwriting risk.

Our hospital contracts provide for a variety of reimbursement arrangements depending on local market dynamics and current hospital utilization efficiency. Most hospitals are reimbursed a fixed amount per day or reimbursed a per-case amount, per admission, for inpatient covered services. A small percentage of hospitals, primarily rural, sole community hospitals, are reimbursed on a discount from approved charge basis for covered services. Our “per-case” reimbursement methods utilize many of the same attributes contained in Medicare’s Diagnosis Related Groups, or DRG, methodology. Hospital outpatient services are reimbursed by fixed case rates, fee schedules or percent of approved charges. Our hospital contracts recognize unique hospital attributes, such as academic medical centers or community hospitals, and the volume of care performed for our members. To improve predictability of expected costs, we frequently use a multi-year contracting approach with providers. In addition, the majority of our hospital contracts include a “pay for performance” component where reimbursement levels are linked to improved clinical performance, patient safety and medical error reduction.

Although fee-for-service combined with pay for performance remains our predominant payment model today, our provider engagement and contracting strategies are moving away from “unit price” or volume-based payment models to payment models that align compensation with the value delivered as measured by health care, quality and cost. We launched the most significant of these efforts, our Enhanced Personal Health Care program, in the fourth quarter of 2012. This program augments traditional fee-for-service with shared savings opportunities for providers when actual health care costs are below projected costs, and providers meet specific quality measures. The quality measures are based on nationally accepted, credible standards (e.g. NCQA, the American Diabetes Association and the American Academy of Pediatrics) and span preventive, acute and chronic care. We understand, however, that payment incentives alone are insufficient to create the large-scale, system-wide transformation required to achieve meaningful impacts on cost, quality and member experience. Accordingly, we invested in care delivery transformation and population health management support structures to help providers succeed under value-based payment models. This support includes our web-based population health management technology and teams of dedicated expert consultants who work alongside providers, sharing best practices, and helping them leverage our data to the benefit of their patients. In some of these arrangements, participating physician practices receive a per-member, per-month clinical coordination fee to compensate them for important care management activities that occur outside of the patient visit (e.g. purchasing an electronic health record or hiring care management nurses), all of which have been shown to reduce healthcare costs and improve care outcomes. Since the launch of Enhanced Personal Health Care, we now have arrangements with provider organizations covering 51% of our PCPs and have rolled this program out in each of the fourteen states where we operate as a licensee of the BCBSA.

Medical Management Programs

Our medical management programs include a broad array of activities that facilitate improvements in the quality of care provided to our members and promote cost-effective medical care. These medical management activities and programs are administered and directed by physicians and nurses. The goals of our medical management strategies are to ensure that the care delivered to our members is supported by appropriate medical and scientific evidence, is received on a timely basis and occurs in the most appropriate location. The following is a general description of our medical management programs, which are available to our members depending on the particular plan or product in which they participate:

Precertification: A traditional medical management program involves assessment of the appropriateness of certain hospitalizations and other medical services prior to the services being rendered. For example, precertification is used to determine whether a set of hospital and medical services is being appropriately applied to the member's clinical condition, in accordance with criteria for medical necessity as that term is defined in the member's benefits contract. All of our health plans have implemented precertification programs for common high-tech radiology studies, including cardiac diagnostic testing, addressing an area of historically significant cost trends. Through our AIM Specialty Health, or AIM, subsidiary we promote appropriate, safe and affordable member care in imaging as well as oncology, sleep management and specialty pharmacy benefits. These expanded specialty benefit management solutions leverage clinical expertise and technology to engage our provider communities and members in more effective and efficient use of outpatient services.

Care Coordination: Another traditional medical management strategy we use is care coordination, which is based on nationally recognized criteria developed by third-party medical specialists. With inpatient care coordination, the requirements and intensity of services during a patient's hospital stay are reviewed, at times by an onsite skilled nurse professional in collaboration with the hospital's medical and nursing staff, in order to coordinate care and determine the most effective transition of care from the hospital setting. In addition, guidance for many continued stay cases is reviewed with physician medical directors to ensure appropriate utilization of medical services. We also coordinate care for outpatient services to help ensure that patients with chronic conditions who receive care from multiple physicians are able to manage the exchange of information between physicians and coordinate office visits to their physicians.

Case Management: We have implemented a medical management strategy focused on identifying the small percentage of the membership that will require a high level of intervention to manage their health care needs. The registered nurses and medical directors focus on members likely to be readmitted to the hospital and help them coordinate their care through pharmacy compliance, post-hospital care, follow-up visits to see their physician and support in their home. We are also working to move increasing aspects of this work to the providers we work with via our provider collaboration programs such as Togetherworks, a set of capabilities, offerings, programs and products that help us partner with providers to leverage data, insights and technology to deliver the right care, at the right time, in the right place.

Formulary management: We have developed formularies, which are selections of drugs based on clinical quality and effectiveness. A pharmacy and therapeutics committee of physicians uses scientific and clinical evidence to ensure that our members have access to the appropriate drug therapies.

Medical policy: A medical policy group, comprised of physician leaders from various areas of the country, working in cooperation with academic medical centers, practicing community physicians and medical specialty organizations such as the American College of Radiology and national organizations such as the Centers for Disease Control and Prevention and the American Cancer Society, determines our national policy for the application of new medical technologies and treatments.

Quality programs: We are actively engaged with our hospital and physician networks to enable them to improve medical and surgical care and achieve better outcomes for our members. We endorse, encourage and incentivize hospitals and physicians to support national initiatives to improve the quality of clinical care and patient outcomes and to reduce medication errors and hospital infections.

External review procedures: We work with outside experts through a process of external review to provide our members scientifically and clinically, evidence-based medical care. When we receive member concerns, we have formal appeals procedures that ultimately allow coverage disputes related to medical necessity decisions under the benefits contract to be settled by independent expert physicians.

Service management: In HMO and POS networks, PCPs serve as the overall coordinators of members' health care needs by providing an array of preventive health services and overseeing referrals to specialists for appropriate medical care. In PPO networks, patients have access to network physicians without a PCP serving as the coordinator of care.

Provider Cost Comparison Tools: Through Estimate Your Cost, Anthem Care Comparison and other tools, our members can compare cost estimates and quality data for common services at contracted providers, with cost estimates accounting for facility, professional and ancillary services. These cost estimates bundle related services typically performed at the time of the procedure, not just for the procedure itself. Users can review cost data for over 400 procedures in 49 states. Members can also estimate out-of-pocket costs based on a member's own benefit coverage, deductible, and out of pocket maximum. We also offer information on overall facility ratings and patient experience using trusted third party data. We continue to work on enhancing and evolving our tools to assist members in making informed and value-based health care decisions. In addition, we collaborate with an external independent vendor to support employers wanting to purchase a transparency and consumer engagement web solution with certain additional functionality.

Personal Health Care Guidance: These services help improve the quality, coordination and safety of health care, enhance communications between patients and their physicians, and reduce medical costs. Examples of services include member and physician messaging, providing access to evidence-based medical guidelines, physician quality profiling, and other consulting services.

Anthem Health Guide: Anthem Health Guide integrates customer service with clinical and wellness coaching to provide easier navigation of health care services for our members. Members are supported by a team of nurses, coaches, educators, and social workers using voice, click-to-chat, secure email and mobile technology. Our Smart Engagement Platform supports this integrated team using our smart engagement triggers for speech recognition, preventative and clinical gaps in care and highlighting when we have members who are identified for current health care support.

Care Management Programs

We continue to expand our *360° Health* suite of integrated care management programs and tools. *360° Health* offers the following programs, among others, which are available to our members depending on the particular plan or product in which they participate, and have been proven to increase quality and reduce medical costs for our members:

ConditionCare and *FutureMoms* are care management and maternity management programs that serve as adjuncts to physician care. Skilled nurse professionals with added support from our team of dietitians, social workers, pharmacists, health educators and other health professionals help participants understand their condition, their doctor's orders and how to become a better self-manager of their condition. We also offer members infertility consultation through our *SpecialOffers@Anthem* program, a comprehensive and integrated assembly of discounted health and wellness products and services from a variety of the nation's leading retailers.

24/7 NurseLine offers access to qualified, registered nurses anytime. This allows our members to make informed decisions about the appropriate level of care and avoid unnecessary worry. This program also includes a referral process to the nearest urgent care facility, a robust audio library, accessible by phone, with more than 600 health and wellness topics, as well as on-line health education topics designed to educate members about symptoms and treatment of many common health concerns.

ComplexCase Management is an advanced care management program that reaches out to participants with multiple health care issues who are at risk for frequent and high levels of medical care in order to offer support and assistance in managing their health care needs. *ComplexCase Management* identifies candidates through claims analysis using predictive modeling techniques, the use of health risk assessment data, utilization management reports and referrals from a physician or one of our other programs, such as the *24/7 NurseLine*.

MyHealth Advantage utilizes integrated information systems and sophisticated data analytics to help our members improve their compliance with evidence-based care guidelines, providing personal care notes that alert members to potential gaps in care, enable more prudent health care choices, and assist in the realization of member out-of-pocket cost savings. Key opportunities are also shared with physicians through *Availity®* at the time of membership eligibility verification. *Availity®* is an electronic data interchange system that allows for the exchange of health information among providers over a secure network.

MyHealth Coach provides our members with a professional guide who helps them navigate the health care system and make better decisions about their well-being. *MyHealth Coach* proactively reaches out to people who are at risk for potentially serious health issues or have complex health care needs. Our health coaches help participants understand and manage chronic conditions, handle any health and wellness related services they need and make smart lifestyle choices.

HealthyLifestyles helps employees transform unhealthy habits into positive ones by focusing on behaviors that can have a positive effect on their health and their employer's financial well-being. *HealthyLifestyles* programs include smoking cessation, weight management, stress management, physical activity, and diet and nutrition.

MyHealth@Anthem is our secure web-based solution, complementing other programs by reinforcing telephonic coaching and mail campaigns. The website engages participants in regularly assessing their health status, gives them feedback about their progress, and tracks important health measures such as blood pressure, weight and blood glucose levels.

Behavioral Health Case Management is an integrated component of the health plan, supporting a wide range of members who are impacted by their behavioral health condition including specialty areas such as eating disorders, co-morbid medical/behavioral health, minors, substance use, and maternity. The program assists members and their families with obtaining appropriate behavioral health treatment, offering community resources, providing education and telephonic support, and promoting provider collaboration.

Autism Spectrum Disorder is a specialized case management program staffed by a dedicated team of clinicians who have been trained on the unique challenges and needs of families with a member who has a diagnosis of autism spectrum disorder. These clinicians provide education, information on community resources to help with care and support, guidance on the appropriate usage of benefits, and assistance in exploring effective treatments, such as medical services, that may help the member and their families.

Employee Assistance Programs provide many resources that allow members to balance work and personal life by providing quick and easy access to confidential resources to help meet the challenges of daily life. Examples of services available in person as well as via telephone or internet are counseling for child care, health and wellness, financial issues, legal issues, adoption and daily living.

Health Care Quality Initiatives

Increasingly, the health care industry is able to define quality health care based on preventive health measurements, outcomes of care and optimal care management for chronic disease. A key to our success has been our ability to work with our network physicians and hospitals to improve the quality and outcomes of the health care services provided to our members. Our ability to promote quality medical care has been recognized by the NCQA, the largest and most respected national accreditation program for managed care health plans.

Several quality health care measures, including the Healthcare Effectiveness Data and Information Set, or HEDIS®, have been incorporated into the NCQA's accreditation processes. HEDIS® measures range from preventive services, such as screening mammography and pediatric immunization, to elements of care, including decreasing the complications of diabetes and improving treatment for patients with heart disease. For health plans, NCQA's highest accreditation status of Excellent is granted only to those plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. Plans earning this accreditation level must also achieve HEDIS® results that are in the highest range of national or regional performance. Details for each of our plans' accreditation levels can be found at www.ncqa.org.

We have created an innovative program called the State Health Index, or SHI, to quantify and track our success in improving the health of our communities. SHI presents a comprehensive picture of a community's health in the 25 states served by our affiliated health plans, and in Washington D.C. It is compiled from public data and includes 18 health indicators in five domains: Maternity and Prenatal Care, Preventive Care, Lifestyle, Disability and Behavioral Health, and Morbidity/Mortality. The metrics are utilized to identify opportunities for health improvement and leverage our strengths to collaborate with community coalitions, patient advocacy organizations, and local and state public health departments. We analyze states' performance measures and prioritize measures for focused improvement. Together with Anthem Foundation, Inc. and state leadership, we create or enhance programs to improve the health of the entire population in these states - not just for our members.

Our wholly-owned health outcomes research subsidiary, HealthCore, Inc., or HealthCore, generates consistent and actionable evidence to support decision making while helping to guide fresh initiatives for a range of stakeholders in the healthcare industry. By leveraging a rich array of medical and pharmacy utilization data queried from administrative claims, patient surveys, medical charts and laboratory diagnostics, among other health records, HealthCore's multi-disciplinary research teams uncover a broad spectrum of safety, effectiveness, pharmacoepidemiology, and health economics evidence. HealthCore's real world evidence and comparative effectiveness research, among others, have played roles in the product planning and development campaigns of biotechnology and pharmaceutical companies, and today it lists most of the leading biologics and drug manufacturers as clients or alliance partners. Its health plan research has led to better insights into evidence-based treatment approaches, the development of value-based initiatives to drive access and adherence to treatment, and the crafting of incentives to modify patient and provider behavior. One of HealthCore's predominant initiatives is its governmental and academic collaborations that include cooperation with some of the country's top universities and federal agencies, including the Food and Drug Administration and the Centers of Disease Control of the National Institutes of Health, and it is an active contributor to the safety surveillance Sentinel program. Additionally, HealthCore has taken a thought-leadership position in the development of pragmatic clinical trials. As a notable contributor to the health outcomes evidence base, HealthCore's research findings are broadly disseminated during presentations at national and international medical meetings and are published in a variety of respected peer-reviewed medical and health services journals.

Our AIM subsidiary supports quality by implementing clinical appropriateness and patient safety solutions for advanced imaging procedures, cardiology, sleep medicine, specialty pharmaceuticals and oncology, including drugs covered under medical benefit and radiation therapy. These programs, based on widely accepted and evidence based clinical guidelines, promote the most appropriate use of diagnostic and therapeutic services to improve the quality of overall health care delivered to our members and members of other health plans that are covered under AIM's programs. To provide additional impact to its clinical appropriateness program, AIM has also implemented a provider assessment program, OptiNet®, which promotes more informed selection of diagnostic imaging and testing facilities by providing cost and facility information to physician offices at the point that a procedure is ordered. We have also leveraged AIM's provider network assessment information to proactively engage and educate our members about imaging providers and sleep testing choices based on site capabilities and cost differences. This program is another example of how we facilitate improvements in the quality of care provided to our members and promote cost effective medical care.

Our wholly-owned analytics-driven subsidiary, Resolution Health, Inc., or RHI, delivers programs to improve the safety, quality and coordination of health care for our members. RHI uses evidence-based proprietary rules and algorithms based on established clinical guidelines and standards of independent accreditation organizations, medical specialty societies, and government agencies such as the National Quality Forum, or NQF, and NCQA. RHI analyzes claims and other data to identify actions that can improve health outcomes at the individual member level. When appropriate, RHI delivers personalized confidential messages, or Personalized Health Insights, to members, providers and care managers. RHI's Personalized Health Insights support total population health management and the results of RHI analyses are used across our enterprise to support HEDIS and other clinical quality measures.

Pricing and Underwriting of Our Products

We price our products based on our assessment of current health care claim costs and emerging health care cost trends, combined with charges for administrative expenses, risk and profit, including charges for ACA taxes and fees, where applicable. We continually review our product designs and pricing guidelines on a national and regional basis so that our products remain competitive and consistent with our profitability goals and strategies.

In applying our pricing to each employer group and customer, we maintain consistent, competitive, disciplined underwriting standards. We employ our proprietary accumulated actuarial and financial data in determining underwriting and pricing parameters for both our fully insured and self-funded business.

In most circumstances, our pricing and underwriting decisions follow a prospective rating process in which a fixed premium is determined at the beginning of the contract period. For fully-insured business, any deviation, favorable or unfavorable, from the medical costs assumed in determining the premium is our responsibility. Some of our larger groups employ retrospective rating reviews, where positive experience is partially refunded to the group, and negative experience is charged against a rate stabilization fund established from the group's favorable experience, or charged against future favorable experience.

BCBSA Licenses

We are a party to license agreements with the BCBSA that entitle us to the exclusive, and in certain areas, non-exclusive use of the Blue Cross and Blue Shield names and marks in assigned geographic territories. BCBSA is a national trade association of Blue Cross and Blue Shield licensees, the primary function of which is to promote and preserve the integrity of the BCBS names and marks, as well as provide certain coordination among the member companies. Each BCBSA licensee is an independent legal organization and is not responsible for obligations of other BCBSA member organizations. We have no right to market products and services using the BCBS names and marks outside of the states in which we are licensed to sell BCBS products. We are required to pay an annual license fee to the BCBSA based on enrollment and also to comply with various operational, governance and financial standards set forth in the licenses.

We believe that we and our licensed affiliates are currently in compliance with these standards. The standards under the license agreements may be modified in certain instances by the BCBSA. See Part I, Item 1A "Risk Factors" in this Annual Report on Form 10-K for additional details of our licensing requirements and the impact if we were not to comply with these license agreements.

Regulation

General

Our operations are subject to comprehensive and detailed state, federal and international regulation throughout the jurisdictions in which we do business. As discussed below, the regulatory aspects of the U.S. health care system have been and will continue to be significantly affected by Health Care Reform and subsequent legislative and regulatory changes at the federal and state levels. Supervisory agencies, including state health, insurance and corporation departments, have broad authority to:

- grant, suspend and revoke licenses to transact business;
- regulate our products and services in great detail;
- regulate, limit, or suspend our ability to market products, including the exclusion of our plans from participating on public exchanges;
- retroactively adjust premium rates;
- monitor our solvency and reserve adequacy;
- scrutinize our investment activities on the basis of quality, diversification and other quantitative criteria; and
- impose monetary and criminal sanctions for non-compliance with regulatory requirements.

To carry out these tasks, these regulators periodically examine our operations and accounts.

Regulation of Insurance Company and HMO Business Activity

The governments of the states in which we conduct business, as well as the federal government, have adopted laws and regulations that govern our business activities in various ways. Further, Health Care Reform has resulted in increased federal regulation that significantly impacts our business. These laws and regulations, which vary significantly from state to state, restrict how we conduct our businesses and result in additional burdens and costs to us. These federal and state laws and regulations are subject to amendments and changing interpretations in each jurisdiction.

States generally require health insurers and HMOs to obtain a certificate of authority prior to commencing operations. If we were to establish a health insurance company or an HMO in any jurisdiction, we generally would have to obtain such a certificate or authorization to expand the operations permitted under an existing certificate if we already operate in the state. The time necessary to obtain such a certificate varies from jurisdiction to jurisdiction. Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. The health benefits business also may be adversely impacted by court and regulatory decisions that expand the interpretations of existing statutes and regulations. It is uncertain whether we can recoup, through higher premiums or other measures, the increased costs of mandated benefits or other increased costs.

caused by potential legislation, regulation or court rulings. See Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K.

Patient Protection and Affordable Care Act

The ACA significantly changed health insurance markets by prohibiting lifetime limits, certain annual limits, member cost-sharing on specified preventive benefits and pre-existing condition exclusions. Further, the ACA implemented certain requirements for insurers including changes to Medicare Advantage payments and the minimum medical loss ratio, or MLR, provision that requires insurers to pay rebates to customers when insurers do not meet or exceed the specified MLR thresholds. In addition, the ACA also required a number of other changes with significant effects on both federal and state health insurance markets, including strict rules on how health insurance is rated, the assessment of new taxes and fees (including annual fees on health insurance companies), the creation of public exchanges for Individuals and Small Groups, the availability of premium subsidies for certain Individual products, and substantial expansions in eligibility for Medicaid. As a number of elected officials at both the national and state level have proposed significant modification, repeal or replacement of Health Care Reform, changes to the health care system are expected which could have far-reaching consequences for our business.

Despite significant preparation for the advent of the public exchanges, there have been many technical difficulties in their implementation, which entail uncertainties associated with mix and volume of business. In addition, CMS issued transitional policies modifying or extending the deadlines for compliance with certain aspects of Health Care Reform. In February 2016, CMS issued transition relief providing that health insurance coverage in the Individual or Small Group markets that is renewed for a policy year beginning on or before October 1, 2017 that would otherwise have been deemed non-compliant with certain market reforms under Health Care Reform, will not be considered by CMS to be out of compliance with respect to such market reforms, provided certain conditions are met and that all such policies end by December 31, 2017. Some states have adopted these transitional policies, some have not and others have not taken a position.

In general, individuals participating in the public exchange markets have had a higher acuity level than the pool of participants we anticipated when we established pricing. Based on our experience in public exchange markets to date, we have made adjustments to our premium rates, and we will continue to evaluate the performance of our public exchange plans going forward. In addition, the risk adjustment, reinsurance, and risk corridor premium stabilization programs of Health Care Reform, or Health Care Reform Premium Stabilization Programs, established to apportion risk amongst insurers, have faced uncertainties related to funding and payment allocations and may not be effective in appropriately mitigating the financial risks related to our public exchange products. These factors may have a material adverse effect on our results of operations if premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions utilized in setting premium rates could have a material adverse effect on our results of operations, financial position, and cash flows.

In addition, there have been material changes and delays in the implementation of the ACA that could have a material adverse effect on our results of operations, financial position, and cash flows. These include:

- Network adequacy standards;
- Reduction in the amount available for payments under the risk corridor program;
- Change in Small Group size expansion;
- Increasingly complex and detailed regulation; and
- Other unanticipated regulatory changes and delays.

These delays and changes may have a material and significant impact on anticipated enrollment in public exchange and off-exchange products, thus affecting the risk pools and premium rates. Further, implementation of the ACA brings with it significant oversight responsibilities by health insurers that may result in increased governmental audits, increased assertions of False Claims Act violations, and an increased risk of other litigation. Finally, the 2016 presidential and congressional election results have created additional uncertainty regarding the future of the ACA and increased the potential for substantial and potentially unforeseen changes to the law that may have a material effect on our business.

The ACA continues to require additional guidance and specificity to be provided by HHS, the Department of Labor, CMS and the Department of the Treasury. Some of the more significant rules are described below:

- The minimum MLR thresholds by line of business, as defined by HHS, are as follows:

Line of Business	%
Large Group	85
Small Group	80
Individual	80

New York state regulations require us to meet a more restrictive MLR threshold of 82% for both Small Group and Individual lines of business. The minimum MLR thresholds disclosed above are based on definitions of an MLR calculation provided by HHS, or specific states, as applicable, and differ from our calculation of “benefit expense ratio” based on premium revenue and benefit expense as reported in accordance with U.S. generally accepted accounting principles, or GAAP. Furthermore, the definitions of the lines of business differ under the various federal and state regulations and may not correspond to our lines of business. Definitions under the MLR regulation also impact insurers differently depending upon their organizational structure or tax status, which could result in a competitive advantage to some insurance providers that may not be available to us, resulting in an uneven playing field in the industry. Significant changes to the MLR requirements may occur through additional regulatory action by HHS.

Health Care Reform also imposed a separate minimum MLR threshold of 85% for Medicare Advantage and Medicare Part D plans beginning in 2014. Medicare Advantage or Medicare Part D plans that do not meet this threshold will have to pay a minimum MLR rebate. If a plan’s MLR is below 85% for three consecutive years beginning with 2014, enrollment will be restricted. A Medicare Advantage or Medicare Part D plan contract will be terminated if the plan’s MLR is below 85% for five consecutive years.

Approximately 82.1% and 34.7% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2016. Approximately 86.8% and 36.0% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2015.

- The ACA created an incentive payment program for Medicare Advantage plans. CMS developed the Medicare Advantage Star Ratings System, which awards between 1.0 and 5.0 stars to Medicare Advantage plans based on performance in several categories, including quality of care and customer service. The star ratings are used by CMS to award quality-based bonus payments to plans that receive a rating of 4.0 or higher. The methodology and measures included in the star ratings system can be modified by CMS annually. As of December 31, 2016, all of our Medicare Advantage plans have received a rating of 3.0 or higher.
- The ACA required states to establish public exchanges through which qualified individuals and qualified small employers may access coverage. If a state failed to establish a public exchange, the federal government established a public exchange in that state. To date there are twelve state-based marketplaces, five state-based marketplaces that rely on the federal platform, and thirty four federal exchange states. In the states in which we offer products on public exchanges, six states have passed legislation or executive orders establishing state-based public exchanges (California, Colorado, Connecticut, Kentucky, Nevada and New York).
- The ACA required the modification of existing products and development of new products to meet the requirements of the legislation, subject to certain transitional relief. Individual and Small Group products must cover essential health benefits as defined in the ACA along with many other requirements and cost sharing features. Individual and Small Group products must meet the definition of the “metal” product requirements (bronze, silver, gold and platinum). Each metal product must satisfy a specific actuarial value. Health insurers participating on public exchanges must offer at least one silver and one gold product. Additionally, effective January 1, 2014, health insurers were required to cancel or discontinue the sale of existing non-ACA-compliant Individual and Small Group products, subject to the conditions of the CMS transitional policies discussed above.

- Regulations require premium rate increases to be reviewed for Small Group and Individual products above specified thresholds, generally 10%, as may be adjusted from time to time. The regulations provide for state insurance regulators to conduct the reviews, except for cases where a state does not have an “effective” rate review program or in federal enforcement states, in which cases HHS will conduct the reviews for any rate increase.
- The Health Care Reform Premium Stabilization Programs introduced new requirements to the MLR calculation, beginning with the 2014 benefit year for the Individual and Small Group markets. The risk adjustment program is a permanent program that transfers dollars from insurers who enroll individuals with lower relative health risk to insurers who enroll individuals with higher relative health risk. Risk adjustment payments/receipts will be determined separately for each state and for Individual and Small Group. The second premium stabilization program is the transitional reinsurance program, a temporary program that ran from 2014 through 2016. The transitional reinsurance program was intended to help stabilize premiums by reimbursing issuers of ACA-compliant non-grandfathered Individual market plans for eligible claims between a defined attachment point and ceiling, at a coinsurance rate defined by HHS. The program was funded through assessments per covered enrollee upon the commercial health insurance market and sponsors of self-funded health benefit plans of approximately \$12.0 billion, \$8.0 billion and \$5.0 billion in 2014, 2015 and 2016, respectively. The reinsurance program has been under significant Congressional scrutiny. Any changes to the final settlements for the reinsurance program could have significant implications for the stability of the exchanges. The final premium stabilization program is the temporary risk corridor program, also a three year program through 2016, that was designed to protect insurers from inaccurate pricing of Individual and Small Group qualified health plans and substantially similar off-exchange products. Beginning in 2014, MLR rebate calculations are adjusted to reflect the impact of the Health Care Reform Premium Stabilization Programs.
- Prior to the implementation of the ACA, health insurers were permitted to use differential pricing, commonly referred to as “rating bands,” based on factors such as health status, gender and age. The ACA precludes health insurers from using health status and gender in the determination of the insurance premium. In addition, rating bands for age cannot vary by more than 3 to 1 and rating bands for tobacco use cannot vary by more than 1.5 to 1. The ongoing use of the 3 to 1 rating bands may have a significant impact on the majority of Individual and Small Group customers and could lead to adverse selection in the market as well as increased variability in projecting future premiums for those customer markets.
- In 2014 significant new taxes and fees became effective for health insurers, some of which may or may not be passed through to customers. The most significant of the taxes and fees is the annual Health Insurance Provider Fee, or HIP Fee, on health insurers that write certain types of health insurance on U.S. risks. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to an adjusted amount of health insurance for all U.S. health risk for those certain lines of business written during the preceding calendar year. The HIP Fee is non-deductible for federal income tax purposes. The total amount due from allocations to health insurers was \$11.3 billion for each of 2016 and 2015 and \$8.0 billion for 2014. We record our estimated liability for the HIP Fee in full at the beginning of the year with a corresponding deferred asset that is amortized on a straight-line basis to general and administrative expense. The final calculation and payment of the annual HIP Fee occurs in the third quarter each year and our portion of the HIP Fee was \$1.2 billion for each of 2016 and 2015 and \$0.9 billion for 2014. The annual HIP Fee has been suspended for 2017 and is currently scheduled to resume and be increased to \$14.3 billion for 2018, unless otherwise changed by subsequent legislative or regulatory action. For 2019 and beyond, the annual HIP Fee will equal the amount for the preceding year increased by the rate of premium growth for the preceding year less the rate of growth in the consumer price index for the preceding calendar year.
- Medicare Advantage reimbursement rates will not increase as much as they would otherwise due to a new payment formula promulgated by the ACA that is expected to significantly reduce reimbursements in the future. We also expect further and ongoing regulatory guidance on a number of issues related to Medicare, evolving methodology for ratings and quality bonus payments, and potential action on an audit methodology to review data submitted under “risk adjuster” programs.

Dodd-Frank Wall Street Reform and Consumer Protection Act

The Dodd-Frank Wall Street Reform and Consumer Protection Act, or the Dodd-Frank Act, includes a number of financial reforms and regulations that affect our business and financial reporting, including margin requirements and reporting and clearing transactions for our investments in derivative instruments. In addition, the Dodd-Frank Act creates a Federal Insurance Office, with limited powers that include information-gathering and subpoena authority for certain parts of our business, including life insurance, but excluding health insurance. The 2016 presidential and congressional election results have created additional uncertainty regarding the future of the Dodd-Frank Act and increased the potential for changes to the law that may affect our business.

HIPAA and Gramm-Leach-Bliley Act

The federal Health Insurance Portability and Accountability Act of 1996, or HIPAA, imposes obligations for issuers of health insurance coverage and health benefit plan sponsors. This law requires guaranteed renewability of health care coverage for most group health plans and certain individuals. Also, the law limited exclusions based on preexisting medical conditions.

The administrative simplification provisions of HIPAA imposed a number of requirements on covered entities (including insurers, HMOs, group health plans, providers and clearinghouses). These requirements include uniform standards of common electronic health care transactions; privacy and security regulations; and unique identifier rules for employers, health plans and providers. Additional federal privacy and security requirements, including breach notification, improved enforcement, and additional limitations on use and disclosure of protected health information were passed through the Health Information Technology for Economic and Clinical Health, or HITECH, Act provisions of the American Recovery and Reinvestment Act of 2009 and corresponding implementing regulations. CMS adopted operating rules for two electronic transactions: eligibility for a health plan and health care claims status. These rules had a January 1, 2013 compliance date and we believe we have effectively complied with the requirements.

The federal Gramm-Leach-Bliley Act generally places restrictions on the disclosure of non-public information to non-affiliated third parties, and requires financial institutions, including insurers, to provide customers with notice regarding how their non-public personal information is used, including an opportunity to “opt out” of certain disclosures. State departments of insurance and certain federal agencies adopted implementing regulations as required by federal law. In addition, a number of states have adopted data security laws and/or regulations, regulating data security and/or requiring security breach notification, which may apply to us in certain circumstances.

Employee Retirement Income Security Act of 1974

The provision of services to certain employee welfare benefit plans is subject to the Employee Retirement Income Security Act of 1974, as amended, or ERISA, a complex set of laws and regulations subject to interpretation and enforcement by the Internal Revenue Service and the Department of Labor. ERISA regulates certain aspects of the relationships between us, the employers that maintain employee welfare benefit plans subject to ERISA and participants in such plans. Some of our administrative services and other activities may also be subject to regulation under ERISA. In addition, certain states require licensure or registration of companies providing third party claims administration services for benefit plans. We provide a variety of products and services to employee welfare benefit plans that are covered by ERISA. Plans subject to ERISA can also be subject to state laws and the question of whether and to what extent ERISA preempts a state law has been, and will continue to be, interpreted by many courts.

HMO and Insurance Holding Company Laws, including Risk-Based Capital Requirements

We are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. These holding company laws and regulations generally require insurance companies and HMOs within an insurance holding company system to register with the insurance department of each state where they are domiciled and to file with those states’ insurance departments certain reports describing capital structure, ownership, financial condition, certain intercompany transactions, enterprise risks, corporate governance and general business operations. In addition, various notice and reporting requirements generally apply to transactions between insurance companies and HMOs and their affiliates within an insurance holding company system,

depending on the size and nature of the transactions. Some insurance holding company laws and regulations require prior regulatory approval or, in certain circumstances, prior notice of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other provisions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends.

Additionally, the holding company acts of the states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company, which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would “control” the insurance holding company. “Control” is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person. Dispositions of control generally are also regulated under the state holding company acts.

The states of domicile of our regulated subsidiaries have statutory risk-based capital, or RBC, requirements for health and other insurance companies and HMOs based on the RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company’s investments and products. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. The law requires increasing degrees of regulatory oversight and intervention as a company’s RBC declines. As of December 31, 2016, the RBC levels of our insurance and HMO subsidiaries exceeded all RBC requirements.

Guaranty Fund Assessments

Under insolvency or guaranty association laws in most states, insurance companies can be assessed for amounts paid by guaranty funds for policyholder losses incurred when an insurance company becomes insolvent. Most state insolvency or guaranty association laws currently provide for assessments based upon the amount of premiums received on insurance underwritten within such state (with a minimum amount payable even if no premium is received). Under many of these guaranty association laws, assessments against insurance companies that issue policies of accident or sickness insurance are made retrospectively. Some states permit insurers to recover assessments paid through full or partial premium tax offsets or through future policyholder assessments.

While the amount and timing of any future assessments cannot be predicted with certainty, we believe that future guaranty association assessments for insurer insolvencies will not have a material adverse effect on our liquidity and capital resources with the exception of exposure related to the Penn Treaty Network America Insurance Company and its subsidiary American Network Insurance Company insolvency as discussed in Note 13, “Commitments and Contingencies,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Employees

At December 31, 2016, we had approximately 53,000 employees. Our employees are an important asset, and we seek to develop them to their full potential. We believe that our relationship with our employees is good.

Available Information

We are a large accelerated filer (as defined in Rule 12b-2 of the Securities Exchange Act of 1934, as amended, or Exchange Act) and are required, pursuant to Item 101 of Regulation S-K, to provide certain information regarding our website and the availability of certain documents filed with or furnished to the U.S. Securities and Exchange Commission, or SEC. Our Internet website is www.antheminc.com. We have included our Internet website address throughout this Annual Report on Form 10-K as textual reference only. The information contained on, or accessible through, our Internet website is not incorporated into this Annual Report on Form 10-K. We make available, free of charge, by mail or through our Internet website, our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act as soon as reasonably practicable after we electronically file such material with or furnish it to the SEC. We also include on our Internet website our Corporate Governance Guidelines, our Standards of Ethical Business Conduct and the charter of each standing committee of our Board.

of Directors. In addition, we intend to disclose on our Internet website any amendments to, or waivers from, our Standards of Ethical Business Conduct that are required to be publicly disclosed pursuant to rules of the SEC and the New York Stock Exchange, or NYSE. Anthem, Inc. is an Indiana corporation incorporated on July 17, 2001.

ITEM 1A. RISK FACTORS.

The following is a description of significant factors that could cause actual results to differ materially from those contained in forward-looking statements made in this Annual Report on Form 10-K and presented elsewhere by management from time to time. Such factors may have a material adverse effect on our business, financial condition, and results of operations and you should carefully consider them. It is not possible to predict or identify all such factors. Consequently, you should not consider any such list to be a complete statement of all our potential risks or uncertainties. Because of these and other factors, past performance should not be considered an indication of future performance.

Health Care Reform, together with the changes in federal and state regulations that have been, and continue to be, enacted to implement it, or future changes involving the significant modification, repeal or replacement of Health Care Reform could adversely affect our business, cash flows, financial condition and results of operations.

The passage of Health Care Reform and subsequent regulations represent significant changes to the U.S. health care system. The legislation and regulations are far-reaching and are intended to expand access to health insurance coverage over time by mandating that most individuals obtain health insurance coverage, increasing the eligibility thresholds for most state Medicaid programs and providing certain individuals and small businesses with tax credits to subsidize a portion of the cost of health insurance coverage. In addition, these laws impose significant fees, assessments and taxes on us and other health insurers, health plans and other industry participants.

Similarly, a number of elected officials at both the federal and state level have proposed substantial changes to the United States' health care system, including the significant modification, repeal or replacement of Health Care Reform, which could have far-reaching consequences for our business.

One of our most significant costs under Health Care Reform is the annual industry-wide HIP Fee. The total amount due from allocations to health insurers in 2016, 2015 and 2014 was \$11.3 billion, \$11.3 billion and \$8.0 billion, respectively, and our portion of the HIP Fee for 2016, 2015 and 2014 was \$1.2 billion, \$1.2 billion and \$0.9 billion, respectively. The HIP Fee has been suspended for 2017 and is currently scheduled to resume in 2018 at the increased amount of \$14.3 billion, with annual adjustments thereafter. Due to the suspension of the HIP Fee for 2017, we may be unable to appropriately price 2017 renewals with policy months occurring in 2018 to appropriately include our portion of the 2018 HIP Fee. The HIP Fee is not deductible for income tax purposes and is allocated pro rata among us and other industry participants based on net premiums written. Health Care Reform also imposed industry-wide reinsurance assessments under a temporary three year program which were \$5.0 billion, \$8.0 billion and \$12.0 billion for 2016, 2015 and 2014, respectively. The reinsurance assessments were based on a national contribution rate assessed, per covered enrollee, upon the commercial health insurance market and sponsors of self-funded health benefit plans. As we are one of the nation's largest health benefits companies, we expect our share of the Health Care Reform fees, assessments and taxes will continue to be significant. We may not be able to include or recoup all or a portion of these fees, assessments and taxes in our premium or public program rates.

Health Care Reform imposes regulations on the health insurance sector, including, but not limited to, guaranteed coverage and expanded benefit requirements; prohibitions on some annual and all lifetime limits on amounts paid on behalf of or to our members; increased restrictions on rescinding coverage; establishment of minimum MLR and customer rebate requirements; creation of a federal rate review process; a requirement to cover preventive services on a first dollar basis; the establishment of public exchanges and essential benefit packages and greater limitations on how we price certain of our products. In addition, the legislation reduces the reimbursement levels for our health plans participating in the Medicare Advantage program over time and limits the amount of executive compensation that is deductible for income tax purposes.

The legislation also contains risk adjustment provisions applicable to the Individual and Small Group markets that effectively transfer funds from health plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to help protect against adverse selection. Effectively adapting to these risk adjustment provisions has required us to modify our operational and strategic initiatives to focus on and manage different populations of potential members than we have in the past. If we are not able to successfully design and implement operational and strategic initiatives to adapt to these changes in

certain of our markets, our financial condition and results of operations may be adversely affected. Further, the Health Care Reform Premium Stabilization programs may not make payments timely, or as expected, due to lower than anticipated collections. For example, through 2016, the risk corridor program has fallen short of expectations and, as a result, payments from the program were approximately 14.9% of the amounts that were requested by health insurance issuers for 2014. No payments from the program have been made by HHS against the amounts owed for 2015 and 2016. Although HHS has stated that future collections under the program will be applied to shortfalls from previous years prior to making payments for subsequent years, there can be no assurance that any remaining funds due under this program will be recovered. As we have consistently done since 2014, we have continued our conservative posture of recording a 100% valuation allowance against any unpaid receivables owed to us under the risk corridor program for the 2014, 2015 and 2016 benefit years.

Although Health Care Reform has been substantially implemented, further regulations and modifications to Health Care Reform, including repeal or replacement, could have a significant impact on us through potential disruption to the employer-based market, cost shifting in the health care delivery system to insurance companies and limitations on the ability to increase premiums to meet costs. We have dedicated material resources and incurred material expenses to implement and comply with Health Care Reform at both the federal and state levels, including significant investments in new products, services and technologies, and we expect to dedicate material resources and incur material expenses going forward to implement and comply with future regulations that provide guidance and clarification on significant portions of the legislation. Health Care Reform and associated regulations are likely to have significant effects on our future operations, which, in turn, could impact the value of our business model and results of operations, including potential impairments of our goodwill and other intangible assets.

Similarly, the significant modification, repeal or replacement of Health Care Reform would likely have significant effects on our business and future operations, some of which may adversely affect our results of operations.

Finally, federal and state regulatory agencies may further restrict our ability to obtain new product approvals, implement changes in premium rates or impose additional restrictions, under new or existing laws that could adversely affect our business, cash flows, financial condition and results of operations.

We are subject to significant government regulation, and changes in the regulation of our business by federal and state regulators may adversely affect our business, cash flows, financial condition and results of operations.

Our business is subject to regulation at the federal and state level. In addition to Health Care Reform, we face regulation associated with many aspects of our business, including, but not limited to, licensing, premiums, marketing activities, provider contracting, access and payment standards, and corporate governance and financial reporting matters.

Our insurance, managed health care and HMO subsidiaries are subject to extensive regulation and supervision by regulatory authorities in each state in which they are licensed or authorized to do business, in addition to regulation by federal agencies. Future regulatory action by state or federal authorities could have a material adverse effect on the profitability or marketability of our health benefits or managed care products or on our business, financial condition and results of operations. In addition, because of our participation in government-sponsored programs such as Medicare and Medicaid, a number of our subsidiaries are also subject to regulation by CMS and state Medicaid agencies, and to changes in government regulations or policy with respect to, among other things, reimbursement levels, eligibility requirements, benefit coverage requirements and additional governmental participation which could also adversely affect our business, financial condition and results of operations. In addition, changes in tax laws and regulations, or changes in the interpretation of tax laws and regulations by federal and/or state authorities may have a material adverse effect on our business, cash flows, operations or financial condition.

State legislatures will continue to focus on health care delivery and financing issues, especially given proposals for the significant modification, repeal or replacement of Health Care Reform. Such issues are sometimes addressed directly by voters in ballot initiatives, such as the recent ballot initiative in Colorado that attempted to replace health insurers in the state with a single government payer. Most states are very focused on how to manage and reduce their budgets and are exploring ways to mitigate cost increases. As such, some states have acted to reduce or limit increases to premium payments. Others have enacted, or are contemplating, significant reform of their health insurance markets to include provisions affecting both public programs and privately-financed health insurance arrangements. If enacted into law, these state proposals could have a material adverse impact on our business, cash flows, operations or financial condition.

The existence of multiple public insurance exchange options has led to increased uncertainties and made our planning for the public exchanges more difficult as we are required to comply with the varying rules of multiple exchanges. In addition, a number of states in which we offer Medicaid products, including Florida, Georgia, Kansas, South Carolina, Tennessee, Texas, Virginia and Wisconsin, have indicated their current decision to opt out of Medicaid expansion, at least for the present time. Where states allow certain programs to expire or opt out of Medicaid expansion, we could experience reduced Medicaid enrollment and reduced growth opportunities. If future modifications to Health Care Reform significantly reduce the Medicaid expansion program, this will negatively impact our Medicaid business.

Additionally, from time to time, Congress has considered, and may consider in the future, various forms of managed care reform legislation which, if adopted, could fundamentally alter the treatment of coverage decisions under ERISA. There have been legislative attempts to limit ERISA's preemptive effect on state laws and litigants' ability to seek damages beyond the benefits offered under their plans. If adopted, such limitations could increase our liability exposure, could permit greater state regulation of our operations, and could expand the scope of damages, including punitive damages, litigants could be awarded. While we cannot predict if any of these initiatives will ultimately become effective or, if enacted, what their terms will be, their enactment could increase our costs, expose us to expanded liability or require us to revise the ways in which we conduct business.

Our inability to contain health care costs, implement increases in premium rates on a timely basis, appropriately price our public exchange products, maintain adequate reserves for policy benefits or maintain cost effective provider agreements may adversely affect our business and profitability.

Our profitability depends in large part on accurately predicting health care costs and on our ability to manage future health care costs through medical management, product design, negotiation of favorable provider contracts and underwriting criteria. Government-imposed limitations on Medicare and Medicaid reimbursement have also caused the private sector to bear a greater share of increasing health care costs. Changes in health care practices, demographic characteristics, inflation, new technologies, the cost of prescription drugs, clusters of high cost cases, changes in the regulatory environment and numerous other factors affecting the cost of health care may adversely affect our ability to predict and manage health care costs, as well as our business, financial condition and results of operations.

Relatively small differences between predicted and actual health care costs as a percentage of premium revenues can result in significant changes in our results of operations, particularly with respect to our products sold through the public exchanges, as we and our competitors have limited experience with pricing such products or the utilization rates for medical or other covered services by members who purchase our products through such exchanges. Further, the public exchange market is currently experiencing significant disruptions, as many insurers have incurred significant losses and announced their withdrawal from public exchange markets in a number of states. For 2016, we experienced losses in our public exchange business as our products were selected by individuals who have a higher risk profile or utilization rate than the pool of participants we anticipated when we established the pricing for these public exchange products. Although we increased our public exchange premiums for 2017, there can be no assurance that these increases in premiums will adequately address the risk that our products continue to be selected by individuals who utilize medical services at a greater rate than anticipated. Health care benefit costs in excess of our cost projections reflected in our public exchange product pricing cannot be recovered in the current premium period through higher premiums. Although federal risk adjustment mechanisms, including risk adjustment payments, could help offset health care benefit costs in excess of our projections if our assumptions regarding cost trends, utilization, enrollment, adverse selection, acuity and other assumptions utilized in setting our premium rates are significantly different than actual results, our income statement and financial position could be adversely affected. If future modifications to Health Care Reform significantly reduce the federal risk adjustment mechanisms, this will impact our assumptions for the next several years.

In addition to the challenge of managing health care costs, we face pressure to contain premium rates. Our customers may renegotiate their contracts to seek to contain their costs or may move to a competitor to obtain more favorable premiums. Further, federal and state regulatory agencies may restrict our ability to implement changes in premium rates. For example, the ACA includes an annual rate review requirement to prohibit unreasonable rate increases, and our plans may be excluded from participating in the public exchanges if they are deemed to have a history of "unreasonable" rate increases. Fiscal concerns regarding the continued viability of programs such as Medicare and Medicaid may cause decreasing reimbursement rates, including retroactive decreases in Medicaid reimbursement rates, delays in premium payments or a lack of sufficient increase in reimbursement rates for government-sponsored programs in which we participate. A limitation on our

ability to increase or maintain our premium or reimbursement levels or a significant loss of membership resulting from our need to increase or maintain premium or reimbursement levels could adversely affect our business, cash flows, financial condition and results of operations.

The reserves that we establish for health insurance policy benefits and other contractual rights and benefits are based upon assumptions concerning a number of factors, including trends in health care costs, expenses, general economic conditions and other factors. To the extent the actual claims experience is unfavorable as compared to our underlying assumptions, our incurred losses would increase and future earnings could be adversely affected.

Our profitability is dependent in part upon our ability to contract on favorable terms with hospitals, physicians, PBM service providers and other health care providers. Physicians, hospitals and other health care providers may refuse to contract with us, and the failure to secure or maintain cost-effective health care provider contracts on competitive terms may result in a loss of membership or higher medical costs, which could adversely affect our business. In addition, consolidation among health care providers, ACO practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other care providers choose may change the way that these providers interact with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which may impact our relationship with these providers or affect the way that we price our products and estimate our costs and may require us to incur costs to change our operations, and our business, cash flows, financial condition and results of operations could be adversely affected.

Our inability to contract with providers, or if providers attempt to use their market position to negotiate more favorable contracts or place us at a competitive disadvantage, or the inability of providers to provide adequate care, could adversely affect our business. In addition, we do not have contracts with all providers that render services to our members and, as a result, do not have a pre-established agreement about the amount of compensation those out-of-network providers will accept for the services they render, which can result in significant litigation or arbitration proceedings, or provider attempts to obtain payment from our members for the difference between the amount we have paid and the amount they have charged.

A significant reduction in the enrollment in our health benefits programs could have an adverse effect on our business and profitability.

A significant reduction in the number of enrollees in our health benefits programs could adversely affect our business, cash flows, financial condition and results of operations. Factors that could contribute to a reduction in enrollment include: reductions in workforce by existing customers; general economic downturn that results in business failures and high unemployment rates; employers no longer offering certain health care coverage as an employee benefit or electing to offer coverage on a voluntary, employee-funded basis; participation on public exchanges; federal and state regulatory changes; failure to obtain new customers or retain existing customers; premium increases and benefit changes; our exit from a specific market; negative publicity and news coverage; and failure to attain or maintain nationally recognized accreditations.

There are various risks associated with participating in Medicaid and Medicare programs, including dependence upon government funding and the timing of payments, compliance with government contracts and increased regulatory oversight.

We contract with various federal and state agencies, including CMS, to provide managed health care services, including Medicare Advantage plans, Medicare Supplement plans, Medicare approved prescription drug plans, Medicaid, TANF, SPD, LTSS, CHIP and ACA-related Medicaid expansion programs. We also provide various administrative services for several other entities offering medical and/or prescription drug plans to their Medicare eligible members through our affiliated companies and we offer employer group waiver plans which provide medical and/or prescription drug coverage to retirees. We are also participating in Medicare and Medicaid dual eligible programs in several states. These programs in our Government Business segment have been the subject of recent regulatory reform initiatives, including Health Care Reform. It is difficult to predict the future impact of Health Care Reform on our Government Business segment due to Health Care Reform's complexity and potential for further modifications. Regulatory reform initiatives or additional changes in existing laws or regulations, or their interpretations, could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Revenues from the Medicare and Medicaid programs are dependent, in whole or in part, upon annual funding from the federal government and/or applicable state governments. The base premium rate paid by each state or federal agency differs depending upon a combination of various factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix, member eligibility category and risk scores. Future Medicare and Medicaid rates may be affected by continued government efforts to contain costs as well as federal and state budgetary constraints. If the federal government or any state in which we operate were to decrease rates paid to us, pay us less than the amount necessary to keep pace with our cost trends or seek an adjustment to previously negotiated rates, it could have a material adverse effect on our business, cash flows, financial condition and results of operations. Further, certain state contracts are subject to cancellation in the event of the unavailability of state funds. In addition, various states' Medicare and Medicaid dual eligible programs are still subject to uncertainty surrounding payment rates and other requirements, which could affect where we seek to participate in these new programs. An unexpected reduction, inadequate government funding or significantly delayed payments for these programs may adversely affect our revenues, cash flow and financial results.

A portion of our premium revenue comes from CMS through our Medicare Advantage and Medicare Part D contracts. As a consequence, our Medicare Advantage and Medicare Part D plans are dependent on federal government funding. The premium rates paid to Medicare plans are established based on benchmarks which are now tied to a percentage of Medicare fee for service, although the rates differ depending on a combination of factors, including upper payment limits established by CMS, a member's health profile and status, age, gender, county or region, benefit mix, member eligibility categories and risk scores. In addition, Medicare Advantage and Medicare Part D plans are subject to MLR rules. Continuing government efforts to contain health care related expenditures, including prescription drug cost, and other federal budgetary constraints that result in changes in the Medicare program, including changes with respect to funding, could lead to reductions in the amount of reimbursement, or other changes that could have a material adverse effect on our business, cash flows, financial condition and results of operations. Risks associated with the Medicare Advantage and Medicare Part D plans include increased medical or pharmaceutical costs, overpayments identified as a result of ongoing auditing and monitoring activities, potential uncollectability of receivables resulting from processing and/or verifying enrollment, inadequacy of underwriting assumptions, inability to receive and process correct information (including inability due to systems issues by the federal government, the applicable state government or us), uncollectability of premiums from members, and limited enrollment periods. While we believe we have adequately reviewed our assumptions and estimates regarding these complex and wide-ranging programs under Medicare Advantage and Medicare Part D, including those related to collectability of receivables and establishment of liabilities, actual results may be materially different than our assumptions and estimates and could have a material adverse effect on our business, financial condition and results of operations. There is also the possibility that Medicare Advantage Special Needs plans, which are authorized through December 31, 2018, will not be re-authorized by Congress. If the Special Needs plans are not re-authorized, there could be a loss of revenue and it would become more difficult to coordinate Medicare benefits with other coverage. Finally, there is the possibility that the Medicare Advantage program could be significantly impacted by any future modification, repeal or replacement of Health Care Reform,

Our contracts with CMS and state governmental agencies contain certain provisions regarding data submission, provider network maintenance, quality measures, claims payment, continuity of care, call center performance and other requirements specific to federal and state program regulations. If we fail to comply with these requirements, we may be subject to fines, penalties, liquidated damages and retrospective adjustments in payments made to our health plans, that could impact our profitability. In addition, we could be required to file a corrective plan of action with additional penalties for noncompliance, including a negative impact on future membership enrollment levels. Further, certain of our CMS and state Medicaid contracts are subject to a competitive procurement process. If our existing contracts are not renewed, or if we are not awarded new contracts as a result of the competitive procurement process, it could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Further, the Medicare Advantage Star Ratings System utilized by CMS to evaluate Medicare Advantage Plans may have a significant effect on our results of operations, as higher rated plans tend to experience increased enrollment and plans with a star rating of 4.0 or higher are eligible for quality-based bonus payments. Our star ratings may be negatively impacted if we fail to meet the quality, performance and regulatory compliance criteria established by CMS. If our star ratings decline, fail to meet or exceed our competitors' ratings or fall short of our expectations, or if quality-based bonus payments associated with star ratings are reduced or eliminated, our financial performance may be adversely impacted.

In addition to the contractual requirements affecting our participation in Medicaid and Medicare programs, we are also subject to various federal and state health care laws and regulations, including those directed at preventing fraud and abuse in

government funded programs. Failure to comply with these laws and regulations could result in investigations, litigation, fines, restrictions on, or exclusions from, program participation, the imposition of corporate integrity agreements or other agreements with a federal or state governmental agency that could adversely impact our business, cash flows, financial condition and results of operations.

We are regularly subject to CMS audits of our Medicare Advantage plans to validate the diagnostic data and patient claims, as well as audits of our Medicare Part D plans by the Medicare Part D Recovery Audit Contractor, or RAC. These audits could result in retrospective adjustments in payments made to our health plans. In addition to these federal programs, a number of states have implemented Medicaid RAC programs which were authorized by the ACA. State RAC programs could increase the number of audits and any subsequent recoupment by the federal and state governments, which could adversely affect our financial condition and results of operations. If we fail to report and correct errors discovered through our own auditing procedures or during a CMS or RAC audit, or otherwise fail to comply with applicable laws and regulations, we could be subject to fines, civil penalties or other sanctions which could have a material adverse effect on our ability to participate in these programs, and on our financial condition, cash flows and results of operations.

In addition, there are an increasing number of investigations regarding compliance with various provisions of the ACA. These investigations are being conducted by both CMS and state regulators. As a result, we could be subject to multiple investigations of the same issue. These investigations, and any possible enforcement actions, could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

We may not complete the acquisition of Cigna within the time frame we anticipate or at all, which could have a negative effect on our business or our results of operations.

On July 23, 2015, we entered into an Agreement and Plan of Merger, or Merger Agreement, under which we will acquire all of the outstanding shares of Cigna. The acquisition is subject to a number of closing conditions, such as antitrust and other regulatory approvals, which may not be received or may take longer than expected. The acquisition is also subject to other risks and uncertainties. If the acquisition is not consummated within the expected time frame, or at all, it could have a negative effect on our ability to execute on our growth strategy or on our financial performance.

Failure to complete the acquisition could negatively impact our share price and future business, as well as our financial results.

If the acquisition is not completed, our ongoing business may be adversely affected and, without realizing any of the benefits of having completed the acquisition, we could be subject to a number of risks, including the following: we may be required to pay Cigna a termination fee of \$1.85 billion or an expense fee of up to \$600 million if the Merger Agreement is terminated under certain circumstances (as more fully described in the Merger Agreement); and we could be subject to litigation related to any failure to complete the acquisition or related to any enforcement proceeding commenced against us to perform our obligations under the Merger Agreement. If the acquisition is not completed, these risks may materialize and may adversely affect our business, cash flows and financial condition.

Cigna's pursuit of litigation to terminate the Merger Agreement and seeking damages against us, together with our own litigation against Cigna, could cause us to incur substantial costs, may present material distractions and, if decided adverse to Anthem, could negatively impact our financial position.

As described in Note 3, Business Acquisitions and Divestiture - *Pending Acquisition of Cigna Corporation*, to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K, on February 14, 2017, Cigna commenced litigation for a declaratory judgment that its purported termination of the Merger Agreement was lawful and seeking damages against us. We promptly filed our own litigation against Cigna seeking to compel Cigna's specific performance of the Merger Agreement and damages against Cigna. These lawsuits could result in substantial costs to us, including litigation costs and potential settlement costs. Further, due to the potential significance of the allegations and damages claimed by Cigna, we expect that our officers will spend substantial time focused on the litigation. Our defense against Cigna's claims, the pursuit of our claims or the settlement, or failure to reach a settlement, for any claims may result in negative media attention, and may adversely affect our business, reputation, financial condition, results of operations, cash flows and market price.

We may experience difficulties in integrating Cigna's business and realizing the expected benefits of the proposed acquisition.

The success of the Cigna acquisition, if completed, will depend, in part, on our ability to realize the anticipated business opportunities and growth prospects from combining our businesses with those of Cigna. We may never realize these business opportunities and growth prospects. Integrating operations will be complex and will require significant efforts and expenditures on the part of both us and Cigna. Our management might have its attention diverted while trying to integrate operations and corporate and administrative infrastructures. We might experience increased competition that limits our ability to expand our business, and we might fail to capitalize on expected business opportunities, including retaining current customers.

The integration process could result in a disruption of each company's ongoing businesses, tax costs or inefficiencies, or inconsistencies in standards, controls, information technology systems, procedures and policies, any of which could adversely affect our ability to maintain relationships with clients, employees or other third parties or our ability to achieve the anticipated benefits of the Cigna acquisition and could harm our financial performance.

If we are unable to successfully or timely integrate the operations of Cigna's business into our business, we may be unable to realize the revenue growth, synergies and other anticipated benefits resulting from the proposed acquisition and our business and results of operations could be adversely affected. Even if we complete the Cigna acquisition, the acquired business may underperform relative to our expectations.

The health benefits industry is subject to negative publicity, which could adversely affect our business and profitability.

The health benefits industry is subject to negative publicity, which can arise from, among other things, the ongoing debate over Health Care Reform, industry consolidation, increases in premium rates and the decision of many insurers to withdraw from, or significantly curtail their participation in, public exchanges. Negative publicity may result in increased regulation and legislative review of industry practices, which may further increase our costs of doing business and adversely affect our profitability by adversely affecting our ability to market our products and services, requiring us to change our products and services, or increasing the regulatory burdens under which we operate.

In addition, as long as we use the Blue Cross and Blue Shield names and marks in marketing our health benefits products and services, any negative publicity concerning the BCBSA or other BCBSA licensees may adversely affect us and the sale of our health benefits products and services. Any such negative publicity could adversely affect our business, cash flows, financial condition and results of operations.

We face competition in many of our markets and customers and brokers have flexibility in moving between competitors.

As a health benefits company, we operate in a highly competitive environment and in an industry that is subject to significant changes from legislative reform, business consolidations, new strategic alliances, aggressive marketing practices by other health benefits organizations and market pressures brought about by an informed and organized customer base, particularly among large employers. For example, we began to compete for sales on public exchanges in 2014, which has required, and will continue to require, us to develop or acquire the tools, including social media tools, necessary to interact with the exchanges and with consumers using the exchanges, increase our focus on individual customers and improve our consumer-focused sales and marketing, customer interfaces and product offerings. These factors have produced and will likely continue to produce significant pressures on our profitability.

We also will have to respond to pricing and other actions taken by existing competitors and potentially disruptive new entrants. Due to the price transparency provided by public exchanges, we face competitive pressures from new and existing competitors in the market for individual health insurance. These risks may be enhanced if employers shift to defined contribution health care benefits plans and make greater utilization of private insurance exchanges or encourage their employees to purchase health insurance on the public exchanges. We can provide no assurance that we will be able to compete successfully on these public exchanges or that we will be able to benefit from any opportunities presented by such exchanges. If we are not competitive on these public exchanges or are unsuccessful in reducing our cost structure, our future growth and profitability may be adversely impacted.

We are currently dependent on the non-exclusive services of independent agents and brokers in the marketing of our health care products, particularly with respect to individuals, seniors and small employer group customers. We face intense competition for the services and allegiance of these independent agents and brokers, who may also market the products of our competitors. Our relationship with our brokers and independent agents could be adversely impacted by changes in our business practices to address Health Care Reform legislation, including potential reductions in commissions and consulting fees paid to agents and brokers. We cannot ensure that we will be able to compete successfully against current and future competitors or that competitive pressures faced by us will not materially and adversely affect our business, cash flows, financial condition and results of operations.

We face intense competition to attract and retain employees. Further, managing key executive succession and retention is critical to our success.

Our success depends on our ability to attract and retain qualified employees to meet current and future needs, integrating and engaging employees who have joined us through acquisitions and achieving productivity gains from our investment in technology. We face intense competition for qualified employees, and there can be no assurance that we will be able to attract and retain such employees or that such competition among potential employers will not result in increasing salaries. An inability to retain existing employees or attract additional employees could have a material adverse effect on our business, cash flows, financial condition and results of operations.

We would be adversely affected if we fail to adequately plan for succession of our Chairman, President and Chief Executive Officer and other senior management and retention of key executives. While we have succession plans in place for members of our senior management, and continue to review and update those plans, and we have employment arrangements with certain key executives, these plans and arrangements do not guarantee that the services of our senior executives will continue to be available to us or that we will be able to attract and retain suitable successors.

A change in our health care product mix may impact our profitability.

Our health care products that involve greater potential risk generally tend to be more profitable than administrative services products and those health care products where the employer groups assume the underwriting risks. Individuals and small employer groups are more likely to purchase our higher-risk health care products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures. Typically, government-sponsored programs also involve our higher-risk health care products. In addition, our products sold on the public exchanges have been less profitable than our other insurance products. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our financial condition and results of operations.

If we fail to adequately adapt to changes in our industry and develop and implement strategic growth opportunities, our ability to grow may be adversely affected.

As a result of significant changes to traditional health insurance in recent years brought about by Health Care Reform and other factors, the health insurance industry has experienced a significant shift in membership to insurance products with lower margins. Moreover, the significant modification, repeal or replacement of Health Care Reform could have far-reaching consequences for our business. In order to profitably grow our business in the future, we need to not only grow our profitable medical membership, but also continue to diversify our sources of revenue and earnings, including through the increased sale of our specialty products, such as dental, vision and other supplemental products, expansion of our non-insurance assets and establishment of new cost of care solutions, including innovations in PBM services. If we are unable to acquire or develop and successfully manage new opportunities that further our strategic objectives and differentiate our products from our competitors, our ability to profitably grow our business could be adversely affected.

As a holding company, we are dependent on dividends from our subsidiaries. These dividends are necessary to pay our outstanding indebtedness. Our regulated subsidiaries are subject to state regulations, including restrictions on the payment of dividends, maintenance of minimum levels of capital and restrictions on investment portfolios.

We are a holding company whose assets include the outstanding shares of common stock (or other ownership interest) of our subsidiaries including our intermediate holding companies and regulated insurance and HMO subsidiaries. Our subsidiaries are separate legal entities. As a holding company, we depend on dividends from our subsidiaries. Furthermore,

our subsidiaries are not obligated to make funds available to us, and creditors of our subsidiaries will have a superior claim to certain of our subsidiaries' assets. Among other restrictions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends. In some states, we have made special undertakings that may limit the ability of our regulated subsidiaries to pay dividends. In addition, our subsidiaries' ability to make any payments to us will also depend on their earnings, the terms of their indebtedness, business and tax considerations and other legal restrictions. Our ability to repurchase shares or pay dividends in the future to our shareholders and meet our obligations, including paying operating expenses and debt service on our outstanding and future indebtedness, will depend upon the receipt of dividends from our subsidiaries. An inability of our subsidiaries to pay dividends in the future in an amount sufficient for us to meet our financial obligations may materially adversely affect our business, cash flows, financial condition and results of operations.

Most of our regulated subsidiaries are subject to RBC standards, imposed by their states of domicile. These laws are based on the RBC Model Act adopted by the NAIC and require our regulated subsidiaries to report their results of risk-based capital calculations to the departments of insurance and the NAIC. Failure to maintain the minimum RBC standards could subject our regulated subsidiaries to corrective action, including state supervision or liquidation. As discussed in more detail below, we are a party to license agreements with the BCBSA which contain certain requirements and restrictions regarding our operations, including minimum capital and liquidity requirements, which could restrict the ability of our regulated subsidiaries to pay dividends.

Our regulated subsidiaries are subject to state laws and regulations that require diversification of their investment portfolios and limit the amount of investments in certain riskier investment categories, such as below-investment-grade fixed maturity securities, mortgage loans, real estate and equity investments, which could generate higher returns on our investments. Failure to comply with these laws and regulations might cause investments exceeding regulatory limitations to be treated as non-admitted assets for purposes of measuring statutory surplus and risk-based capital, and, in some instances, require the sale of those investments.

We have substantial indebtedness outstanding and may incur additional indebtedness in the future in connection with the Cigna acquisition or otherwise. Such indebtedness could also adversely affect our ability to pursue desirable business opportunities.

Our debt service obligations require us to use a portion of our cash flow to pay interest and principal on debt instead of for other corporate purposes, including funding future expansion. If our cash flow and capital resources are insufficient to service our debt obligations, we may be forced to seek extraordinary dividends from our subsidiaries, sell assets, seek additional equity or debt capital or restructure our debt. However, these measures might be unsuccessful or inadequate in permitting us to meet scheduled debt service obligations.

If the Cigna acquisition is consummated, we expect to have incurred acquisition-related indebtedness of approximately \$26.5 billion and to have assumed approximately \$5.1 billion of Cigna's outstanding debt. Our substantially increased indebtedness and debt-to-equity ratio on a recent historical basis will have the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and may increase our borrowing costs. In addition, the amount of cash required to service our increased indebtedness levels and thus the demands on our cash resources may be greater than the percentages of cash flows required to service our indebtedness or the indebtedness of Cigna individually prior to the acquisition. The increased levels of indebtedness could also reduce funds available for our investments in product development as well as capital expenditures, share repurchases, shareholder dividends, other desirable business opportunities and other activities and may create competitive disadvantages for us relative to other companies with lower debt levels.

In addition to the expected acquisition-related debt financing described above, we may also incur future debt obligations that might subject us to restrictive covenants that could affect our financial and operational flexibility. Our breach or failure to comply with any of these covenants could result in a default under our credit agreement or other indebtedness. If we default under our credit agreement, the lenders could cease to make further extensions of credit or cause all of our outstanding debt obligations under our credit agreement to become immediately due and payable, together with accrued and unpaid interest. If the indebtedness under our notes or our credit agreement or our other indebtedness is accelerated, we may be unable to repay or finance the amounts due.

A downgrade in our credit ratings could have an adverse effect on our business, financial condition and results of operations.

Claims-paying ability and financial strength ratings by nationally recognized statistical rating organizations are an important factor in establishing the competitive position of insurance companies and health benefits companies. We believe our strong credit ratings are an important factor in marketing our products to customers, since credit ratings information is broadly disseminated and generally used throughout the industry. In addition, if our credit ratings are downgraded or placed under review, our business, financial condition and results of operations could be adversely impacted by limitations on future borrowings and a potential increase in our borrowing costs. Our ratings reflect each rating agency's opinion of our financial strength, operating performance and ability to meet our obligations to policyholders and creditors, and are not evaluations directed toward the protection of investors in our common stock.

Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. Following the announcement of the Cigna acquisition, each of Standard & Poor's, A.M. Best, Fitch and Moody's placed certain of our debt, financial strength and other credit ratings under review for a possible downgrade.

We face risks related to litigation.

We are, or may in the future, be a party to a variety of legal actions that may affect any business, such as employment and employment discrimination-related suits and administrative charges before government agencies, employee benefit claims, breach of contract actions, tort claims and intellectual property-related litigation. In addition, because of the nature of our business, we are subject to a variety of legal actions relating to our business operations, including the design, administration and offering of our products and services. These could include claims relating to the denial of health care benefits; the rescission of health insurance policies; development or application of medical policy; medical malpractice actions; product liability claims; allegations of anti-competitive and unfair business activities; provider disputes over compensation; provider tiering programs; narrow networks; termination of provider contracts; the recovery of overpayments from providers; self-funded business; disputes over co-payment calculations; reimbursement of out-of-network claims; the failure to disclose certain business or corporate governance practices; the failure to comply with various state or federal laws, including but not limited to, ERISA and the Mental Health Parity Act; and customer audits and contract performance, including government contracts. These actions or proceedings could have a material adverse effect on our business, cash flows, financial condition and results of operations.

In addition, we are also involved in, or may in the future be party to, pending or threatened litigation of the character incidental to the business transacted or arising out of our operations or our 2001 demutualization, including, but not limited to, breaches of security and violations of privacy requirements (including as a result of the cyber attack reported by us in February 2015, as more fully described under Note 13, "Commitments and Contingencies - *Cyber Attack Incident*," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K), shareholder actions, compliance with federal and state laws and regulations (including *qui tam* or "whistleblower" actions), or sales and acquisitions of businesses or assets. From time to time, we are involved as a party in various governmental investigations, audits, reviews and administrative proceedings, including challenges to the award of government contracts by disappointed bidders. These investigations, audits and reviews include routine and special investigations by various state insurance departments, state attorneys general and the U.S. Attorney General. Following an investigation, we may be subject to civil or criminal fines, penalties and other sanctions if we are determined to be in violation of applicable laws or regulations. Liabilities that may result from these actions could have a material adverse effect on our cash flows, results of operations or financial position.

Recent court decisions and legislative activity may increase our exposure for any of these types of claims. In some cases, substantial non-economic (including injunctive relief), treble or punitive damages may be sought. Although we maintain insurance coverage for some of these potential liabilities, some liabilities and damages may not be covered by insurance, insurers may dispute coverage or the amount of insurance may not be enough to cover the damages awarded. In addition, insurance coverage for all or certain forms of liability may become unavailable or prohibitively expensive in the future. Any adverse judgment against us resulting in such damage awards could have an adverse effect on our cash flows, results of operations and financial condition.

Further, litigation brought against the federal and some state governments over Health Care Reform could have a material adverse effect on our business, cash flows, financial condition and results of operations as changes to Health Care Reform resulting from this litigation create uncertainty over the applicability and enforceability of portions of the law and the various regulations, which impacts our strategy and could negatively impact our future growth opportunities.

Our future obligations for state guaranty association assessments could increase in the event of increased insolvencies of health insurance plans.

Under insolvency or guaranty association laws in most states, insurance companies can be assessed for amounts paid by guaranty funds for policyholder losses incurred when a health insurance plan becomes insolvent. Most state insolvency or guaranty association laws provide for assessments based upon the amount of premiums received on insurance underwritten within such state. Although health insurance company insolvencies have been infrequent, we have experienced increased assessments in recent years after a number of smaller health insurance companies and Consumer Operated and Oriented Plans failed to establish premiums that were sufficient to cover the cost of care for their members. We may continue to experience increased assessments in the future if premiums established by other companies for their health insurance products, including certain long-term care products, are inadequate to cover the cost of care. We are not currently able to estimate our potential financial obligations, losses, or the availability of potential offsets associated with potential increases in guaranty association assessments; however, any significant increase in guaranty association assessments could have a material adverse effect on our business, cash flows, financial condition and results of operations.

There are various risks associated with providing health care services.

The direct provision of health care services by our CareMore subsidiary involves risks of additional litigation arising from medical malpractice actions based on our treatment decisions or brought against us or our physician associates for alleged malpractice or professional liability claims arising out of the delivery of health care and related services. In addition, liability may arise from maintaining health care premises that serve the public. If we fail to maintain adequate insurance coverage for these liabilities, or if such insurance is not available, the resulting costs could adversely affect our cash flows, financial condition and results of operations.

Additionally, many states in which our CareMore subsidiary operates limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals. Business corporations generally may not exercise control over the medical decisions of physicians ("corporate practice of medicine") and we are not licensed to practice medicine. Rules and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary from state to state. Further, certain federal and state laws, including those covering our Medicare and Medicaid plans, prohibit the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of patient care opportunities, including, but not limited to, Medicare patients, and also generally prohibit physicians from making referrals to any entity providing certain designated health services if the referring physician or related person has an ownership or financial interest in the entity. Any enforcement actions by governmental officials alleging non-compliance with these rules and regulations could adversely affect our business, cash flows, financial condition and results of operations.

We are a party to license agreements with the BCBSA that entitle us to the exclusive and in certain areas non-exclusive use of the Blue Cross and Blue Shield names and marks in our geographic territories. The termination of these license agreements or changes in the terms and conditions of these license agreements could adversely affect our business, financial condition and results of operations. Upon completion of the Cigna acquisition, we may not initially be in compliance with the BCBSA's national "best efforts" requirement.

We use the Blue Cross and Blue Shield names and marks as identifiers for our products and services under licenses from the BCBSA. Our license agreements with the BCBSA contain certain requirements and restrictions regarding our operations and our use of the Blue Cross and Blue Shield names and marks, including: minimum capital and liquidity requirements imposed by the BCBSA; enrollment and customer service performance requirements; participation in programs that provide portability of membership between plans; disclosures to the BCBSA relating to enrollment and financial conditions; disclosures as to the structure of the Blue Cross and Blue Shield system in contracts with third parties and in public statements; plan governance requirements; cyber security requirements; a requirement that at least 80% (or, in the case of Blue Cross of California, substantially all) of a licensee's annual combined local net revenue, as defined by the BCBSA,

attributable to health care plans and related services within its service areas must be sold, marketed, administered or underwritten under the Blue Cross and Blue Shield names and marks; a requirement that neither a plan nor any of its licensed affiliates may permit an entity other than a plan or a licensed affiliate to obtain control of the plan or the licensed affiliate or to acquire a substantial portion of its assets related to licensable services; a requirement that we divide our Board of Directors into three classes serving staggered three-year terms; a requirement that we guarantee certain contractual and financial obligations of our licensed affiliates; and a requirement that we indemnify the BCBSA against any claims asserted against it resulting from the contractual and financial obligations of any subsidiary that serves as a fiscal intermediary providing administrative services for Medicare Parts A and B. Failure to comply with the foregoing requirements could result in a termination of the license agreements.

In addition, our license agreements with the BCBSA include a requirement that at least 66 2/3% of our annual combined national net revenue, as defined by the BCBSA, attributable to health care plans and related services must be sold, marketed, administered or underwritten under the Blue Cross and Blue Shield names and marks, referred to as the "National Best Efforts Requirement." Due to the size of Cigna's business, we may not be in compliance with the National Best Efforts Requirement immediately after completion of the acquisition.

We will be required to submit an action plan for coming into compliance with the National Best Efforts Requirement within 120 days of the completion of the Cigna acquisition if we are out of compliance following closing of the acquisition. Under current BCBSA standards, we would be required to cure any non-compliance with the National Best Efforts Requirement within 24 months from the date when the relevant BCBSA committee makes a determination on our action plan. We believe there are multiple options at our disposal to regain compliance within the allotted timeframe, if necessary. Although we strongly believe there would be numerous ways in which we could re-establish compliance with the National Best Efforts Requirement within the required 24 month period, there can be no guarantee such efforts will be successful, and failure to comply with the requirement could ultimately result in a termination of our license agreements under certain circumstances.

The standards under the license agreements may be modified in certain instances by the BCBSA. For example, from time to time there have been proposals considered by the BCBSA to modify the terms of the license agreements to restrict various potential business activities of licensees. These proposals have included, among other things, a limitation on the ability of a licensee to make its provider networks available to insurance carriers or other entities not holding a Blue Cross or Blue Shield license. To the extent that such amendments to the license agreements are adopted in the future, they could have a material adverse effect on our future expansion plans or results of operations, or our ability to come back into compliance with the National Best Efforts Requirement if the Cigna acquisition is consummated. Further, BCBS licensees have certain requirements to perform administrative services for members of other BCBS licensees. If we or another BCBS licensee is not in compliance with all legal requirements or are unable to perform administrative services as required, this could have an adverse effect on our members and our ability to maintain our licenses, which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Upon the occurrence of an event causing termination of the license agreements, we would no longer have the right to use the Blue Cross and Blue Shield names and marks or to sell Blue Cross and Blue Shield health insurance products and services in one or more of our service areas. Furthermore, the BCBSA would be free to issue a license to use the Blue Cross and Blue Shield names and marks in these service areas to another entity. Our existing Blue Cross and Blue Shield members would be provided with instructions for obtaining alternative products and services licensed by the BCBSA. Events that could cause the termination of a license agreement with the BCBSA include failure to comply with minimum capital requirements imposed by the BCBSA, failure to comply with governance requirements such as maintaining a classified board structure, a change of control or violation of the BCBSA ownership limitations on our capital stock, impending financial insolvency and the appointment of a trustee or receiver or the commencement of any action against a licensee seeking its dissolution. We believe that the Blue Cross and Blue Shield names and marks are valuable identifiers of our products and services in the marketplace.

Upon termination of a license agreement, the BCBSA would have the right to impose a "Re-establishment Fee" upon us, which would be used in part to fund the establishment of a replacement Blue Cross and/or Blue Shield licensee in the vacated service area. The fee is set at \$98.33 per licensed enrollee. As of December 31, 2016, we reported 30.0 million Blue Cross and/or Blue Shield enrollees. If the Re-establishment Fee was applied to our total Blue Cross and/or Blue Shield enrollees,

we would be assessed approximately \$2.9 billion by the BCBSA. As a result, termination of the license agreements would have a material adverse effect on our business, financial condition and results of operations.

Regional concentrations of our business may subject us to economic downturns in those regions.

The states in which we operate that have the largest concentrations of revenues include California, Georgia, Indiana, New York, Ohio, Texas and Virginia. Due to this concentration of business in these states, we are exposed to potential losses resulting from the risk of state specific or regional economic downturns impacting these states. If such negative economic conditions do not improve, we may experience a reduction in existing and new business, which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Large-scale medical emergencies may have a material adverse effect on our business, cash flows, financial condition and results of operations.

Large-scale medical emergencies can take many forms and can cause widespread illness and death. For example, federal and state law enforcement officials have issued warnings about potential terrorist activity involving biological and other weapons. In addition, natural disasters such as hurricanes and the potential for a widespread pandemic of influenza coupled with the lack of availability of appropriate preventative medicines can have a significant impact on the health of the population of widespread areas. If the United States were to experience widespread bioterrorism or other attacks, large-scale natural disasters in our concentrated coverage areas or a large-scale pandemic or epidemic, our covered medical expenses could rise and we could experience a material adverse effect on our business, cash flows, financial condition and results of operations or, in the event of extreme circumstances, our viability could be threatened.

We have built a significant portion of our current business through mergers and acquisitions, joint ventures and strategic alliances and we expect to pursue such opportunities in the future.

The following are some of the risks associated with mergers, acquisitions, joint ventures and strategic alliances, referred to collectively as business combinations, that could have a material adverse effect on our business, cash flows, financial condition and results of operations:

- some of the acquired businesses may not achieve anticipated revenues, earnings or cash flow, business opportunities, synergies, growth prospects and other anticipated benefits;
- the goodwill or other intangible assets established as a result of our business combinations may be incorrectly valued or become non-recoverable;
- we may assume liabilities that were not disclosed to us or which were under-estimated;
- we may experience difficulties in integrating acquired businesses, be unable to integrate acquired businesses successfully or as quickly as expected, and be unable to realize anticipated economic, operational and other benefits in a timely manner, which could result in substantial costs and delays or other operational, technical or financial problems;
- business combinations, and proposed business combinations that are not completed, could disrupt our ongoing business, lead to the incurrence of significant fees, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies and procedures;
- we may finance future business combinations by issuing common stock for some or all of the purchase price, which could dilute the ownership interests of our shareholders;
- we may also incur additional debt related to future business combinations;
- we would be competing with other firms, some of which may have greater financial and other resources, to acquire attractive companies; and
- future business combinations may make it difficult to comply with the requirements of the BCBSA and lead to an increased risk that our BCBSA license agreements may be terminated.

The value of our intangible assets may become impaired.

Due largely to our past mergers, acquisitions and divestitures, goodwill and other intangible assets represent a substantial portion of our assets. If we make additional acquisitions, it is likely that we will record additional intangible assets on our consolidated balance sheets. The value we place on intangible assets may be adversely impacted if acquired businesses fail to perform in a manner consistent with our assumptions.

In accordance with applicable accounting standards, we periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may no longer be recoverable, in which case a charge to income may be necessary. This impairment testing requires us to make assumptions and judgments regarding the estimated fair value of our reporting units, including goodwill and other intangible assets. In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately. Estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used. If estimated fair values are less than the carrying values of goodwill and other intangible assets with indefinite lives in future impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially affect our results of operations and shareholders' equity in the period in which the impairment occurs. A material decrease in shareholders' equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

In addition, the estimated value of our reporting units may be impacted as a result of business decisions we make associated with the implementation of the various Health Care Reform regulations. Such decisions, which could unfavorably affect our ability to support the carrying value of certain goodwill and other intangible assets, could result in impairment charges in future periods.

Adverse securities and credit market conditions may significantly affect our ability to meet liquidity needs.

During periods of increased volatility, adverse securities and credit markets may exert downward pressure on the availability of liquidity and credit capacity for certain issuers. We need liquidity to pay our operating expenses, make payments on our indebtedness and pay capital expenditures. The principal sources of our cash receipts are premiums, administrative fees, investment income, other revenue, proceeds from the sale or maturity of our investment securities, proceeds from borrowings and proceeds from the issuance of common stock under our employee stock plans.

Our access to additional financing will depend on a variety of factors such as market conditions, the general availability of credit, the volume of trading activities, the availability of credit to our industry, our credit ratings and credit capacity, as well as the possibility that customers or lenders could develop a negative perception of our long- or short-term financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If one or a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value may result in a loss charged to income.

The market values of our investments vary from time to time depending on economic and market conditions. For various reasons, we may sell certain of our investments at prices that are less than the carrying value of the investments. During periods in which interest rates are relatively low, as in recent years, our investment income could be adversely impacted. In addition, in periods of declining interest rates, bond calls and mortgage loan prepayments generally increase, resulting in the reinvestment of these funds at the then lower market rates. In periods of rising interest rates, the market values of our fixed maturity securities will generally decrease, which could result in material unrealized or realized losses on investments in future periods. In addition, defaults by issuers, primarily from investments in corporate and municipal bonds, who fail to pay or perform their obligations, could reduce net investment income, which would adversely affect our profitability. We cannot assure you that our investment portfolios will produce positive returns.

In accordance with FASB guidance for debt and equity investments, we classify fixed maturity and equity securities in our investment portfolio as “available-for-sale” or “trading” and report those securities at fair value. Current and long-term available-for-sale investment securities represented a significant percentage of our total consolidated assets at December 31, 2016.

Changes in the economic environment, including periods of increased volatility of the securities markets, can increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. We believe we have adequately reviewed our investment securities for impairment and we believe that we have appropriately estimated the fair values of our investment securities. However, over time, the economic and market environment may provide additional insight, which could change our judgment regarding the fair value of certain securities and/or impairment. Given the sometimes rapidly changing market conditions and the significant judgments involved, there is continuing risk that further declines in fair value may occur and material other-than-temporary impairments may be charged to income in future periods, resulting in realized losses.

We may not be able to realize the value of our deferred tax assets.

In accordance with applicable accounting standards, we separately recognize deferred tax assets and deferred tax liabilities. Such deferred tax assets and deferred tax liabilities represent the tax effect of temporary differences between financial reporting and tax reporting measured at tax rates enacted at the time the deferred tax asset or liability is recorded.

At each financial reporting date, we evaluate our deferred tax assets to determine the likely realization of the benefit of the temporary differences. Our evaluation includes a review of the types of temporary differences that created the deferred tax asset; the amount of taxes paid on both capital gains and ordinary income in prior periods and available for a carry-back claim; the forecasted future taxable income, and therefore, the likely future deduction of the deferred tax item; and any other significant issues that might impact the realization of the deferred tax asset. If it is more likely than not that all or a portion of the deferred tax asset may not be realized, we establish a valuation allowance. Significant judgment is required in determining an appropriate valuation allowance.

Any future increase in the valuation allowance would result in additional income tax expense and a decrease in shareholders’ equity, which could materially affect our financial position and results of operations in the period in which the increase occurs. A material decrease in shareholders’ equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

An unauthorized disclosure of sensitive or confidential member or employee information, including by cyber attack or other security breach, could cause a loss of data, give rise to remediation or other expenses, expose us to liability under federal and state laws, and subject us to litigation and investigations, which could have an adverse effect on our business, cash flows, financial condition and results of operations.

As part of our normal operations, we collect, process and retain certain sensitive and confidential information. We are subject to various federal, state and international laws and rules regarding the use and disclosure of certain sensitive or confidential information, including HIPAA, the HITECH Act, the Gramm-Leach-Bliley Act, and numerous state laws governing personal information. Despite the security measures we have in place to help ensure data security and compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to cyber attacks, security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events.

In February 2015, we reported the discovery that certain of our information technology systems had been the target of an external cyber attack, as more fully described under Note 13, “Commitments and Contingencies - *Cyber Attack Incident*,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K. The attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many individuals and employees. We have incurred expenses to investigate and remediate this matter and expect to continue to incur expenses of this nature in the foreseeable future. Actions have been filed in various federal and state courts and other claims have been or may be asserted against us, allegedly arising out of the cyber attack. Further, we may be subject to additional litigation and governmental investigations which could divert the attention of management from the operation of our business, result in reputational damage and have a material adverse impact on our business, cash flows, financial

condition and results of operations. While we have contingency plans and insurance coverage for potential liabilities of this nature, these may not be sufficient to cover all claims and liabilities.

In addition, we cannot ensure that we will be able to identify, prevent or contain the effects of additional cyber attacks or other cybersecurity risks in the future that bypass our security measures or disrupt our information technology systems or business. As a result, cybersecurity and the continued development and enhancement of our controls, processes and practices designed to protect our systems, computers, software, data and networks from attack, damage and unauthorized access, remain a priority for us. Noncompliance with any privacy or security laws and regulations, or any security breach, cyber attack or cybersecurity breach, and any incident involving the misappropriation, loss or other unauthorized disclosure or use of, or access to, sensitive or confidential member information, whether by us or by one of our vendors, could require us to expend significant resources to continue to modify or enhance our protective measures and to remediate any damage. In addition, this could result in interruptions to our operations and damage our reputation, and could also result in regulatory enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

The failure to effectively maintain and upgrade our information systems could adversely affect our business.

Our business depends significantly on effective information systems, and we have many different information systems for our various businesses. As a result of our merger and acquisition activities, we have acquired additional systems. Our information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and develop new systems in order to keep pace with continuing changes in information processing technology, emerging cybersecurity risks and threats, evolving industry and regulatory standards including public exchanges and other aspects of Health Care Reform, compliance with legal requirements, private insurance exchanges and changing customer preferences. In addition, we may from time to time obtain significant portions of our systems-related or other services or facilities from independent third parties, which may make our operations vulnerable if such third parties fail to perform adequately.

Failure to adequately implement and maintain effective and efficient information systems with sufficiently advanced technological capabilities, or our failure to efficiently and effectively consolidate our information systems to eliminate redundant or obsolete applications, could result in competitive and cost disadvantages to us compared to our competitors, a diversion of management's time and could have a material adverse effect on our business, financial condition and results of operations. If the information we rely upon to run our business were found to be inaccurate or unreliable or if we fail to adequately maintain our information systems and data integrity effectively, we could experience problems in determining medical cost estimates and establishing appropriate pricing and reserves, incur disputes with customers and providers, incur regulatory problems, including sanctions and penalties, incur increases in operating expenses or suffer other adverse consequences, including a decrease in membership.

We are dependent on the success of our relationships with third parties for various services and functions, including PBM services.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Certain of these third parties provide us with significant portions of our business infrastructure and operating requirements, and we could become overly dependent on key vendors, which could cause us to lose core competencies. A termination of our agreements with, or disruption in the performance of, one or more of these service providers could result in service disruptions or unavailability, reduced service quality and effectiveness, increased or duplicative costs, an inability to meet our obligations to our customers or require us to seek alternative service providers on less favorable contract terms, any of which could adversely affect our business, reputation, cash flows, financial condition and operating results.

In particular, we are a party to an agreement with Express Scripts whereby Express Scripts is the exclusive provider of certain PBM services to our plans, excluding our CareMore subsidiary and certain self-insured members, who have exclusive agreements with different PBM service providers. The Express Scripts PBM services include, but are not limited to, pharmacy network management, mail order and specialty drug fulfillment, claims processing, rebate management and specialty pharmaceutical management services. Accordingly, the agreement contains certain financial and operational requirements obligating both Express Scripts and us. The failure of either party to meet the respective requirements could potentially serve as a basis for early termination of the contract. As more fully described under Note 13, "Commitments and

Contingencies - *Litigation*,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K, we filed suit against Express Scripts in March 2016 alleging breaches of the agreement, and Express Scripts filed a countersuit. If this relationship was terminated, we may not be able to meet the full demands of our customers, which could have a material adverse effect on our business, reputation and results of operations, particularly if Express Scripts failed to provide post-termination services. In addition, our failure to meet certain minimum script volume requirements results in financial penalties that could have a material adverse effect on our results of operations.

Indiana law, other applicable laws, our articles of incorporation and bylaws, and provisions of our BCBSA license agreements may prevent or discourage takeovers and business combinations that our shareholders might consider in their best interest.

Indiana law and our articles of incorporation and bylaws may delay, defer, prevent or render more difficult a takeover attempt that our shareholders might consider in their best interests. For instance, they may prevent our shareholders from receiving the benefit from any premium to the market price of our common stock offered by a bidder in a takeover context. Even in the absence of a takeover attempt, the existence of these provisions may adversely affect the prevailing market price of our common stock if they are viewed as discouraging takeover attempts in the future.

We are regulated as an insurance holding company and subject to the insurance holding company acts of the states in which our insurance company subsidiaries are domiciled, as well as similar provisions included in the health statutes and regulations of certain states where these subsidiaries are regulated as managed care companies or HMOs. The insurance holding company acts and regulations and these similar health provisions restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes and regulations, without such approval or an exemption, no person may acquire any voting security of a domestic insurance company or HMO, or an insurance holding company which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would “control” the insurance holding company, insurance company or HMO. “Control” is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person. Further, the Indiana business corporation law contains business combination provisions that, in general, prohibit for five years any business combination with a beneficial owner of 10% or more of our common stock unless the holder’s acquisition of the stock was approved in advance by our Board of Directors.

Our articles of incorporation restrict the beneficial ownership of our capital stock in excess of specific ownership limits. The ownership limits restrict beneficial ownership of our voting capital stock to less than 10% for institutional investors and less than 5% for non-institutional investors, both as defined in our articles of incorporation. Additionally, no person may beneficially own shares of our common stock representing a 20% or more ownership interest in us. These restrictions are intended to ensure our compliance with the terms of our licenses with the BCBSA. Our articles of incorporation prohibit ownership of our capital stock beyond these ownership limits without prior approval of a majority of our continuing directors (as defined in our articles of incorporation). In addition, as discussed above in the risk factor describing our license agreements with the BCBSA, such license agreements are subject to termination upon a change of control and re-establishment fees would be imposed upon termination of the license agreements.

Certain other provisions included in our articles of incorporation and bylaws may also have anti-takeover effects and may delay, defer or prevent a takeover attempt that our shareholders might consider in their best interests. In particular, our articles of incorporation and bylaws: divide our Board of Directors into three classes serving staggered three-year terms (which is required by our license agreement with the BCBSA); permit our Board of Directors to determine the terms of and issue one or more series of preferred stock without further action by shareholders; restrict the maximum number of directors; limit the ability of shareholders to remove directors; impose restrictions on shareholders’ ability to fill vacancies on our Board of Directors; prohibit shareholders from calling special meetings of shareholders; impose advance notice requirements for shareholder proposals and nominations of directors to be considered at meetings of shareholders; and prohibit shareholders from amending our bylaws.

We also face other risks that could adversely affect our business, financial condition or results of operations, which include:

- any requirement to restate financial results in the event of inappropriate application of accounting principles;

- a significant failure of our internal control over financial reporting;
- failure of our prevention and control systems related to employee compliance with internal policies, including data security;
- provider fraud that is not prevented or detected and impacts our medical costs or those of self-insured customers;
- failure to protect our proprietary information; and
- failure of our corporate governance policies or procedures.

ITEM 1B. UNRESOLVED SEC STAFF COMMENTS.

None.

ITEM 2. PROPERTIES.

Our principal executive offices are located at 120 Monument Circle, Indianapolis, Indiana. In addition to this location, we have significant operating facilities located in each of the fourteen states where we operate as licensees of the BCBSA, in each of the additional ten states where Amerigroup conducts business and in the additional state of Arizona where CareMore conducts business. A majority of these locations are leased properties. Our facilities support our various business segments. We believe that our properties are adequate and suitable for our business as presently conducted as well as for the foreseeable future.

ITEM 3. LEGAL PROCEEDINGS.

For information regarding our legal proceedings, see the “*Litigation*,” “*Cyber Attack Incident*” and “*Other Contingencies*” sections of Note 13, “Commitments and Contingencies” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

ITEM 4. MINE SAFETY DISCLOSURES.

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES.

Market Prices

Our common stock, par value \$0.01 per share, is listed on the NYSE under the symbol "ANTM." On February 10, 2017, the closing price on the NYSE was \$162.32. As of February 10, 2017, there were 67,279 shareholders of record of our common stock. The following table presents high and low sales prices for our common stock on the NYSE for the periods indicated.

	High	Low
2016		
First Quarter	\$ 144.69	\$ 115.63
Second Quarter	148.00	122.91
Third Quarter	143.18	122.52
Fourth Quarter	148.26	114.85
2015		
First Quarter	\$ 160.64	\$ 122.86
Second Quarter	173.59	148.29
Third Quarter	165.93	134.62
Fourth Quarter	149.87	126.25

Dividends

The quarterly cash dividend declared by our Board of Directors was \$0.6500, \$0.6250, and \$0.4375, per share in 2016, 2015 and 2014, respectively. On February 22, 2017, our Board of Directors declared a quarterly cash dividend to shareholders of \$0.6500 per share.

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors. Further, our ability to pay dividends to our shareholders, if authorized by our Board of Directors, is significantly dependent upon the receipt of dividends from our subsidiaries, including Anthem Insurance Companies, Inc., Anthem Southeast, Inc., Anthem Holding Corp., WellPoint Holding Corp., WellPoint Acquisition, LLC, WellPoint Insurance Services, Inc., ATH Holding Company, LLC, Anthem Partnership Holding Company, LLC and SellCore, Inc. The payment of dividends by our insurance subsidiaries without prior approval of the insurance department of each subsidiary's domiciliary jurisdiction is limited by formula. Dividends in excess of these amounts are subject to prior approval by the respective insurance departments.

Under the terms of the Merger Agreement with Cigna, during the period before completion of the merger, we will not declare, set aside, make or pay any dividend with respect to our capital stock, other than (1) regular quarterly cash dividends with declaration, record and payment dates consistent with past practice and in accordance with our dividend policy as of the date of the Merger Agreement and (2) dividends payable by a directly or indirectly wholly owned subsidiary to Anthem or to another directly or indirectly wholly owned subsidiary of Anthem. The cash dividend declared by our Board of Directors on February 22, 2017 was in accordance with the terms of the Merger Agreement.

Securities Authorized for Issuance under Equity Compensation Plans

The information required by this Item concerning securities authorized for issuance under our equity compensation plans is set forth in or incorporated by reference into Part III, Item 12 "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters" in this Annual Report on Form 10-K.

Issuer Purchases of Equity Securities

The following table presents information related to our repurchases of common stock for the periods indicated:

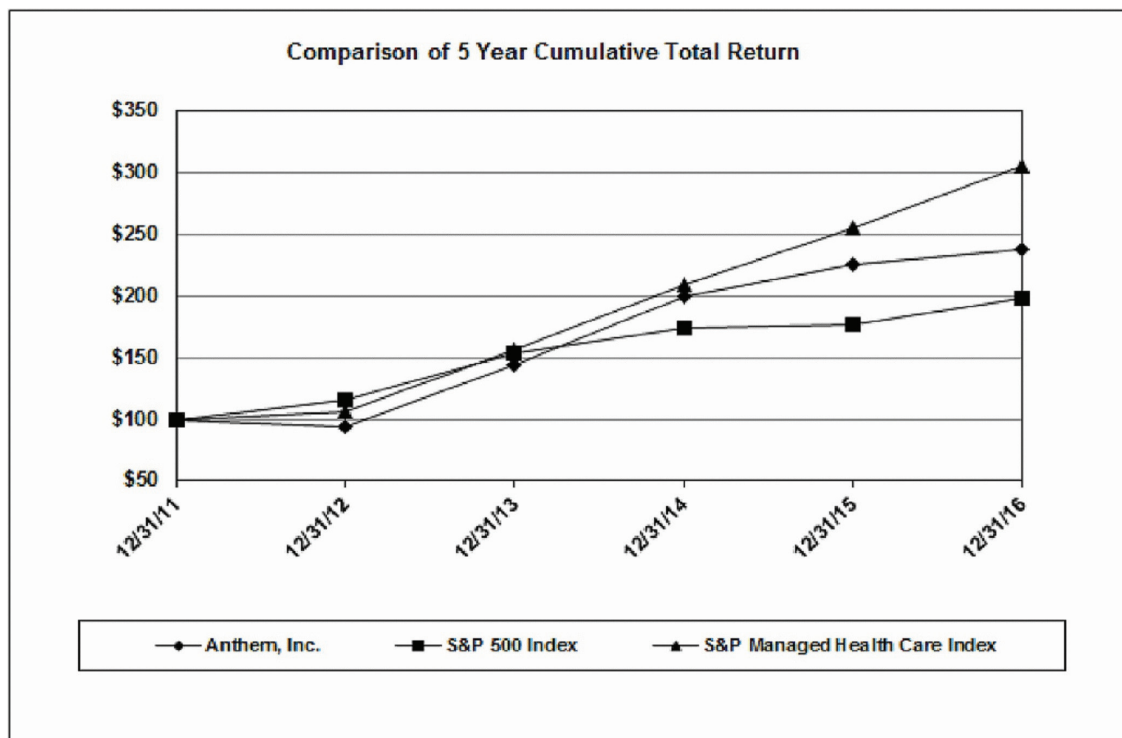
Period	Total Number of Shares Purchased ¹	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Programs ²	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Programs
<i>(In millions, except share and per share data)</i>				
October 1, 2016 to October 31, 2016	7,712	\$ 123.03	—	\$ 4,175.9
November 1, 2016 to November 30, 2016	963	121.52	—	4,175.9
December 1, 2016 to December 31, 2016	7,765	144.80	—	4,175.9
	<u>16,440</u>		<u>—</u>	

- ¹ Total number of shares purchased represents shares delivered to or withheld by us in connection with employee payroll tax withholding upon exercise or vesting of stock awards. Stock grants to employees and directors and stock issued for stock option plans and stock purchase plans in the consolidated statements of shareholders' equity are shown net of these shares purchased.
- ² Represents the number of shares repurchased through the common stock repurchase program authorized by our Board of Directors, which the Board evaluates periodically. There were no share repurchases under the common stock repurchase program during the year ended December 31, 2016. The Board of Directors has authorized our common stock repurchase program since 2003. The Board's most recent authorized increase to the program was \$5,000.0 on October 2, 2014. No duration has been placed on our common stock repurchase program and we reserve the right to discontinue the program at any time.

Performance Graph

The following Performance Graph and related information compares the cumulative total return to shareholders of our common stock for the period from December 31, 2011 through December 31, 2016, with the cumulative total return over such period of (i) the Standard & Poor's 500 Stock Index (the "S&P 500 Index") and (ii) the Standard & Poor's Managed Health Care Index (the "S&P Managed Health Care Index"). The graph assumes an investment of \$100 on December 31, 2011 in each of our common stock, the S&P 500 Index and the S&P Managed Health Care Index (and the reinvestment of all dividends).

The comparisons shown in the graph below are based on historical data and we caution that the stock price performance shown in the graph below is not indicative of, and is not intended to forecast, the potential future performance of our common stock. Information used in the graph was obtained from S&P Capital IQ, a source believed to be reliable, but we are not responsible for any errors or omissions in such information. The following graph and related information shall not be deemed "soliciting materials" or to be "filed" with the SEC, nor shall such information be incorporated by reference into any future filing under the Exchange Act, except to the extent that we specifically incorporate it by reference into such filing.



	December 31,					
	2011	2012	2013	2014	2015	2016
Anthem, Inc.	\$ 100	\$ 94	\$ 145	\$ 200	\$ 226	\$ 237
S&P 500 Index	100	116	154	175	177	198
S&P Managed Health Care Index	100	106	157	209	255	305

Based upon an initial investment of \$100 on December 31, 2011 with dividends reinvested.

ITEM 6. SELECTED FINANCIAL DATA.

The table below provides selected consolidated financial data of Anthem. The information has been derived from our consolidated financial statements for each of the years in the five year period ended December 31, 2016. You should read this selected consolidated financial data in conjunction with the audited consolidated financial statements and notes as of and for the year ended December 31, 2016 included in Part II, Item 8 “Financial Statements and Supplementary Data,” and Part II, Item 7 “Management’s Discussion and Analysis of Financial Condition and Results of Operations” included in this Annual Report on Form 10-K.

	As of and for the Years Ended December 31				
	2016	2015 ¹	2014 ²	2013 ²	2012 ^{1,2}
<i>(in millions, except where indicated and except per share data)</i>					
Income Statement Data					
Total operating revenue ³	\$ 84,194.0	\$ 78,404.8	\$ 73,021.7	\$ 70,191.4	\$ 60,514.0
Total revenues	84,863.0	79,156.5	73,874.1	71,023.5	61,497.2
Income from continuing operations	2,469.8	2,560.0	2,560.1	2,634.3	2,651.0
Net income	2,469.8	2,560.0	2,569.7	2,489.7	2,655.5
Per Share Data					
Basic net income per share - continuing operations	\$ 9.39	\$ 9.73	\$ 9.28	\$ 8.83	\$ 8.25
Diluted net income per share - continuing operations	9.21	9.38	8.96	8.67	8.17
Dividends per share	2.60	2.50	1.75	1.50	1.15
Other Data (unaudited)					
Benefit expense ratio ⁴	84.8%	83.3%	83.1%	85.1%	85.3%
Selling, general and administrative expense ratio ⁵	14.9%	16.0%	16.1%	14.2%	14.3%
Income from continuing operations before income taxes as a percentage of total revenues	5.4%	5.9%	5.9%	5.4%	6.3%
Net income as a percentage of total revenues	2.9%	3.2%	3.5%	3.5%	4.3%
Medical membership <i>(in thousands)</i>	39,919	38,599	37,499	35,653	36,130
Balance Sheet Data					
Cash and investments	\$ 25,519.0	\$ 23,124.7	\$ 23,777.7	\$ 22,395.9	\$ 22,464.6
Total assets	65,083.1	61,717.8	61,676.3	59,095.3	58,610.7
Long-term debt, less current portion	14,358.5	15,324.5	14,019.6	13,477.4	14,069.3
Total liabilities	39,982.7	38,673.7	37,425.0	34,330.1	34,808.0
Total shareholders’ equity	25,100.4	23,044.1	24,251.3	24,765.2	23,802.7

- 1 The net assets of and results of operations for Simply Healthcare Holdings, Inc. and AMERIGROUP Corporation are included from their respective acquisition dates of February 17, 2015 and December 24, 2012.
- 2 The operating results of 1-800 CONTACTS, Inc. are reported as discontinued operations at December 31, 2014, 2013 and 2012 as a result of the divestiture completed on January 31, 2014. Included in net income for the year ended December 31, 2014 is income from discontinued operations, net of tax, of \$9.6. Included in net income for the year ended December 31, 2013 is a loss from discontinued operations, net of tax, of \$144.6. Included in net income for the year ended December 31, 2012 is income from discontinued operations, net of tax, of \$4.5.
- 3 Operating revenue is obtained by adding premiums, administrative fees and other revenue.
- 4 The benefit expense ratio represents benefit expenses as a percentage of premium revenue.
- 5 The selling, general and administrative expense ratio represents selling, general and administrative expenses as a percentage of total operating revenue.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS.

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

References in this Annual Report on Form 10-K to the terms "we," "our," "us," "Anthem" or the "Company" refer to Anthem, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries.

This Management's Discussion and Analysis, or MD&A, should be read in conjunction with our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Overview

We manage our operations through three reportable segments: Commercial and Specialty Business, Government Business and Other. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, merger and acquisition activity and changing laws and regulations. As a result, these reportable segments may change in the future.

Our Commercial and Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial and Specialty Business segment offer fully-insured health products; provide a broad array of managed care services to self-funded customers including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services; and provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal health care guidance.

Our Government Business segment includes Medicare and Medicaid businesses, National Government Services, or NGS, and services provided to the federal government in connection with the Federal Employee Program, or FEP. Medicare business includes services such as Medicare Advantage, Medicare Part D, and Medicare Supplement. Medicaid business includes our managed care alternatives through publicly funded health care programs, including Medicaid; Temporary Assistance for Needy Family, or TANF, programs; programs for seniors and people with disabilities, or SPD; programs for long-term services and support, or LTSS; Children's Health Insurance Programs, or CHIP, and Medicaid expansion programs. NGS acts as a Medicare contractor for the federal government in several regions across the nation.

Our Other segment includes other businesses that do not individually meet the quantitative thresholds for an operating segment as defined by Financial Accounting Standards Board, or FASB, guidance, as well as corporate expenses not allocated to the other reportable segments.

Our operating revenue consists of premiums, administrative fees and other revenue. Premium revenue comes from fully-insured contracts where we indemnify our policyholders against costs for covered health and life benefits. Administrative fees come from contracts where our customers are self-insured, or where the fee is based on either processing of transactions or a percent of network discount savings realized. Additionally, we earn administrative fee revenues from our Medicare processing business and from other health-related businesses including disease management programs. Other revenue includes miscellaneous income other than premium revenue and administrative fees.

Our benefit expense primarily includes costs of care for health services consumed by our fully-insured members, such as outpatient care, inpatient hospital care, professional services (primarily physician care) and pharmacy benefit costs. All four components are affected both by unit costs and utilization rates. Unit costs include the cost of outpatient medical procedures per visit, inpatient hospital care per admission, physician fees per office visit and prescription drug prices. Utilization rates represent the volume of consumption of health services and typically vary with the age and health status of our members and their social and lifestyle choices, along with clinical protocols and medical practice patterns in each of our markets. A portion of benefit expense recognized in each reporting period consists of actuarial estimates of claims incurred but not yet paid by us. Any changes in these estimates are recorded in the period the need for such an adjustment arises. While we offer a diversified mix of managed care products and services through our managed care plans, our aggregate cost of care can fluctuate based on a change in the overall mix of these products and services. Our managed care plans include: preferred provider organizations, or PPOs; health maintenance organizations, or HMOs; point-of-service plans, or POS plans;

traditional indemnity plans and other hybrid plans, including consumer-driven health plans, or CDHPs; and hospital only and limited benefit products.

We classify certain claims-related costs as benefit expense to reflect costs incurred for our members' traditional medical care, as well as those expenses which improve our members' health and medical outcomes. These claims-related costs may be comprised of expenses incurred for: (i) medical management, including case and utilization management; (ii) health and wellness, including disease management services for such conditions as diabetes, high-risk pregnancies, congestive heart failure and asthma management and wellness initiatives like weight-loss programs and smoking cessation treatments; and (iii) clinical health policy. These types of claims-related costs are designed to ultimately lower our members' cost of care.

Our selling expense consists of external broker commission expenses, and generally varies with premium or membership volume. Our general and administrative expense consists of fixed and variable costs. Examples of fixed costs are depreciation, amortization and certain facilities expenses. Certain variable costs, such as premium taxes, vary directly with premium volume. Other variable costs, such as salaries and benefits, do not vary directly with changes in premium but are more aligned with changes in membership. The acquisition or loss of a significant block of business would likely impact staffing levels and thus, associated compensation expense. Other variable costs include professional and consulting expenses and advertising. Other factors can impact our administrative cost structure, including systems efficiencies, inflation and changes in productivity.

Our results of operations depend in large part on our ability to accurately predict and effectively manage health care costs through effective contracting with providers of care to our members and our medical management and health and wellness programs. Several economic factors related to health care costs, such as regulatory mandates of coverage as well as direct-to-consumer advertising by providers and pharmaceutical companies, have a direct impact on the volume of care consumed by our members. The potential effect of escalating health care costs, any changes in our ability to negotiate competitive rates with our providers and any regulatory or market driven restrictions on our ability to obtain adequate premium rates to offset overall inflation in health care costs, including increases in unit costs and utilization resulting from the aging of the population and other demographics, as well as advances in medical technology, may impose further risks to our ability to profitably underwrite our business, and may have a material impact on our results of operations.

In March 2016, we filed a lawsuit against our vendor for pharmacy benefit management services, Express Scripts, Inc., or Express Scripts, seeking to recover damages for pharmacy pricing that is higher than competitive benchmark pricing and damages related to operational breaches, and seeking various declarations under the agreement between the parties. In April 2016, Express Scripts filed an answer to the lawsuit disputing our contractual claims and alleging various defenses and counterclaims. For additional information regarding this lawsuit, see Note 13, "Commitments and Contingencies - Litigation," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

On July 24, 2015, we and Cigna Corporation, or Cigna, announced that we entered into an Agreement and Plan of Merger, or Merger Agreement, dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and our direct wholly-owned subsidiary, pursuant to which we will acquire all outstanding shares of Cigna, or the Acquisition. This Acquisition will further our goal of creating a premier health benefits company with critical diversification and scale to lead the transformation of health care delivery for consumers. Cigna is a global health services organization that delivers affordable and personalized products and services to customers through employer-based, government-sponsored and individual coverage arrangements. All of Cigna's products and services are provided exclusively by or through its operating subsidiaries, including Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Life Insurance Company of North America and Cigna Life Insurance Company of New York. Such products and services include an integrated suite of health services, such as medical, dental, behavioral health, pharmacy, vision, supplemental benefits, and other related products including group life, accident and disability insurance. Cigna maintains sales capability in 30 countries and jurisdictions.

Under the terms of the Merger Agreement, Cigna's shareholders will receive \$103.40 in cash and 0.5152 shares of our common stock for each Cigna common share outstanding. The value of the transaction is estimated to be approximately \$53,000.0 based on the closing price of our common stock on the New York Stock Exchange on July 23, 2015. The final purchase price will be determined based on our closing stock price on the date of closing of the Acquisition. The combined company will reflect a pro forma equity ownership comprised of approximately 67% Anthem shareholders and approximately 33% Cigna shareholders. We expect to finance the cash portion of the Acquisition through available cash on

hand and the issuance of new debt. We are party to a bridge facility commitment letter and a joinder agreement with a group of lenders which provides up to \$19,500.0 under a 364-day senior unsecured bridge term loan credit facility to finance the Acquisition in the event that we have not received proceeds from any combination of (i) senior unsecured term loans, (ii) common or preferred equity or equity-linked securities and/or (iii) senior unsecured notes in a public offering or private placement in an aggregate principal amount of at least \$19,500.0 prior to the consummation of the Acquisition. In addition, in August 2015, we entered into a term loan facility which will provide up to \$4,000.0 to finance a portion of the Acquisition. The commitment of the lenders to provide the bridge facility and the term loan facility is subject to several conditions, including the completion of the Acquisition. We expect that our pro forma debt-to-capital ratio will approximate 49% following the closing of the Acquisition and we are committed to deleveraging to the low 40% range approximately twenty-four months following the closing. We also expect to maintain our common stock dividend and we will maintain flexibility with our share repurchase program. The Acquisition is subject to certain state regulatory approvals, other standard closing conditions and customary approvals required under the Hart-Scott-Rodino Antitrust Improvements Act. For additional information, see "Risk Factors" included in Part I, Item 1A; and Note 3, "Business Acquisitions and Divestiture - *Pending Acquisition of Cigna Corporation*" included in Part II, Item 8 of this Annual Report on Form 10-K.

In July 2016, the U.S. Department of Justice, or DOJ, along with certain state attorneys general, filed a civil antitrust lawsuit in the U.S. District Court for the District of Columbia, or District Court, seeking to block the Acquisition. Trial commenced in November 2016 and concluded in January 2017. On January 18, 2017, we provided notice to Cigna that we had elected to extend the termination date under the Merger Agreement from January 31, 2017 until April 30, 2017. On February 8, 2017, the District Court ruled in favor of the DOJ, and following our motion to expedite the appeal, which was granted on February 17, 2017, we promptly appealed the District Court's ruling to the U.S. Circuit Court of Appeals for the District of Columbia Circuit, or the Appellate Court. On February 14, 2017, Cigna purported to terminate the Merger Agreement and commenced litigation against us in the Delaware Court of Chancery, or Delaware Court, seeking damages and a declaratory judgment that its purported termination of the Merger Agreement was lawful, among other claims. We believe Cigna's allegations are without merit. Also on February 14, 2017, we initiated our own litigation against Cigna in the Delaware Court seeking a temporary restraining order to enjoin Cigna from terminating the Merger Agreement, specific performance compelling Cigna to comply with the Merger Agreement and damages. On February 15, 2017, the Delaware Court granted our motion for a temporary restraining order and issued an order enjoining Cigna from terminating the Merger Agreement. The temporary restraining order became effective immediately and will remain in place pending any further order from the Delaware Court. A hearing will be scheduled the week of April 10, 2017. We intend to vigorously defend the Acquisition in both the Circuit Court and the Delaware Court and remain committed to completing the Acquisition as soon as practicable. If the Merger Agreement is terminated because the required regulatory approvals cannot be obtained, under certain conditions, we could be obligated to pay a \$1,850.0 termination fee to Cigna.

On February 17, 2015, we completed our acquisition of Simply Healthcare Holdings, Inc., or Simply Healthcare, a leading managed care company for people enrolled in Medicaid and Medicare programs in the state of Florida. This acquisition aligns with our strategy for continued growth in our Government Business segment. For additional information about this acquisition, see Note 3, "Business Acquisitions and Divestiture - *Acquisition of Simply Healthcare*" included in Part II, Item 8 of this Annual Report on Form 10-K.

The future results of our operations will also be impacted by certain external forces and resulting changes in our business model and strategy. In 2010, the Patient Protection and Affordable Care Act, or ACA, as well as the Health Care and Education Reconciliation Act of 2010, or collectively, Health Care Reform, became law, causing significant changes to the U.S. health care system. Since then, significant regulations have been enacted by the U.S. Department of Health and Human Services, or HHS, the Department of Labor and the Department of the Treasury. The legislation and regulations are far-reaching and are intended to expand access to health insurance coverage over time by mandating that most individuals obtain health insurance coverage, increasing the eligibility thresholds for most state Medicaid programs and providing certain individuals and small businesses with tax credits to subsidize a portion of the cost of health insurance coverage. As a result of the complexity of the law, its impact on health care in the United States, the continuing modification and interpretation of Health Care Reform rules and the potential for significant future changes to the law, we continue to analyze and refine our estimates of the ultimate impact of Health Care Reform on our business, cash flows, financial condition and results of operations. Health Care Reform presented us with new growth opportunities, but also introduced new risks, regulatory challenges and uncertainties, and required changes in the way products are designed, underwritten, priced, distributed and administered. Changes to our business are likely to continue for the next several years as elected officials at the national and state level have proposed significant modification to existing laws and regulations, including the potential repeal or

replacement of Health Care Reform. For additional discussion, see Part I, Item 1 “Business - Regulation,” and Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K.

Pricing in our Commercial and Specialty Business segment, including our Individual and Small Group lines of business, remains competitive and we strive to price our health care benefit products consistent with anticipated underlying medical trends. We believe our pricing strategy, based on predictive modeling, proprietary research and data-driven processes have positioned us to benefit from the potential growth opportunities available in fully-insured commercial products as a result of Health Care Reform and any subsequent changes to the current regulatory scheme. In the Individual and Small Group markets, we offer on-exchange products through state or federally facilitated marketplaces, referred to as public exchanges, and off-exchange products. Federal premium subsidies are available for certain members, subject to income and family size, who purchase public exchange products. We believe that our pricing strategy, brand name and network quality will provide a strong foundation for commercial risk membership growth opportunities in the future.

In our Individual markets we offer bronze, silver and gold products, both on and off the public exchanges, in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. Additionally, we offer platinum products, both on and off the public exchanges, in California and New York.

In our Small Group markets, we offer bronze, silver and gold products, off the public exchanges, in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. We offer platinum products, off the public exchanges, in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, New York, Virginia and Wisconsin. We offer bronze, silver and gold products, on the public exchanges, in Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio and Virginia. Additionally, we offer platinum products on the public exchange in Connecticut.

Private exchanges have gained visibility in the marketplace based on the promise of helping employers reduce costs, increase consumer engagement and manage the complexities created by the ACA and other market forces. While private exchanges have been a distribution channel in the Medicare and Individual markets for some time, in more recent years the Commercial market has received an increased level of attention from the consulting and broker communities as well as health insurance carriers. In response, we have continued our broad-based strategy of offering Anthem Health Marketplace's consumer experience platform to groups, while also participating in four large national consultant-led exchanges, several regional broker-led exchanges and various Individual, Commercial and Medicare exchanges. To date, adoption levels in the Commercial market overall have been lower than analyst predictions. While the ultimate volume, pace of growth and winning business models remain highly uncertain in this space, we continue to believe we are well positioned to adapt with the market as it evolves.

Health Care Reform imposes regulations on the health insurance sector, including, but not limited to, guaranteed coverage and expanded benefit requirements; prohibitions on some annual and all lifetime limits on amounts paid on behalf of or to our members; increased restrictions on rescinding coverage; establishment of minimum medical loss ratio, or MLR, and customer rebate requirements; establishment of a mandatory annual Health Insurance Provider Fee, or HIP Fee; creation of a federal rate review process; a requirement to cover preventive services on a first dollar basis; the establishment of public exchanges and essential benefit packages and greater limitations on how we price certain of our products. In addition, the legislation reduces the reimbursement levels for our health plans participating in the Medicare Advantage program over time and limits the amount of executive compensation that is deductible for income tax purposes.

As a result of Health Care Reform, HHS issued MLR regulations that require us to meet minimum MLR thresholds for Large Group, Small Group and Individual lines of business. Plans that do not meet the minimum thresholds will have to pay a MLR rebate. For purposes of determining MLR rebates, HHS has defined the types of costs that should be included in the MLR rebate calculation. However, certain components of the MLR calculation as defined by HHS cannot be classified consistently under U.S. generally accepted accounting principles, or GAAP. While considered benefit expense or a reduction of premium revenue by HHS, certain of these costs are classified as other types of expense, such as income tax expense or general and administrative expense, in our GAAP basis financial statements. Accordingly, the benefit expense ratio determined using our consolidated GAAP operating results is not comparable to the MLR calculated under HHS regulations.

Health Care Reform also imposed a separate minimum MLR threshold of 85% for Medicare Advantage and Medicare Part D plans beginning in 2014. Medicare Advantage or Medicare Part D plans that do not meet this threshold will have to pay a minimum MLR rebate. If a plan's MLR is below 85% for three consecutive years beginning with 2014, enrollment will

be restricted. A Medicare Advantage or Medicare Part D plan contract will be terminated if the plan's MLR is below 85% for five consecutive years.

Beginning in 2014, Health Care Reform imposed an annual HIP Fee on health insurers that write certain types of health insurance on U.S. risks. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to an adjusted amount of health insurance for all U.S. health risk for those certain lines of business written during the preceding calendar year. The HIP Fee is non-deductible for federal income tax purposes. The total amount collected from allocations to health insurers was \$11,300.0 for each of 2016 and 2015 and \$8,000.0 for 2014. We record our estimated liability for the HIP Fee in full at the beginning of the year with a corresponding deferred asset that is amortized on a straight-line basis to general and administrative expense. The final calculation and payment of the annual HIP Fee occurs in the third quarter each year and our portion of the HIP Fee for 2016, 2015 and 2014 was \$1,176.3, \$1,207.5 and \$893.3, respectively. The annual HIP Fee to be allocated to all health insurers has been suspended for 2017 and is scheduled to resume and be increased to \$14,300.0 for 2018, without subsequent legislative or regulatory action. For 2019 and beyond, the annual HIP Fee will equal the amount for the preceding year increased by the rate of premium growth for the preceding year less the rate of growth in the consumer price index for the preceding calendar year.

These and other provisions of Health Care Reform are likely to have significant effects on our future operations, which, in turn, could impact the value of our business model and results of operations, including potential impairments of our goodwill and other intangible assets. We will continue to evaluate the impact of Health Care Reform including any substantial changes to existing laws or regulations that may impact our business. For additional discussion regarding Health Care Reform, see Part I, Item 1 "Business—Regulation" and Part I, Item 1A "Risk Factors" in this Annual Report on Form 10-K.

Finally, federal and state regulatory agencies may further restrict our ability to obtain new product approvals, implement changes in premium rates or impose additional restrictions, under new or existing laws that could adversely affect our business, cash flows, financial condition and results of operations.

We are also subject to regulations that may result in assessments under state insurance guaranty association laws. The National Organization of Life & Health Insurance Guaranty Associations, or NOLHGA, is a voluntary organization consisting of the state life and health insurance guaranty associations located throughout the U.S. Such associations, working together with NOLHGA, provide a safety net for their state's policyholders, ensuring that they continue to receive coverage, subject to state maximum limits, even if their insurer is declared insolvent. In 2009, the Pennsylvania Insurance Commissioner placed Penn Treaty Network America Insurance Company and its subsidiary American Network Insurance Company, or collectively Penn Treaty, in rehabilitation, an intermediate action before insolvency. After failing to develop a viable rehabilitation plan, the Pennsylvania Insurance Commissioner filed a petition to convert the rehabilitation to a liquidation, with the liquidation expected to commence following the coordination of certain scheduling matters. When Penn Treaty is placed in liquidation, we and other insurers will be obligated to pay a portion of their policyholder claims through state guaranty association assessments in future periods. At December 31, 2016, we estimate our portion of the assessments for the Penn Treaty insolvency will approximate \$190.0 to \$220.0. In accordance with FASB guidance, the ultimate amount of the assessments will be recognized as an expense in the period in which a court ordered liquidation is entered. Payment of the assessments will be largely recovered through premium billing surcharges and premium tax credits over future years.

In addition to the external forces discussed in the preceding paragraphs, our results of operations are impacted by levels and mix of membership. In recent years, we have experienced membership growth due to the quality and pricing of our health benefits products and services, improved economic conditions, decreases in unemployment, acquisitions, entry into new markets and expansions in existing markets. In addition, we believe the self-insured portion of our group membership base will continue to increase as a percentage of total group membership. However, these membership trends could be negatively impacted by various factors that could have a material adverse effect on our future results of operations such as general economic downturns that result in business failures, failure to obtain new customers or retain existing customers, premium increases, benefit changes or our exit from a specific market. Further, our mix of membership may include more individuals with a higher acuity level obtaining coverage through our products available on the public exchanges, which may not be appropriately adjusted for in our premium rates.

In February 2015, we reported that we were the target of a sophisticated external cyber attack. The attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many individuals and employees. We have continued to implement security enhancements since this incident. For additional information about the cyber attack, see Note 13, "Commitments and Contingencies - *Cyber Attack Incident*," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Also see Part I, Item 1A "Risk Factors" in this Annual Report on Form 10-K, for a discussion of the factors identified above and other risk factors that could cause actual results to differ materially from those contained in forward-looking statements made in this Annual Report on Form 10-K and presented elsewhere by management from time to time.

Executive Summary

We are one of the largest health benefits companies in the United States in terms of medical membership, serving 39.9 medical members through our affiliated health plans as of December 31, 2016. We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as BCBS in 10 New York City metropolitan and surrounding counties, and as Blue Cross or BCBS in selected upstate counties), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield or Empire Blue Cross (in our New York service areas). We also conduct business through arrangements with other BCBS licensees in South Carolina and Western New York. Through our AMERIGROUP Corporation, or Amerigroup, subsidiary, we conduct business in Florida, Georgia, Iowa, Kansas, Louisiana, Maryland, Nevada, New Jersey, New Mexico, New York, Tennessee, Texas, and Washington. In addition, we conduct business through our Simply Healthcare Holdings, Inc., or Simply Healthcare, subsidiary in Florida. We also serve customers throughout the country as HealthLink, UniCare (including a non-risk arrangement with Massachusetts), and in certain Arizona, California, Nevada and Virginia markets through our CareMore Health Group, Inc., or CareMore, subsidiary. We are licensed to conduct insurance operations in all 50 states through our subsidiaries.

On January 31, 2014, we sold our 1-800 CONTACTS, Inc. business and our glasses.com related assets, or collectively, 1-800 CONTACTS. The operating results for 1-800 CONTACTS for the one month ended January 31, 2014 are reported as discontinued operations within the consolidated statements of income included in Part II, Item 8 of this Annual Report on Form 10-K. These results were previously reported in the Commercial and Specialty Business segment. Unless otherwise specified, all financial information disclosed in this MD&A is from continuing operations, other than net income, diluted earnings per share and cash flows. In accordance with FASB guidance, we have elected to not separately disclose net cash provided by or used in operating, investing, and financing activities and the net effect of those cash flows on cash and cash equivalents for discontinued operations during the periods presented. For additional information regarding these transactions, see Note 3, "Business Acquisitions and Divestiture - *Divestiture of 1-800 CONTACTS*," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Operating revenue for the year ended December 31, 2016 was \$84,194.0, an increase of \$5,789.2, or 7.4%, from the year ended December 31, 2015. The increase in operating revenue was primarily a result of higher premium revenue in both our Government Business and Commercial and Specialty Business segments, and, to a lesser extent, increased administrative fees in our Commercial and Specialty Business segment. These increases were partially offset by lower administrative fees in our Government Business segment.

Net income for the year ended December 31, 2016 was \$2,469.8, a decrease of \$90.2, or 3.5%, from the year ended December 31, 2015. The decrease in net income was primarily due to lower operating results in our Government Business segment, an increase in transaction costs associated with our pending acquisition of Cigna, a decrease in net earnings from investment activities and an increase in interest expense.

Our diluted earnings per share, or EPS, for the year ended December 31, 2016 was \$9.21, a decrease of \$0.17, or 1.8%, from the year ended December 31, 2015. Our diluted shares for the year ended December 31, 2016 were 268.1, a decrease of 4.8, or 1.8% compared to the year ended December 31, 2015. The decrease in EPS resulted from the decrease in net income, partially offset by the impact of a lower number of shares outstanding in 2016.

Operating cash flow for the year ended December 31, 2016 was \$3,204.5, or 1.3 times net income. Operating cash flow for the year ended December 31, 2015 was \$4,116.0, or 1.6 times net income. The decrease in operating cash flow from 2015 of \$911.5 was primarily attributable to an increase in claims payments due to higher medical cost experience and growth in membership. The decrease was further due to the timing of claim reimbursements from our self-insured customers. These decreases were partially offset by an increase in premium receipts as a result of rate increases across our businesses designed to cover overall cost trends and growth in membership. The decrease was further offset by an increase in pharmacy rebates received.

Our results of operations discussed throughout this MD&A are determined in accordance with GAAP. We also calculate operating revenue and operating gain to further aid investors in understanding and analyzing our core operating results and comparing them among periods. We define operating revenue as premium income, administrative fees and other revenues. Operating gain is calculated as total operating revenue less benefit expense, and selling, general and administrative expense. We use these measures as a basis for evaluating segment performance, allocating resources, forecasting future operating performance and setting incentive compensation targets. This information is not intended to be considered in isolation or as a substitute for income before income tax expense, net income or EPS prepared in accordance with GAAP, and may not be comparable to similarly titled measures reported by other companies. For additional details on operating gain, see our "Reportable Segments Results of Operations" discussion included in this MD&A. For a reconciliation of reportable segment operating revenue to the amounts of total revenue included in the consolidated statements of income and a reconciliation of reportable segment operating gain to income from continuing operations before income tax expense, see Note 19, "Segment Information," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We intend to expand through a combination of organic growth, strategic acquisitions, including the pending acquisition of Cigna, and efficient use of capital in both existing and new markets. Our growth strategy is designed to enable us to take advantage of additional economies of scale as well as providing us access to new and evolving technologies and products. In addition, we believe geographic and product diversity reduces our exposure to local or regional regulatory, economic and competitive pressures and provides us with increased opportunities for growth. While we have achieved strong growth as a result of strategic mergers and acquisitions, we have also achieved organic growth in our existing markets over time by delivering excellent service, offering competitively priced products, providing access to high quality provider networks and effectively capitalizing on the brand strength of the Blue Cross and Blue Shield names and marks.

Significant Transactions

While Health Care Reform has caused significant changes to the U.S. health care system in recent years, the significant transactions that have occurred over the last three years that have impacted or will impact our capital structure or that have or will influence how we conduct our business operations include:

- Pending acquisition of Cigna;
- Acquisition of Simply Healthcare (2015);
- Board of Directors declaration of dividends on common stock (2014 through February 2017); authorization for repurchases of our common stock (2017 and prior); and debt repurchases and new debt issuance (2015 and prior); and
- Divestiture of 1-800 CONTACTS (2014).

For additional information regarding these transactions, see Note 3, "Business Acquisitions and Divestiture," Note 12, "Debt" and Note 14, "Capital Stock," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Membership

Our medical membership includes seven different customer types: Local Group, Individual, National Accounts, BlueCard®, Medicare, Medicaid and FEP. BCBS-branded business generally refers to members in our service areas licensed by the BCBSA. Non-BCBS-branded business refers to Amerigroup, CareMore and Simply Healthcare members as well as HealthLink and UniCare members predominantly outside of our BCBSA service areas.

- Local Group consists of those employer customers with less than 5% of eligible employees located outside of the headquarter state, as well as customers with more than 5% of eligible employees located outside of the headquarter state with up to 5,000 eligible employees. In addition, Local Group includes UniCare members and Employer Group Medicare Advantage members, or retired members of Local Group accounts who have selected a Medicare Advantage product. Local Group accounts are generally sold through brokers or consultants working with industry specialists from our in-house sales force and are offered both on and off the public exchanges. Local Group insurance premiums may be based on claims incurred by the group or sold on a self-insured basis. The customer's buying decision is typically based upon the size and breadth of our networks, customer service, the quality of our medical management services, the administrative cost included in our quoted price, our financial stability, reputation and our ability to effectively service large complex accounts. Local Group accounted for 38.7%, 39.5% and 40.4% of our medical members at December 31, 2016, 2015 and 2014, respectively.
- Individual consists of individual customers under age 65 and their covered dependents. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the Internet. Individual business is sold on a fully-insured basis. We offer on-exchange products through public exchanges and off-exchange products. Federal premium subsidies are available only for certain public exchange Individual products. Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network, and the efficiency of administration. Customer turnover is generally higher with Individual as compared to Local Group. Individual business accounted for 4.2%, 4.3% and 4.8% of our medical members at December 31, 2016, 2015 and 2014, respectively.
- National Accounts generally consist of multi-state employer groups primarily headquartered in an Anthem service area with at least 5% of the eligible employees located outside of the headquarter state and with more than 5,000 eligible employees. Some exceptions are allowed based on broker and consultant relationships. Service area is defined as the geographic area in which we are licensed to sell BCBS products. National Accounts are generally sold through independent brokers or consultants retained by the customer working with our in-house sales force. We believe we have an advantage when competing for very large National Accounts due to the size and breadth of our networks and our ability to access the national provider networks of BCBS companies at their competitive local market rates. In addition, Employer Group Medicare Advantage members related to National Accounts groups are reported as part of National Accounts membership. The Employer Group Medicare Advantage members represent less than 1.0% of National Accounts membership. National Accounts represented 19.4%, 19.1% and 19.1% of our medical members at December 31, 2016, 2015 and 2014, respectively.
- BlueCard® host customers represent enrollees of Blue Cross and/or Blue Shield plans not owned by Anthem who receive health care services in our BCBSA licensed markets. BlueCard® membership consists of estimated host members using the national BlueCard® program. Host members are generally members who reside in or travel to a state in which an Anthem subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer-sponsored health plan issued by a non-Anthem controlled BCBSA licensee (i.e., the "home plan"). We perform certain administrative functions for BlueCard® members, for which we receive administrative fees from the BlueCard® members' home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan. Host members are computed using, among other things, the average number of BlueCard® claims received per month. BlueCard® host membership accounted for 13.9%, 14.0% and 14.1% of our medical members at December 31, 2016, 2015 and 2014, respectively.
- Medicare customers are Medicare-eligible individual members age 65 and over who have enrolled in Medicare Advantage, a managed care alternative for the Medicare program, who have purchased Medicare Supplement benefit coverage, some disabled members under age 65, or members of all ages with end stage renal disease. We also include in the Medicare category members enrolled in our dual eligible Medicare-Medicaid Plans, or MMPs, in the states where we participate. Medicare Supplement policies are sold to Medicare recipients as supplements to the benefits they receive from the Medicare program. Rates are filed with and in some cases approved by state insurance

departments. Most of the premium for Medicare Advantage is paid directly by the federal government on behalf of the participant who may also be charged a small premium. Medicare Supplement and Medicare Advantage products are marketed in the same manner, primarily through independent agents and brokers. Medicare business accounted for 3.6%, 3.7% and 3.7% of our medical members at December 31, 2016, 2015 and 2014, respectively.

- Medicaid membership represents eligible members who receive health care benefits through publicly funded health care programs, including Medicaid, TANF, SPD, LTSS, CHIP and Medicaid expansion programs. Total Medicaid program business accounted for 16.4%, 15.3% and 13.8% of our medical members at December 31, 2016, 2015 and 2014, respectively.
- FEP members consist of United States government employees and their dependents within our geographic markets through our participation in the national contract between the BCBSA and the U.S. Office of Personnel Management. FEP business accounted for 3.9%, 4.1% and 4.1% of our medical members at December 31, 2016, 2015 and 2014, respectively.

In addition to reporting our medical membership by customer type, we report by funding arrangement according to the level of risk that we assume in the product contract. Our two principal funding arrangement categories are fully-insured and self-funded. Fully-insured products are products in which we indemnify our policyholders against costs for health benefits. Self-funded products are offered to customers, generally larger employers, who elect to retain most or all of the financial risk associated with their employees' health care costs. Some self-funded customers choose to purchase stop loss coverage to limit their retained risk.

The following table presents our medical membership by customer type, funding arrangement and reportable segment as of December 31, 2016, 2015 and 2014. Also included below is other membership by product. The medical membership and other membership presented are unaudited and in certain instances include estimates of the number of members represented by each contract at the end of the period.

(In thousands)	December 31			2016 vs. 2015		2015 vs. 2014	
	2016	2015	2014	Change	% Change	Change	% Change
Medical Membership							
Customer Type							
Local Group	15,429	15,241	15,137	188	1.2 %	104	0.7 %
Individual	1,664	1,675	1,793	(11)	(0.7)%	(118)	(6.6)%
National:							
National Accounts	7,741	7,355	7,155	386	5.2 %	200	2.8 %
BlueCard®	5,550	5,407	5,279	143	2.6 %	128	2.4 %
Total National	13,291	12,762	12,434	529	4.1 %	328	2.6 %
Medicare	1,438	1,439	1,404	(1)	(0.1)%	35	2.5 %
Medicaid	6,527	5,914	5,193	613	10.4 %	721	13.9 %
FEP	1,570	1,568	1,538	2	0.1 %	30	2.0 %
Total Medical Membership	39,919	38,599	37,499	1,320	3.4 %	1,100	2.9 %
Funding Arrangement							
Self-Funded	24,688	23,666	22,800	1,022	4.3 %	866	3.8 %
Fully-Insured	15,231	14,933	14,699	298	2.0 %	234	1.6 %
Total Medical Membership	39,919	38,599	37,499	1,320	3.4 %	1,100	2.9 %
Reportable Segment							
Commercial and Specialty Business	30,384	29,678	29,364	706	2.4 %	314	1.1 %
Government Business	9,535	8,921	8,135	614	6.9 %	786	9.7 %
Total Medical Membership	39,919	38,599	37,499	1,320	3.4 %	1,100	2.9 %
Other Membership							
Life and Disability Members	4,732	4,849	4,762	(117)	(2.4)%	87	1.8 %
Dental Members	5,486	5,206	4,995	280	5.4 %	211	4.2 %
Dental Administration Members	5,294	5,282	4,918	12	0.2 %	364	7.4 %
Vision Members	6,388	5,641	5,096	747	13.2 %	545	10.7 %
Medicare Advantage Part D Members	629	622	690	7	1.1 %	(68)	(9.9)%
Medicare Part D Standalone Members	350	371	467	(21)	(5.7)%	(96)	(20.6)%

December 31, 2016 Compared to December 31, 2015

Medical Membership (in thousands)

During the year ended December 31, 2016, total medical membership increased 1,320, or 3.4%, primarily due to increases in our Medicaid, National Accounts, Local Group and BlueCard® membership.

Self-funded medical membership increased 1,022, or 4.3%, primarily due to increases in our National Accounts, Large Group accounts and BlueCard® membership.

Fully-insured membership increased 298, or 2.0%, primarily due to growth in our Medicaid business, partially offset by declines in Local Group fully-insured membership.

Local Group membership increased 188, or 1.2%, primarily due to growth in our Large Group self-funded accounts as a result of new sales and conversions of fully-insured contracts to self-funded administrative service only, or ASO contracts. The increase was partially offset by attrition in our fully-insured product offerings resulting from competitive pressures and conversions to self-funded ASO contracts.

Individual membership decreased 11, or 0.7%, primarily due to attrition in non-ACA-compliant product offerings, partially offset by growth in ACA-compliant off- and on-exchange product offerings.

National Accounts membership increased 386, or 5.2%, primarily due to the implementation of new large multi-state employer group contracts and expansion in existing employer group accounts.

BlueCard® membership increased 143, or 2.6%, primarily due to higher membership activity at other BCBSA plans whose members reside in or travel to our licensed areas.

Medicare membership decreased 1, or 0.1%, primarily due to membership losses from strategic market exits, partially offset by growth in certain existing markets.

Medicaid membership increased 613, or 10.4%, primarily due to new business expansions and organic growth in existing markets.

FEP membership increased 2, or 0.1%, primarily due to higher sales during the open enrollment period.

Other Membership (in thousands)

Our Other products are often ancillary to our health business and can therefore be impacted by corresponding changes in our medical membership.

Life and disability membership decreased 117, or 2.4%, primarily due to higher lapses in our fully-insured Local Group business.

Dental membership increased 280, or 5.4%, primarily due to new sales and growth in our Local Group and ACA-compliant Individual product offerings.

Dental administration membership increased 12, or 0.2%, primarily due to membership expansion under current contracts.

Vision membership increased 747, or 13.2%, primarily due to growth in our Local Group, National accounts and ACA-compliant Individual product offerings.

Medicare Advantage Part D membership increased 7, or 1.1%, primarily due to higher sales during the open enrollment period.

Medicare Part D standalone membership decreased 21, or 5.7%, primarily due to our product repositioning strategies and select strategic actions in certain markets.

December 31, 2015 Compared to December 31, 2014

Medical Membership (in thousands)

During the year ended December 31, 2015, total medical membership increased 1,100, or 2.9%, primarily due to increases in our Medicaid, National Accounts, BlueCard® and Local Group membership, partially offset by decreases in our Individual membership.

Self-funded medical membership increased 866, or 3.8%, primarily due to increases in our Local Group self-funded accounts as a result of new sales and conversions of fully-insured contracts to self-funded ASO contracts, and growth in our National Accounts and BlueCard® membership.

Fully-insured membership increased 234, or 1.6%, primarily due to growth in our Medicaid and Medicare businesses including membership acquired with the acquisition of Simply Healthcare, and increased sales in our Individual business ACA-compliant on- and off-exchange product offerings. These increases were partially offset by Local Group fully-insured membership declines, largely driven by conversions of fully-insured contracts to self-funded ASO contracts and our decision to exit the Georgia employer group Medicare product offering. The increase was further offset by attrition in our Individual business non-ACA-compliant product offerings.

Local Group membership increased 104, or 0.7%, primarily due to increases in our self-funded accounts. The increase in membership was partially offset by attrition in our Small Group line of business resulting from product mix changes as members moved into Health Care Reform product offerings and competitive pressures. The increase was further offset by fully-insured membership declines resulting from our decision to exit the Georgia employer group Medicare product offering.

Individual membership decreased 118, or 6.6%, primarily due to attrition in non-ACA-compliant product offerings, partially offset by increased sales in ACA-compliant on- and off-exchange product offerings.

National Accounts membership increased 200, or 2.8%, primarily due to new sales and in-group change.

BlueCard® membership increased 128, or 2.4%, primarily due to favorable membership activity at other BCBSA plans whose members reside in or travel to our licensed areas.

Medicare membership increased 35, or 2.5%, primarily due to membership acquired through the acquisition of Simply Healthcare and growth in our MMPs primarily due to commencement of operations in new dual eligible markets.

Medicaid membership increased 721, or 13.9%, primarily due to commencement of operations in new markets including membership acquired through the acquisition of Simply Healthcare, and growth through Health Care Reform expansions.

FEP membership increased 30, or 2.0%, primarily due to higher sales during open enrollment.

Other Membership (in thousands)

Our Other products are often ancillary to our health business and can therefore be impacted by corresponding changes in our medical membership.

Life and disability membership increased 87, or 1.8%, primarily due to growth and higher sales in our Local Group business.

Dental membership increased 211, or 4.2%, primarily due to new sales and growth in our Local Group and Individual businesses, partially offset by attrition in our off-exchange Local Group and Individual business product offerings.

Dental administration membership increased 364, or 7.4%, primarily due to the acquisition of a large managed dental contract pursuant to which we provide dental administrative services.

Vision membership increased 545, or 10.7%, primarily due to increased sales and penetration in our Medicare business, and growth in our Local Group, National Accounts and Individual businesses. These increases were partially offset by attrition in our off-exchange Local Group and Individual business product offerings.

Medicare Advantage Part D membership decreased 68, or 9.9%, primarily due to membership declines resulting from our decision to exit the Georgia employer group Medicare product offering, partially offset by commencement of operations in new dual eligible markets and membership acquired through the acquisition of Simply Healthcare.

Medicare Part D standalone membership decreased 96, or 20.6%, primarily due to our product repositioning strategies and select strategic actions in certain markets.

Cost of Care

The following discussion summarizes our aggregate underlying cost of care trends for the year ended December 31, 2016 for our Local Group fully-insured business only.

Our cost of care trends are calculated by comparing the year-over-year change in average per member per month claim costs. While our cost of care trend varies by geographic location, based on underlying medical cost trends, we estimate that our aggregate cost of care trend was in the lower end of the 7.0% to 7.5% range for the full year of 2016. We anticipate that medical cost trends will be in the range of 6.5% to 7.0% in 2017.

Outpatient and professional utilization have been consistent with prior years. Inpatient and pharmacy utilization have been lower than in prior years. Consistent with prior years, provider rate increases were a primary driver of medical cost trends. We continually negotiate with hospitals and physicians to manage these cost trends. We commonly negotiate multi-year contracts with hospitals and physicians, minimizing annual fluctuations in medical cost trend. We remain committed to optimizing our reimbursement rates and strategies to help address the cost pressures faced by employers and consumers. Unit cost increases, as well as increases in high cost specialty drug offerings and usage, were also a driver of pharmacy cost. For example, high cost Hepatitis C drug therapies continued to put upward pressure on pharmacy trend. We have negotiated to lower the cost of these Hepatitis C drug therapies and continue to review clinical appropriateness of these new Hepatitis C drug therapies to ensure members receive the most appropriate treatment and length of therapy.

In response to cost trends, we continue to pursue contracting and plan design changes, promote and implement performance-based contracts that reward clinical outcomes and quality, and expand care management programs. We are taking a leadership role in the area of payment reform as evidenced by our Enhanced Personal Health Care program. By establishing the primary care doctor as central to the coordination of a patient's health care needs, the initiative builds on the success of current patient-centered medical home programs in helping to improve patient care while lowering costs.

A number of clinical management initiatives are in place to help mitigate inpatient trend. Focused review efforts continue in key areas, including targeting outlier facilities for length of stay and readmission, and high risk maternity and neonatal intensive care unit cases, as noted below. Additionally, we continue to refine our programs related to readmission management, focused behavioral health readmission reduction and post-discharge follow-up care.

- *Neonatal Intensive Care Unit Focused Review* - Collaborative teams focus on developing a comprehensive plan of care and safe and effective discharge planning so that individuals can be released from the Neonatal Intensive Care Unit as soon as medically appropriate.

Outpatient costs are a collection of different types of expenses, such as outpatient facilities, labs, x-rays, emergency room, occupational and physical therapy and many others. Example programs developed to mitigate outpatient costs are as follows:

- *Cancer Care Quality Program* - This program, developed in collaboration with our subsidiary AIM Specialty Health, identifies certain cancer treatment pathways selected based upon current medical evidence, peer-reviewed published literature, consensus guidelines and our clinical policies to support oncologists in identifying cancer treatment therapies that are highly effective and provide greater value.
- *Avoidable Emergency Room Visits* - This program seeks to help educate members and providers about potentially avoidable emergency room visits. Phone calls and mailings are used to inform members of alternate sites of care, such as primary care physicians, urgent care facilities, and walk-in doctor's offices that can replace visits to the emergency room in certain situations.
- *Specialty Drug Site of Care* - This program, when clinically appropriate and safe, uses clinical site of care review to encourage utilization of certain specialty drugs in more effective settings such as physician offices, ambulatory infusion suites and in the home using home infusion therapy.
- *Fraud and Abuse* - This program, through investigation and identification of providers with an invalid medical license and/or expired prescribing privileges, seeks to prevent improper payment of medical or pharmacy claims.

Consolidated Results of Operations

Our consolidated summarized results of operations for the years ended December 31, 2016, 2015 and 2014 are discussed in the following section.

	Years Ended December 31			Change			
				2016 vs. 2015		2015 vs. 2014	
	2016	2015	2014	\$	%	\$	%
Total operating revenue	\$ 84,194.0	\$ 78,404.8	\$ 73,021.7	\$ 5,789.2	7.4 %	\$ 5,383.1	7.4 %
Net investment income	779.5	677.6	724.4	101.9	15.0 %	(46.8)	(6.5)%
Net realized gains on financial instruments	4.9	157.5	177.0	(152.6)	(96.9)%	(19.5)	(11.0)%
Other-than-temporary impairment losses on investments	(115.4)	(83.4)	(49.0)	(32.0)	(38.4)%	(34.4)	(70.2)%
Total revenues	84,863.0	79,156.5	73,874.1	5,706.5	7.2 %	5,282.4	7.2 %
Benefit expense	66,834.4	61,116.9	56,854.9	5,717.5	9.4 %	4,262.0	7.5 %
Selling, general and administrative expense	12,557.9	12,534.8	11,748.4	23.1	0.2 %	786.4	6.7 %
Other expense ¹	915.3	873.8	902.7	41.5	4.7 %	(28.9)	(3.2)%
Total expenses	80,307.6	74,525.5	69,506.0	5,782.1	7.8 %	5,019.5	7.2 %
Income from continuing operations before income tax expense	4,555.4	4,631.0	4,368.1	(75.6)	(1.6)%	262.9	6.0 %
Income tax expense	2,085.6	2,071.0	1,808.0	14.6	0.7 %	263.0	14.5 %
Income from continuing operations	2,469.8	2,560.0	2,560.1	(90.2)	(3.5)%	(0.1)	— %
Income from discontinued operations, net of tax²	—	—	9.6	—	NM³	(9.6)	NM³
Net income	\$ 2,469.8	\$ 2,560.0	\$ 2,569.7	\$ (90.2)	(3.5)%	\$ (9.7)	(0.4)%
Average diluted shares outstanding	268.1	272.9	285.9	(4.8)	(1.8)%	(13.0)	(4.5)%
Diluted net income per share:							
Diluted - continuing operations	\$ 9.21	\$ 9.38	\$ 8.96	\$ (0.17)	(1.8)%	\$ 0.42	4.7 %
Diluted - discontinued operations ²	—	—	0.03	—	NM ³	(0.03)	NM ³
Diluted net income per share	\$ 9.21	\$ 9.38	\$ 8.99	\$ (0.17)	(1.8)%	\$ 0.39	4.3 %
Benefit expense ratio ⁴	84.8%	83.3%	83.1%		150bp ⁵		20bp ⁵
Selling, general and administrative expense ratio ⁶	14.9%	16.0%	16.1%		(110)bp ⁵		(10)bp ⁵
Income from continuing operations before income taxes as a percentage of total revenue	5.4%	5.9%	5.9%		(50)bp ⁵		0bp ⁵
Net income as a percentage of total revenue	2.9%	3.2%	3.5%		(30)bp ⁵		(30)bp ⁵

Certain of the following definitions are also applicable to all other results of operations tables in this discussion:

- Includes interest expense, amortization of other intangible assets and gain/loss on extinguishment of debt.
- The operating results of 1-800 CONTACTS are reported as discontinued operations as a result of the divestiture completed on January 31, 2014.
- Calculation not meaningful.
- Benefit expense ratio represents benefit expense as a percentage of premium revenue. Premiums for the years ended December 31, 2016, 2015 and 2014 were \$78,860.1, \$73,385.1 and \$68,389.8, respectively. Premiums are included in total operating revenue presented above.
- bp = basis point; one hundred basis points = 1%.
- Selling, general and administrative expense ratio represents selling, general and administrative expense as a percentage of total operating revenue.

Year Ended December 31, 2016 Compared to the Year Ended December 31, 2015

Total operating revenue increased \$5,789.2, or 7.4%, to \$84,194.0 in 2016, resulting primarily from higher premiums, and, to a lesser extent, increased administrative fees. Higher premiums were largely due to rate increases across our businesses designed to cover overall cost trends. The increase was further attributable to membership increases in our Medicaid and ACA-compliant off- and on-exchange Individual business product offerings. Additionally, adjustments to accruals for the Health Care Reform risk adjustment premium stabilization program and increased reimbursed benefit utilization in our FEP business contributed to the increase in premiums. The increase in premiums was partially offset by the declines in fully-insured membership in our Small Group business and lapses in non-ACA-compliant Individual business product offerings. The increase in administrative fees primarily resulted from membership growth and rate increases for self-funded members in our National Accounts and Large Group businesses.

Net investment income increased \$101.9, or 15.0%, to \$779.5 in 2016, primarily due to higher income from alternative investments.

Net realized gains on financial instruments decreased \$152.6, or 96.9%, to \$4.9 in 2016, primarily due to an increase in net realized losses on derivative financial instruments, largely as a result of losses recognized on options entered in to economically hedge the variability of cash flows in the interest payments on anticipated future financings. The decrease was further due to lower net realized gains on sales of equity securities. These decreases were partially offset by an increase in net realized gains on sales of fixed maturity securities.

Other-than-temporary impairment losses on investments increased \$32.0, or 38.4%, to \$115.4 in 2016, primarily due to an increase in impairment losses on fixed maturity securities, partially offset by a decrease in impairment losses on equity securities.

Benefit expense increased \$5,717.5, or 9.4%, to \$66,834.4 in 2016, primarily due to increased costs as a result of overall cost trends across our businesses. The increase was further attributable to membership growth in our Medicaid business and ACA-compliant off- and on-exchange Individual business product offerings. These increases were partially offset by the declines in fully-insured membership in our Small Group business and non-ACA-compliant Individual business product offerings.

Our benefit expense ratio increased 150 basis points to 84.8% in 2016. The increase in the ratio was largely driven by our Medicaid business due to increases in medical cost experience that exceeded the impact of premium rate adjustments, higher than expected medical cost experience in the Iowa market, which we began serving in 2016, and increases in membership as our Medicaid business has a higher benefit expense ratio than our consolidated average. The increase in the ratio was further due to higher medical costs experience in our Individual and Local Group businesses. These increases were partially offset by adjustments to estimates of prior year accruals related to the Health Care Reform risk adjustment premium stabilization program and improved medical cost performance in our Medicare business.

Selling, general and administrative expense was \$12,557.9 and \$12,534.8 in 2016 and 2015, respectively. Our selling, general and administrative expense ratio decreased 110 basis points to 14.9% in 2016. The decrease in the ratio was primarily a result of lower costs related to expense efficiency initiatives and the increase in operating revenue, including the impact of Medicaid membership growth in our Government Business segment, which has a lower selling, general and administrative expense ratio than our consolidated average.

Other expense increased \$41.5, or 4.7%, to \$915.3 in 2016, primarily due to higher interest expense in 2016 driven by amortization of the fees incurred for the bridge facility commitment letter and joinder agreement entered into during the third quarter of 2015 to partially fund the pending acquisition of Cigna. The increase in interest expense was partially offset by a decrease in amortization of intangible assets.

Income tax expense increased \$14.6, or 0.7%, to \$2,085.6 in 2016. The effective tax rates in 2016 and 2015 were 45.8% and 44.7%, respectively. The increase in income tax expense and the effective tax rate was primarily due to the increase in non-deductible costs incurred associated with the pending acquisition of Cigna and the increase in our California deferred state tax expense resulting from recent California legislation related to Managed Care Organizations. The increase was further due to favorable 2015 tax adjustments related to state audit settlements. These increases were partially offset by the

non-recurring impact of an adverse California franchise tax ruling recognized in 2015 and a decrease in income before income tax expense.

Our net income as a percentage of total revenue decreased 30 basis points to 2.9% in 2016 as compared to 2015 as a result of all factors discussed above.

Year Ended December 31, 2015 Compared to the Year Ended December 31, 2014

Total operating revenue increased \$5,383.1, or 7.4% to \$78,404.8 in 2015, resulting primarily from higher premiums, and, to a lesser extent, increased administrative fees. Higher premiums were mainly due to membership increases across our Government Business segment, including membership obtained through the acquisition of Simply Healthcare, and rate increases across our businesses designed to cover overall cost trends and the increase in the HIP Fee. The increase in premiums was further attributable to membership increases in our ACA-compliant on- and off-exchange Individual business product offerings and refinement of estimates associated with Medicare risk score revenue in the prior year. The increase in premiums was offset, in part, by the fully-insured membership declines in our Local Group business, attrition in non-ACA-compliant Individual business product offerings and adjustments to accruals for the Health Care Reform risk adjustment premium stabilization program. The increase in administrative fees primarily resulted from rate increases and membership growth for self-funded members in our Local Group and National Accounts businesses.

Net investment income decreased \$46.8, or 6.5%, to \$677.6 in 2015, primarily due to lower income from alternative investments, partially offset by higher investment yields on fixed maturity securities.

Net realized gains on financial instruments decreased \$19.5, or 11.0%, to \$157.5 in 2015, primarily due to an increase in net realized losses on sales of fixed maturity securities, partially offset by an increase in net realized gains on sales of equity securities and settlements of derivative financial instruments.

Other-than-temporary impairment losses on investments increased \$34.4, or 70.2%, to \$83.4 in 2015, primarily due to an increase in impairment losses on equity and fixed maturity securities.

Benefit expense increased \$4,262.0, or 7.5%, to \$61,116.9 in 2015, primarily due to increase in overall cost trends across our businesses, membership growth across our Government Business segment, including membership obtained through the acquisition of Simply Healthcare, and membership growth in our ACA-compliant on- and off-exchange Individual business product offerings. These increases were partially offset by the fully-insured membership declines in our Local Group business and non-ACA-compliant Individual business product offerings, as described above.

Our benefit expense ratio increased 20 basis points to 83.3% in 2015, largely driven by changes in the mix of the product portfolio, higher than expected medical costs in our Individual business, and adjustments to accruals related to the Health Care Reform risk adjustment premium stabilization program. These increases were partially offset by improvement in our Local Group business and certain Medicare lines of business predominantly due to improved medical cost performance. The increase in the ratio was further offset by refinement of estimates associated with Medicare risk score revenue in the prior year.

Selling, general and administrative expense increased \$786.4, or 6.7%, to \$12,534.8 in 2015. Our selling, general and administrative expense ratio decreased 10 basis points to 16.0% in 2015. The increase in the expense was primarily due to increased associate costs to support our growth in membership. The increase in expense was further due to net increases in Health Care Reform fees, primarily due to an increase in the HIP Fee of \$314.2, and increased premium taxes as a result of the growth in premiums. These increases were partially offset by a decrease in assessments related to the Health Care Reform reinsurance premium stabilization program of \$163.4. The decrease in the ratio was primarily due to the impact of Medicaid membership growth in our Government Business segment, which has a lower selling, general and administrative expense ratio than our consolidated average.

Other expense decreased \$28.9, or 3.2%, to \$873.8 in 2015, primarily due to changes in gains and losses on the extinguishment of debt. For the year ended December 31, 2015, we recognized net gains on extinguishment of debt of \$9.3 compared to net losses on extinguishment of debt of \$81.1 for the year ended December 31, 2014. The decrease in other expense was partially offset by higher interest expense in 2015 driven by higher outstanding debt balances and the amortization of fees incurred for the obtainment of the bridge facility commitment letter and joinder agreement to partially

fund the pending acquisition of Cigna. The decrease in other expense was further offset by an increase in amortization of intangible assets. For additional information related to our borrowings, see "Liquidity and Capital Resources - Debt," below.

Income tax expense increased \$263.0, or 14.5%, to \$2,071.0 in 2015. The effective tax rates in 2015 and 2014 were 44.7% and 41.4%, respectively. The increase in income tax expense was primarily due to the increase of the non-tax deductible HIP Fee, increased income before income taxes and increased state tax expense as a result of an adverse California franchise tax ruling. The increase in the effective tax rate for 2015 was primarily due to the increase in the non-tax deductible HIP fee and the state tax impact of the adverse California franchise tax ruling.

Our net income as a percentage of total revenue decreased 30 basis points to 3.2% in 2015 as compared to 2014 as a result of all factors discussed above.

Reportable Segments Results of Operations

We use operating gain to evaluate the performance of our reportable segments, which are Commercial and Specialty Business; Government Business; and Other. Operating gain is calculated as total operating revenue less benefit expense and selling, general and administrative expense. It does not include net investment income, net realized gains on financial instruments, other-than-temporary impairment losses recognized in income, interest expense, amortization of other intangible assets, (gain) loss on extinguishment of debt or income taxes, as these items are managed in a corporate shared service environment and are not the responsibility of operating segment management.

The discussion of segment results for the years ended December 31, 2016, 2015 and 2014 presented below are based on operating gain, as described above, and operating margin, which is calculated as operating gain divided by operating revenue. Our definitions of operating gain and operating margin may not be comparable to similarly titled measures reported by other companies. For additional information, see Note 19, "Segment Information," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Our Commercial and Specialty Business, Government Business, and Other segments' summarized results of operations for the years ended December 31, 2016, 2015 and 2014 are as follows:

	Years Ended December 31			Change			
				2016 vs. 2015		2015 vs. 2014	
	2016	2015	2014	\$	%	\$	%
Commercial and Specialty Business							
Operating revenue	\$ 38,692.1	\$ 37,570.8	\$ 39,199.6	\$ 1,121.3	3.0 %	\$ (1,628.8)	(4.2)%
Operating gain	\$ 3,195.2	\$ 2,854.0	\$ 3,260.9	\$ 341.2	12.0 %	\$ (406.9)	(12.5)%
Operating margin	8.3%	7.6%	8.3%		70bp		(70)bp
Government Business							
Operating revenue	\$ 45,477.7	\$ 40,813.0	\$ 33,796.4	\$ 4,664.7	11.4 %	\$ 7,016.6	20.8 %
Operating gain	\$ 1,784.3	\$ 1,978.5	\$ 1,191.9	\$ (194.2)	(9.8)%	\$ 786.6	66.0 %
Operating margin	3.9%	4.8%	3.5%		(90)bp		130bp
Other							
Operating revenue ¹	\$ 24.2	\$ 21.0	\$ 25.7	\$ 3.2	15.2 %	\$ (4.7)	(18.3)%
Operating loss ²	\$ (177.8)	\$ (79.4)	\$ (34.4)	\$ (98.4)	123.9 %	\$ (45.0)	130.8 %

¹ Fluctuations not material.

² Fluctuations are primarily a result of changes in unallocated corporate expenses. The increases in 2016 and 2015 were primarily due to transaction costs associated with our pending acquisition of Cigna.

Year Ended December 31, 2016 Compared to the Year Ended December 31, 2015

Commercial and Specialty Business

Operating revenue increased \$1,121.3, or 3.0%, to \$38,692.1 in 2016, primarily due to premium rate increases designed to cover overall cost trends in our Local Group and Individual businesses. The increase was further attributable to adjustments to accruals for the Health Care Reform risk adjustment premium stabilization program, membership growth in our ACA-compliant off- and on-exchange Individual business product offerings and increased administrative fees. The increase in administrative fees was primarily due to membership growth and rate increases for self-funded members in our National Accounts and self-funded Large Group businesses. The increase in operating revenue was partially offset by declines in fully-insured membership in our Small Group business and lapses in non-ACA-compliant Individual business product offerings.

Operating gain increased \$341.2, or 12.0%, to \$3,195.2 in 2016, primarily due to adjustments to accruals for the Health Care Reform risk adjustment premium stabilization program and lower selling, general and administrative expense related to expense efficiency initiatives. The increase was further attributable to membership growth in our National Accounts and self-funded Large Group businesses. These increases were partially offset by higher medical cost experience in our Individual and Local Group businesses and decreases in fully-insured Small Group membership.

The operating margin in 2016 was 8.3%, a 70 basis point increase over 2015, primarily due to the factors discussed in the preceding two paragraphs.

Government Business

Operating revenue increased \$4,664.7, or 11.4%, to \$45,477.7 in 2016. The increase in operating revenue was primarily due to increased premiums in our Medicaid business as a result of membership growth through new business expansions and organic growth in existing markets. The increase in operating revenue was also due to rate increases designed to cover overall cost trends in our Medicaid and Medicare businesses and increased premiums in our FEP business, due to increased reimbursed benefit utilization.

Operating gain decreased \$194.2, or 9.8%, to \$1,784.3 in 2016, primarily due to increases in medical cost experience in our Medicaid business that exceeded the impact of premium rate adjustments and higher than expected medical cost experience in the Iowa Medicaid market, which we began serving in 2016. These decreases were partially offset by lower selling, general and administrative expense related to expense efficiency initiatives, improved medical cost performance in our Medicare business and the favorable impact of a retroactive change in the minimum MLR calculation under California's Medicaid expansion program.

The operating margin in 2016 was 3.9%, a 90 basis point decrease from 2015, primarily due to the factors discussed in the preceding two paragraphs.

Year Ended December 31, 2015 Compared to the Year Ended December 31, 2014

Commercial and Specialty Business

Operating revenue decreased \$1,628.8, or 4.2%, to \$37,570.8 in 2015, due in part to fully-insured membership declines in our Large Group business largely driven by the discontinuation of our Georgia employer group Medicare product offering. The decrease in operating revenue was further attributable to attrition in our Small Group line of business resulting from both product mix changes as members moved into Health Care Reform product offerings and competitive pressures. Additionally, operating revenue decreased as a result of attrition in non-ACA-compliant Individual business product offerings and adjustments to accruals for the Health Care Reform risk adjustment premium stabilization program. These decreases were partially offset by premium rate increases in our Individual and Local Group lines of business designed to cover overall cost trends and the increase in the HIP Fee. The decrease in operating revenue was further offset by membership growth in our ACA-compliant on- and off-exchange Individual business product offerings and increased administrative fees. The increase in administrative fees was primarily attributable to membership growth and rate increases for self-funded members in our Large Group and National Accounts businesses.

Operating gain decreased \$406.9, or 12.5%, to \$2,854.0 in 2015, primarily due to higher than expected medical costs in our Individual business, membership declines in our fully-insured Local Group and Individual lines of business and adjustments to accruals for the Health Care Reform risk adjustment premium stabilization program. These decreases were partially offset by an increase in operating gain in our Local Group business primarily due to improved medical cost performance. The increase in operating gain was further offset by increases in self-funded membership in our Local Group and National Accounts businesses.

The operating margin in 2015 was 7.6%, a 70 basis point decrease from 2014, primarily due to the factors discussed in the preceding two paragraphs.

Government Business

Operating revenue increased \$7,016.6, or 20.8%, to \$40,813 in 2015. The increase in operating revenue was primarily due to increased premiums in our Medicaid business as a result of membership growth through commencement of operations in new markets including membership obtained through the acquisition of Simply Healthcare, membership growth through Health Care Reform expansions and membership growth in existing markets. The increase in Medicaid premiums was further due to rate increases designed to cover overall cost trends and the increase in the HIP Fee. The increase in operating revenue was further attributable to premium increases in our Medicare business as a result of rate increases designed to cover overall cost trends, the acquisition of Simply Healthcare and refinement of estimates associated with Medicare risk score revenue in the prior year. Finally, increased premiums in our FEP business primarily due to increased benefit utilization contributed to the increase in operating revenue.

Operating gain increased \$786.6, or 66.0%, to \$1,978.5 in 2015, primarily due to membership growth and improved medical cost performance in certain markets in our Medicaid and Medicare business, and refinement of estimates associated with Medicare risk score revenue in the prior year that did not recur in the current year. The increase in operating gain was further attributable to higher reimbursements for the non-tax deductible portion of the HIP Fee. These increases were partially offset by higher administrative costs to support our growth in membership.

The operating margin in 2015 was 4.8%, a 130 basis point increase over 2014, primarily due to the factors discussed in the preceding two paragraphs.

Critical Accounting Policies and Estimates

We prepare our consolidated financial statements in conformity with GAAP. Application of GAAP requires management to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes and within this MD&A. We consider our most important accounting policies that require significant estimates and management judgment to be those policies with respect to liabilities for medical claims payable, income taxes, goodwill and other intangible assets, investments and retirement benefits, which are discussed below. Our other significant accounting policies are summarized in Note 2, "Basis of Presentation and Significant Accounting Policies," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We continually evaluate the accounting policies and estimates used to prepare the consolidated financial statements. In general, our estimates are based on historical experience, evaluation of current trends, information from third party professionals and various other assumptions that we believe to be reasonable under the known facts and circumstances.

Medical Claims Payable

The most subjective accounting estimate in our consolidated financial statements is our liability for medical claims payable. At December 31, 2016, this liability was \$7,892.6 and represented 19.7% of our total consolidated liabilities. We record this liability and the corresponding benefit expense for incurred but not paid claims, including the estimated costs of processing such claims. Incurred but not paid claims include (1) an estimate for claims that are incurred but not reported, as well as claims reported to us but not yet processed through our systems, which approximated 96.5%, or \$7,619.9, of our total medical claims liability as of December 31, 2016; and (2) claims reported to us and processed through our systems but not yet paid, which approximated 3.5%, or \$272.7, of the total medical claims payable as of December 31, 2016. The level of claims payable processed through our systems but not yet paid may fluctuate from one period end to the next, from approximately 1% to 5% of our total medical claims liability, due to timing of when claim payments are made.

Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be appropriate under moderately adverse circumstances. We determine the amount of the liability for incurred but not paid claims by following a detailed actuarial process that entails using both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this process, historical paid claims data is formatted into “claim triangles,” which compare claim incurred dates to the dates of claim payments. This information is analyzed to create “completion factors” that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims.

For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather they are projected by estimating the claims expense for those months based on recent claims expense levels and health care trend levels, or “trend factors.”

Because the reserve methodology is based upon historical information, it must be adjusted for known or suspected operational and environmental changes. These adjustments are made by our actuaries based on their knowledge and their estimate of emerging impacts to benefit costs and payment speed. Circumstances to be considered in developing our best estimate of reserves include changes in utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations. A comparison of prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In our comparison of prior year, the methods and assumptions are not changed as reserves are recalculated; rather the availability of additional paid claims information drives our changes in the re-estimate of the unpaid claim liability. To the extent appropriate, changes in such development are recorded as a change to current period benefit expense.

We regularly review and set assumptions regarding cost trends and utilization when initially establishing claim liabilities. We continually monitor and adjust the claims liability and benefit expense based on subsequent paid claims activity. If it is determined that our assumptions regarding cost trends and utilization are significantly different than actual results, our income statement and financial position could be impacted in future periods. Adjustments of prior year estimates may result in additional benefit expense or a reduction of benefit expense in the period an adjustment is made. Further, due to the considerable variability of health care costs, adjustments to claim liabilities occur each period and are sometimes significant as compared to the net income recorded in that period. Prior period development is recognized immediately upon the actuary’s judgment that a portion of the prior period liability is no longer needed or that an additional liability should have been accrued. That determination is made when sufficient information is available to ascertain that the re-estimate of the liability is reasonable.

While there are many factors that are used as a part of the estimation of our medical claims payable liability, the two key assumptions having the most significant impact on our incurred but not paid claims liability as of December 31, 2016 were the completion and trend factors. As discussed above, these two key assumptions can be influenced by utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations.

There is variation in the reasonable choice of completion factors by duration for durations of three months through twelve months where the completion factors have the most significant impact. As previously discussed, completion factors tend to be less reliable for the most recent months and therefore are not specifically utilized for months one and two. In our analysis for the claim liabilities at December 31, 2016, the variability in months three to five was estimated to be between 40 and 90 basis points, while months six through twelve have much lower variability ranging from 0 to 30 basis points.

The difference in completion factor assumptions, assuming moderately adverse experience, results in variability of 2%, or approximately \$178.0, in the December 31, 2016 incurred but not paid claims liability, depending on the completion

factors chosen. It is important to note that the completion factor methodology inherently assumes that historical completion rates will be reflective of the current period. However, it is possible that the actual completion rates for the current period will develop differently from historical patterns and therefore could fall outside the possible variations described herein.

The other major assumption used in the establishment of the December 31, 2016 incurred but not paid claim liability was the trend factors. In our analysis for the period ended December 31, 2016, there was a 320 basis point differential in the high and low trend factors assuming moderately adverse experience. This range of trend factors would imply variability of 5%, or approximately \$359.0, in the incurred but not paid claims liability, depending upon the trend factors used. Because historical trend factors are often not representative of current claim trends, the trend experience for the most recent six to nine months, plus knowledge of recent events likely affecting current trends, have been taken into consideration in establishing the incurred but not paid claims liability at December 31, 2016.

See Note 11, "Medical Claims Payable," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K, for a reconciliation of the beginning and ending balance for medical claims payable for the years ended December 31, 2016, 2015 and 2014. Components of the total incurred claims for each year include amounts accrued for current year estimated claims expense as well as adjustments to prior year estimated accruals. In Note 11, "Medical Claims Payable," the line labeled "Net incurred medical claims: Prior years redundancies" accounts for those adjustments made to prior year estimates. The impact of any reduction of "Net incurred medical claims: Prior years redundancies" may be offset as we establish the estimate of "Net incurred medical claims: Current year." Our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for our claims. When we recognize a release of the redundancy, we disclose the amount that is not in the ordinary course of business, if material.

The ratio of current year medical claims paid as a percent of current year net medical claims incurred was 89.1% for both 2016 and 2015 and 89.4% for 2014. This ratio serves as an indicator of claims processing speed whereby claims were processed at the same speed in 2016 and 2015. The decrease in the ratio in 2015 from 2014 reflects a decrease in claims processing speed.

We calculate the percentage of prior years' redundancies in the current year as a percent of prior years' net incurred claims payable less prior years' redundancies in the current year in order to demonstrate the development of the prior years' reserves. This metric was 14.0% for the year ended December 31, 2016, 15.1% for the year ended December 31, 2015 and 9.7% for the year ended December 31, 2014. The year ended December 31, 2016 metric reflects a slightly lower level of conservatism than the metric for the year ended December 31, 2015. The year ended December 31, 2015 metric reflects a higher level of conservatism than the metric for year ended December 31, 2014.

We calculate the percentage of prior years' redundancies in the current period as a percent of prior years' net incurred medical claims to indicate the percentage of redundancy included in the preceding year calculation of current year net incurred medical claims. We believe this calculation supports the reasonableness of our prior year estimate of incurred medical claims and the consistency in our methodology. For the year ended December 31, 2016, this metric was 1.4%, which was calculated using the redundancy of \$850.4. This metric was 1.4% for 2015 and 1.0% for 2014.

The following table shows the variance between total net incurred medical claims as reported in Note 11, "Medical Claims Payable," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K, for each of 2015 and 2014 and the incurred claims for such years had it been determined retrospectively (computed as the difference between "net incurred medical claims – current year" for the year shown and "net incurred medical claims – prior years redundancies" for the immediately following year):

	Years Ended December 31	
	2015	2014
Total net incurred medical claims, as reported	\$ 59,908.2	\$ 55,763.9
Retrospective basis, as described above	59,858.0	55,505.6
Variance	\$ 50.2	\$ 258.3
Variance to total net incurred medical claims, as reported	0.1%	0.5%

Given that our business is primarily short tailed (which means that medical claims are generally paid within twelve months of the member receiving service from the provider), the variance to total net incurred medical claims, as reported above, is used to assess the reasonableness of our estimate of ultimate incurred medical claims for a given calendar year with the benefit of one year of experience. We expect that substantially all of the development of the 2016 estimate of medical claims payable will be known during 2017.

The 2015 variance to total net incurred medical claims, as reported of 0.1% was lower than the 2014 percentage of 0.5%. The lower 2015 variance was driven by a higher level of incurred claims recognized in 2015 as compared to 2014, with an approximately similar level of prior year redundancies recognized in each of the subsequent years.

Income Taxes

We account for income taxes in accordance with FASB guidance, which requires, among other things, the separate recognition of deferred tax assets and deferred tax liabilities. Such deferred tax assets and deferred tax liabilities represent the tax effect of temporary differences between financial reporting and tax reporting measured at tax rates enacted at the time the deferred tax asset or liability is recorded. A valuation allowance must be established for deferred tax assets if it is "more likely than not" that all or a portion may be unrealized. Our judgment is required in determining an appropriate valuation allowance.

At each financial reporting date, we assess the adequacy of the valuation allowance by evaluating each of our deferred tax assets based on the following:

- the types of temporary differences that created the deferred tax asset;
- the amount of taxes paid in prior periods and available for a carry-back claim;
- the forecasted future taxable income, and therefore, likely future deduction of the deferred tax item; and
- any significant other issues impacting the likely realization of the benefit of the temporary differences.

We, like other companies, frequently face challenges from tax authorities regarding the amount of taxes due. These challenges include questions regarding the timing and amount of deductions that we have taken on our tax returns. In evaluating any additional tax liability associated with various positions taken in our tax return filings, we record additional liabilities for potential adverse tax outcomes. Based on our evaluation of our tax positions, we believe we have appropriately accrued for uncertain tax benefits, as required by the guidance. To the extent we prevail in matters we have accrued for, our future effective tax rate would be reduced and net income would increase. If we are required to pay more than accrued, our future effective tax rate would increase and net income would decrease. Our effective tax rate and net income in any given future period could be materially impacted.

In the ordinary course of business, we are regularly audited by federal and other tax authorities, and from time to time, these audits result in proposed assessments. We believe our tax positions comply with applicable tax law and we intend to defend our positions vigorously through the federal, state and local appeals processes. We believe we have adequately provided for any reasonable foreseeable outcome related to these matters. Accordingly, although their ultimate resolution may require additional tax payments, we do not anticipate any material impact on our results of operations from these matters.

For additional information, see Note 7, "Income Taxes," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Goodwill and Other Intangible Assets

Our consolidated goodwill at December 31, 2016 was \$17,561.2 and other intangible assets were \$7,964.9. The sum of goodwill and other intangible assets represented 39.2% of our total consolidated assets and 101.7% of our consolidated shareholders' equity at December 31, 2016.

We follow FASB guidance for business combinations and goodwill and other intangible assets, which specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Under the guidance, goodwill and other intangible assets (with indefinite lives) are not amortized but are tested for impairment at least annually. Furthermore, goodwill and other intangible assets are allocated to reporting units for purposes of the annual impairment test.

Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units, which include goodwill and other intangible assets. In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately.

We complete our annual impairment tests of existing goodwill and other intangible assets with indefinite lives during the fourth quarter of each year. These tests involve the use of estimates related to the fair value of goodwill at the reporting unit level and other intangible assets with indefinite lives, and require a significant degree of management judgment and the use of subjective assumptions. Certain interim impairment tests are also performed when potential impairment indicators exist or changes in our business or other triggering events occur.

Fair value is estimated using the income and market approaches for goodwill at the reporting unit level and the income approach for our indefinite lived intangible assets. Use of the income and market approaches for our goodwill impairment test reflects our view that both valuation methodologies provide a reasonable estimate of fair value. The income approach is developed using assumptions about future revenue, expenses and net income derived from our internal planning process. These estimated future cash flows are then discounted. Our assumed discount rate is based on our industry's weighted-average cost of capital. Market valuations are based on observed multiples of certain measures including revenue, EBITDA (earnings before interest, taxes, depreciation and amortization), and book value of invested capital (debt and equity) and include market comparisons to publicly traded companies in our industry.

We did not incur any impairment losses as a result of our 2016 annual impairment tests as the estimated fair values of our reporting units were substantially in excess of the carrying values as of December 31, 2016. Additionally, we do not believe that the estimated fair values of our reporting units are at risk of becoming impaired in the next twelve months. However, as a result of certain provisions of Health Care Reform, along with current economic conditions, we have experienced lower operating margins in certain lines of business. Those margins could become further compressed with adverse changes in federal and state laws and regulations. As a result, the estimated fair values of certain of our reporting units with goodwill could fall below their carrying values in future periods and if that were to occur, we would be required to record impairment losses at that time.

While we believe we have appropriately allocated the purchase price of our acquisitions, this allocation requires many assumptions to be made regarding the fair value of assets and liabilities acquired. In addition, estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used. If estimated fair values are less than the carrying values of goodwill and other intangibles with indefinite lives in future annual impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

For additional information, see Note 3, "Business Acquisitions and Divestiture" and Note 9, "Goodwill and Other Intangible Assets," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Investments

Current and long-term available-for-sale investment securities were \$19,187.4 at December 31, 2016 and represented 29.5% of our total consolidated assets at December 31, 2016. We classify fixed maturity and equity securities in our investment portfolio as "available-for-sale" or "trading" and report those securities at fair value. Certain fixed maturity securities are available to support current operations and, accordingly, we classify such investments as current assets without regard to their contractual maturity. Investments used to satisfy contractual, regulatory or other requirements are classified as long-term, without regard to contractual maturity.

We review investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both qualitative and quantitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the length of time and the extent to which a security's market value has been less than its cost, the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors), financial condition and near term prospects of the issuer, including the credit ratings and changes in the credit ratings of the issuer, recommendations of investment advisors, and forecasts of economic, market or industry trends. In addition, for equity securities, we determine whether we have the intent and ability to hold the security for a period of time to allow for a

recovery of its fair value above its carrying amount. If any declines of equity securities are determined to be other-than-temporary, we charge the losses to income when that determination is made.

Certain FASB other-than-temporary impairment, or OTTI, guidance applies to fixed maturity securities and provides guidance on the recognition, presentation of, and disclosures for OTTIs. If a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, the decline in value is deemed to be other-than-temporary and is presented within the Other-than-temporary impairment losses recognized in income line item on our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, the credit component of the OTTI is presented within the Other-than-temporary impairment losses recognized in income line item on our consolidated statements of income and the non-credit component of the OTTI is recognized in other comprehensive income. Furthermore, unrealized losses entirely caused by non-credit related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive income.

The credit component of an OTTI is determined primarily by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting our best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of acquisition. For mortgage-backed and asset-backed securities, cash flow estimates are based on assumptions regarding the underlying collateral including prepayment speeds, vintage, type of underlying asset, geographic concentrations, default rates, recoveries and changes in value. For all other debt securities, cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings, and estimates regarding timing and amount of recoveries associated with a default.

We have a committee of accounting and investment associates and management that is responsible for managing the impairment review process. The current economic environment and volatility of securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets.

We believe we have adequately reviewed our investment securities for impairment and that our investment securities are carried at fair value. However, over time, the economic and market environment may provide additional insight regarding the fair value of certain securities, which could change our judgment regarding impairment. This could result in other-than-temporary impairment losses on investments being charged against future income. Given the current market conditions and the significant judgments involved, there is continuing risk that further declines in fair value may occur and additional, material other-than-temporary impairment losses on investments may be recorded in future periods.

In addition to available-for-sale investment securities, we held additional long-term investments of \$2,240.5, or 3.4% of total consolidated assets, at December 31, 2016. These long-term investments consisted primarily of certain other equity investments, cash surrender value of corporate-owned life insurance policies and real estate. Due to their less liquid nature, these investments are classified as long-term.

Through our investing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in equity market valuations. We manage the market risks through our investment policy, which establishes credit quality limits and limits on investments in individual issuers. Ineffective management of these risks could have an impact on our future earnings and financial position. Our investment portfolio includes fixed maturity securities with a fair value of \$17,687.5 at December 31, 2016. The weighted-average credit rating of these securities was "A" as of December 31, 2016. Included in this balance are investments in fixed maturity securities of states, municipalities and political subdivisions and investments in mortgage-backed securities of \$1,301.4 and \$1.8, respectively, that are guaranteed by third parties. With the exception of eighteen securities with a fair value of \$7.2, these securities are all investment-grade and carry a weighted-average credit rating of "A" as of December 31, 2016. The securities are guaranteed by a number of different guarantors and we do not have any significant exposure to any single guarantor (neither indirect through the guarantees, nor direct through investment in the guarantor). Further, due to the high underlying credit rating of the issuers, the weighted-average credit rating of the fixed maturity securities without a guarantee, for which such information is available, was "A" as of December 31, 2016.

Fair values of available-for-sale fixed maturity and equity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level I or Level II inputs for the determination of fair value in accordance with FASB guidance for fair value measurements and disclosures. We have controls in place to review the pricing services' qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable.

We obtain only one quoted price for each security from the pricing services, which are derived through recently reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. As we are responsible for the determination of fair value, we perform monthly analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. Our analysis includes a review of month-to-month price fluctuations. If unusual fluctuations are noted in this review, we may obtain additional information from other pricing services to validate the quoted price. There were no adjustments to quoted market prices obtained from the pricing services during the years ended December 31, 2016 and 2015.

In certain circumstances, it may not be possible to derive pricing model inputs from observable market activity, and therefore, such inputs are estimated internally. Such securities are designated Level III in accordance with FASB guidance. Securities designated Level III at December 31, 2016 totaled \$481.4 and represented approximately 2.3% of our total assets measured at fair value on a recurring basis. Our Level III securities primarily consisted of certain corporate securities, equity securities and structured securities for which observable inputs were not always available and the fair values of these securities were estimated using internal estimates for inputs including, but not limited to, prepayment speeds, credit spreads, default rates and benchmark yields.

For additional information, see Part II, Item 7A "Quantitative and Qualitative Disclosures about Market Risk," and Part II, Item 8, Note 2, "Basis of Presentation and Significant Accounting Policies," Note 4, "Investments," and Note 6, "Fair Value," to our audited consolidated financial statements included in this Annual Report on Form 10-K.

Retirement Benefits

Pension Benefits

We sponsor defined benefit pension plans for some of our employees. These plans are accounted for in accordance with FASB guidance for retirement benefits, which requires that amounts recognized in financial statements be determined on an actuarial basis. As permitted by the guidance, we calculate the value of plan assets as described below. Further, the difference between our expected rate of return and the actual performance of plan assets, as well as certain changes in pension liabilities, are amortized over future periods.

An important factor in determining our pension expense is the assumption for expected long-term return on plan assets. As of our December 31, 2016 measurement date, we selected a weighted-average long-term rate of return on plan assets of 7.95%. We use a total portfolio return analysis in the development of our assumption. Factors such as past market performance, the long-term relationship between fixed maturity and equity securities, interest rates, inflation and asset allocations are considered in the assumption. The assumption includes an estimate of the additional return expected from active management of the investment portfolio. Peer data and an average of historical returns are also reviewed for appropriateness of the selected assumption. We believe our assumption of future returns is reasonable. However, if we lower our expected long-term return on plan assets, future contributions to the pension plan and pension expense would likely increase.

This assumed long-term rate of return on assets is applied to a calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over three years, producing the expected return on plan assets that is included in the determination of pension expense. We apply a corridor approach to amortize unrecognized actuarial gains or losses. Under this approach, only accumulated net actuarial gains or losses in excess of 10% of the greater of the projected benefit obligation or the fair value of plan assets are amortized over the average remaining service or lifetime of the

workforce as a component of pension expense. The net deferral of past asset gains or losses affects the calculated value of plan assets and, ultimately, future pension expense.

The discount rate reflects the current rate at which the pension liabilities could be effectively settled at the end of the year based on our most recent measurement date. At the December 31, 2016 measurement date, the selected weighted-average discount rate was 3.77%, compared to 3.92% at the December 31, 2015 measurement date. We developed this rate using a yield curve approach. Using yields available on high-quality fixed maturity securities with various maturity dates, the yield curve approach provides a "customized" rate, which is meant to match the expected cash flows of our specific benefit plans. The net effect of changes in the discount rate, as well as the net effect of other changes in actuarial assumptions and experience, have been deferred and amortized as a component of pension expense in accordance with FASB guidance.

In managing the plan assets, our objective is to be a responsible fiduciary while minimizing financial risk. Plan assets include a diversified mix of investment grade fixed maturity securities, equity securities and alternative investments across a range of sectors and levels of capitalization to maximize the long-term return for a prudent level of risk. In addition to producing a reasonable return, the investment strategy seeks to minimize the volatility in our expense and cash flow.

Other Postretirement Benefits

We provide most associates with certain medical, vision and dental benefits upon retirement. We use various actuarial assumptions, including a discount rate and the expected trend in health care costs, to estimate the costs and benefit obligations for our retiree benefits.

At our December 31, 2016 measurement date, the selected discount rate for all plans was 3.82%, compared to a discount rate of 4.01% at the December 31, 2015 measurement date. We developed this rate using a yield curve approach as described above.

The assumed health care cost trend rates used to measure the expected cost of pre-Medicare (those who are not currently eligible for Medicare benefits) other benefits at our December 31, 2016 measurement date was 8.00% for 2017 with a gradual decline to 4.50% by the year 2028. The assumed health care cost trend rates used to measure the expected cost of post-Medicare (those who are currently eligible for Medicare benefits) other benefits at our December 31, 2016 measurement date was 6.00% for 2017 with a gradual decline to 4.50% by the year 2024. These estimated trend rates are subject to change in the future. The health care cost trend rate assumption has a significant effect on the amounts reported. For example, an increase in the assumed health care cost trend rate of one percentage point would increase the postretirement benefit obligation as of December 31, 2016 by \$42.2 and would increase service and interest costs by \$1.8. Conversely, a decrease in the assumed health care cost trend rate of one percentage point would decrease the postretirement benefit obligation as of December 31, 2016 by \$36.2 and would decrease service and interest costs by \$1.5.

For additional information regarding our retirement benefits, see Note 10, "Retirement Benefits," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

New Accounting Pronouncements

For information regarding new accounting pronouncements that were issued or became effective during the year ended December 31, 2016 that had, or are expected to have a material impact on our financial position, results of operations or financial statement disclosures, see the "*Recently Adopted Accounting Guidance*" and "*Recent Accounting Guidance Not Yet Adopted*" sections of Note 2, "Basis of Presentation and Significant Accounting Policies" to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Liquidity and Capital Resources

Introduction

Our cash receipts result primarily from premiums, administrative fees, investment income, other revenue, proceeds from the sale or maturity of our investment securities, proceeds from borrowings, and proceeds from the issuance of common stock under our employee stock plans. Cash disbursements result mainly from claims payments, administrative expenses, taxes, purchases of investment securities, interest expense, payments on borrowings, acquisitions, capital expenditures, repurchases

of our debt securities and common stock and the payment of cash dividends. Cash outflows fluctuate with the amount and timing of settlement of these transactions. Any future decline in our profitability would likely have an unfavorable impact on our liquidity.

We manage our cash, investments and capital structure so we are able to meet the short and long-term obligations of our business while maintaining financial flexibility and liquidity. We forecast, analyze and monitor our cash flows to enable investment and financing within the overall constraints of our financial strategy.

A substantial portion of the assets held by our regulated subsidiaries are in the form of cash and cash equivalents and investments. After considering expected cash flows from operating activities, we generally invest cash that exceeds our near term obligations in longer term marketable fixed maturity securities to improve our overall investment income returns. Our investment strategy is to make investments consistent with insurance statutes and other regulatory requirements, while preserving our asset base. Our investments are generally available-for-sale to meet liquidity and other needs. Our subsidiaries pay out excess capital annually in the form of dividends to their respective parent companies for general corporate use, as permitted by applicable regulations.

The availability of financing in the form of debt or equity is influenced by many factors including our profitability, operating cash flows, debt levels, debt ratings, contractual restrictions, regulatory requirements and market conditions. The securities and credit markets have in the past experienced higher than normal volatility, although current market conditions are more stable. During recent years, the federal government and various governmental agencies have taken a number of steps to restore liquidity in the financial markets and to help relieve the credit crisis and strengthen the regulation of the financial services market. In addition, governments around the world have developed their own plans to provide liquidity and security in the credit markets and to ensure adequate capital in certain financial institutions.

We have a \$2,500.0 commercial paper program. Should commercial paper issuance be unavailable, we have the ability to use a combination of cash on hand and/or our \$3,500.0 senior revolving credit facility to redeem any outstanding commercial paper upon maturity. Additionally, we believe the lenders participating in our credit facility would be willing and able to provide financing in accordance with their legal obligations. In addition to the \$3,500.0 senior revolving credit facility, we estimate that we will receive approximately \$1,900.0 of dividends from our subsidiaries during 2017, which also provides further operating and financial flexibility.

The table below outlines the cash flows provided by or used in operating, investing and financing activities for the years ended December 31, 2016, 2015 and 2014:

	Years Ended December 31		
	2016	2015	2014
Cash flows provided by (used in):			
Operating activities	\$ 3,204.5	\$ 4,116.0	\$ 3,369.3
Investing activities	(513.9)	(1,151.5)	(974.9)
Financing activities	(732.9)	(2,997.4)	(1,822.5)
Effect of foreign exchange rates on cash and cash equivalents	4.1	(5.3)	(7.1)
Increase (decrease) in cash and cash equivalents	\$ 1,961.8	\$ (38.2)	\$ 564.8

Liquidity—Year Ended December 31, 2016 Compared to Year Ended December 31, 2015

During the year ended December 31, 2016, net cash flow provided by operating activities was \$3,204.5, compared to \$4,116.0 for the year ended December 31, 2015, a decrease of \$911.5. The decrease was primarily attributable to an increase in claims payments due to higher medical cost experience and growth in membership. The decrease was further due to the timing of claim reimbursements from our self-insured customers. These decreases were partially offset by an increase in premium receipts as a result of rate increases across our businesses designed to cover overall cost trends and growth in membership. The decrease was further offset by an increase in pharmacy rebates received.

Net cash flow used in investing activities was \$513.9 during the year ended December 31, 2016, compared to \$1,151.5 for the year ended December 31, 2015. The decrease in cash flow used in investing activities of \$637.6 was primarily due to a

decrease in cash used for the purchase of subsidiaries, as net cash used in investing activities during the year ended December 31, 2015 included the purchase of Simply Healthcare while there were no purchases of subsidiaries during the year ended December 31, 2016. This decrease was partially offset by an increase in net purchases of investments.

Net cash flow used in financing activities was \$732.9 during the year ended December 31, 2016, compared to \$2,997.4 for the year ended December 31, 2015. The decrease in cash flow used in financing activities of \$2,264.5 primarily resulted from a decrease in common stock repurchases, as we did not repurchase any common stock during the year ended December 31, 2016. The decrease was further due to a decrease in net repayments of short- and long-term borrowings and changes in bank overdrafts. The decrease in cash flow used in financing activities was partially offset by changes in commercial paper borrowings, payments on debt-related derivatives in 2016, a decrease in proceeds from the issuance of common stock under our employee stock plans and a decrease in excess tax benefits from share-based compensation.

Liquidity— Year Ended December 31, 2015 Compared to Year Ended December 31, 2014

During the year ended December 31, 2015, net cash flow provided by operating activities was \$4,116.0, compared to \$3,369.3 for the year ended December 31, 2014, an increase of \$746.7. The increase was primarily attributable to an increase in premium receipts as a result of rate increases across our businesses designed to cover overall cost trends and the HIP Fee, and growth in membership. The increase in cash provided by operating activities was further attributable to the receipt of the reinsurance recoveries payment related to the 2014 Health Care Reform reinsurance premium stabilization program and payments made in 2014 that did not recur in 2015 for the adjudication of claims relating to the New York State contract conversion from our fully-insured Local Group business to a self-funded ASO contract. The increase in cash provided by operating activities was partially offset by an increase in claims payments, primarily as a result of membership growth, an increase in income tax payments and an increase in the annual HIP Fee payment.

Net cash flow used in investing activities was \$1,151.5 during the year ended December 31, 2015, compared to \$974.9 for the year ended December 31, 2014. The increase in cash flow used in investing activities of \$176.6 primarily resulted from changes in cash flows relating to the purchase and sale of subsidiaries. Cash utilized for the purchase of subsidiaries during the year ended December 31, 2015 primarily related to the purchase of Simply Healthcare. During the year ended December 31, 2014, cash was provided by the sale of our 1-800 CONTACTS business and glasses.com related assets. The increase in cash flow used in investing activities was partially offset by changes in securities lending collateral and a decrease in net purchases of investments.

Net cash flow used in financing activities was \$2,997.4 during the year ended December 31, 2015, compared to \$1,822.5 for the year ended December 31, 2014. The increase in cash flow used in financing activities of \$1,174.9 primarily resulted from changes in long-term borrowings as a result of net repayments of long-term borrowings during 2015 compared to net proceeds from long-term borrowings during 2014. The increase in cash flow used in financing activities was further attributable to changes in securities lending payable, changes in bank overdrafts, an increase in cash dividends paid to shareholders and a decrease in proceeds from the issuance of common stock under our employee stock plans. The increase in cash flow used in financing activities was partially offset by a decrease in common stock repurchases, an increase in net proceeds from commercial paper borrowings, an increase in net proceeds from short-term borrowings and an increase in excess tax benefits from share-based compensation.

Financial Condition

We maintained a strong financial condition and liquidity position, with consolidated cash, cash equivalents and investments, including long-term investments, of \$25,519.0 at December 31, 2016. Since December 31, 2015, total cash, cash equivalents and investments, including long-term investments, increased by \$2,394.3 primarily due to cash generated from operations, an increase in bank overdrafts changes, proceeds from the issuance of common stock under our employee stock plans and excess tax benefits from share-based compensation. These increases were partially offset by cash dividends paid to shareholders, purchases of property and equipment, payments on debt-related derivatives and net repayments of short-term and commercial paper borrowings.

Many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their respective parent companies. Certain accounting practices prescribed by insurance regulatory authorities, or statutory accounting practices, differ from GAAP. Changes that occur in statutory

accounting practices, if any, could impact our subsidiaries' future dividend capacity. In addition, we have agreed to certain undertakings to regulatory authorities, including the requirement to maintain certain capital levels in certain of our subsidiaries.

At December 31, 2016, we held \$1,445.8 of cash, cash equivalents and investments at the parent company, which are available for general corporate use, including investment in our businesses, acquisitions, potential future common stock repurchases and dividends to shareholders, repurchases of debt securities and debt and interest payments.

Debt

During the year ended December 31, 2015, we repurchased \$920.0 of the aggregate principal balance of our outstanding senior convertible debentures due 2042, or the Debentures. In addition, \$66.6 aggregate principal balance was surrendered for conversion by certain holders in accordance with the terms and provisions of the indenture governing the Debentures. We elected to settle the excess of the principal amount of the repurchases and conversions with cash for total payments of \$2,055.7. We recognized a gain on the extinguishment of debt related to the Debentures of \$12.7, based on the fair values of the debt on the repurchase and conversion settlement dates.

On September 10, 2015, we repaid, upon maturity, the \$625.0 outstanding principal balance of our 1.25% senior unsecured notes due 2015. Additionally, during the year ended December 31, 2015, we repurchased \$13.0 of outstanding principal balance of certain other senior unsecured notes, plus applicable premium, accrued and unpaid interest, for cash totaling \$16.2. We recognized a loss on extinguishment of debt of \$3.4 on the repurchase of these notes.

On May 12, 2015, we issued 25.0 Equity Units, pursuant to an underwriting agreement dated May 6, 2015, in an aggregate principal amount of \$1,250.0. Each Equity Unit has a stated amount of \$50 (whole dollars) and consists of a purchase contract obligating the holder to purchase a certain number of shares of our common stock on May 1, 2018, subject to earlier termination or settlement, for a price in cash of \$50 (whole dollars); and a 5% undivided beneficial ownership interest in \$1,000 (whole dollars) principal amount of our 1.900% remarketable subordinated notes, due 2028. We received \$1,228.8 in cash proceeds from the issuance of the Equity Units, net of underwriting discounts and commissions and offering expenses payable by us, and recorded \$1,250.0 in long-term debt.

On September 15, 2014, we redeemed the \$500.0 outstanding principal balance of our 5.000% senior unsecured notes due 2014, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling \$512.3. We recognized a loss on extinguishment of debt of \$2.3 on the redemption of these notes.

On September 11, 2014, we redeemed the \$1,097.9 outstanding principal balance of our 5.250% senior unsecured notes due 2016, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling \$1,178.2. We recognized a loss on extinguishment of debt of \$67.6 on the redemption of these notes.

Additionally, during the year ended December 31, 2014, we repurchased \$52.0 of outstanding principal amount of certain other senior unsecured notes, plus applicable premium for early redemption plus accrued and unpaid interest, for cash totaling \$61.0. We recognized a loss on extinguishment of debt of \$11.2 for the year ended December 31, 2014 on the repurchase of these notes.

On August 12, 2014, we issued \$850.0 of 2.250% notes due 2019, \$800.0 of 3.500% notes due 2024, \$800.0 of 4.650% notes due 2044, and \$250.0 of 4.850% notes due 2054 under our shelf registration statement. We used the proceeds from this offering in part to fund the purchase price of the 5.000% and 5.250% senior unsecured notes discussed above, and the remaining net proceeds were used for general corporate purposes. Interest on the notes is payable semi-annually in arrears on February 15 and August 15 of each year and commenced on February 15, 2015. The notes have a call feature that allows us to redeem the notes at any time at our option and a put feature that allows a note holder to redeem the notes upon the occurrence of both a change in control event and a downgrade of the notes below an investment grade rating. For additional information related to our borrowing activities, see Note 12, "Debt" to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We calculate our consolidated debt-to-capital ratio, a non-GAAP measure, from the amounts presented on our audited consolidated balance sheets included in Part II, Item 8 of this Annual Report on Form 10-K. Our debt-to-capital ratio is calculated as the sum of short-term borrowings, plus current portion of long-term debt, plus long-term debt, less current

portion, divided by the sum of short-term borrowings, plus current portion of long-term debt, plus long-term debt, less current portion, plus total shareholders' equity. We believe our debt-to-capital ratio assists investors and rating agencies in measuring our overall leverage and additional borrowing capacity. In addition, our bank covenants include a maximum debt-to-capital ratio that we cannot and did not exceed. Our debt-to-capital ratio may not be comparable to similarly titled measures reported by other companies. Our consolidated debt-to-capital ratio was 38.5% and 40.8% as of December 31, 2016 and 2015, respectively. We expect that our pro forma debt-to-capital ratio will approximate 49% following the closing of the acquisition of Cigna, and we are committed to deleveraging to the low 40% range approximately twenty-four months following the closing.

Our senior debt is rated "A" by Standard & Poor's, "BBB" by Fitch, Inc., "Baa2" by Moody's Investor Service, Inc. and "bbb+" by AM Best Company, Inc. Following the announcement of the Merger Agreement, each of these rating agencies placed certain of our debt, financial strength and other credit ratings under review for a possible downgrade, however, we intend to maintain our senior debt investment grade ratings. If our credit ratings are downgraded, our business, financial condition and results of operations could be adversely impacted by limitations on future borrowings and a potential increase in our borrowing costs.

Future Sources and Uses of Liquidity

During the year ended December 31, 2015, we entered into a bridge facility commitment letter and a joinder agreement, and a term loan facility, to finance a portion of the pending acquisition of Cigna. In January 2017, we reduced the amount available under the bridge facility commitment letter from \$22,500.0 to \$19,500.0, and extended the termination date under the Merger Agreement, as well as the availability for commitments under the bridge facility and term loan facility, to April 30, 2017. The commitment of the lenders to provide the bridge facility and the term loan facility is subject to several conditions, including the completion of the acquisition of Cigna. For additional information, see the "Overview" section included in this "Management's Discussion and Analysis of Financial Condition and Results of Operations"; and Note 3, "Business Acquisitions and Divestiture - *Pending Acquisition of Cigna Corporation*" included in Part II, Item 8 of this Annual Report on Form 10-K.

We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansion.

We have a senior revolving credit facility, or the Facility, with a group of lenders for general corporate purposes. The Facility provides credit up to \$3,500.0 and expires on August 25, 2020. The interest rate on the Facility is based on either the LIBOR rate or a base rate plus a predetermined rate based on our public debt rating at the date of utilization. Our ability to borrow under the Facility is subject to compliance with certain covenants. There were no amounts outstanding under the senior revolving credit facilities at December 31, 2016 or 2015.

We have an authorized commercial paper program of up to \$2,500.0, the proceeds of which may be used for general corporate purposes. At December 31, 2016 and 2015, we had \$629.0 and \$682.2, respectively, of borrowings outstanding under our commercial paper program. Commercial paper borrowings are classified as long-term debt as our general practice and intent is to replace short-term commercial paper outstanding at expiration with additional short-term commercial paper for an uninterrupted period extending for more than one year and we have the ability to redeem our commercial paper with borrowings under the senior revolving credit facility described above.

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati and the Federal Home Loan Bank of Atlanta, collectively, the FHLBs, and as a member we have the ability to obtain short-term cash advances subject to certain minimum collateral requirements. At December 31, 2016 and 2015, \$440.0 and \$540.0, respectively, were outstanding under our short-term FHLBs borrowings.

As discussed in "Financial Condition" above, many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid. Based upon these requirements, we are currently estimating approximately \$1,900.0 of dividends to be paid to the parent company during 2017. During 2016, we received \$2,688.8 of dividends from our subsidiaries.

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors.

A summary of the cash dividend activity for the year ended December 31, 2016 is as follows:

Declaration Date	Record Date	Payment Date	Cash Dividend per Share	Total
February 18, 2016	March 10, 2016	March 25, 2016	\$ 0.6500	\$ 170.7
April 26, 2016	June 10, 2016	June 24, 2016	0.6500	170.9
July 26, 2016	September 9, 2016	September 26, 2016	0.6500	171.1
November 1, 2016	December 5, 2016	December 21, 2016	0.6500	171.3

On February 22, 2017, our Board of Directors declared a quarterly cash dividend of \$0.6500 per share on the outstanding shares of our common stock. This quarterly dividend is payable on March 24, 2017 to the shareholders of record as of March 10, 2017.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. On October 2, 2014, the Board of Directors authorized a \$5,000.0 increase to the common stock repurchase program. Repurchases may be made from time to time at prevailing market prices, subject to certain restrictions on volume, pricing and timing. The repurchases are effected from time to time in the open market, through negotiated transactions, including accelerated share repurchase agreements, and through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. Our stock repurchase program is discretionary as we are under no obligation to repurchase shares. We repurchase shares under the program when we believe it is a prudent use of capital. The excess cost of the repurchased shares over par value is charged on a pro rata basis to additional paid-in capital and retained earnings. There were no common stock repurchases during the year ended December 31, 2016. Total authorization remaining at December 31, 2016 was \$4,175.9 and we expect to utilize the remaining authorized amount over a multi-year period, subject to market and industry conditions.

Contractual Obligations and Commitments

Our estimated contractual obligations and commitments as of December 31, 2016 are as follows:

		Payments Due by Period								
		Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years				
On-Balance Sheet:										
Debt ¹	\$	24,551.2	\$	2,571.1	\$	3,615.7	\$	2,320.1	\$	16,044.3
Other long-term liabilities ²		1,260.8		419.6		453.5		302.1		85.6
Off-Balance Sheet:										
Purchase obligations ³		2,059.0		975.6		984.0		99.4		—
Operating lease commitments		770.5		149.7		258.5		161.2		201.1
Investment commitments ⁴		798.0		324.8		316.8		137.3		19.1
Total contractual obligations and commitments	\$	29,439.5	\$	4,440.8	\$	5,628.5	\$	3,020.1	\$	16,350.1

¹ Includes estimated interest expense.

² Primarily consists of reserves for future policy benefits, projected other postretirement benefits, deferred compensation, supplemental executive retirement plan liabilities and certain other miscellaneous long-term obligations. Estimated future payments for funded pension benefits have been excluded from this table as we had no funding requirements under ERISA at December 31, 2016 as a result of the value of the assets in the plans.

³ Includes estimated payments for future services under contractual arrangements from third-party service contracts.

⁴ Includes unfunded capital commitments for alternative investments.

The above table does not contain \$150.0 of gross liabilities for uncertain tax positions and interest for which we cannot reasonably estimate the timing of the resolutions with the respective taxing authorities. For further information, see Note 7, "Income Taxes," to the audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

In addition to the contractual obligations and commitments discussed above, we have a variety of other contractual agreements related to acquiring materials and services used in our operations. However, we do not believe these other agreements contain material noncancelable commitments.

We believe that funds from future operating cash flows, cash and investments and funds available under our senior revolving credit facility, bridge facility, term loan facility and/or from public or private financing sources, will be sufficient for future operations and commitments, and for capital acquisitions and other strategic transactions.

Off-Balance Sheet Arrangements

We do not have any off-balance sheet derivative instruments, guarantee transactions, agreements or other contractual arrangements or any indemnification agreements that will require funding in future periods. We have not transferred assets to an unconsolidated entity that serve as credit, liquidity or market risk support to such entity. We do not hold any variable interest in an unconsolidated entity where such entity provides us with financing, liquidity, market risk or credit risk support.

Risk-Based Capital

Our regulated subsidiaries' states of domicile have statutory risk-based capital, or RBC, requirements for health and other insurance companies and health maintenance organizations largely based on the National Association of Insurance Commissioners, or NAIC, RBC Model Act. These RBC requirements are intended to measure capital adequacy, taking into account the risk characteristics of an insurer's investments and products. The NAIC sets forth the formula for calculating the RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company's business. In general, under the RBC Model Act, an insurance company must submit a report of its RBC level to the state insurance department or insurance commissioner, as appropriate, at the end of each calendar year. Our regulated subsidiaries' respective RBC levels as of December 31, 2016, which was the most recent date for which reporting was required, were in excess of all mandatory RBC requirements. In addition to exceeding the RBC requirements, we are in compliance with the liquidity and capital requirements for a licensee of the BCBSA and with the tangible net worth requirements applicable to certain of our California subsidiaries.

For additional information, see Note 21, "Statutory Information," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Forward-Looking Statements

This document contains certain forward-looking information about us that is intended to be covered by the safe harbor for "forward-looking statements" provided by the Private Securities Litigation Reform Act of 1995. Forward-looking statements are generally not historical facts. Words such as "expect," "feel," "believe," "will," "may," "should," "anticipate," "intend," "estimate," "project," "forecast," "plan," and similar expressions are intended to identify forward-looking statements. These statements include, but are not limited to: financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Such statements are subject to certain risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking statements. These risks and uncertainties include: those discussed and identified in our public filings with the U.S. Securities and Exchange Commission, or SEC; increased government participation in, or regulation or taxation of health benefits and managed care operations, including, but not limited to, the impact of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, or Health Care Reform, and the impact of any future modification, repeal or replacement of Health Care Reform; trends in health care costs and utilization rates; our ability to secure sufficient premium rates including regulatory approval for and implementation of such rates; our participation in federal and state health insurance exchanges under Health Care Reform, which have experienced and continue to experience challenges due to implementation of initial and phased-in

provisions of Health Care Reform, and which entail uncertainties associated with the mix and volume of business, particularly in our Individual and Small Group markets, that could negatively impact the adequacy of our premium rates and which may not be sufficiently offset by the risk apportionment provisions of Health Care Reform; the ultimate outcome of our pending acquisition of Cigna Corporation ("Cigna") (the "Acquisition"), including our ability to achieve the synergies and value creation contemplated by the Acquisition within the expected time period, or at all, and the risk that unexpected costs will be incurred in connection therewith; the ultimate outcome and results of integrating our and Cigna's operations and disruption from the Acquisition making it more difficult to maintain businesses and operational relationships; the possibility that the Acquisition does not close, including, but not limited to, due to the failure to satisfy the closing conditions, including the receipt of required regulatory approvals; Cigna's litigation to terminate the pending Acquisition and claim damages against us, together with our own litigation against Cigna, and the potential for such litigation to cause us to incur substantial costs, materially distract management and negatively impact our reputation and financial position; the risks and uncertainties detailed by Cigna with respect to its business as described in its reports and documents filed with the SEC; our ability to contract with providers on cost-effective and competitive terms; competitor pricing below market trends of increasing costs; reduced enrollment, as well as a negative change in our health care product mix; risks and uncertainties regarding Medicare and Medicaid programs, including those related to non-compliance with the complex regulations imposed thereon and funding risks with respect to revenue received from participation therein; a downgrade in our financial strength ratings; increases in costs and other liabilities associated with increased litigation, government investigations, audits or reviews; medical malpractice or professional liability claims or other risks related to health care services provided by our subsidiaries; our ability to repurchase shares of our common stock and pay dividends on our common stock due to the adequacy of our cash flow and earnings and other considerations; non-compliance by any party with the Express Scripts, Inc. pharmacy benefit management services agreement, which could result in financial penalties, our inability to meet customer demands, and sanctions imposed by governmental entities, including the Centers for Medicare and Medicaid Services; events that result in negative publicity for us or the health benefits industry; failure to effectively maintain and modernize our information systems; events that may negatively affect our licenses with the Blue Cross and Blue Shield Association; state guaranty fund assessments for insolvent insurers; possible impairment of the value of our intangible assets if future results do not adequately support goodwill and other intangible assets; intense competition to attract and retain employees; unauthorized disclosure of member or employee sensitive or confidential information, including the impact and outcome of investigations, inquiries, claims and litigation related to the cyber attack we reported in February 2015; changes in economic and market conditions, as well as regulations that may negatively affect our investment portfolios and liquidity; possible restrictions in the payment of dividends by our subsidiaries and increases in required minimum levels of capital and the potential negative effect from our substantial amount of outstanding indebtedness; general risks associated with mergers, acquisitions and strategic alliances; various laws and provisions in our governing documents that may prevent or discourage takeovers and business combinations; future public health epidemics and catastrophes; and general economic downturns. Readers are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. We do not undertake to update or revise any forward-looking statements, except as required by applicable securities laws. Investors are also advised to carefully review and consider the various risks and other disclosures discussed in our SEC reports.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK.

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

As a result of our investing and borrowing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in market valuations. Potential impacts discussed below are based upon sensitivity analyses performed on our financial position as of December 31, 2016. Actual results could vary from these estimates. Our primary objectives with our investment portfolio are to provide safety and preservation of capital, sufficient liquidity to meet cash flow requirements, the integration of investment strategy with the business operations and an attainment of a competitive after-tax total return.

Investments

Our investment portfolio is exposed to three primary sources of risk: credit quality risk, interest rate risk and market valuation risk.

The primary risks associated with our fixed maturity securities are credit quality risk and interest rate risk. Credit quality risk is defined as the risk of a credit event, such as a ratings downgrade or default, to an individual fixed maturity security and the potential loss attributable to that event. Credit quality risk is managed through our investment policy, which establishes credit quality limitations on the overall portfolio as well as diversification and percentage limits on securities of individual issuers. The result is a well-diversified portfolio of fixed maturity securities, with an average credit rating of approximately "A." Interest rate risk is defined as the potential for economic losses on fixed maturity securities due to a change in market interest rates. Our fixed maturity portfolio is invested primarily in U.S. government securities, corporate bonds, asset-backed bonds, mortgage-related securities and municipal bonds, all of which have exposure to changes in the level of market interest rates. Interest rate risk is managed by maintaining asset duration within a band based upon our liabilities, operating performance and liquidity needs. Additionally, we have the capability of holding any security to maturity, which would allow us to realize full par value.

Our available-for-sale investment portfolio includes corporate securities which account for 42.2% of the total portfolio at December 31, 2016 and are subject to credit/default risk. In a declining economic environment, corporate yields will usually increase prompted by concern over the ability of corporations to make interest payments, thus causing a decrease in the price of corporate securities, and the decline in value of the corporate fixed maturity portfolio. We manage this risk through fundamental credit analysis, diversification of issuers and industries and an average credit rating of our corporate fixed maturity portfolio of approximately "BBB."

Our equity portfolio is comprised of large capitalization and small capitalization domestic equities, foreign equities and index mutual funds. Our equity portfolio is subject to the volatility inherent in the stock market, driven by concerns over economic conditions, earnings and sales growth, inflation, and consumer confidence. These systemic risks cannot be managed through diversification alone. However, more routine risks, such as stock/industry specific risks, are managed by investing in a diversified equity portfolio.

As of December 31, 2016, 92.2% of our available-for-sale investments were fixed maturity securities. Market risk is addressed by actively managing the duration, allocation and diversification of our investment portfolio. We have evaluated the impact on the fixed maturity portfolio's fair value considering an immediate 100 basis point change in interest rates. A 100 basis point increase in interest rates would result in an approximate \$782.4 decrease in fair value, whereas a 100 basis point decrease in interest rates would result in an approximate \$765.7 increase in fair value. While we classify our fixed maturity securities as "available-for-sale" for accounting purposes, we believe our cash flows and duration of our portfolio should allow us to hold securities to maturity, thereby avoiding the recognition of losses should interest rates rise significantly.

As of December 31, 2016, 7.8% of our available-for-sale investments were equity securities. An immediate 10% decrease in each equity investment's value, arising from market movement, would result in a fair value decrease of \$150.0. Alternatively, an immediate 10% increase in each equity investment's value, attributable to the same factor, would result in a fair value increase of \$150.0.

For additional information regarding our investments, see Part II, Item 8, Note 4, "Investments," to our audited consolidated financial statements and "Critical Accounting Policies and Estimates - Investments" within Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

Long-Term Debt

Our total long-term debt at December 31, 2016 consists of senior unsecured notes, remarketable subordinated notes, convertible debentures, commercial paper and subordinated surplus notes by one of our insurance subsidiaries. At December 31, 2016, the carrying value and estimated fair value of our long-term debt was \$15,286.9 and \$16,507.6, respectively. This debt is subject to interest rate risk as these instruments have fixed interest rates and the fair value is affected by changes in market interest rates. Should interest rates increase or decrease in the future, the estimated fair value of our fixed rate debt would decrease or increase accordingly.

For additional information regarding our long-term debt, see Note 6, "Fair Value" and Note 12, "Debt" to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Derivatives

We have exposure to economic losses due to interest rate risk arising from changes in the level or volatility of interest rates. We attempt to mitigate our exposure to interest rate risk through the use of derivative financial instruments. These strategies include the use of interest rate swaps and forward contracts, which are used to lock-in interest rates or to hedge (on an economic basis) interest rate risks associated with variable rate debt. We have used these types of instruments as designated hedges against specific liabilities.

Changes in interest rates will affect the estimated fair value of these derivatives. As of December 31, 2016, we recorded a net asset of \$526.1, the estimated fair value of the swaps at that date. We have evaluated the impact on the interest rate swaps' fair value considering an immediate 100 basis point change in interest rates. A 100 basis point increase in interest rates would result in an approximate \$696.3 decrease in fair value, whereas a 100 basis point decrease in interest rates would result in an approximate \$696.3 increase in fair value.

We also utilize put and call options on the S&P 500 index to hedge, on an economic basis, the exposure of our equity security portfolio to fluctuations in the equity markets. While the impact of fluctuations in the equity markets on these derivatives are largely offset by changes in the fair values of our equity security portfolio, the change in fair value of the derivatives is recognized immediately in our income statement, whereas the change in fair value of our equity securities is recognized in accumulated other comprehensive income. Accordingly, a decrease in the S&P 500 index of 10% would result in an approximate increase of \$42.6 in the fair value of these derivatives. An increase in the S&P 500 index of 10% would result in an approximate decrease of \$24.3 in the fair value of these derivatives.

For additional information regarding our derivatives, see Note 5, "Derivative Financial Instruments" to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K. Also for accounting related to securities in our equity portfolio, see "Critical Accounting Policies and Estimates – Investments" within Part II, Item 7 "Management Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA.

ANTHEM, INC.

CONSOLIDATED FINANCIAL STATEMENTS

Years ended December 31, 2016, 2015 and 2014

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**Report of Independent Registered
Public Accounting Firm**

The Board of Directors and Shareholders of Anthem, Inc.

We have audited the accompanying consolidated balance sheets of Anthem, Inc. (the "Company") as of December 31, 2016 and 2015, and the related consolidated statements of income, comprehensive income, shareholders' equity, and cash flows for each of the three years in the period ended December 31, 2016. Our audits also included the financial statement schedule listed in the Index at Item 15(a). These financial statements and schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements and schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Anthem, Inc. at December 31, 2016 and 2015, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2016, in conformity with U.S. generally accepted accounting principles. Also, in our opinion, the related financial statement schedule, when considered in relation to the basic financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Anthem, Inc.'s internal control over financial reporting as of December 31, 2016, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 22, 2017 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Indianapolis, Indiana
February 22, 2017

Anthem, Inc.
Consolidated Balance Sheets

	December 31, 2016	December 31, 2015
<i>(In millions, except share data)</i>		
Assets		
Current assets:		
Cash and cash equivalents	\$ 4,075.3	\$ 2,113.5
Investments available-for-sale, at fair value:		
Fixed maturity securities (amortized cost of \$16,991.8 and \$16,950.0)	17,163.1	16,920.0
Equity securities (cost of \$1,076.1 and \$1,055.8)	1,468.5	1,441.8
Other invested assets, current	15.8	19.1
Accrued investment income	164.5	170.8
Premium and self-funded receivables	5,860.8	4,602.8
Other receivables	2,536.6	2,421.4
Income taxes receivable	168.7	316.6
Securities lending collateral	1,079.8	1,300.4
Other current assets	1,781.8	1,555.7
Total current assets	34,314.9	30,862.1
Long-term investments available-for-sale, at fair value:		
Fixed maturity securities (amortized cost of \$524.6 and \$550.4)	524.4	558.2
Equity securities (cost of \$27.2 and \$27.3)	31.4	31.0
Other invested assets, long-term	2,240.5	2,041.1
Property and equipment, net	1,977.9	2,019.8
Goodwill	17,561.2	17,562.2
Other intangible assets	7,964.9	8,158.0
Other noncurrent assets	467.9	485.4
Total assets	\$ 65,083.1	\$ 61,717.8
Liabilities and shareholders' equity		
Liabilities		
Current liabilities:		
Policy liabilities:		
Medical claims payable	\$ 7,892.6	\$ 7,569.8
Reserves for future policy benefits	71.8	71.9
Other policyholder liabilities	2,221.1	2,256.5
Total policy liabilities	10,185.5	9,898.2
Unearned income	971.9	1,145.5
Accounts payable and accrued expenses	4,014.9	3,318.8
Security trades pending payable	93.5	73.1
Securities lending payable	1,078.9	1,300.9
Short-term borrowings	440.0	540.0
Current portion of long-term debt	928.4	—
Other current liabilities	3,581.3	2,816.1
Total current liabilities	21,294.4	19,092.6
Long-term debt, less current portion	14,358.5	15,324.5
Reserves for future policy benefits, noncurrent	666.1	631.7
Deferred tax liabilities, net	2,779.9	2,630.6
Other noncurrent liabilities	883.8	994.3
Total liabilities	39,982.7	38,673.7
Commitments and contingencies—Note 13		
Shareholders' equity		
Preferred stock, without par value, shares authorized - 100,000,000; shares issued and outstanding - none	—	—
Common stock, par value \$0.01, shares authorized - 900,000,000; shares issued and outstanding - 263,747,395 and 261,238,188	2.6	2.6
Additional paid-in capital	8,805.1	8,555.6
Retained earnings	16,560.6	14,778.5
Accumulated other comprehensive loss	(267.9)	(292.6)
Total shareholders' equity	25,100.4	23,044.1

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Income

	Years Ended December 31		
	2016	2015	2014
<i>(In millions, except per share data)</i>			
Revenues			
Premiums	\$ 78,860.1	\$ 73,385.1	\$ 68,389.8
Administrative fees	5,298.8	4,976.6	4,590.6
Other revenue	35.1	43.1	41.3
Total operating revenue	84,194.0	78,404.8	73,021.7
Net investment income	779.5	677.6	724.4
Net realized gains on financial instruments	4.9	157.5	177.0
Other-than-temporary impairment losses on investments:			
Total other-than-temporary impairment losses on investments	(147.1)	(99.9)	(56.2)
Portion of other-than-temporary impairment losses recognized in other comprehensive income	31.7	16.5	7.2
Other-than-temporary impairment losses recognized in income	(115.4)	(83.4)	(49.0)
Total revenues	84,863.0	79,156.5	73,874.1
Expenses			
Benefit expense	66,834.4	61,116.9	56,854.9
Selling, general and administrative expense:			
Selling expense	1,391.5	1,441.1	1,490.1
General and administrative expense	11,166.4	11,093.7	10,258.3
Total selling, general and administrative expense	12,557.9	12,534.8	11,748.4
Interest expense	723.0	653.0	600.7
Amortization of other intangible assets	192.3	230.1	220.9
(Gain) loss on extinguishment of debt	—	(9.3)	81.1
Total expenses	80,307.6	74,525.5	69,506.0
Income from continuing operations before income tax expense	4,555.4	4,631.0	4,368.1
Income tax expense	2,085.6	2,071.0	1,808.0
Income from continuing operations	2,469.8	2,560.0	2,560.1
Income from discontinued operations, net of tax	—	—	9.6
Net income	\$ 2,469.8	\$ 2,560.0	\$ 2,569.7
Basic net income per share:			
Basic - continuing operations	\$ 9.39	\$ 9.73	\$ 9.28
Basic - discontinued operations	—	—	0.03
Basic net income per share	\$ 9.39	\$ 9.73	\$ 9.31
Diluted net income per share:			
Diluted - continuing operations	\$ 9.21	\$ 9.38	\$ 8.96
Diluted - discontinued operations	—	—	0.03
Diluted net income per share	\$ 9.21	\$ 9.38	\$ 8.99
Dividends per share	\$ 2.60	\$ 2.50	\$ 1.75

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Comprehensive Income

	Years Ended December 31		
	2016	2015	2014
<i>(In millions)</i>			
Net income	\$ 2,469.8	\$ 2,560.0	\$ 2,569.7
Other comprehensive income (loss), net of tax:			
Change in net unrealized gains/losses on investments	117.9	(384.3)	118.6
Change in non-credit component of other-than-temporary impairment losses on investments	5.4	(5.6)	(3.9)
Change in net unrealized gains/losses on cash flow hedges	(87.3)	(45.2)	(3.6)
Change in net periodic pension and postretirement costs	(13.4)	(26.0)	(118.1)
Foreign currency translation adjustments	2.1	(3.4)	(4.3)
Other comprehensive income (loss)	<u>24.7</u>	<u>(464.5)</u>	<u>(11.3)</u>
Total comprehensive income	<u>\$ 2,494.5</u>	<u>\$ 2,095.5</u>	<u>\$ 2,558.4</u>

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Cash Flows

	Years Ended December 31		
	2016	2015	2014
<i>(In millions)</i>			
Operating activities			
Net income	\$ 2,469.8	\$ 2,560.0	\$ 2,569.7
Adjustments to reconcile net income to net cash provided by operating activities:			
Net realized gains on financial instruments	(4.9)	(157.5)	(177.0)
Other-than-temporary impairment losses recognized in income	115.4	83.4	49.0
(Gain) loss on extinguishment of debt	—	(9.3)	81.1
Gain on disposal from discontinued operations	—	—	(3.2)
Loss (gain) on disposal of assets	4.5	16.0	(1.7)
Deferred income taxes	126.9	(65.9)	30.7
Amortization, net of accretion	807.8	802.1	744.5
Depreciation expense	104.0	105.8	106.5
Impairment of property and equipment	44.8	1.8	7.9
Share-based compensation	164.6	148.2	168.9
Excess tax benefits from share-based compensation	(53.5)	(95.8)	(46.4)
Changes in operating assets and liabilities:			
Receivables, net	(1,380.5)	(42.9)	(1,899.7)
Other invested assets	(19.4)	5.9	(21.7)
Other assets	(127.7)	33.8	405.5
Policy liabilities	321.7	193.0	1,240.6
Unearned income	(173.6)	33.9	255.1
Accounts payable and accrued expenses	116.6	(219.3)	(14.4)
Other liabilities	605.7	686.4	(7.9)
Income taxes	178.8	41.5	(34.0)
Other, net	(96.5)	(5.1)	(84.2)
Net cash provided by operating activities	3,204.5	4,116.0	3,369.3
Investing activities			
Purchases of fixed maturity securities	(10,157.7)	(9,792.0)	(9,613.4)
Proceeds from fixed maturity securities:			
Sales	8,636.0	8,909.2	8,066.0
Maturities, calls and redemptions	1,418.6	1,313.6	1,318.7
Purchases of equity securities	(1,476.3)	(1,561.4)	(912.0)
Proceeds from sales of equity securities	1,592.8	1,471.1	746.5
Purchases of other invested assets	(433.1)	(505.8)	(205.7)
Proceeds from sales of other invested assets	304.9	85.9	124.7
Changes in collateral and settlement of non-hedging derivatives	(34.5)	(36.5)	(67.4)
Changes in securities lending collateral	222.0	214.4	(545.6)
Purchases of subsidiaries, net of cash acquired	—	(638.9)	—
Proceeds from sale of subsidiary, net of cash sold	—	—	740.0
Purchases of property and equipment	(583.6)	(638.2)	(714.6)
Proceeds from sales of property and equipment	—	35.3	88.0
Other, net	(3.0)	(8.2)	(0.1)
Net cash used in investing activities	(513.9)	(1,151.5)	(974.9)
Financing activities			
Net (repayments of) proceeds from commercial paper borrowings	(53.2)	682.2	(379.2)
Proceeds from long-term borrowings	—	1,226.5	2,700.0
Repayments of long-term borrowings	—	(2,697.2)	(1,730.1)
Proceeds from short-term borrowings	2,400.0	2,760.0	2,050.0
Repayments of short-term borrowings	(2,500.0)	(2,620.0)	(2,050.0)
Changes in securities lending payable	(222.0)	(214.4)	545.6
Changes in bank overdrafts	513.8	(243.8)	173.0
Premiums paid on equity call options	—	(16.7)	—
Proceeds from sale of put options	—	16.6	—
Repurchase and retirement of common stock	—	(1,515.8)	(2,998.8)

Simply Healthcare Plans, Inc.
D/B/A Clear Health Alliance

Attachment 2016 Anthem Inc.
Annual Report - Form 10 K

Change in collateral and settlements of debt-related derivatives	(360.4)	—	—
Cash dividends	(684.0)	(656.6)	(480.7)
Proceeds from issuance of common stock under employee stock plans	119.4	186.0	301.3
Excess tax benefits from share-based compensation	53.5	95.8	46.4
Net cash used in financing activities	(732.9)	(2,997.4)	(1,822.5)
Effect of foreign exchange rates on cash and cash equivalents	4.1	(5.3)	(7.1)
Change in cash and cash equivalents	1,961.8	(38.2)	564.8
Cash and cash equivalents at beginning of year	2,113.5	2,151.7	1,586.9
Cash and cash equivalents at end of year	\$ 4,075.3	\$ 2,113.5	\$ 2,151.7

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Shareholders' Equity

	Common Stock		Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Shareholders' Equity
	Number of Shares	Par Value				
(In millions)						
January 1, 2014	293.3	\$ 2.9	\$ 10,765.2	\$ 13,813.9	\$ 183.2	\$ 24,765.2
Net income	—	—	—	2,569.7	—	2,569.7
Other comprehensive loss	—	—	—	—	(11.3)	(11.3)
Settlement of equity options	—	—	(31.4)	—	—	(31.4)
Repurchase and retirement of common stock	(30.4)	(0.2)	(1,115.5)	(1,883.1)	—	(2,998.8)
Dividends and dividend equivalents	—	—	—	(486.1)	—	(486.1)
Issuance of common stock under employee stock plans, net of related tax benefits	5.2	—	444.0	—	—	444.0
December 31, 2014	268.1	2.7	10,062.3	14,014.4	171.9	24,251.3
Net income	—	—	—	2,560.0	—	2,560.0
Other comprehensive loss	—	—	—	—	(464.5)	(464.5)
Premiums for and settlement of equity options	—	—	(14.0)	—	—	(14.0)
Repurchase and retirement of common stock	(10.4)	(0.1)	(382.2)	(1,133.5)	—	(1,515.8)
Dividends and dividend equivalents	—	—	—	(662.4)	—	(662.4)
Issuance of common stock under employee stock plans, net of related tax benefits	3.5	—	308.2	—	—	308.2
Convertible debenture repurchases and conversions	—	—	(1,287.8)	—	—	(1,287.8)
Equity Units contract payments and issuance costs	—	—	(130.9)	—	—	(130.9)
December 31, 2015	261.2	2.6	8,555.6	14,778.5	(292.6)	23,044.1
Net income	—	—	—	2,469.8	—	2,469.8
Other comprehensive income	—	—	—	—	24.7	24.7
Dividends and dividend equivalents	—	—	—	(687.7)	—	(687.7)
Issuance of common stock under employee stock plans, net of related tax benefits	2.5	—	249.2	—	—	249.2
Equity Units issuance costs adjustment	—	—	0.3	—	—	0.3
December 31, 2016	263.7	\$ 2.6	\$ 8,805.1	\$ 16,560.6	\$ (267.9)	\$ 25,100.4

See accompanying notes.

Anthem, Inc.

Notes to Consolidated Financial Statements

December 31, 2016

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

1. Organization

References to the terms “we,” “our,” “us,” “Anthem” or the “Company” used throughout these Notes to Consolidated Financial Statements refer to Anthem, Inc., an Indiana corporation, and unless the context otherwise requires, its direct and indirect subsidiaries.

We are one of the largest health benefits companies in the United States in terms of medical membership, serving 39.9 medical members through our affiliated health plans as of December 31, 2016. We offer a broad spectrum of network-based managed care plans to large and small employer, individual, Medicaid and Medicare markets. Our managed care plans include: preferred provider organizations, or PPOs; health maintenance organizations, or HMOs; point-of-service, or POS, plans; traditional indemnity plans and other hybrid plans, including consumer-driven health plans, or CDHPs; and hospital only and limited benefit products. In addition, we provide a broad array of managed care services to self-funded customers, including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services. We provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal health care. We also provide services to the federal government in connection with the Federal Employee Program, or FEP. We sold contact lenses, eyeglasses and other ocular products through our 1-800 CONTACTS, Inc., or 1-800 CONTACTS, business which was divested on January 31, 2014.

We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as BCBS in 10 New York City metropolitan and surrounding counties, and as Blue Cross or BCBS in selected upstate counties), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield or Empire Blue Cross (in our New York service areas). We also conduct business through arrangements with other BCBS licensees in South Carolina and Western New York. Through our AMERIGROUP Corporation, or Amerigroup, subsidiary, we conduct business in Florida, Georgia, Iowa, Kansas, Louisiana, Maryland, Nevada, New Jersey, New Mexico, New York, Tennessee, Texas, and Washington. In addition, we conduct business through our Simply Healthcare Holdings, Inc., or Simply Healthcare, subsidiary in Florida. We also serve customers throughout the country as HealthLink, UniCare (including a non-risk arrangement with Massachusetts), and in certain Arizona, California, Nevada and Virginia markets through our CareMore Health Group, Inc., or CareMore, subsidiary. We are licensed to conduct insurance operations in all 50 states through our subsidiaries.

2. Basis of Presentation and Significant Accounting Policies

Basis of Presentation: The accompanying consolidated financial statements include the accounts of Anthem and its subsidiaries and have been prepared in conformity with U.S. generally accepted accounting principles, or GAAP. All significant intercompany accounts and transactions have been eliminated in consolidation.

Certain of our subsidiaries operate outside of the United States and have functional currencies other than the U.S. dollar, or USD. We translate the assets and liabilities of those subsidiaries to USD using the exchange rate in effect at the end of the period. We translate the revenues and expenses of those subsidiaries to USD using the average exchange rates in effect during the period. The net effect of these translation adjustments is included in “Foreign currency translation adjustments” in our consolidated statements of comprehensive income.

Reclassifications: Certain prior year amounts have been reclassified to conform to the current year presentation.

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

Use of Estimates: The preparation of consolidated financial statements in conformity with GAAP requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and Cash Equivalents: Cash and cash equivalents includes available cash and all highly liquid investments with maturities of three months or less when purchased. We control a number of bank accounts that are used exclusively to hold customer funds for the administration of customer benefits. At December 31, 2016 and 2015, we held \$157.0 and \$122.6, respectively, of customer funds with an offsetting liability in other current liabilities.

Investments: Certain Financial Accounting Standards Board, or FASB, other-than-temporary impairment, or OTTI, guidance applies to fixed maturity securities and provides guidance on the recognition, presentation of, and disclosures for OTTIs. If a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, the decline in value is deemed to be other-than-temporary and is presented within the Other-than-temporary impairment losses recognized in income line item on our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, the credit component of the OTTI is presented within the Other-than-temporary impairment losses recognized in income line item on our consolidated statements of income and the non-credit component of the OTTI is recognized in other comprehensive income. Furthermore, unrealized losses entirely caused by non-credit related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive income, or AOCI.

The credit component of an OTTI is determined primarily by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting our best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of acquisition. For mortgage-backed and asset-backed securities, cash flow estimates are based on assumptions regarding the underlying collateral including prepayment speeds, vintage, type of underlying asset, geographic concentrations, default rates, recoveries and changes in value. For all other debt securities, cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings, and estimates regarding timing and amount of recoveries associated with a default.

The unrealized gains or losses on our current and long-term equity securities classified as available-for-sale are included in accumulated other comprehensive income as a separate component of shareholders' equity, unless the decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such equity securities until their full cost can be recovered, in which case such equity securities are written down to fair value and the loss is charged to other-than-temporary impairment losses recognized in income.

We maintain various rabbi trusts to account for the assets and liabilities under certain deferred compensation plans. Under these plans, the participants can defer certain types of compensation and elect to receive a return on the deferred amounts based on the changes in fair value of various investment options, primarily a variety of mutual funds. We have corporate-owned life insurance policies on certain participants in the deferred compensation plans. The cash surrender value of the corporate-owned life insurance policies is reported in other invested assets, long-term, in the consolidated balance sheets. The remaining rabbi trust assets are generally invested according to the participant's investment election, and are classified as trading, which are reported in other invested assets, current, in the consolidated balance sheets.

We use the equity method of accounting for investments in companies in which our ownership interest enables us to influence the operating or financial decisions of the investee company. Our proportionate share of equity in net income of these unconsolidated affiliates is reported with net investment income.

For asset-backed securities included in fixed maturity securities, we recognize income using an effective yield based on anticipated prepayments and the estimated economic life of the securities. When estimates of prepayments change, the effective yield is recalculated to reflect actual payments to date and anticipated future payments. The net investment in the securities is adjusted to the amount that would have existed had the new effective yield been applied since the acquisition of the securities. Such adjustments are reported with net investment income.

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

Investment income is recorded when earned. All securities sold resulting in investment gains and losses are recorded on the trade date. Realized gains and losses are determined on the basis of the cost or amortized cost of the specific securities sold.

We participate in securities lending programs whereby marketable securities in our investment portfolio are transferred to independent brokers or dealers in exchange for cash and securities collateral. Under FASB guidance related to accounting for transfers and servicing of financial assets and extinguishments of liabilities, we recognize the collateral as an asset, which is reported as "Securities lending collateral" on our consolidated balance sheets and we record a corresponding liability for the obligation to return the collateral to the borrower, which is reported as "Securities lending payable." The securities on loan are reported in the applicable investment category on our consolidated balance sheets. Unrealized gains or losses on securities lending collateral are included in accumulated other comprehensive income as a separate component of shareholders' equity. The market value of loaned securities and that of the collateral pledged can fluctuate in non-synchronized fashions. To the extent the loaned securities' value appreciates faster or depreciates slower than the value of the collateral pledged, we are exposed to the risk of the shortfall. As a primary mitigating mechanism, the loaned securities and collateral pledged are marked to market on a daily basis and the shortfall, if any, is collected accordingly. Secondly, the collateral level is set at 102% of the value of the loaned securities, which provides a cushion before any shortfall arises. The investment of the cash collateral is subject to market risk, which is managed by limiting the investments to higher quality and shorter duration instruments.

Premium and Self-Funded Receivables: Premium and self-funded receivables include the uncollected amounts from fully-insured and self-funded groups, individuals and government programs, and are reported net of an allowance for doubtful accounts of \$333.5 and \$318.3 at December 31, 2016 and 2015, respectively. The allowance for doubtful accounts is based on historical collection trends and our judgment regarding the ability to collect specific accounts.

Other Receivables: Other receivables include pharmacy rebates, provider advances, claims recoveries, reinsurance, proceeds due from brokers on investment trades, other government receivables and other miscellaneous amounts due to us. These receivables are reported net of an allowance for doubtful accounts of \$197.6 and \$301.2 at December 31, 2016 and 2015, respectively, which is based on historical collection trends and our judgment regarding the ability to collect specific accounts.

Income Taxes: We file a consolidated income tax return. Deferred income tax assets and liabilities are recognized for temporary differences between the financial statement and tax return bases of assets and liabilities based on enacted tax rates and laws. The deferred tax benefits of the deferred tax assets are recognized to the extent realization of such benefits is more likely than not. Deferred income tax expense or benefit generally represents the net change in deferred income tax assets and liabilities during the year, excluding the impact from amounts initially recorded for business combinations, if any, and amounts recorded to accumulated other comprehensive income. Current income tax expense represents the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported.

We account for income tax contingencies in accordance with FASB guidance that contains a model to address uncertainty in tax positions and clarifies the accounting for income taxes by prescribing a minimum recognition threshold, which all income tax positions must achieve before being recognized in the financial statements.

Property and Equipment: Property and equipment is recorded at cost, net of accumulated depreciation. Depreciation is computed principally by the straight-line method over estimated useful lives ranging from fifteen to thirty-nine years for buildings and improvements, three to five years for data processing equipment and computer software, and the lesser of the remaining life of the building lease, if any, or seven years for furniture and other equipment. Leasehold improvements are depreciated over the term of the related lease. Certain costs related to the development or purchase of internal-use software are capitalized and amortized over five years.

Goodwill and Other Intangible Assets: FASB guidance requires business combinations to be accounted for using the acquisition method of accounting and it also specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Goodwill represents the excess of cost of acquisition over the fair value of net assets acquired. Other intangible assets represent the values assigned to customer relationships, provider and hospital networks, Blue Cross and Blue Shield and other trademarks, licenses, non-compete and other agreements. Goodwill and other intangible assets are allocated to reportable segments based on the relative fair value of the components of the businesses acquired.

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

Goodwill and other intangible assets with indefinite lives are not amortized but are tested for impairment at least annually. We complete our annual impairment tests of existing goodwill and other intangible assets with indefinite lives during the fourth quarter of each year. Certain interim impairment tests are also performed when potential impairment indicators exist or changes in our business or other triggering events occur. Goodwill and other intangible assets are allocated to reporting units for purposes of the annual goodwill impairment test. In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately.

FASB guidance allows for qualitative assessments of whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount for purposes of a goodwill impairment analysis and whether it is more likely than not that an indefinite-lived intangible asset is impaired for purposes of an indefinite-lived intangible asset impairment analysis. Quantitative analysis must be performed if qualitative analyses are not conclusive. Entities also have the option to bypass the assessment of qualitative factors and proceed directly to performing quantitative analyses. We begin our annual tests with quantitative analyses. Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units, including goodwill and other intangible assets with indefinite lives. Estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used.

Fair value for purposes of the goodwill impairment test is calculated using a blend of a projected income and market valuation approach. The projected income approach is developed using assumptions about future revenue, expenses and net income derived from our internal planning process. Our assumed discount rate is based on our industry's weighted-average cost of capital and reflects volatility associated with the cost of equity capital. Market valuations include market comparisons to publicly traded companies in our industry and are based on observed multiples of certain measures including revenue, EBITDA (earnings before interest, taxes, depreciation and amortization) and book value of invested capital. A goodwill impairment loss is recognized to the extent that the carrying amount exceeds the asset's fair value. This determination is made at the reporting unit level and consists of two steps. First, the fair value of a reporting unit is determined and compared to its carrying amount. Second, if the carrying amount of a reporting unit exceeds its fair value, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation on a business acquisition, at the impairment test date.

The fair value of indefinite-lived intangible assets is estimated and compared to the carrying value. We estimate the fair value of indefinite-lived intangible assets using a projected income approach. We recognize an impairment loss when the estimated fair value of indefinite-lived intangible assets is less than the carrying value. If significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

Derivative Financial Instruments: We primarily invest in the following types of derivative financial instruments: interest rate swaps, forward contracts, put and call options, credit default swaps, embedded derivatives, warrants and swaptions. Derivatives embedded within non-derivative instruments, such as options embedded in convertible fixed maturity securities, are bifurcated from the host instrument when the embedded derivative is not clearly and closely related to the host instrument. Our use of derivatives is limited by statutes and regulations promulgated by the various regulatory bodies to which we are subject, and by our own derivative policy. Our derivative use is generally limited to hedging purposes, on an economic basis, and we generally do not use derivative instruments for speculative purposes.

We have exposure to economic losses due to interest rate risk arising from changes in the level or volatility of interest rates. We attempt to mitigate our exposure to interest rate risk through active portfolio management, including rebalancing our existing portfolios of assets and liabilities, as well as changing the characteristics of investments to be purchased or sold in the future. In addition, derivative financial instruments are used to modify the interest rate exposure of certain liabilities or forecasted transactions. These strategies include the use of interest rate swaps and forward contracts, which are used to lock-in interest rates or to hedge, on an economic basis, interest rate risks associated with variable rate debt. We have used these types of instruments as designated hedges against specific liabilities.

All investments in derivatives are recorded as assets or liabilities at fair value. If certain correlation, hedge effectiveness and risk reduction criteria are met, a derivative may be specifically designated as a hedge of exposure to changes in fair value or cash flow. The accounting for changes in the fair value of a derivative depends on the intended use of the derivative and

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

the nature of any hedge designation thereon. Amounts excluded from the assessment of hedge effectiveness, if any, as well as the ineffective portion of the gain or loss, are reported in results of operations immediately. If the derivative is not designated as a hedge, the gain or loss resulting from the change in the fair value of the derivative is recognized in results of operations in the period of change. Cash flows associated with the settlement of non-designated derivatives are shown on a net basis in investing activity in our consolidated statements of cash flow.

From time to time, we may also purchase derivatives to hedge, on an economic basis, our exposure to foreign currency exchange fluctuations associated with the operations of certain of our subsidiaries. We generally use futures or forward contracts for these transactions. We generally do not designate these contracts as hedges and, accordingly, the changes in fair value of these derivatives are recognized in income immediately.

Credit exposure associated with non-performance by the counterparties to derivative instruments is generally limited to the uncollateralized fair value of the asset related to instruments recognized in the consolidated balance sheets. We attempt to mitigate the risk of non-performance by selecting counterparties with high credit ratings and monitoring their creditworthiness and by diversifying derivatives among multiple counterparties. At December 31, 2016, we believe there were no material concentrations of credit risk with any individual counterparty.

We generally enter into master netting agreements, which reduce credit risk by permitting net settlement of transactions with the same counterparty. Certain of our derivative agreements also contain credit support provisions that require us or the counterparty to post collateral if there are declines in the derivative fair value or our credit rating. The derivative assets and derivative liabilities are reported at their fair values net of collateral and netting by the counterparty.

Retirement Benefits: We recognize the funded status of pension and other postretirement benefit plans on the consolidated balance sheets based on fiscal-year-end measurements of plan assets and benefit obligations. Prepaid pension benefits represent prepaid costs related to defined benefit pension plans and are reported with other noncurrent assets. Postretirement benefits represent outstanding obligations for retiree medical, life, vision and dental benefits. Liabilities for pension and other postretirement benefits are reported with current and noncurrent liabilities based on the amount by which the actuarial present value of benefits payable in the next twelve months included in the benefit obligation exceeds the fair value of plan assets.

We determine the expected return on plan assets using the calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over three years. We apply a corridor approach to amortize unrecognized actuarial gains or losses. Under this approach, only accumulated net actuarial gains or losses in excess of 10% of the greater of the projected benefit obligation or the fair value of plan assets are amortized over the average remaining service or lifetime of the workforce as a component of net periodic benefit cost.

Medical Claims Payable: Liabilities for medical claims payable include estimated provisions for incurred but not paid claims on an undiscounted basis, as well as estimated provisions for expenses related to the processing of claims. Incurred but not paid claims include (1) an estimate for claims that are incurred but not reported, as well as claims reported to us but not yet processed through our systems; and (2) claims reported to us and processed through our systems but not yet paid.

Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be appropriate under moderately adverse circumstances. We determine the amount of the liability for incurred but not paid claims by following a detailed actuarial process that entails using both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this process, historical paid claims data is formatted into "claim triangles," which compare claim incurred dates to the dates of claim payments. This information is analyzed to create "completion factors" that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims.

For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather they

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

are projected by estimating the claims expense for those months based on recent claims expense levels and health care trend levels, or “trend factors.”

We regularly review and set assumptions regarding cost trends and utilization when initially establishing claim liabilities. We continually monitor and adjust the claims liability and benefit expense based on subsequent paid claims activity. If it is determined that our assumptions regarding cost trends and utilization are significantly different than actual results, our income statement and financial position could be impacted in future periods.

Premium deficiencies are recognized when it is probable that expected claims and administrative expenses will exceed future premiums on existing medical insurance contracts without consideration of investment income. Determination of premium deficiencies for longer duration life and disability contracts includes consideration of investment income. For purposes of premium deficiencies, contracts are deemed to be either short or long duration and are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts. Once established, premium deficiencies are released commensurate with actual claims experience over the remaining life of the contract. No premium deficiencies were established at December 31, 2016 or 2015.

Benefit expense includes incurred medical claims as well as quality improvement expenses for our fully-insured members. Quality improvement activities are those designed to improve member health outcomes, prevent hospital readmissions and improve patient safety. They also include expenses for wellness and health promotion provided to our members.

Reserves for Future Policy Benefits: Reserves for future policy benefits include liabilities for life and long-term disability insurance policy benefits based upon interest, mortality and morbidity assumptions from published actuarial tables, modified based upon our experience. Future policy benefits also include liabilities for insurance policies for which some of the premiums received in earlier years are intended to pay anticipated benefits to be incurred in future years. Future policy benefits are continually monitored and reviewed, and when reserves are adjusted, differences are reflected in benefit expense.

The current portion of reserves for future policy benefits relates to the portion of such reserves that we expect to pay within one year. We believe that our liabilities for future policy benefits, along with future premiums received are adequate to satisfy our ultimate benefit liability; however, these estimates are inherently subject to a number of variable circumstances. Consequently, the actual results could differ materially from the amounts recorded in our consolidated financial statements.

Other Policyholder Liabilities: Other policyholder liabilities include rate stabilization reserves associated with retrospectively rated insurance contracts and certain case-specific reserves. Other policyholder liabilities also includes liabilities for premium refunds based upon the minimum medical loss ratio, or MLR, the relative health risk of members, or other contractual or regulatory requirements. Rate stabilization reserves represent accumulated premiums that exceed what customers owe us based on actual claim experience. The timing of payment of these retrospectively rated refunds is based on the contractual terms with the customers and can vary from period to period based on the specific contractual requirements.

We are required to meet certain minimum MLR thresholds prescribed by the Patient Protection and Affordable Care Act, or ACA, and related Health Care and Education Reconciliation Act of 2010, or collectively, Health Care Reform. If we do not meet or exceed the minimum MLR thresholds specified by Health Care Reform, we are required to pay rebates to certain customers. Minimum MLR rebates are calculated by applicable line of business (Large Group, Small Group, Individual and Medicare) and legal entity in accordance with regulations issued by the Department of Health and Human Services, or HHS. Such calculations are made using estimated calendar year medical loss expense and premiums, as defined by HHS.

We follow HHS guidelines for determining the types of expenses that may be included in our minimum MLR rebate calculations, which differ from benefit expense and premiums as reported in our consolidated financial statements prepared in conformity with GAAP. Certain amounts reported as expense in our GAAP basis consolidated financial statements may be reported as a reduction of premiums in accordance with HHS regulations. In addition, profit amounts included in our payments to third party administrative service providers are recorded as benefit expense in our consolidated GAAP financial statements while HHS does not allow for the inclusion of these expenses within the medical loss expense for purposes of calculating minimum MLR.

Revenue Recognition: Premiums for fully-insured contracts are recognized as revenue over the period insurance coverage is provided, and, if applicable, net of amounts recognized for the Health Care Reform minimum MLR rebates, risk

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

adjustment, reinsurance and risk corridor or contractual premium stabilization programs. Premium payments from contracted government agencies are based on eligibility lists produced by the government agencies. Premiums related to the unexpired contractual coverage periods are reflected in the accompanying consolidated balance sheets as unearned income. Premiums include revenue from retrospectively rated contracts where revenue is based on the estimated loss experience of the contract. Premium revenue includes an adjustment for retrospectively rated refunds based on an estimate of incurred claims. Premium rates for certain lines of business are subject to approval by the Department of Insurance of each respective state. Additionally, delays in annual premium rate changes from contracted government agencies require that we defer the recognition of any increases to the period in which the premium rates become final. The value of the impact can be significant in the period in which it is recognized dependent on the magnitude of the premium rate increase, the membership to which it applies and the length of the delay between the effective date of the rate increase and the final contract date. Premium rate decreases are recognized in the period the change in premium rate becomes effective and the change in the rate is known, which may be prior to the period when the contract amendment affecting the rate is finalized.

Administrative fees include revenue from certain group contracts that provide for the group to be at risk for all, or with supplemental insurance arrangements, a portion of their claims experience. We charge these self-funded groups an administrative fee, which is based on the number of members in a group or the group's claim experience. In addition, administrative fees include amounts received for the administration of Medicare or certain other government programs. Under our self-funded arrangements, revenue is recognized as administrative services are performed. All benefit payments under these programs are excluded from benefit expense.

Share-Based Compensation: Our current compensation philosophy provides for share-based compensation, including stock options, restricted stock awards and an employee stock purchase plan. Stock options are granted for a fixed number of shares with an exercise price at least equal to the fair value of the shares at the date of the grant. Restricted stock awards are issued at the fair value of the stock on the grant date. The employee stock purchase plan allows for a purchase price per share which is 95% of the fair value of a share of common stock on the last trading day of the plan quarter. The employee stock purchase plan discount is not recognized as compensation expense based on GAAP guidance. All other share-based payments to employees are recognized as compensation expense in the income statement based on their fair values. Additionally, excess tax benefits, which result from actual tax benefits exceeding deferred tax benefits previously recognized based on grant date fair value, are recognized as additional paid-in-capital and are reclassified from operating cash flows to financing cash flows in the consolidated statements of cash flows. Our share-based employee compensation plans and assumptions are described in Note 14, "Capital Stock." Also see "*Recent Accounting Guidance Not Yet Adopted*" within this Note 2 for reference to pending accounting changes related to share-based compensation.

Advertising and Marketing Costs: We use print, broadcast and other advertising to promote our products and to develop our corporate image. We market our products through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships for Individual and Medicare customers, and for certain Local Group customers with a smaller employee base. Products for National Accounts and Local Group customers with a larger employee base are generally sold through independent brokers or consultants retained by the customer and working with industry specialists from our in-house sales force. In the Individual and Small Group markets we offer products through state or federally facilitated marketplaces, or public exchanges, and off-exchange products. The cost of advertising and marketing for product promotion is expensed as incurred while advertising and marketing costs associated with corporate image is expensed when first aired. Total advertising and marketing expense was \$246.2, \$313.5 and \$337.0 for the years ended December 31, 2016, 2015 and 2014, respectively.

Health Insurance Provider Fee: Beginning in 2014, Health Care Reform imposed an annual Health Insurance Provider Fee, or HIP Fee, on health insurers that write certain types of health insurance on U.S. risks. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to an adjusted amount of health insurance for all U.S. health risk for those certain lines of business written during the preceding calendar year. The HIP Fee is non-deductible for federal income tax purposes. The total amount collected from allocations to health insurers was \$11,300.0 for each of 2016 and 2015 and \$8,000.0 for 2014. We record our estimated liability for the HIP Fee in full at the beginning of the year with a corresponding deferred asset that is amortized on a straight-line basis to general and administrative expense. The final calculation and payment of the annual HIP Fee occurs in the third quarter each year and our portion of the HIP Fee for 2016, 2015 and 2014 was \$1,176.3, \$1,207.5 and \$893.3, respectively. The annual HIP Fee to be allocated to all health insurers has been suspended for 2017 and is scheduled to resume and be increased to \$14,300.0 for 2018, without subsequent legislative or regulatory action. For 2019 and beyond, the annual HIP

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

Fee will equal the amount for the preceding year increased by the rate of premium growth for the preceding year less the rate of growth in the consumer price index for the preceding calendar year.

Earnings per Share: Earnings per share amounts, on a basic and diluted basis, have been calculated based upon the weighted-average common shares outstanding for the period.

Basic earnings per share excludes dilution and is computed by dividing income available to common shareholders by the weighted-average number of common shares outstanding for the period. Diluted earnings per share includes the dilutive effect of stock options, restricted stock and convertible debentures, using the treasury stock method. The treasury stock method assumes exercise of stock options and vesting of restricted stock, with the assumed proceeds used to purchase common stock at the average market price for the period. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Recently Adopted Accounting Guidance: In May 2015, the Financial Accounting Standards Board, or FASB, issued Accounting Standards Update No. 2015-09, *Financial Services—Insurance (Topic 944): Disclosures about Short-Duration Contracts*, or ASU 2015-09. This amendment requires new and expanded disclosures in interim and annual reporting periods related to the liability for unpaid claims and claim adjustment expenses for short-duration insurance contracts. ASU 2015-09 became effective for our annual reporting period ended December 31, 2016, and interim reporting periods beginning January 1, 2017. The adoption of ASU 2015-09 did not have an impact on our consolidated financial position, results of operations or cash flows.

In April 2015, the FASB issued Accounting Standards Update No. 2015-05, *Intangibles - Goodwill and Other - Internal-Use Software (Subtopic 350-40): Customer's Accounting for Fees Paid in a Cloud Computing Arrangement*, or ASU 2015-05. This update provides guidance to help entities determine whether a cloud computing arrangement contains a software license that should be accounted for as internal-use software or as a service contract. ASU 2015-05 became effective January 1, 2016 and we elected to adopt the provisions of the new guidance prospectively to all arrangements entered into or materially modified on or after January 1, 2016. The adoption of ASU 2015-05 did not have an impact on our consolidated financial position, results of operations or cash flows.

In February 2015, the FASB issued Accounting Standards Update No. 2015-02, *Consolidation (Topic 810): Amendments to the Consolidation Analysis*, or ASU 2015-02. This update amended the consolidation guidance by modifying the evaluation criteria for whether limited partnerships and similar legal entities are variable interest entities or voting interest entities, eliminating the presumption that a general partner should consolidate a limited partnership, and affecting the consolidation analysis of reporting entities that are involved with variable interest entities. We adopted the provisions of ASU 2015-02 effective January 1, 2016 and re-evaluated all legal entity investments under the revised consolidation model. The adoption of ASU 2015-02 did not have a material impact on our consolidated financial position, results of operations or cash flows.

Recent Accounting Guidance Not Yet Adopted: In December 2016, the FASB issued Accounting Standards Update No. 2016-20, *Technical Corrections and Improvements to Topic 606, Revenue from Contracts with Customers*, or ASU 2016-20. In May 2016, the FASB issued Accounting Standards Update No. 2016-12, *Revenue from Contracts With Customers (Topic 606): Narrow-Scope Improvements and Practical Expedients*, or ASU 2016-12. In April 2016, the FASB issued Accounting Standards Update No. 2016-10, *Revenue from Contracts with Customers (Topic 606): Identifying Performance Obligations and Licensing*, or ASU 2016-10. In March 2016, the FASB issued Accounting Standards Update No. 2016-08, *Revenue from Contracts with Customers (Topic 606): Principal versus Agent Considerations (Reporting Revenue Gross versus Net)*, or ASU 2016-08. These updates provide additional clarification and implementation guidance on the previously issued Accounting Standards Update No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*, or ASU 2014-09. The amendments in ASU 2016-20 provide technical corrections to various implementation examples and clarifying guidance on the treatment of capitalized advertising costs, impairment testing of capitalized contract costs, performance obligation disclosures and scope exceptions. The amendments in ASU 2016-12 provide clarifying guidance on assessing collectability; noncash consideration; presentation of sales taxes; and transition. The amendments in ASU 2016-10 provide clarifying guidance on the materiality and evaluation of performance obligations; treatment of shipping and handling costs; and determining whether an entity's promise to grant a license provides a customer with either a right to use or a right to access an entity's intellectual property. The amendments in ASU 2016-08 clarify how an entity should identify the specified good or service for the principal versus agent evaluation and how it should apply the control principle to certain types of

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

arrangements. Collectively, these updates will require a company to recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. The adoption of ASU 2016-20, ASU 2016-12, ASU 2016-10 and ASU 2016-08 is to coincide with an entity's adoption of ASU 2014-09, which we intend to adopt for interim and annual reporting periods beginning after December 15, 2017. Upon the effective date, these updates will supersede almost all existing revenue recognition guidance under GAAP, with certain exceptions, including an exception for our premium revenues, recorded on the Premiums line item on our consolidated statements of income, which will continue to be accounted for in accordance with the provisions of Accounting Standards Codification, or ASC, Topic 944, *Financial Services - Insurance*. Our administrative service and other contracts that will be subject to these Accounting Standards Updates are recorded in the Administrative fees and Other revenue line items on our consolidated statements of income and represent approximately 6.0% of our consolidated total operating revenue on our consolidated statements of income at December 31, 2016. The new guidance permits adoption through either a full retrospective approach or a modified retrospective approach with a cumulative effect adjustment to retained earnings. We are still in the process of evaluating the impact that these updates will have on our results of operations, cash flows, consolidated financial position and related disclosures and the method of adoption we will ultimately choose.

In November 2016, the FASB issued Accounting Standards Update No. 2016-18, *Statement of Cash Flows (Topic 230): Restricted Cash*, or ASU 2016-18. This update amends ASC Topic 230 to add or clarify guidance on the classification and presentation of restricted cash in the statement of cash flows. The guidance requires entities to show the changes in the total of cash, cash equivalents, restricted cash and restricted cash equivalent in the statement of cash flows. The guidance will be applied retrospectively and is effective for annual periods beginning after December 15, 2017, and interim periods within those years, with early adoption permitted. We are currently evaluating the effects the adoption of ASU 2016-18 will have on our consolidated statements of cash flows, if any. ASU 2016-18 will not impact our results of operations.

In August 2016, the FASB issued Accounting Standards Update No. 2016-15, *Statement of Cash Flows (Topic 230): Classification of Certain Cash Receipts and Cash Payments*, or ASU 2016-15. This update addresses the presentation and classification on the statement of cash flows for eight specific items, with the objective of reducing existing diversity in practice in how certain cash receipts and cash payments are presented and classified. ASU 2016-15 is effective for interim and annual reporting periods beginning after December 15, 2017, with early adoption permitted. We are currently evaluating the effects the adoption of ASU 2016-15 will have on our consolidated statements of cash flows, if any. ASU 2016-15 will not impact our results of operations.

In June 2016, the FASB issued Accounting Standards Update No. 2016-13, *Financial Instruments - Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments*, or ASU 2016-13. This update introduces a current expected credit loss model for measuring expected credit losses for certain types of financial instruments held at the reporting date based on historical experience, current conditions and reasonable supportable forecasts. ASU 2016-13 replaces the current incurred loss model for measuring expected credit losses, requires expected losses on available-for-sale debt securities to be recognized through an allowance for credit losses rather than as reductions in the amortized cost of the securities, and provides for additional disclosure requirements. ASU 2016-13 is effective for interim and annual reporting periods beginning after December 15, 2019, with early adoption permitted for interim and annual reporting periods beginning after December 15, 2018. We are currently evaluating the effects the adoption of ASU 2016-13 will have on our consolidated financial statements, results of operations and cash flows.

In March 2016, the FASB issued Accounting Standards Update No. 2016-09, *Compensation - Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting*, or ASU 2016-09. The amendments in this update simplify several aspects of accounting for and reporting on share-based payment transactions, including the income tax consequences, classification of awards as either equity or liabilities, and classification on the statement of cash flows. The amendments in ASU 2016-09 are effective for interim and annual reporting periods beginning after December 15, 2016, with early adoption permitted. The various amendments are to be applied differently upon adoption with certain amendments being applied prospectively, retrospectively and under a modified retrospective transition method. The primary impact of adoption will be the prospective recognition of all excess tax benefits and tax deficiencies related to stock compensation in our provision for income tax expense recognized in the statement of income rather than as additional paid-in capital in shareholders' equity, for all periods following adoption. We adopted ASU 2016-09 effective January 1, 2017.

In February 2016, the FASB issued Accounting Standards Update No. 2016-02, *Leases (Topic 842)*, or ASU 2016-02. Upon the effective date, ASU 2016-02 will supersede the current lease guidance in Topic 840, *Leases*. Under the new

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Notes to Consolidated Financial Statements (continued)

guidance, lessees will be required to recognize for all leases, with the exception of short-term leases, a lease liability, which is a lessee's obligation to make lease payments arising from a lease, measured on a discounted basis. Concurrently, lessees will be required to recognize a right-of-use asset, which is an asset that represents the lessee's right to use, or control the use of, a specified asset for the lease term. ASU 2016-02 is effective for interim and annual reporting periods beginning after December 15, 2018, with early adoption permitted. The guidance is required to be applied using a modified retrospective transition approach for leases existing at, or entered into after, the beginning of the earliest comparative periods presented in the financial statements. We are currently evaluating the effects the adoption of ASU 2016-02 will have on our consolidated financial statements, results of operations and cash flows.

In January 2016, the FASB issued Accounting Standards Update No. 2016-01, *Financial Instruments - Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities*, or ASU 2016-01. The amendments in ASU 2016-01 change the accounting for non-consolidated equity investments that are not accounted for under the equity method of accounting by requiring changes in fair value to be recognized in income. Under current guidance, changes in fair value for investments of this nature are recognized in accumulated other comprehensive income as a component of shareholders' equity. Additionally, ASU 2016-01 simplifies the impairment assessment of equity investments without readily determinable fair values; requires entities to use the exit price when estimating the fair value of financial instruments; and modifies various presentation disclosure requirements for financial instruments. ASU 2016-01 is effective for interim and annual reporting periods beginning after December 15, 2017. We are currently evaluating the effects the adoption of ASU 2016-01 will have on our results of operations and related disclosures.

There were no other new accounting pronouncements that were issued or became effective during the year ended December 31, 2016 that had, or are expected to have, a material impact on our financial position, results of operations, cash flows or financial statement disclosures.

3. Business Acquisitions and Divestiture

Pending Acquisition of Cigna Corporation

On July 24, 2015, we and Cigna Corporation, or Cigna, announced that we entered into an Agreement and Plan of Merger, or Merger Agreement, dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and our direct wholly-owned subsidiary, pursuant to which we will acquire all outstanding shares of Cigna, or the Acquisition. This Acquisition will further our goal of creating a premier health benefits company with critical diversification and scale to lead the transformation of health care delivery for consumers. Cigna is a global health services organization that delivers affordable and personalized products and services to customers through employer-based, government-sponsored and individual coverage arrangements. All of Cigna's products and services are provided exclusively by or through its operating subsidiaries, including Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Life Insurance Company of North America and Cigna Life Insurance Company of New York. Such products and services include an integrated suite of health services, such as medical, dental, behavioral health, pharmacy, vision, supplemental benefits, and other related products including group life, accident and disability insurance. Cigna maintains sales capability in 30 countries and jurisdictions.

Under the terms of the Merger Agreement, Cigna's shareholders will receive \$103.40 in cash and 0.5152 shares of our common stock for each Cigna common share outstanding. The value of the transaction is estimated to be approximately \$53,000.0 based on the closing price of our common stock on the New York Stock Exchange on July 23, 2015. The final purchase price will be determined based on our closing stock price on the date of closing of the Acquisition. The combined company will reflect a pro forma equity ownership comprised of approximately 67% Anthem shareholders and approximately 33% Cigna shareholders. We expect to finance the cash portion of the Acquisition through available cash on hand and the issuance of new debt. We are party to a bridge facility commitment letter and a joinder agreement with a group of lenders which provides up to \$19,500.0 under a 364-day senior unsecured bridge term loan credit facility to finance the Acquisition in the event that we have not received proceeds from any combination of (i) senior unsecured term loans, (ii) common or preferred equity or equity-linked securities and/or (iii) senior unsecured notes in a public offering or private placement in an aggregate principal amount of at least \$19,500.0 prior to the consummation of the Acquisition. In addition, in August 2015, we entered into a term loan facility which will provide up to \$4,000.0 to finance a portion of the Acquisition. The commitment of the lenders to provide the bridge facility and the term loan facility is subject to several conditions, including the completion of the Acquisition.

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Notes to Consolidated Financial Statements (continued)

In July 2016, the U.S. Department of Justice, or DOJ, along with certain state attorneys general, filed a civil antitrust lawsuit in the U.S. District Court for the District of Columbia, or District Court, seeking to block the Acquisition. Trial commenced in November 2016 and concluded in January 2017. On January 18, 2017, we provided notice to Cigna that we had elected to extend the termination date under the Merger Agreement from January 31, 2017 until April 30, 2017. On February 8, 2017, the District Court ruled in favor of the DOJ, and following our motion to expedite the appeal, which was granted on February 17, 2017, we promptly appealed the District Court's ruling to the U.S. Circuit Court of Appeals for the District of Columbia Circuit, or the Appellate Court. On February 14, 2017, Cigna purported to terminate the Merger Agreement and commenced litigation against us in the Delaware Court of Chancery, or Delaware Court, seeking damages and a declaratory judgment that its purported termination of the Merger Agreement was lawful, among other claims. We believe Cigna's allegations are without merit. Also on February 14, 2017, we initiated our own litigation against Cigna in the Delaware Court seeking a temporary restraining order to enjoin Cigna from terminating the Merger Agreement, specific performance compelling Cigna to comply with the Merger Agreement and damages. On February 15, 2017, the Delaware Court granted our motion for a temporary restraining order and issued an order enjoining Cigna from terminating the Merger Agreement. The temporary restraining order became effective immediately and will remain in place pending any further order from the Delaware Court. A hearing will be scheduled the week of April 10, 2017. We intend to vigorously defend the Acquisition in both the Circuit Court and the Delaware Court and remain committed to completing the Acquisition as soon as practicable. If the Merger Agreement is terminated because the required regulatory approvals cannot be obtained, under certain conditions, we could be obligated to pay a \$1,850.0 termination fee to Cigna.

Acquisition of Simply Healthcare

On February 17, 2015, we completed our acquisition of Simply Healthcare, a leading managed care company for people enrolled in Medicaid and Medicare programs in Florida. This acquisition aligns with our strategy for continued growth in our Government Business segment.

In accordance with FASB accounting guidance for business combinations, the consideration transferred was allocated to the fair value of Simply Healthcare's assets acquired and liabilities assumed, including identifiable intangible assets. The excess of the consideration transferred over the fair value of net assets acquired resulted in non-tax-deductible goodwill of \$474.7 at December 31, 2015, all of which was allocated to our Government Business segment. Goodwill recognized from the acquisition of Simply Healthcare primarily relates to the future economic benefits arising from the assets acquired and is consistent with our stated intentions to strengthen our position and expand operations in the government sector to service Medicaid and Medicare enrollees. There were no additional measurement period adjustments to the provisional amounts recorded at December 31, 2015.

The fair value of the net assets acquired from Simply Healthcare includes \$430.0 of other intangible assets at December 31, 2015, which primarily consist of indefinite-lived state licenses and finite-lived customer relationships with amortization periods ranging from 2 to 4 years.

The results of operations of Simply Healthcare are included in our consolidated financial statements within our Government Business segment for the period following February 17, 2015. The pro forma effects of this acquisition for prior periods were not material to our consolidated results of operations.

Divestiture of 1-800 CONTACTS

In December 2013, we entered into a definitive agreement to sell our 1-800 CONTACTS business to the private equity firm Thomas H. Lee Partners, L.P. In Addition, we entered into an asset purchase agreement with Luxottica Group to sell our glasses.com related assets, or collectively, 1-800 CONTACTS. The sales were completed on January 31, 2014 and did not result in any material difference to the loss on disposal from discontinued operations recorded during the year ended December 31, 2013. The operating results for 1-800 CONTACTS for the one month ended January 31, 2014 are reported as discontinued operations in the accompanying consolidated statements of income. The operating results for 1-800 CONTACTS were previously reported in the Commercial and Specialty Business segment.

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Notes to Consolidated Financial Statements (continued)

4. Investments

A summary of current and long-term investments, available-for-sale, at December 31, 2016 and 2015 is as follows:

			Gross Unrealized Losses				Non-Credit Component of Other-Than- Temporary Impairments Recognized in AOCI
	Cost or Amortized Cost	Gross Unrealized Gains	Less than 12 Months	12 Months or Greater	Estimated Fair Value		
December 31, 2016							
Fixed maturity securities:							
United States Government securities	\$ 561.7	\$ 2.5	\$ (5.7)	\$ —	\$ 558.5	\$	—
Government sponsored securities	40.1	0.3	(0.3)	(0.1)	40.0		—
States, municipalities and political subdivisions, tax-exempt	6,024.6	139.1	(55.2)	(3.2)	6,105.3		(3.8)
Corporate securities	8,011.7	159.5	(49.5)	(27.1)	8,094.6		(3.4)
Residential mortgage-backed securities	1,916.9	32.3	(15.3)	(4.6)	1,929.3		—
Commercial mortgage-backed securities	216.8	1.2	(0.3)	(3.4)	214.3		—
Other debt securities	744.6	6.4	(1.5)	(4.0)	745.5		—
Total fixed maturity securities	17,516.4	341.3	(127.8)	(42.4)	17,687.5	\$	(7.2)
Equity securities	1,103.3	407.3	(10.7)	—	1,499.9		
Total investments, available-for-sale	\$ 18,619.7	\$ 748.6	\$ (138.5)	\$ (42.4)	\$ 19,187.4		
December 31, 2015							
Fixed maturity securities:							
United States Government securities	\$ 349.5	\$ 2.0	\$ (1.6)	\$ —	\$ 349.9	\$	—
Government sponsored securities	75.6	0.5	(0.1)	(0.1)	75.9		—
States, municipalities and political subdivisions, tax-exempt	5,976.7	284.1	(4.0)	(5.2)	6,251.6		—
Corporate securities	8,209.7	61.1	(267.2)	(110.5)	7,893.1		(15.4)
Residential mortgage-backed securities	1,724.5	41.2	(7.6)	(7.2)	1,750.9		—
Commercial mortgage-backed securities	407.6	1.4	(4.3)	(0.4)	404.3		—
Other debt securities	756.8	4.1	(5.8)	(2.6)	752.5		—
Total fixed maturity securities	17,500.4	394.4	(290.6)	(126.0)	17,478.2	\$	(15.4)
Equity securities	1,083.1	420.6	(30.9)	—	1,472.8		
Total investments, available-for-sale	\$ 18,583.5	\$ 815.0	\$ (321.5)	\$ (126.0)	\$ 18,951.0		

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Notes to Consolidated Financial Statements (continued)

For available-for-sale securities in an unrealized loss position at December 31, 2016 and 2015, the following table summarizes the aggregate fair values and gross unrealized losses by length of time those securities have continuously been in an unrealized loss position.

	Less than 12 Months			12 Months or Greater		
	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss
<i>(Securities are whole amounts)</i>						
December 31, 2016						
Fixed maturity securities:						
United States Government securities	51	\$ 359.9	\$ (5.7)	—	\$ —	\$ —
Government sponsored securities	18	26.4	(0.3)	1	1.0	(0.1)
States, municipalities and political subdivisions, tax-exempt	1,022	1,849.0	(55.2)	28	60.7	(3.2)
Corporate securities	1,272	2,640.6	(49.5)	203	422.8	(27.1)
Residential mortgage-backed securities	430	905.8	(15.3)	114	136.9	(4.6)
Commercial mortgage-backed securities	19	61.2	(0.3)	24	60.8	(3.4)
Other debt securities	66	144.3	(1.5)	55	133.8	(4.0)
Total fixed maturity securities	2,878	5,987.2	(127.8)	425	816.0	(42.4)
Equity securities	452	233.1	(10.7)	—	—	—
Total fixed maturity and equity securities	3,330	\$ 6,220.3	\$ (138.5)	425	\$ 816.0	\$ (42.4)
December 31, 2015						
Fixed maturity securities:						
United States Government securities	48	\$ 248.4	\$ (1.6)	2	\$ 0.9	\$ —
Government sponsored securities	13	18.3	(0.1)	6	8.2	(0.1)
States, municipalities and political subdivisions, tax-exempt	198	467.8	(4.0)	43	83.0	(5.2)
Corporate securities	2,492	4,912.3	(267.2)	372	447.0	(110.5)
Residential mortgage-backed securities	298	668.3	(7.6)	119	186.3	(7.2)
Commercial mortgage-backed securities	66	263.0	(4.3)	17	38.5	(0.4)
Other debt securities	153	488.2	(5.8)	28	77.0	(2.6)
Total fixed maturity securities	3,268	7,066.3	(290.6)	587	840.9	(126.0)
Equity securities	792	261.1	(30.9)	—	—	—
Total fixed maturity and equity securities	4,060	\$ 7,327.4	\$ (321.5)	587	\$ 840.9	\$ (126.0)

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

The amortized cost and fair value of available-for-sale fixed maturity securities at December 31, 2016, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because the issuers of the securities may have the right to prepay obligations.

	Amortized Cost	Estimated Fair Value
Due in one year or less	\$ 381.4	\$ 381.1
Due after one year through five years	4,821.7	4,883.9
Due after five years through ten years	5,629.8	5,718.1
Due after ten years	4,549.8	4,560.8
Mortgage-backed securities	2,133.7	2,143.6
Total available-for-sale fixed maturity securities	<u>\$ 17,516.4</u>	<u>\$ 17,687.5</u>

The major categories of net investment income for the years ended December 31 are as follows:

	2016	2015	2014
Fixed maturity securities	\$ 673.1	\$ 679.0	\$ 644.1
Equity securities	61.7	61.7	57.7
Cash equivalents	3.6	0.7	0.8
Other	84.9	(22.6)	66.3
Investment income	<u>823.3</u>	<u>718.8</u>	<u>768.9</u>
Investment expense	<u>(43.8)</u>	<u>(41.2)</u>	<u>(44.5)</u>
Net investment income	<u>\$ 779.5</u>	<u>\$ 677.6</u>	<u>\$ 724.4</u>

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Notes to Consolidated Financial Statements (continued)

Net realized investment gains/losses and net change in unrealized appreciation/depreciation on investments for the years ended December 31 are as follows:

	2016	2015	2014
Net realized gains (losses):			
Fixed maturity securities:			
Gross realized gains from sales	\$ 209.9	\$ 135.9	\$ 198.2
Gross realized losses from sales	(152.1)	(182.1)	(50.6)
Net realized gains (losses) from sales of fixed maturity securities	57.8	(46.2)	147.6
Equity securities:			
Gross realized gains from sales	205.5	233.4	93.5
Gross realized losses from sales	(50.0)	(45.1)	(13.9)
Net realized gains from sales of equity securities	155.5	188.3	79.6
Other investments:			
Gross realized gains from sales	7.2	5.0	13.1
Gross realized losses from sales	(0.4)	—	—
Net realized gains from sales of other investments	6.8	5.0	13.1
Net realized gains	220.1	147.1	240.3
Other-than-temporary impairment losses recognized in income:			
Fixed maturity securities	(74.7)	(31.2)	(22.3)
Equity securities	(22.3)	(35.6)	(13.5)
Other investments	(18.4)	(16.6)	(13.2)
Other-than-temporary impairment losses recognized in income	(115.4)	(83.4)	(49.0)
Change in net unrealized gains (losses) on investments:			
Fixed maturity securities	193.3	(372.9)	145.2
Equity securities	6.9	(217.7)	36.5
Other investments	(2.5)	(4.1)	—
Total change in net unrealized gains (losses) on investments	197.7	(594.7)	181.7
Deferred income tax (expense) benefit	(79.8)	210.4	(63.1)
Net change in net unrealized gains (losses) on investments	117.9	(384.3)	118.6
Net realized gains on investments, other-than-temporary impairment losses recognized in income and net change in net unrealized gains (losses) on investments	\$ 222.6	\$ (320.6)	\$ 309.9

A primary objective in the management of our fixed maturity and equity portfolios is to maximize total return relative to underlying liabilities and respective liquidity needs. In achieving this goal, assets may be sold to take advantage of market conditions or other investment opportunities as well as tax considerations. Sales will generally produce realized gains and losses. In the ordinary course of business, we may sell securities at a loss for a number of reasons, including, but not limited to: (i) changes in the investment environment; (ii) expectations that the fair value could deteriorate further; (iii) desire to reduce exposure to an issuer or an industry; (iv) changes in credit quality; or (v) changes in expected cash flow.

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Notes to Consolidated Financial Statements (continued)

Proceeds from fixed maturity securities, equity securities and other invested assets and the related gross realized gains and gross realized losses for the years ended December 31 are as follows:

	2016	2015	2014
Proceeds	\$ 11,952.3	\$ 11,779.8	\$ 10,255.9
Gross realized gains	422.6	374.3	304.8
Gross realized losses	(202.5)	(227.2)	(64.5)

A significant judgment in the valuation of investments is the determination of when an other-than-temporary decline in value has occurred. We follow a consistent and systematic process for recognizing impairments on securities that sustain other-than-temporary declines in value. We have established a committee responsible for the impairment review process. The decision to impair a security incorporates both quantitative criteria and qualitative information. The impairment review process considers a number of factors including, but not limited to: (i) the length of time and the extent to which the fair value has been less than book value, (ii) the financial condition and near term prospects of the issuer, (iii) our intent and ability to retain impaired investments for a period of time sufficient to allow for any anticipated recovery in fair value, (iv) our intent to sell or the likelihood that we will need to sell a fixed maturity security before recovery of its amortized cost basis, (v) whether the debtor is current on interest and principal payments, (vi) the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors) and (vii) general market conditions and industry or sector specific factors. For securities that are deemed to be other-than-temporarily impaired, the security is adjusted to fair value and the resulting losses are recognized in the consolidated statements of income. The new cost basis of the impaired securities is not increased for future recoveries in fair value.

Other-than-temporary impairments recorded in 2016, 2015 and 2014 were primarily the result of the continued credit deterioration on specific issuers in the bond markets and the fair values of certain equity securities remaining below cost for an extended period of time. There were no individually significant OTTI losses on investments by issuer during 2016, 2015 or 2014.

Investment securities are exposed to various risks, such as interest rate, market and credit. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is possible that changes in these risk factors in the near term could have an adverse material impact on our results of operations or shareholders' equity.

The changes in the amount of the credit component of OTTI losses on fixed maturity securities recognized in income, for which a portion of the OTTI losses was recognized in other comprehensive income, was not material for the years ended December 31, 2016, 2015 or 2014.

At December 31, 2016 and 2015, no investments exceeded 10% of shareholders' equity.

At December 31, 2016 and 2015, the carrying value of fixed maturity investments that did not produce income during the years then ended were \$0.5 and \$0.2, respectively.

As of December 31, 2016 and 2015, we had committed approximately \$789.1 and \$662.3, respectively, to future capital calls from various third-party investments in exchange for an ownership interest in the related entities.

At December 31, 2016 and 2015, securities with carrying values of approximately \$524.4 and \$558.2, respectively, were deposited by our insurance subsidiaries under requirements of regulatory authorities.

In the tables above, certain amounts for the years ended December 31, 2015 and 2014 have been reclassified to conform to the current year presentation. The reclassifications do not impact amounts presented in the financial statements.

Securities Lending Programs

The fair value of the collateral received at the time of the securities lending transactions amounted to \$1,078.9 and \$1,300.9 at December 31, 2016 and 2015, respectively. The value of the collateral represented 103% of the market value of the securities on loan at December 31, 2016 and 2015.

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Notes to Consolidated Financial Statements (continued)

The remaining contractual maturity of our securities lending agreements at December 31, 2016 is as follows:

	Overnight and Continuous	Less than 30 days	30-90 days	Greater Than 90 days	Total
Securities lending transactions					
United States Government securities	\$ 79.5	\$ 25.2	\$ 48.2	\$ 8.7	\$ 161.6
Corporate securities	658.8	—	—	—	658.8
Equity securities	255.5	1.3	—	—	256.8
Other debt securities	1.7	—	—	—	1.7
Total	<u>\$ 995.5</u>	<u>\$ 26.5</u>	<u>\$ 48.2</u>	<u>\$ 8.7</u>	<u>\$ 1,078.9</u>

5. Derivative Financial Instruments

We primarily invest in the following types of derivative financial instruments: interest rate swaps, futures, forward contracts, put and call options, swaptions, embedded derivatives and warrants. We also enter into master netting agreements which reduce credit risk by permitting net settlement of transactions. At December 31, 2016, we had posted collateral of \$92.4 and received collateral of \$591.1 related to our derivative financial instruments. At December 31, 2015, we had posted collateral of \$182.7 and received collateral of \$32.2 related to our derivative financial instruments.

In addition to collateral posted for derivative transactions, from time to time, we may have cash on deposit to meet certain regulatory requirements, which are included in Cash and cash equivalents on the balance sheets. At December 31, 2016 and 2015, we had cash on deposit of \$405.3 and \$79.9, respectively.

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

A summary of the aggregate contractual or notional amounts and estimated fair values related to derivative financial instruments at December 31, 2016 and 2015 is as follows:

	Contractual/ Notional Amount	Balance Sheet Location	Estimated Fair Value	
			Asset	(Liability)
December 31, 2016				
Hedging instruments				
Interest rate swaps - fixed to floating	\$ 1,385.0	Other assets/other liabilities	\$ 4.0	\$ (0.7)
Interest rate swaps - forward starting pay fixed	4,775.0	Other assets/other liabilities	528.8	(6.0)
Subtotal hedging	6,160.0	Subtotal hedging	532.8	(6.7)
Non-hedging instruments				
Interest rate swaps	209.4	Equity securities	4.7	(0.2)
Options	10,280.2	Other assets/other liabilities	220.7	(233.9)
Futures	185.3	Equity securities	0.5	(1.1)
Subtotal non-hedging	10,674.9	Subtotal non-hedging	225.9	(235.2)
Total derivatives	\$ 16,834.9	Total derivatives	758.7	(241.9)
		Amounts netted	(92.8)	92.8
		Net derivatives	\$ 665.9	\$ (149.1)
December 31, 2015				
Hedging instruments				
Interest rate swaps - fixed to floating	\$ 1,385.0	Other assets/other liabilities	\$ 7.0	\$ (0.8)
Interest rate swaps - forward starting pay fixed	4,650.0	Other assets/other liabilities	15.7	(90.9)
Subtotal hedging	6,035.0	Subtotal hedging	22.7	(91.7)
Non-hedging instruments				
Interest rate swaps	271.7	Equity securities	1.2	(6.0)
Options	16,917.4	Other assets/other liabilities	305.7	(332.1)
Futures	152.0	Equity securities	0.1	(0.2)
Subtotal non-hedging	17,341.1	Subtotal non-hedging	307.0	(338.3)
Total derivatives	\$ 23,376.1	Total derivatives	329.7	(430.0)
		Amounts netted	(170.6)	170.6
		Net derivatives	\$ 159.1	\$ (259.4)

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

Fair Value Hedges

We have entered into various interest rate swap contracts to convert a portion of our interest rate exposure on our long-term debt from fixed rates to floating rates. The floating rates payable on all of our fair value hedges are benchmarked to LIBOR. A summary of our outstanding fair value hedges at December 31, 2016 and 2015 is as follows:

Type of Fair Value Hedges	Year Entered Into	Outstanding Notional Amount		Interest Rate Received	Expiration Date
		2016	2015		
Interest rate swap	2015	\$ 200.0	\$ 200.0	4.350 %	August 15, 2020
Interest rate swap	2014	150.0	150.0	4.350	August 15, 2020
Interest rate swap	2013	10.0	10.0	4.350	August 15, 2020
Interest rate swap	2012	200.0	200.0	4.350	August 15, 2020
Interest rate swap	2012	625.0	625.0	1.875	January 15, 2018
Interest rate swap	2012	200.0	200.0	2.375	February 15, 2017
Total notional amount outstanding		<u>\$ 1,385.0</u>	<u>\$ 1,385.0</u>		

A summary of the effect of fair value hedges on our income statement for the years ended December 31, 2016, 2015 and 2014 is as follows:

Type of Fair Value Hedges	Income Statement Location of Hedge Gain	Hedge Gain Recognized	Hedged Item	Income Statement Location of Hedged Item Loss	Hedged Item Loss Recognized
Year ended December 31, 2016					
Interest rate swaps	Interest expense	<u>\$ 8.1</u>	Fixed rate debt	Interest expense	<u>\$ (8.1)</u>
Year ended December 31, 2015					
Interest rate swaps	Interest expense	<u>\$ 12.1</u>	Fixed rate debt	Interest expense	<u>\$ (12.1)</u>
Year ended December 31, 2014					
Interest rate swaps	Interest expense	<u>\$ 25.5</u>	Fixed rate debt	Interest expense	<u>\$ (25.5)</u>

Cash Flow Hedges

We have entered into a series of forward starting pay fixed interest rate swaps with the objective of eliminating the variability of cash flows in the interest payments on anticipated future financings beginning in 2017. During 2016, swaps in the notional amount of \$5,900.0 expired. We paid an aggregate of \$745.7 to the swap counter parties upon expiration. We performed a final effectiveness test upon the expiration of each swap. The ineffective portion of the hedge loss of \$7.7 was recorded as a net realized loss on financial instruments. The effective portion of the hedge loss of \$738.0 was recorded in accumulated other comprehensive loss. Following the expiration of these swaps, we entered into a new series of forward starting pay fixed interest rate swaps to replace the expired swaps. As of December 31, 2016, we recognized a hedge gain of \$522.8 on the new swaps, which was recorded in accumulated other comprehensive loss. We had \$4,775.0 and \$4,650.0 in notional amount outstanding under these swaps at December 31, 2016 and 2015, respectively.

The unrecognized loss for all outstanding, expired and terminated cash flow hedges included in accumulated other comprehensive loss, net of tax, was \$168.4 and \$81.1 at December 31, 2016 and 2015, respectively. As of December 31, 2016, the total amount of amortization over the next twelve months for all cash flow hedges is estimated to increase interest expense by approximately \$9.9.

Anthem, Inc.

Notes to Consolidated Financial Statements (continued)

A summary of the effect of cash flow hedges on our financial statements for the years ended December 31, 2016, 2015 and 2014 is as follows:

Type of Cash Flow Hedge	Effective Portion			Ineffective Portion	
	Pretax Hedge Loss Recognized in Other Comprehensive Income (Loss)	Income Statement Location of Loss from Accumulated Other Comprehensive Loss	Hedge Loss Reclassified from Accumulated Other Comprehensive Loss	Income Statement Location of Loss Recognized	Hedge Loss Recognized
Year ended December 31, 2016					
Forward starting pay fixed swaps	\$ (140.1)	Interest expense	\$ (5.8)	Net realized gains on financial instruments	\$ (7.7)
Year ended December 31, 2015					
Forward starting pay fixed swaps	\$ (75.2)	Interest expense	\$ (5.5)	None	\$ —
Year ended December 31, 2014					
Forward starting pay fixed swaps	\$ —	Interest expense	\$ (5.0)	None	\$ —

We test for cash flow hedge effectiveness at hedge inception and re-assess at the end of each reporting period. No amounts were excluded from the assessment of hedge effectiveness, and no ineffectiveness was recognized, except for the amounts described above related to the expired interest rate swaps.

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

Non-Hedging Derivatives

A summary of the effect of non-hedging derivatives on our income statement for the years ended December 31, 2016, 2015 and 2014 is as follows:

Type of Non-hedging Derivatives	Income Statement Location of Gain (Loss) Recognized	Derivative Gain (Loss) Recognized
Year ended December 31, 2016		
Interest rate swaps	Net realized gains on financial instruments	\$ 0.2
Options	Net realized gains on financial instruments	(209.1)
Futures	Net realized gains on financial instruments	1.4
Total		<u>\$ (207.5)</u>
Year ended December 31, 2015		
Derivatives embedded in convertible fixed maturity securities	Net realized gains on financial instruments	\$ (22.2)
Interest rate swaps	Net realized gains on financial instruments	(1.9)
Options	Net realized gains on financial instruments	34.6
Futures	Net realized gains on financial instruments	(0.1)
Total		<u>\$ 10.4</u>
Year ended December 31, 2014		
Derivatives embedded in convertible fixed maturity securities	Net realized gains on financial instruments	\$ 11.6
Interest rate swaps	Net realized gains on financial instruments	(11.6)
Options	Net realized gains on financial instruments	(53.3)
Futures	Net realized gains on financial instruments	(10.0)
Total		<u>\$ (63.3)</u>

During 2016, certain options classified as non-hedging derivatives expired and we paid the counter parties \$164.4.

6. Fair Value

Assets and liabilities recorded at fair value in the consolidated balance sheets are categorized based upon the level of judgment associated with the inputs used to measure their fair value. Level inputs, as defined by FASB guidance for fair value measurements and disclosures, are as follows:

Level Input:	Input Definition:
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The following methods, assumptions and inputs were used to determine the fair value of each class of the following assets and liabilities recorded at fair value in the consolidated balance sheets:

Cash equivalents: Cash equivalents primarily consist of highly rated money market funds with maturities of three months or less, and are purchased daily at par value with specified yield rates. Due to the high ratings and short-term nature of the funds, we designate all cash equivalents as Level I.

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

Fixed maturity securities, available-for-sale: Fair values of available-for-sale fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level I or Level II inputs for the determination of fair value to facilitate fair value measurements and disclosures. United States Government securities represent Level I securities, while Level II securities primarily include corporate securities, securities from states, municipalities and political subdivisions, mortgage-backed securities and certain other asset back securities. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. We have controls in place to review the pricing services' qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. We also have certain fixed maturity securities, primarily corporate debt securities, that are designated Level III securities. For these securities, the valuation methodologies may incorporate broker quotes or discounted cash flow analyses using assumptions for inputs such as expected cash flows, benchmark yields, credit spreads, default rates and prepayment speeds that are not observable in the markets.

Equity securities, available-for-sale: Fair values of equity securities are generally designated as Level I and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level II. We also have certain equity securities, including private equity securities, for which the fair value is estimated based on each security's current condition and future cash flow projections. Such securities are designated Level III. The fair values of these private equity securities are generally based on either broker quotes or discounted cash flow projections using assumptions for inputs such as the weighted-average cost of capital, long-term revenue growth rates and earnings before interest, taxes, depreciation and amortization, or EBITDA, and/or revenue multiples that are not observable in the markets.

Other invested assets, current: Other invested assets, current include securities held in rabbi trusts that are classified as trading. These securities are designated Level I securities as fair values are based on quoted market prices.

Securities lending collateral: Fair values of securities lending collateral are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level I or Level II inputs for the determination of fair value, to facilitate fair value measurements and disclosures.

Derivatives: Fair values are based on the quoted market prices by the financial institution that is the counterparty to the derivative transaction. We independently verify prices provided by the counterparties using valuation models that incorporate market observable inputs for similar derivative transactions. Derivatives are designated as Level II securities.

In addition, the following methods and assumptions were used to determine the fair value of each class of pension benefit plan assets and other benefit plan assets not defined above (see Note 10, "Retirement Benefits," for fair values of benefit plan assets):

Mutual funds: Fair values are based on quoted market prices, which represent the net asset value, or NAV, of shares held.

Common and collective trusts: Fair values of common/collective trusts that replicate traded money market funds are based on cost, which approximates fair value. Fair values of common/collective trusts that invest in securities are valued at the NAV of the shares held, where the trust applies fair value measurements to the underlying investments to determine the NAV.

Partnership interests: Fair values are estimated based on the plan's proportionate share of the undistributed partners' capital as reported in audited financial statements of the partnership.

Contract with insurance company: Fair value of the contract in the insurance company general investment account is determined by the insurance company based on the fair value of the underlying investments of the account.

Investment in DOL 103-12 trust: Fair value is based on the plan's proportionate share of the fair value of investments held by the trust, qualified as a Department of Labor Regulation 2520.103-12 entity, or DOL 103-12 trust, as reported in the

Anthem, Inc.

Notes to Consolidated Financial Statements (continued)

audited financial statements of the trust, where the trustee applies fair value measurements to the underlying investments of the trust.

Life insurance contracts: Fair value is based on the cash surrender value of the policies as reported by the insurer.

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

A summary of fair value measurements by level for assets and liabilities measured at fair value on a recurring basis at December 31, 2016 and 2015 is as follows:

	Level I	Level II	Level III	Total
December 31, 2016				
Assets:				
Cash equivalents	\$ 1,546.0	\$ —	\$ —	\$ 1,546.0
Investments available-for-sale:				
Fixed maturity securities:				
United States Government securities	558.5	—	—	558.5
Government sponsored securities	—	40.0	—	40.0
States, municipalities and political subdivisions, tax-exempt	—	6,105.3	—	6,105.3
Corporate securities	79.9	7,775.9	238.8	8,094.6
Residential mortgage-backed securities	—	1,917.3	12.0	1,929.3
Commercial mortgage-backed securities	—	214.3	—	214.3
Other debt securities	53.4	649.3	42.8	745.5
Total fixed maturity securities	691.8	16,702.1	293.6	17,687.5
Equity securities	1,200.2	111.9	187.8	1,499.9
Other invested assets, current	15.8	—	—	15.8
Securities lending collateral	726.0	353.8	—	1,079.8
Derivatives	—	758.7	—	758.7
Total assets	\$ 4,179.8	\$ 17,926.5	\$ 481.4	\$ 22,587.7
Liabilities:				
Derivatives	\$ —	\$ (241.9)	\$ —	\$ (241.9)
Total liabilities	\$ —	\$ (241.9)	\$ —	\$ (241.9)
December 31, 2015				
Assets:				
Cash equivalents	\$ 701.0	\$ —	\$ —	\$ 701.0
Investments available-for-sale:				
Fixed maturity securities:				
United States Government securities	349.9	—	—	349.9
Government sponsored securities	—	75.9	—	75.9
States, municipalities and political subdivisions, tax-exempt	—	6,251.6	—	6,251.6
Corporate securities	77.6	7,629.3	186.2	7,893.1
Residential mortgage-backed securities	—	1,750.9	—	1,750.9
Commercial mortgage-backed securities	—	402.4	1.9	404.3
Other debt securities	55.7	671.2	25.6	752.5
Total fixed maturity securities	483.2	16,781.3	213.7	17,478.2
Equity securities	1,253.8	116.9	102.1	1,472.8
Other invested assets, current	19.1	—	—	19.1
Securities lending collateral	708.1	592.3	—	1,300.4
Derivatives	—	329.7	—	329.7
Total assets	\$ 3,165.2	\$ 17,820.2	\$ 315.8	\$ 21,301.2
Liabilities:				
Derivatives	\$ —	\$ (430.0)	\$ —	\$ (430.0)
Total liabilities	\$ —	\$ (430.0)	\$ —	\$ (430.0)

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

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level III inputs for the years ended December 31, 2016, 2015 and 2014 is as follows:

	Corporate Securities	Residential Mortgage- backed Securities	Commercial Mortgage- backed Securities	Other Debt Securities	Equity Securities	Total
Year ended December 31, 2016						
Beginning balance at January 1, 2016	\$ 186.2	\$ —	\$ 1.9	\$ 25.6	\$ 102.1	\$ 315.8
Total (losses) gains:						
Recognized in net income	(2.9)	—	—	—	0.7	(2.2)
Recognized in accumulated other comprehensive income	(2.0)	—	—	(0.5)	(0.5)	(3.0)
Purchases	170.2	4.3	—	—	222.6	397.1
Sales	(5.4)	—	—	—	(136.7)	(142.1)
Settlements	(56.8)	—	—	(0.9)	(0.4)	(58.1)
Transfers into Level III	6.6	9.3	—	28.8	—	44.7
Transfers out of Level III	(57.1)	(1.6)	(1.9)	(10.2)	—	(70.8)
Ending balance at December 31, 2016	<u>\$ 238.8</u>	<u>\$ 12.0</u>	<u>\$ —</u>	<u>\$ 42.8</u>	<u>\$ 187.8</u>	<u>\$ 481.4</u>
Change in unrealized losses included in net income related to assets still held for the year ended December 31, 2016	<u>\$ (2.0)</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ (2.0)</u>
Year ended December 31, 2015						
Beginning balance at January 1, 2015	\$ 144.6	\$ —	\$ 3.3	\$ 6.6	\$ 48.3	\$ 202.8
Total gains (losses):						
Recognized in net income	1.4	—	—	0.2	(1.5)	0.1
Recognized in accumulated other comprehensive income	0.7	—	—	(0.2)	3.9	4.4
Purchases	132.6	—	1.1	28.3	52.1	214.1
Sales	(11.7)	—	(1.1)	(0.9)	(13.8)	(27.5)
Settlements	(51.6)	—	(1.4)	(0.2)	—	(53.2)
Transfers into Level III	4.8	—	—	—	13.1	17.9
Transfers out of Level III	(34.6)	—	—	(8.2)	—	(42.8)
Ending balance at December 31, 2015	<u>\$ 186.2</u>	<u>\$ —</u>	<u>\$ 1.9</u>	<u>\$ 25.6</u>	<u>\$ 102.1</u>	<u>\$ 315.8</u>
Change in unrealized losses included in net income related to assets still held for the year ended December 31, 2015	<u>\$ (0.6)</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ (1.4)</u>	<u>\$ (2.0)</u>
Year ended December 31, 2014						
Beginning balance at January 1, 2014	\$ 115.2	\$ —	\$ 6.5	\$ 14.8	\$ 41.4	\$ 177.9
Total (losses) gains:						
Recognized in net income	(4.4)	—	—	—	(0.7)	(5.1)
Recognized in accumulated other comprehensive income	8.5	—	—	0.4	2.8	11.7
Purchases	68.9	—	3.6	6.5	15.9	94.9
Sales	(48.0)	—	—	(3.6)	(10.6)	(62.2)
Settlements	(11.0)	—	(3.7)	(0.4)	—	(15.1)
Transfers into Level III	24.8	—	—	—	—	24.8
Transfers out of Level III	(9.4)	—	(3.1)	(11.1)	(0.5)	(24.1)
Ending balance at December 31, 2014	<u>\$ 144.6</u>	<u>\$ —</u>	<u>\$ 3.3</u>	<u>\$ 6.6</u>	<u>\$ 48.3</u>	<u>\$ 202.8</u>
Change in unrealized losses included in net income related to assets still held for the year ended December 31, 2014	<u>\$ (11.1)</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ (0.7)</u>	<u>\$ (11.8)</u>

Transfers between levels, if any, are recorded as of the beginning of the reporting period. There were no material transfers between levels during the years ended December 31, 2016, 2015 or 2014.

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

Certain assets and liabilities are measured at fair value on a nonrecurring basis; that is, the instruments are not measured at fair value on an ongoing basis but are subject to fair value adjustments only in certain circumstances. As disclosed in Note 3, "Business Acquisitions and Divestiture", we completed our acquisition of Simply Healthcare on February 17, 2015. The values of net assets acquired in our acquisition of Simply Healthcare and resulting goodwill and other intangible assets were recorded at fair value primarily using Level III inputs. The majority of Simply Healthcare's assets acquired and liabilities assumed were recorded at their carrying values as of the respective date of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in our acquisition of Simply Healthcare were internally estimated based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets could be expected to generate in the future. We developed internal estimates for the expected cash flows and discount rate in the present value calculation. Other than the assets acquired and liabilities assumed in our acquisition of Simply Healthcare described above, there were no other assets or liabilities measured at fair value on a nonrecurring basis during the years ended December 31, 2016 or 2015.

Our valuation policy is determined by members of our treasury and accounting departments. Whenever possible, our policy is to obtain quoted market prices in active markets to estimate fair values for recognition and disclosure purposes. Where quoted market prices in active markets are not available, fair values are estimated using discounted cash flow analyses, broker quotes or other valuation techniques. These techniques are significantly affected by our assumptions, including discount rates and estimates of future cash flows. Potential taxes and other transaction costs are not considered in estimating fair values. Our valuation policy is generally to obtain only one quoted price for each security from third party pricing services, which are derived through recently reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information. When broker quotes are used, we generally obtain only one broker quote per security. As we are responsible for the determination of fair value, we perform monthly analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. This analysis is performed by our internal treasury personnel who are familiar with our investment portfolios, the pricing services engaged and the valuation techniques and inputs used. Our analysis includes a review of month-to-month price fluctuations. If unusual fluctuations are noted in this review, we may obtain additional information from other pricing services to validate the quoted price. There were no adjustments to quoted market prices obtained from the pricing services during the years ended December 31, 2016, 2015 or 2014.

In addition to the preceding disclosures on assets recorded at fair value in the consolidated balance sheets, FASB guidance also requires the disclosure of fair values for certain other financial instruments for which it is practicable to estimate fair value, whether or not such values are recognized in the consolidated balance sheets.

Non-financial instruments such as real estate, property and equipment, other current assets, deferred income taxes, intangible assets and certain financial instruments, such as policy liabilities, are excluded from the fair value disclosures. Therefore, the fair value amounts cannot be aggregated to determine our underlying economic value.

The carrying amounts reported in the consolidated balance sheets for cash, accrued investment income, premium and self-funded receivables, other receivables, income taxes receivable/payable, unearned income, accounts payable and accrued expenses, security trades pending payable, securities lending payable and certain other current liabilities approximate fair value because of the short term nature of these items. These assets and liabilities are not listed in the table below.

The following methods and assumptions were used to estimate the fair value of each class of financial instrument that is recorded at its carrying value on the consolidated balance sheets:

Other invested assets, long-term: Other invested assets, long-term include primarily our investments in limited partnerships, joint ventures and other non-controlled corporations, as well as the cash surrender value of corporate-owned life insurance policies. Investments in limited partnerships, joint ventures and other non-controlled corporations are carried at our share in the entities' undistributed earnings, which approximates fair value. The carrying value of corporate-owned life insurance policies represents the cash surrender value as reported by the respective insurer, which approximates fair value.

Short-term borrowings: The fair value of our short-term borrowings is based on quoted market prices for the same or similar debt, or, if no quoted market prices were available, on the current market interest rates estimated to be available to us for debt of similar terms and remaining maturities.

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

Long-term debt - commercial paper: The carrying amount for commercial paper approximates fair value as the underlying instruments have variable interest rates at market value.

Long-term debt - senior unsecured notes, remarketable subordinated notes and surplus notes: The fair values of our notes are based on quoted market prices in active markets for the same or similar debt, or, if no quoted market prices are available, on the current market observable rates estimated to be available to us for debt of similar terms and remaining maturities.

Long-term debt—convertible debentures: The fair value of our convertible debentures is based on the quoted market price in the active private market in which the convertible debentures trade.

A summary of the estimated fair values by level of each class of financial instrument that is recorded at its carrying value on our consolidated balance sheets at December 31, 2016 and 2015 are as follows:

	Carrying Value	Estimated Fair Value			
		Level I	Level II	Level III	Total
December 31, 2016					
Assets:					
Other invested assets, long-term	\$ 2,240.5	\$ —	\$ —	\$ 2,240.5	\$ 2,240.5
Liabilities:					
Debt:					
Short-term borrowings	440.0	—	440.0	—	440.0
Commercial paper	629.0	—	629.0	—	629.0
Notes	14,323.8	—	14,858.4	—	14,858.4
Convertible debentures	334.1	—	1,020.2	—	1,020.2
December 31, 2015					
Assets:					
Other invested assets, long-term	\$ 2,041.1	\$ —	\$ —	\$ 2,041.1	\$ 2,041.1
Liabilities:					
Debt:					
Short-term borrowings	540.0	—	540.0	—	540.0
Commercial paper	682.2	—	682.2	—	682.2
Notes	14,311.6	—	14,523.2	—	14,523.2
Convertible debentures	330.7	—	980.1	—	980.1

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

7. Income Taxes

The components of deferred income taxes at December 31 are as follows:

	2016	2015
Deferred tax assets relating to:		
Retirement benefits	\$ 362.9	\$ 364.8
Accrued expenses	331.9	344.6
Insurance reserves	229.5	247.1
Net operating loss carryforwards	9.2	18.1
Bad debt reserves	119.6	154.8
State income tax	59.8	43.4
Deferred compensation	38.2	40.1
Investment basis difference	42.4	62.2
Other	110.5	68.4
Total deferred tax assets	1,304.0	1,343.5
Deferred tax liabilities relating to:		
Unrealized gains on securities	202.9	127.8
Intangible assets:		
Trademarks and state Medicaid licenses	2,547.6	2,547.6
Customer, provider and hospital relationships	194.1	269.2
Internally developed software and other amortization differences	450.5	436.6
Retirement benefits	267.3	252.7
Debt discount	60.8	61.9
State deferred tax	106.0	36.4
Depreciation and amortization	54.1	44.2
Other	200.6	197.7
Total deferred tax liabilities	4,083.9	3,974.1
Net deferred tax liability	\$ (2,779.9)	\$ (2,630.6)

The elimination of the valuation allowance during 2015 was attributable to a reduction in a statutory state income tax rate and continued utilization of state net operating losses.

Significant components of the provision for income taxes for the years ended December 31 consist of the following:

	2016	2015	2014
Current tax expense:			
Federal	\$ 1,862.6	\$ 1,996.6	\$ 1,629.4
State and local	93.9	133.0	65.8
Total current tax expense	1,956.5	2,129.6	1,695.2
Deferred tax expense (benefit)	129.1	(58.6)	112.8
Total income tax expense	\$ 2,085.6	\$ 2,071.0	\$ 1,808.0

State and local current tax expense is reported gross of federal benefit, and includes amounts related to true up of prior years' tax, audit settlements, uncertain tax positions and state tax credits. Such items are included in multiple lines in the following rate reconciliation table on a net of federal tax basis.

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

A reconciliation of income tax expense recorded in the consolidated statements of income and amounts computed at the statutory federal income tax rate for the years ended December 31 is as follows:

	2016		2015		2014	
	Amount	Percent	Amount	Percent	Amount	Percent
Amount at statutory rate	\$ 1,594.4	35.0 %	\$ 1,620.9	35.0 %	\$ 1,528.8	35.0 %
State and local income taxes net of federal tax benefit	61.5	1.4	75.3	1.6	49.0	1.1
Tax exempt interest and dividends received deduction	(61.7)	(1.4)	(63.2)	(1.3)	(65.9)	(1.5)
HIP Fee	411.7	9.0	422.6	9.1	312.6	7.2
Other, net	79.7	1.8	15.4	0.3	(16.5)	(0.4)
Total income tax expense	\$ 2,085.6	45.8 %	\$ 2,071.0	44.7 %	\$ 1,808.0	41.4 %

During the year ended December 31, 2016, we recognized income tax expense of \$411.7, or \$1.54 per diluted share, as a result of the non-tax deductibility of the HIP Fee payments.

During the year ended December 31, 2015, we recognized income tax expense of \$422.6, or \$1.55 per diluted share, as a result of the non-tax deductibility of the HIP Fee payments. We also recognized income tax expense of \$42.3, or \$0.16 per diluted share, as a result of an adverse California franchise tax ruling. This expense is allocated between the "State and local income taxes net of federal tax benefit" and the "Other, net" line items in the table above.

During the year ended December 31, 2014, we recognized income tax expense of \$312.6, or \$1.09 per diluted share, as a result of the non-tax deductibility of the HIP Fee payments.

The change in the carrying amount of gross unrecognized tax benefits from uncertain tax positions for the years ended December 31 is as follows:

	2016	2015
Balance at January 1	\$ 212.0	\$ 115.8
Additions based on:		
Tax positions related to current year	—	39.8
Tax positions related to prior years	13.9	65.1
Reductions based on:		
Tax positions related to current year	(1.1)	—
Tax positions related to prior years	(88.4)	(7.9)
Settlements with taxing authorities	(5.3)	(0.8)
Balance at December 31	\$ 131.1	\$ 212.0

The table above excludes interest, net of related tax benefits, which is treated as income tax expense (benefit) under our accounting policy. The interest is included in the amounts described in the following paragraph.

As of December 31, 2016, \$102.4 of unrecognized tax benefits would impact our effective tax rate in future periods, if recognized. Also included in the table above is \$2.4 that would be recognized as an adjustment to additional paid-in capital, which would not affect our effective tax rate.

For the years ended December 31, 2016, 2015 and 2014, we recognized net interest expense (benefits) of \$6.6, \$(1.8) and \$(4.2), respectively. We had accrued approximately \$18.9 and \$12.3 for the payment of interest at December 31, 2016 and 2015, respectively.

As of December 31, 2016, as further described below, certain tax years remain open to examination by the Internal Revenue Service, or IRS, and various state and local authorities. In addition, we continue to discuss certain industry issues

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

with the IRS. As a result of these examinations and discussions, we have recorded amounts for uncertain tax positions. It is anticipated that the amount of unrecognized tax benefits will change in the next twelve months due to possible settlements of audits and changes in temporary items. However, the ultimate resolution of these items is dependent on the completion of negotiations with various taxing authorities. While it is difficult to determine when other tax settlements will actually occur, it is reasonably possible that one could occur in the next twelve months and our unrecognized tax benefits could change within a range of approximately \$3.1 to \$(75.1).

We are a member of the IRS Compliance Assurance Process, or CAP. The objective of CAP is to reduce taxpayer burden and uncertainty while assuring the IRS of the accuracy of tax returns prior to filing, thereby reducing or eliminating the need for post-filing examinations.

As of December 31, 2016, the IRS examination of our 2016 tax year continues to be in process. During 2016, the examination of our 2015 tax year was resolved with the IRS.

In certain states, we pay premium taxes in lieu of state income taxes. Premium taxes are reported with general and administrative expense.

At December 31, 2016, we had unused federal tax net operating loss carryforwards of approximately \$19.0 to offset future taxable income. The loss carryforwards expire in the years 2017 through 2034. During 2016, 2015 and 2014, federal income taxes paid totaled \$1,665.2, \$1,952.1 and \$1,659.0, respectively.

8. Property and Equipment

A summary of property and equipment at December 31 is as follows:

	2016	2015
Land and improvements	\$ 21.2	\$ 21.5
Building and improvements	215.1	216.6
Data processing equipment, furniture and other equipment	1,024.5	1,046.1
Computer software, purchased and internally developed	2,416.7	2,344.9
Leasehold improvements	462.4	429.3
Property and equipment, gross	4,139.9	4,058.4
Accumulated depreciation and amortization	(2,162.0)	(2,038.6)
Property and equipment, net	<u>\$ 1,977.9</u>	<u>\$ 2,019.8</u>

Depreciation expense for 2016, 2015 and 2014 was \$104.0, \$105.8 and \$106.5, respectively. Amortization expense on computer software and leasehold improvements for 2016, 2015 and 2014 was \$472.0, \$409.8 and \$367.8, respectively, which includes amortization expense on computer software, both purchased and internally developed, for 2016, 2015 and 2014 of \$411.8, \$366.7 and \$329.2, respectively. Capitalized costs related to the internal development of software of \$2,157.2 and \$2,024.7 at December 31, 2016 and 2015, respectively, are reported with computer software.

During the years ended December 31, 2016, 2015 and 2014, we recognized \$25.3, \$1.8 and \$7.9, respectively, of impairments related to computer software (primarily internally developed). We also recognized \$19.5 of impairments related to data processing equipment in 2016. These impairments were due to project cancellation or asset replacement, some of which resulted from a change in strategic focus needed to effectively manage business operations in a post-Health Care Reform environment.

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

9. Goodwill and Other Intangible Assets

No goodwill is allocated to our Other segment. A summary of the change in the carrying amount of goodwill for our Commercial and Specialty Business segment and Government Business segment (see Note 19, "Segment Information") for 2016 and 2015 is as follows:

	Commercial and Specialty Business	Government Business	Total
Balance as of January 1, 2015	\$ 11,818.9	\$ 5,263.1	\$ 17,082.0
Acquisitions	—	480.2	480.2
Balance as of December 31, 2015	11,818.9	5,743.3	17,562.2
Other adjustments	(1.0)	—	(1.0)
Balance as of December 31, 2016	\$ 11,817.9	\$ 5,743.3	\$ 17,561.2
Accumulated impairment as of December 31, 2016	\$ (41.0)	\$ —	\$ (41.0)

The increase in goodwill in 2015 was primarily due to the acquisition of Simply Healthcare in February 2015. For additional information regarding this acquisition, see Note 3, "Business Acquisitions and Divestiture".

As required by FASB guidance, we completed annual impairment tests of existing goodwill and other intangible assets with indefinite lives during 2016, 2015 and 2014. We perform these annual impairment tests during the fourth quarter. FASB guidance also requires interim impairment testing to be performed when potential impairment indicators exist. These tests involve the use of estimates related to the fair value of goodwill and intangible assets with indefinite lives and require a significant degree of management judgment and the use of subjective assumptions. The fair values were estimated using the income and market value valuation methods, incorporating Level III internal estimates for inputs, including, but not limited to, revenue projections, income projections, cash flows and discount rates. We did not incur any impairment losses in 2016, 2015 or 2014 as the estimated fair values of our reporting units were substantially in excess of their carrying values.

The components of other intangible assets as of December 31 are as follows:

	2016			2015		
	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
Intangible assets with finite lives:						
Customer relationships	\$ 3,310.9	\$ (2,759.7)	\$ 551.2	\$ 3,394.4	\$ (2,670.0)	\$ 724.4
Provider and hospital relationships	150.5	(65.9)	84.6	150.9	(58.6)	92.3
Other	89.4	(50.6)	38.8	90.7	(39.7)	51.0
Total	3,550.8	(2,876.2)	674.6	3,636.0	(2,768.3)	867.7
Intangible assets with indefinite lives:						
Blue Cross and Blue Shield and other trademarks	6,298.7	—	6,298.7	6,298.7	—	6,298.7
State Medicaid licenses	991.6	—	991.6	991.6	—	991.6
Total	7,290.3	—	7,290.3	7,290.3	—	7,290.3
Other intangible assets	\$ 10,841.1	\$ (2,876.2)	\$ 7,964.9	\$ 10,926.3	\$ (2,768.3)	\$ 8,158.0

As of December 31, 2016, the estimated amortization expense for each of the five succeeding years is as follows: 2017, \$158.8; 2018, \$127.9; 2019, \$101.0; 2020, \$74.9; and 2021, \$55.9.

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

10. Retirement Benefits

We sponsor various non-contributory employee defined benefit plans through certain subsidiaries.

The Anthem Cash Balance Plan A and the Anthem Cash Balance Plan B are cash balance pension plans covering certain eligible employees of the affiliated companies that participate in these plans. Effective January 1, 2006, benefits were curtailed, with the result that most participants stopped accruing benefits but continue to earn interest on benefits accrued prior to the curtailment. Certain participants subject to collective bargaining and certain other participants who met grandfathering rules continue to accrue benefits. Participants that do not receive credits and/or benefit accruals are included in the Anthem Cash Balance Plan A, while current employees who are still receiving credits and/or benefits participate in the Anthem Cash Balance Plan B. Several pension plans acquired through various corporate mergers and acquisitions have been merged into these plans in prior years.

The UGS Pension Plan is a defined benefit pension plan with a cash balance component. The UGS Pension Plan covers eligible employees of the affiliated companies that participate in the UGS Pension Plan. Effective January 1, 2004, benefits were curtailed, with the result that most participants stopped accruing benefits but continue to earn interest on benefits previously accrued. Certain employees subject to collective bargaining and certain other employees who met grandfathering rules continue to accrue benefits.

The Employees' Retirement Plan of Blue Cross of California, or the BCC Plan, is a defined benefit pension plan that covers eligible employees of Blue Cross of California who are covered by a collective bargaining agreement. Effective January 1, 2007, benefits were curtailed under the BCC Plan with the result that no Blue Cross of California employees hired or rehired after December 31, 2006 are eligible to participate in the BCC Plan.

All of the plans' assets consist primarily of common stocks, fixed maturity securities, investment funds and short-term investments. The funding policies for all plans are to contribute amounts at least sufficient to meet the minimum funding requirements set forth in the Employee Retirement Income Security Act of 1974, as amended, or ERISA, including amendment by the Pension Protection Act of 2006, and in accordance with income tax regulations, plus such additional amounts as are necessary to provide assets sufficient to meet the benefits to be paid to plan participants.

We use a December 31 measurement date for determining benefit obligations and fair value of plan assets.

The following tables disclose consolidated "pension benefits," which include the defined benefit pension plans described above, and consolidated "other benefits," which include postretirement health and welfare benefits including medical, vision and dental benefits offered to certain employees. Calculations were computed using assumptions at the December 31 measurement dates.

The reconciliation of the benefit obligation is as follows:

	Pension Benefits		Other Benefits	
	2016	2015	2016	2015
Benefit obligation at beginning of year	\$ 1,833.3	\$ 1,914.4	\$ 578.7	\$ 646.6
Service cost	11.6	13.1	1.6	2.1
Interest cost	68.5	68.2	22.4	23.4
Plan amendment	—	0.8	—	—
Actuarial loss (gain)	32.2	(41.2)	(4.2)	(58.1)
Benefits paid	(120.7)	(122.0)	(33.3)	(35.3)
Benefit obligation at end of year	\$ 1,824.9	\$ 1,833.3	\$ 565.2	\$ 578.7

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

The changes in the fair value of plan assets are as follows:

	Pension Benefits		Other Benefits	
	2016	2015	2016	2015
Fair value of plan assets at beginning of year	\$ 1,865.2	\$ 1,985.0	\$ 328.4	\$ 347.9
Actual return on plan assets	132.2	(1.5)	21.8	(1.2)
Employer contributions	11.1	3.7	14.9	17.3
Benefits paid	(120.7)	(122.0)	(33.3)	(35.6)
Fair value of plan assets at end of year	<u>\$ 1,887.8</u>	<u>\$ 1,865.2</u>	<u>\$ 331.8</u>	<u>\$ 328.4</u>

The net amount included in the consolidated balance sheets is as follows:

	Pension Benefits		Other Benefits	
	2016	2015	2016	2015
Noncurrent assets	\$ 126.7	\$ 103.4	\$ —	\$ —
Current liabilities	(3.7)	(10.5)	—	—
Noncurrent liabilities	(60.1)	(61.0)	(233.4)	(250.3)
Net amount at December 31	<u>\$ 62.9</u>	<u>\$ 31.9</u>	<u>\$ (233.4)</u>	<u>\$ (250.3)</u>

The net amounts included in accumulated other comprehensive loss that have not been recognized as components of net periodic benefit costs are as follows:

	Pension Benefits		Other Benefits	
	2016	2015	2016	2015
Net actuarial loss	\$ 655.8	\$ 635.0	\$ 146.6	\$ 162.7
Prior service cost (credit)	0.5	(0.1)	(59.7)	(73.5)
Net amount before tax at December 31	<u>\$ 656.3</u>	<u>\$ 634.9</u>	<u>\$ 86.9</u>	<u>\$ 89.2</u>

The estimated net actuarial loss and prior service credit for the defined benefit pension plans that will be reclassified from accumulated other comprehensive loss into net periodic benefit costs over the next year are \$18.0 and \$0.6, respectively. The estimated net actuarial loss and prior service credit for postretirement benefit plans that will be reclassified from accumulated other comprehensive loss into net periodic benefit costs over the next year are \$11.5 and \$13.6, respectively.

The accumulated benefit obligation for the defined benefit pension plans was \$1,821.1 and \$1,829.6 at December 31, 2016 and 2015, respectively.

As of December 31, 2016, certain pension plans had accumulated benefit obligations in excess of plan assets. For those same plans, the projected benefit obligation was also in excess of plan assets. Such plans had a combined projected benefit obligation, accumulated benefit obligation and fair value of plan assets of \$100.6, \$98.5 and \$36.8, respectively.

The weighted-average assumptions used in calculating the benefit obligations for all plans are as follows:

	Pension Benefits		Other Benefits	
	2016	2015	2016	2015
Discount rate	3.77%	3.92%	3.82%	4.01%
Rate of compensation increase	3.00%	3.00%	3.00%	3.00%
Expected rate of return on plan assets	7.95%	7.84%	7.00%	7.00%

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

The components of net periodic benefit cost (benefit credit) included in the consolidated statements of income are as follows:

	2016	2015	2014
Pension Benefits			
Service cost	\$ 11.6	\$ 13.1	\$ 13.0
Interest cost	68.5	68.2	74.1
Expected return on assets	(147.1)	(143.2)	(137.5)
Recognized actuarial loss	19.0	25.7	21.0
Amortization of prior service credit	(0.6)	(0.6)	(0.8)
Settlement loss	7.3	6.5	5.2
Net periodic benefit credit	<u>\$ (41.3)</u>	<u>\$ (30.3)</u>	<u>\$ (25.0)</u>
Other Benefits			
Service cost	\$ 1.6	\$ 2.1	\$ 3.2
Interest cost	22.4	23.4	26.3
Expected return on assets	(22.4)	(23.7)	(23.4)
Recognized actuarial loss	12.4	15.3	9.4
Amortization of prior service credit	(13.8)	(14.4)	(14.4)
Net periodic benefit cost	<u>\$ 0.2</u>	<u>\$ 2.7</u>	<u>\$ 1.1</u>

During the years ended December 31, 2016, 2015 and 2014 we incurred total settlement losses of \$7.3, \$6.5 and \$5.2, respectively, as lump-sum payments exceeded the service cost and interest cost components of net periodic benefit cost for certain of our plans.

The weighted-average assumptions used in calculating the net periodic benefit cost for all plans are as follows:

	2016	2015	2014
Pension Benefits			
Discount rate	3.92%	3.66%	4.39%
Rate of compensation increase	3.00%	3.00%	3.00%
Expected rate of return on plan assets	7.84%	7.62%	7.66%
Other Benefits			
Discount rate	4.01%	3.74%	4.48%
Rate of compensation increase	3.00%	3.00%	3.00%
Expected rate of return on plan assets	7.00%	7.00%	7.00%

The assumed health care cost trend rates used to measure the expected cost of pre-Medicare (those who are not currently eligible for Medicare benefits) other benefits at our December 31, 2016 measurement date was 8.00% for 2017 with a gradual decline to 4.50% by the year 2028. The assumed health care cost trend rates used to measure the expected cost of post-Medicare (those who are currently eligible for Medicare benefits) other benefits at our December 31, 2016 measurement date was 6.00% for 2017 with a gradual decline to 4.50% by the year 2024. These estimated trend rates are subject to change in the future. The health care cost trend rate assumption has a significant effect on the amounts reported. For example, an increase in the assumed health care cost trend rate of one percentage point would increase the postretirement benefit obligation as of December 31, 2016 by \$42.2 and would increase service and interest costs by \$1.8. Conversely, a decrease in the assumed health care cost trend rate of one percentage point would decrease the postretirement benefit obligation as of December 31, 2016 by \$36.2 and would decrease service and interest costs by \$1.5.

Anthem, Inc.

Notes to Consolidated Financial Statements (continued)

Plan assets include a diversified mix of investment grade fixed maturity securities, equity securities and alternative investments across a range of sectors and levels of capitalization to maximize the long-term return for a prudent level of risk. The weighted-average target allocation for pension benefit plan assets is 45% equity securities, 46% fixed maturity securities, and 9% to all other types of investments. Equity securities primarily include a mix of domestic securities, foreign securities and mutual funds invested in equities. Fixed maturity securities primarily include treasury securities, corporate bonds, and asset-backed investments issued by corporations and the U.S. government. Other types of investments primarily include partnership interests, collective trusts that replicate money market funds and insurance contracts designed specifically for employee benefit plans. As of December 31, 2016, there were no significant concentrations of investments in the pension benefit assets or other benefit assets. No plan assets were invested in Anthem common stock.

Pension benefit assets and other benefit assets recorded at fair value are categorized based upon the level of judgment associated with the inputs used to measure their fair value.

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

The fair values of our pension benefit assets and other benefit assets by asset category and level inputs at December 31, 2016, excluding cash, investment income receivable and amounts due to/from brokers, resulting in a net asset of \$2.8, are as follows (see Note 6, "Fair Value," for additional information regarding the definition of level inputs):

	Level I	Level II	Level III	Total
December 31, 2016				
Pension Benefit Assets:				
Equity securities:				
U.S. securities	\$ 561.4	\$ 4.4	\$ —	\$ 565.8
Foreign securities	264.5	—	—	264.5
Mutual funds	36.6	—	—	36.6
Fixed maturity securities:				
Government securities	183.9	—	—	183.9
Corporate securities	—	385.9	—	385.9
Asset-backed securities	—	134.7	—	134.7
Other types of investments:				
Common and collective trusts	—	27.5	—	27.5
Partnership interests	—	—	112.5	112.5
Insurance company contracts	—	—	173.3	173.3
Treasury futures contracts	0.3	—	—	0.3
Total pension benefit assets	<u>\$ 1,046.7</u>	<u>\$ 552.5</u>	<u>\$ 285.8</u>	<u>\$ 1,885.0</u>
Other Benefit Assets:				
Equity securities:				
U.S. securities	\$ 13.0	\$ 0.2	\$ —	\$ 13.2
Foreign securities	5.4	—	—	5.4
Mutual funds	47.1	—	—	47.1
Fixed maturity securities:				
Government securities	2.7	—	—	2.7
Corporate securities	—	7.9	—	7.9
Asset-backed securities	—	5.8	—	5.8
Other types of investments:				
Common and collective trusts	—	1.0	—	1.0
Partnership interests	—	—	1.2	1.2
Life insurance contracts	—	—	237.7	237.7
Investment in DOL 103-12 trust	—	9.8	—	9.8
Total other benefit assets	<u>\$ 68.2</u>	<u>\$ 24.7</u>	<u>\$ 238.9</u>	<u>\$ 331.8</u>

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

The fair values of our pension benefit assets and other benefit assets by asset category and level inputs at December 31, 2015, excluding cash, investment income receivable and amounts due to/from brokers, resulting in a net asset of \$3.4, are as follows (see Note 6, "Fair Value," for additional information regarding the definition of level inputs):

	Level I	Level II	Level III	Total
December 31, 2015				
Pension Benefit Assets:				
Equity securities:				
U.S. securities	\$ 542.8	\$ 4.4	\$ —	\$ 547.2
Foreign securities	258.8	—	—	258.8
Mutual funds	34.7	—	—	34.7
Fixed maturity securities:				
Government securities	176.6	—	—	176.6
Corporate securities	—	364.0	—	364.0
Asset-backed securities	—	141.1	—	141.1
Other types of investments:				
Common and collective trusts	—	48.1	—	48.1
Partnership interests	—	—	117.1	117.1
Insurance company contracts	—	—	174.2	174.2
Total pension benefit assets	\$ 1,012.9	\$ 557.6	\$ 291.3	\$ 1,861.8
Other Benefit Assets:				
Equity securities:				
U.S. securities	\$ 16.8	\$ 0.3	\$ —	\$ 17.1
Foreign securities	7.4	—	—	7.4
Mutual funds	36.6	—	—	36.6
Fixed maturity securities:				
Government securities	3.8	—	—	3.8
Corporate securities	—	9.5	—	9.5
Asset-backed securities	—	7.7	—	7.7
Other types of investments:				
Common and collective trusts	—	1.5	—	1.5
Partnership interests	—	—	1.5	1.5
Life insurance contracts	—	—	229.9	229.9
Investment in DOL 103-12 trust	—	13.4	—	13.4
Total other benefit assets	\$ 64.6	\$ 32.4	\$ 231.4	\$ 328.4

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Notes to Consolidated Financial Statements (continued)

A reconciliation of the beginning and ending balances of plan assets measured at fair value using Level III inputs for the years ended December 31, 2016, 2015 and 2014 is as follows:

	Partnership Interests	Insurance Company Contracts	Life Insurance Contracts	Total
Year ended December 31, 2016				
Beginning balance at January 1, 2016	\$ 118.6	\$ 174.2	\$ 229.9	\$ 522.7
Actual return on plan assets:				
Relating to assets still held at the reporting date	(3.5)	(3.1)	10.8	4.2
Purchases	17.8	8.9	—	26.7
Sales	(19.2)	(6.7)	(3.0)	(28.9)
Ending balance at December 31, 2016	<u>\$ 113.7</u>	<u>\$ 173.3</u>	<u>\$ 237.7</u>	<u>\$ 524.7</u>
Year ended December 31, 2015				
Beginning balance at January 1, 2015	\$ 122.2	\$ 187.7	\$ 238.4	\$ 548.3
Actual return on plan assets:				
Relating to assets still held at the reporting date	(5.9)	(5.7)	(6.8)	(18.4)
Purchases	10.9	7.0	—	17.9
Sales	(8.6)	(14.8)	(1.7)	(25.1)
Ending balance at December 31, 2015	<u>\$ 118.6</u>	<u>\$ 174.2</u>	<u>\$ 229.9</u>	<u>\$ 522.7</u>
Year ended December 31, 2014				
Beginning balance at January 1, 2014	\$ 160.3	\$ 197.4	\$ 230.0	\$ 587.7
Actual return on plan assets:				
Relating to assets still held at the reporting date	(5.4)	1.4	8.4	4.4
Purchases	8.4	11.6	—	20.0
Sales	(41.1)	(22.7)	—	(63.8)
Ending balance at December 31, 2014	<u>\$ 122.2</u>	<u>\$ 187.7</u>	<u>\$ 238.4</u>	<u>\$ 548.3</u>

There were no transfers between Levels I, II and III during the years ended December 31, 2016, 2015 and 2014.

Our current funding strategy is to fund an amount at least equal to the minimum required funding as determined under ERISA with consideration of maximum tax deductible amounts. We may elect to make discretionary contributions up to the maximum amount deductible for income tax purposes. For the years ended December 31, 2016, 2015 and 2014, no material contributions were necessary to meet ERISA required funding levels. However, during the years ended December 31, 2016, 2015 and 2014, we made tax deductible discretionary contributions to the pension benefit plans of \$11.1, \$3.7 and \$3.6, respectively. Employer contributions to other benefit plans represent discretionary contributions and do not include payments to retirees for current benefits.

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

Our estimated future payments for pension benefits and postretirement benefits, which reflect expected future service, as appropriate, are as follows:

	Pension Benefits	Other Benefits
2017	\$ 157.9	\$ 41.4
2018	154.0	42.2
2019	153.1	42.5
2020	147.8	42.5
2021	143.0	42.2
2022 – 2026	637.6	197.4

In addition to the defined benefit plans, we maintain the Anthem 401(k) Plan which is a qualified defined contribution plan covering substantially all employees. Voluntary employee contributions are matched by us subject to certain limitations. Contributions made by us totaled \$131.5, \$125.4 and \$111.1 during 2016, 2015 and 2014, respectively.

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

11. Medical Claims Payable

A reconciliation of the beginning and ending balances for medical claims payable, by segment (see Note 19, "Segment Information"), for the year ended December 31, 2016 is as follows:

	Commercial & Specialty Business	Government Business	Total
Gross medical claims payable, beginning of year	\$ 3,396.1	\$ 4,173.7	\$ 7,569.8
Ceded medical claims payable, beginning of year	(635.7)	(9.9)	(645.6)
Net medical claims payable, beginning of year	2,760.4	4,163.8	6,924.2
Net incurred medical claims:			
Current year	27,797.3	38,574.1	66,371.4
Prior years redundancies	(466.5)	(383.9)	(850.4)
Total net incurred medical claims	27,330.8	38,190.2	65,521.0
Net payments attributable to:			
Current year medical claims	25,119.3	34,037.3	59,156.6
Prior years medical claims	2,226.2	3,708.9	5,935.1
Total net payments	27,345.5	37,746.2	65,091.7
Net medical claims payable, end of year	2,745.7	4,607.8	7,353.5
Ceded medical claims payable, end of year	521.3	17.8	539.1
Gross medical claims payable, end of year	\$ 3,267.0	\$ 4,625.6	\$ 7,892.6

A reconciliation of the beginning and ending balances for medical claims payable, by segment, for the year ended December 31, 2015 is as follows:

	Commercial & Specialty Business	Government Business	Total
Gross medical claims payable, beginning of year	\$ 3,541.4	\$ 3,319.8	\$ 6,861.2
Ceded medical claims payable, beginning of year	(762.5)	(4.9)	(767.4)
Net medical claims payable, beginning of year	2,778.9	3,314.9	6,093.8
Business combinations and purchase adjustments	—	121.8	121.8
Net incurred medical claims:			
Current year	26,798.5	33,909.9	60,708.4
Prior years redundancies	(480.3)	(319.9)	(800.2)
Total net incurred medical claims	26,318.2	33,590.0	59,908.2
Net payments attributable to:			
Current year medical claims	24,145.7	29,922.0	54,067.7
Prior years medical claims	2,191.0	2,940.9	5,131.9
Total net payments	26,336.7	32,862.9	59,199.6
Net medical claims payable, end of year	2,760.4	4,163.8	6,924.2
Ceded medical claims payable, end of year	635.7	9.9	645.6
Gross medical claims payable, end of year	\$ 3,396.1	\$ 4,173.7	\$ 7,569.8

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

A reconciliation of the beginning and ending balances for medical claims payable, by segment, for the year ended December 31, 2014 is as follows:

	Commercial & Specialty Business	Government Business	Total
Gross medical claims payable, beginning of year	\$ 3,129.9	\$ 2,997.3	\$ 6,127.2
Ceded medical claims payable, beginning of year	(21.7)	(1.7)	(23.4)
Net medical claims payable, beginning of year	3,108.2	2,995.6	6,103.8
Net incurred medical claims:			
Current year	27,708.1	28,597.7	56,305.8
Prior years redundancies	(239.5)	(302.4)	(541.9)
Total net incurred medical claims	27,468.6	28,295.3	55,763.9
Net payments attributable to:			
Current year medical claims	25,016.9	25,337.0	50,353.9
Prior years medical claims	2,781.0	2,639.0	5,420.0
Total net payments	27,797.9	27,976.0	55,773.9
Net medical claims payable, end of year	2,778.9	3,314.9	6,093.8
Ceded medical claims payable, end of year	762.5	4.9	767.4
Gross medical claims payable, end of year	\$ 3,541.4	\$ 3,319.8	\$ 6,861.2

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any period end are continually reviewed and re-estimated as information regarding actual claims payments, or runout, becomes known. This information is compared to the originally established year end liability. Negative amounts reported for incurred medical claims related to prior years result from claims being settled for amounts less than originally estimated. The prior year redundancy of \$850.4 shown above for the year ended December 31, 2016 represents an estimate based on paid claim activity from January 1, 2016 to December 31, 2016. Medical claim liabilities are usually described as having a "short tail," which means that they are generally paid within twelve months of the member receiving service from the provider. Accordingly, the majority of the \$850.4 redundancy relates to claims incurred in calendar year 2015.

The following table provides a summary of the two key assumptions having the most significant impact on our incurred but not paid liability estimates for the years ended December 31, 2016, 2015 and 2014, which are the completion and trend factors. These two key assumptions can be influenced by utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations.

	Favorable Developments by Changes in Key Assumptions		
	2016	2015	2014
Assumed trend factors	\$ (591.3)	\$ (467.9)	\$ (399.5)
Assumed completion factors	(259.1)	(332.3)	(142.4)
Total	\$ (850.4)	\$ (800.2)	\$ (541.9)

The favorable development recognized in 2016 and 2015 resulted primarily from trend factors in late 2015 and late 2014, respectively, developing more favorably than originally expected as well as a smaller but significant contribution from completion factor development. The favorable development recognized in 2014 was driven by trend factors in late 2013 developing more favorably than originally expected.

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

The reconciliation of net incurred medical claims to benefit expense included in the consolidated statements of income is as follows:

	Years Ended December 31		
	2016	2015	2014
Net incurred medical claims:			
Commercial & Specialty Business	\$ 27,330.8	\$ 26,318.2	\$ 27,468.6
Government Business	38,190.2	33,590.0	28,295.3
Total net incurred medical claims	65,521.0	59,908.2	55,763.9
Quality improvement and other claims expense	1,313.4	1,208.7	1,091.0
Benefit expense	\$ 66,834.4	\$ 61,116.9	\$ 56,854.9

Incurred and paid claims development, net of reinsurance, for the Commercial & Specialty Business for the years ended December 31, 2016, 2015 and 2014 is as follows:

<i>Commercial & Specialty Business</i>		Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Year		2014	2015	2016
2014 & Prior	\$	30,576.8	\$ 30,096.5	\$ 30,121.8
2015			26,798.5	26,306.6
2016				27,797.3
Total				\$ 84,225.7

<i>Commercial & Specialty Business</i>		Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Year		2014	2015	2016
2014 & Prior	\$	27,797.9	\$ 29,988.9	\$ 30,095.6
2015			24,145.7	26,265.1
2016				25,119.3
Total				\$ 81,480.0

At December 31, 2016, the total of incurred but not reported liabilities plus expected development on reported claims for the Commercial & Specialty Business was \$26.2, \$41.5 and \$2,678.0 for the claim years 2014 and prior, 2015 and 2016, respectively.

At December 31, 2016, the cumulative number of reported claims for the Commercial & Specialty Business was 131.6, 118.6 and 111.2 for the claims years 2014 and prior, 2015 and 2016, respectively.

Incurred and paid claims development, net of reinsurance, for the Government Business as of and for the years ended December 31, 2016, 2015 and 2014 is as follows:

<i>Government Business</i>		Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Claim Year		2014	2015	2016
2014 & Prior	\$	31,290.9	\$ 30,971.0	\$ 30,911.5
2015			33,909.9	33,585.6
2016				38,574.1
Total				\$ 103,071.2

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

<i>Government Business</i>	Claim Year	Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
		2014	2015	2016
2014 & Prior		\$ 27,976.0	\$ 30,916.9	\$ 30,906.0
2015			29,800.3	33,520.2
2016				34,037.2
Total				\$ 98,463.4

At December 31, 2016, the total of incurred but not reported liabilities plus expected development on reported claims for the Government Business was \$5.5, \$65.4 and \$4,536.9 for the claim years 2014 and prior, 2015 and 2016, respectively.

At December 31, 2016, the cumulative number of reported claims for the Government Business was 193.0, 189.0 and 193.6 for the claims years 2014 and prior, 2015 and 2016, respectively.

The information about incurred and paid claims development for the years ended December 31, 2014 and 2015, for both the Commercial & Specialty Business and Government Business, is presented as supplementary information.

The cumulative number of reported claims for each claim year for both the Commercial & Specialty Business and Government Business have been developed using historical data captured by our claim payment systems. The provided claim amounts are not a precise tool for understanding utilization of medical services. They could be impacted by a variety of factors including changes in provider billing practices, provider reimbursement arrangements, mix of services, benefit design or processing systems. The cumulative number of reported claims has been provided to comply with FASB accounting standards and is not used by management in its claims analysis. Our cumulative number of reported claims may not be comparable to similar measures reported by other health benefits companies.

The reconciliation of the Commercial & Specialty Business and Government Business incurred and paid claims development information, reflected in the tables above, to the consolidated ending balance for medical claims payable, as of December 31, 2016, is as follows:

	Commercial & Specialty Business	Government Business	Total
Cumulative incurred claims and allocated claim adjustment expenses, net of reinsurance	\$ 84,225.7	\$ 103,071.2	\$ 187,296.9
Less: cumulative paid claims and allocated claim adjustment expenses, net of reinsurance	81,480.0	98,463.4	179,943.4
Net medical claims payable, end of year	2,745.7	4,607.8	7,353.5
Ceded medical claims payable, end of year	521.3	17.8	539.1
Gross medical claims payable, end of year	\$ 3,267.0	\$ 4,625.6	\$ 7,892.6

12. Debt

Short-term Borrowings

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati and the Federal Home Loan Bank of Atlanta, collectively, the FHLBs, and as a member we have the ability to obtain short-term cash advances subject to certain minimum collateral requirements. At December 31, 2016 and 2015, \$440.0 and \$540.0, respectively, were outstanding under our short-term FHLBs borrowings. These outstanding short-term FHLBs borrowings at December 31, 2016 and 2015 had fixed interest rates of 0.643% and 0.424%, respectively.

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

Long-term Debt

The carrying value of long-term debt at December 31 consists of the following:

	2016	2015
Senior unsecured notes:		
2.375%, due 2017	\$ 400.1	\$ 399.9
5.875%, due 2017	528.3	527.6
1.875%, due 2018	624.3	621.9
2.300%, due 2018	647.5	645.9
2.250%, due 2019	845.6	843.9
7.000%, due 2019	439.4	438.9
4.350%, due 2020	700.0	702.9
3.700%, due 2021	696.9	696.2
3.125%, due 2022	843.8	842.7
3.300%, due 2023	993.3	992.2
3.500%, due 2024	791.9	790.9
5.950%, due 2034	444.7	444.5
5.850%, due 2036	768.3	768.0
6.375%, due 2037	639.9	639.6
5.800%, due 2040	193.9	193.8
4.625%, due 2042	886.3	885.8
4.650%, due 2043	985.9	985.5
4.650%, due 2044	790.8	790.5
5.100%, due 2044	593.6	593.3
4.850%, due 2054	246.8	246.6
Remarketable subordinated notes:		
1.900%, due 2028	1,237.6	1,236.1
Surplus notes:		
9.000%, due 2027	24.9	24.9
Senior convertible debentures:		
2.750%, due 2042	334.1	330.7
Variable rate debt:		
Commercial paper program	629.0	682.2
Total long-term debt	15,286.9	15,324.5
Current portion of long-term debt	(928.4)	—
Long-term debt, less current portion	\$ 14,358.5	\$ 15,324.5

All debt is a direct obligation of Anthem, Inc., except for the surplus notes and the FHLB borrowings.

We generally issue senior unsecured notes for long-term borrowing purposes. Certain of these notes may have a call feature that allows us to redeem the notes at any time at our option and/or a put feature that allows a note holder to redeem the notes upon the occurrence of both a change in control event and a downgrade of the notes below an investment grade rating.

On September 10, 2015, we repaid, upon maturity, the \$625.0 outstanding principal balance of our 1.25% Notes due 2015. Additionally, during the year ended December 31, 2015, we repurchased \$13.0 of outstanding principal balance of

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

certain senior unsecured notes, plus applicable premium and accrued and unpaid interest, for cash totaling \$16.2. We recognized a loss on extinguishment of debt of \$3.4 on the repurchase of these notes.

On May 12, 2015, we issued 25.0 Equity Units, pursuant to an underwriting agreement dated May 6, 2015, in an aggregate principal amount of \$1,250.0. Each Equity Unit has a stated amount of \$50 (whole dollars) and consists of a purchase contract obligating the holder to purchase a certain number of shares of our common stock on May 1, 2018, subject to earlier termination or settlement, for a price in cash of \$50 (whole dollars); and a 5% undivided beneficial ownership interest in \$1,000 (whole dollars) principal amount of our 1.900% remarketable subordinated notes, or RSNs, due 2028. We received \$1,228.8 in cash proceeds from the issuance of the Equity Units, net of underwriting discounts, commissions and offering expenses payable by us, and recorded \$1,250.0 in long-term debt. The proceeds are being used for general corporate purposes, including, but not limited to, the repurchase of a portion of our outstanding senior convertible debentures due 2042. On May 1, 2018, if the applicable market value of our common stock is equal to or greater than \$207.6487 per share, the settlement rate will be 0.2406 shares of our common stock. If the applicable market value of our common stock is less than \$207.6487 per share but greater than \$143.7568 per share, the settlement rate will be a number of shares of our common stock equal to \$50 (whole dollars) divided by the applicable market value of our common stock. If the applicable market value of common stock is less than or equal to \$143.7568 per share, the settlement rate will be 0.3479 shares of our common stock. Holders of the Equity Units may elect early settlement at a minimum settlement rate of 0.2406 shares of our common stock for each purchase contract being settled. The RSNs are pledged as collateral to secure the purchase of common stock under the related stock purchase contracts. Quarterly interest payments on the RSNs commenced on August 1, 2015. The RSNs are scheduled to be remarketed during the five business day period ending on April 26, 2018 and may be remarketed earlier, at our election, during the period from January 30, 2018 through April 12, 2018. Following the remarketing, the interest rate on the RSNs will be set to current market rates and interest will be payable semi-annually. At December 31, 2016 and 2015, the stock purchase contract liability was \$62.0 and \$102.3, respectively, and is included in other current liabilities and other noncurrent liabilities with a corresponding offset to additional paid-in capital in our consolidated balance sheet. Contract adjustment payments commenced on August 1, 2015 at a rate of 3.350% per annum on the stated amount per Equity Unit. Subject to certain specified terms and conditions, we have the right to defer payments on all or part of the contract adjustment payments but not beyond the contract settlement date and we have the right to defer payment of interest on the RSNs but not beyond the purchase contract settlement date or maturity date.

Surplus notes are unsecured obligations of Anthem Insurance Companies, Inc., or Anthem Insurance, a wholly owned subsidiary, and are subordinate in right of payment to all of Anthem Insurance's existing and future indebtedness. Any payment of interest or principal on the surplus notes may be made only with the prior approval of the Indiana Department of Insurance, or IDOI, and only out of capital and surplus funds of Anthem Insurance that the IDOI determines to be available for the payment under Indiana insurance laws.

We have a senior revolving credit facility, or the Facility, with a group of lenders for general corporate purposes. The facility provides credit up to \$3,500.0 and matures on August 25, 2020. The interest rate on the Facility is based on either the LIBOR rate or a base rate plus a predetermined rate based on our public debt rating at the date of utilization. Our ability to borrow under the Facility is subject to compliance with certain covenants. There were no amounts outstanding under the senior revolving credit facilities at December 31, 2016 or 2015.

We have an authorized commercial paper program of up to \$2,500.0, the proceeds of which may be used for general corporate purposes. At December 31, 2016, we had \$629.0 outstanding under our commercial paper program with a weighted-average interest rate of 0.9715%. At December 31, 2015, we had \$682.2 outstanding under our commercial paper program with a weighted-average interest rate of 0.7050%. Commercial paper borrowings have been classified as long-term debt at December 31, 2016 and 2015, as our general practice and intent is to replace short-term commercial paper outstanding at expiration with additional short-term commercial paper for an uninterrupted period extending for more than one year and we have the ability to redeem our commercial paper with borrowings under the senior credit facility described above.

During the year ended December 31, 2015, we entered into a bridge facility commitment letter and a joinder agreement, and a term loan facility, to finance a portion of the pending acquisition of Cigna. We paid \$106.6 in fees in connection with the bridge facility which were capitalized in other current assets and amortized as interest expense. We recorded \$104.0 and \$36.8 of interest expense related to the amortization of the bridge loan facility and other related fees during the years ended December 31, 2016 and 2015, respectively. In January 2017, we reduced the size of the bridge facility from \$22,500.0 to \$19,500.0 and extended the termination date under the Merger Agreement, as well as the availability of commitments under

Anthem, Inc.

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the bridge facility and term loan facility, to April 30, 2017. In connection with the extension of the bridge facility, we paid \$97.5 in fees, which will be amortized through April 30, 2017. The commitment of the lenders to provide the bridge facility and term loan facility is subject to several conditions, including the completion of the Cigna acquisition. For additional information, see the “*Pending Acquisition of Cigna Corporation*” section of Note 3, “Business Acquisitions and Divestiture.”

Convertible Debentures

On October 9, 2012, we issued \$1,500.0 of senior convertible debentures, or the Debentures. The Debentures are governed by an indenture dated as of October 9, 2012 between us and The Bank of New York Mellon Trust Company, N.A., as trustee, or the Indenture. The Debentures bear interest at a rate of 2.750% per year, payable semi-annually in arrears in cash on April 15 and October 15 of each year, and mature on October 15, 2042, unless earlier redeemed, repurchased or converted into shares of common stock at the applicable conversion rate. The Debentures also have a contingent interest feature that will require us to pay additional interest based on certain thresholds and for certain events, as defined in the Indenture, beginning on October 15, 2022.

Holders may convert their Debentures at their option prior to the close of business on the business day immediately preceding April 15, 2042, only under the following circumstances: (1) during any fiscal quarter if the last reported sale price of our common stock for at least 20 trading days during a period of 30 consecutive trading days ending on the last trading day of the preceding fiscal quarter is greater than or equal to 130% of the applicable conversion price on each applicable trading day; (2) during the five business day period after any 10 consecutive trading day period, or the measurement period, in which the trading price per \$1,000 (whole dollars) principal amount of Debentures for each trading day of that measurement period was less than 98% of the product of the last reported sale price of our common stock and the applicable conversion rate on each such day; (3) if we call any or all of the Debentures for redemption, at any time prior to the close of business on the third scheduled trading day prior to the redemption date; or (4) upon the occurrence of specified corporate events, as defined in the Indenture. On and after April 15, 2042 and until the close of business on the third scheduled trading day immediately preceding the Debentures’ maturity date of October 15, 2042, holders may convert their Debentures into common stock at any time irrespective of the preceding circumstances. The Debentures are redeemable at our option at any time on or after October 20, 2022, upon the occurrence of certain events, as defined in the Indenture.

Upon conversion of the Debentures, we will deliver cash up to the aggregate principal amount of the Debentures converted. With respect to any conversion obligation in excess of the aggregate principal amount of the Debentures converted, we have the option to settle the excess with cash, shares of our common stock or a combination thereof based on a daily conversion value, determined in accordance with the Indenture. The initial conversion rate for the Debentures was 13.2319 shares of our common stock per Debenture, which represented a 25% conversion premium based on the closing price of \$60.46 per share of our common stock on October 2, 2012 (the date the Debentures’ terms were finalized) and is equivalent to an initial conversion price of \$75.575 per share of our common stock.

During the year ended December 31, 2015, we repurchased \$920.0 in aggregate principal of the Debentures. In addition, \$66.6 aggregate principal was surrendered for conversion by certain holders in accordance with the terms and provisions of the Indenture. We elected to settle the excess of the principal amount of the repurchases and conversions with cash for total payments of \$2,055.7. We recognized a gain on the extinguishment of debt related to the Debentures of \$12.7, based on the fair values of the debt on the repurchase and conversion settlement dates.

As of December 31, 2016, our common stock was last traded at a price of \$143.77 per share. If the remaining Debentures had been converted or matured at December 31, 2016, we would be obligated to pay the principal of the Debentures plus an amount in cash or shares equal to \$493.2. The Debentures and underlying shares of our common stock have not been and will not be registered under the Securities Act of 1933, as amended, or the Securities Act, or any state securities laws and may not be offered or sold in the United States absent registration or an applicable exemption from registration requirements. The Debentures were offered and sold to qualified institutional buyers pursuant to Rule 144A under the Securities Act.

We have accounted for the Debentures in accordance with the cash conversion guidance in FASB guidance for debt with conversion and other options. As a result, the value of the embedded conversion option, net of deferred taxes and equity issuance costs, has been bifurcated from its debt host and recorded as a component of “additional paid-in capital” in our consolidated balance sheets.

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The following table summarizes at December 31, 2016 the related balances, conversion rate and conversion price of the Debentures:

Outstanding principal amount	\$	513.4
Unamortized debt discount	\$	173.6
Net debt carrying amount	\$	334.1
Equity component carrying amount	\$	186.1
Conversion rate (shares of common stock per \$1,000 of principal amount)		13.6368
Effective conversion price (per \$1,000 of principal amount)	\$	73.3306

The remaining amortization period of the unamortized debt discount as of December 31, 2016 is approximately 26 years. The unamortized discount will be amortized into interest expense using the effective interest method based on an effective interest rate of 5.130%, which represents the market interest rate for a comparable debt instrument that does not have a conversion feature. During the years ended December 31, 2016 and 2015, we recognized \$17.3 and \$32.5, respectively, of interest expense related to the Debentures, of which \$14.1 and \$26.6, respectively, represented interest expense recognized at the stated interest rate of 2.750% and \$3.2 and \$5.9, respectively, represented interest expense resulting from amortization of the debt discount.

Total interest paid during 2016, 2015 and 2014 was \$594.9, \$604.0, and \$575.9, respectively.

We were in compliance with all applicable covenants under all of our outstanding debt agreements at December 31, 2016 and 2015.

Future maturities of all long-term debt outstanding at December 31, 2016 are as follows: 2017, \$1,557.4; 2018, \$1,271.8; 2019, \$1,285.0; 2020, \$700.0; 2021, \$696.9 and thereafter, \$9,775.8.

13. Commitments and Contingencies

Litigation

In the ordinary course of business, we are defendants in, or parties to, a number of pending or threatened legal actions or proceedings. To the extent a plaintiff or plaintiffs in the following cases have specified in their complaint or in other court filings the amount of damages being sought, we have noted those alleged damages in the descriptions below. With respect to the cases described below, we contest liability and/or the amount of damages in each matter and believe we have meritorious defenses.

We are defending a certified class action filed as a result of the 2001 demutualization of Anthem Insurance. The lawsuit names Anthem Insurance as well as Anthem, Inc. and is captioned *Ronald Gold, et al. v. Anthem, Inc. et al.* Anthem Insurance's 2001 Plan of Conversion, or the Plan, provided for the conversion of Anthem Insurance from a mutual insurance company into a stock insurance company pursuant to Indiana law. Under the Plan, Anthem Insurance distributed the fair value of the company at the time of conversion to its Eligible Statutory Members, or ESMs, in the form of cash or Anthem common stock in exchange for their membership interests in the mutual company. Plaintiffs in *Gold* allege that Anthem Insurance distributed value to the wrong ESMs. A trial on liability was held in October 2014. In June 2015, the court entered judgment for Anthem Insurance on all issues, finding that (i) Anthem Insurance correctly determined the state of Connecticut to be an ESM, not Plaintiffs; (ii) Anthem Insurance acted in good faith in making this determination, while Plaintiffs failed to present sufficient evidence to override a presumption that Anthem Insurance's ESM determination was correct; and (iii) Plaintiffs failed to prove the breach of any contractual obligation. In July 2015, Plaintiffs filed a notice of appeal from the judgment entered for Anthem Insurance. In December 2015, the Connecticut Supreme Court decided it would hear the appeal directly rather than the appeal going to the intermediate appellate court. Oral arguments were held in October 2016 and the appeal is currently under consideration by the court. We intend to vigorously seek the affirmation of the trial court's judgment; however, the suit's ultimate outcome cannot be presently determined.

We are currently a defendant in eleven putative class actions relating to out-of-network, or OON, reimbursement that were consolidated into a single multi-district lawsuit called *In re WellPoint, Inc. (n/k/a Anthem, Inc.) Out-of-Network "UCR"*

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Notes to Consolidated Financial Statements (continued)

Rates Litigation that is pending in the United States District Court for the Central District of California. The lawsuits were filed in 2009. The plaintiffs include current and former members on behalf of a putative class of members who received OON services for which the defendants paid less than billed charges, the American Medical Association, four state medical associations, OON physicians, OON non-physician providers, the American Podiatric Medical Association, California Chiropractic Association and the California Psychological Association on behalf of putative classes of OON physicians and all OON non-physician health care providers. The plaintiffs filed several amended complaints alleging that the defendants violated the Racketeer Influenced and Corrupt Organizations Act, or RICO, the Sherman Antitrust Act, ERISA, federal regulations, and state law by using an OON reimbursement database called Ingenix and by using non-Ingenix OON reimbursement methodologies. The most recent pleading filed by the plaintiffs is a Fourth Amended Complaint to which we filed a motion to dismiss most, but not all, of the claims. In July 2013 the court issued an order granting in part and denying in part our motion. The court held that the federal and state anti-trust claims along with the RICO claims should be dismissed in their entirety with prejudice. The court further found that the ERISA claims, to the extent they involved non-Ingenix methodologies, along with those that involved our alleged non-disclosures should be dismissed with prejudice. The court also dismissed most of the plaintiffs' state law claims with prejudice. The only claims that remain after the court's decision are an ERISA benefits claim relating to claims priced based on Ingenix, a breach of contract claim on behalf of one subscriber plaintiff, a breach of implied covenant claim on behalf of one subscriber plaintiff, and one subscriber plaintiff's claim under the California Unfair Competition Law. The plaintiffs filed a motion for reconsideration of the motion to dismiss order, which the court granted in part and denied in part. The court ruled that the plaintiffs adequately allege that one Georgia provider plaintiff is deemed to have exhausted administrative remedies regarding non-Ingenix methodologies based on the facts alleged regarding that plaintiff. Fact discovery is complete. The plaintiffs filed a motion for class certification in November 2013 seeking six different classes. Following oral argument, the court denied the plaintiffs' motion for class certification in late 2014. The California subscriber plaintiffs filed a motion for leave to file a renewed motion for class certification with more narrowly defined proposed classes, which the court denied. All but two of the individually named subscribers and all of the providers and medical associations dismissed their claims with prejudice. We filed a motion for summary judgment in March 2016, and a motion for summary judgment was also filed by one of the remaining individual plaintiffs. In July 2016, the court denied plaintiffs' motion and granted our motion for summary judgment on all remaining claims. One plaintiff filed a motion for reconsideration, which was denied, and then filed an appeal of the court's denial of the motion for reconsideration, which is currently pending. In October 2016, the court entered final judgment in the case in our favor. We intend to vigorously defend these suits; however, their ultimate outcome cannot be presently determined.

We are a defendant in multiple lawsuits that were initially filed in 2012 against the BCBSA as well as Blue Cross and/or Blue Shield licensees across the country. The cases were consolidated into a single multi-district lawsuit called *In re Blue Cross Blue Shield Antitrust Litigation* that is pending in the United States District Court for the Northern District of Alabama. Generally, the suits allege that the BCBSA and the Blue plans have engaged in a conspiracy to horizontally allocate geographic markets through license agreements, best efforts rules (which limit the percentage of non-Blue revenue of each plan), restrictions on acquisitions and other arrangements in violation of the Sherman Antitrust Act and related state laws. The cases were brought by two putative nationwide classes of plaintiffs, health plan subscribers and providers. Subscriber and provider plaintiffs each filed consolidated amended complaints in July 2013. The consolidated amended subscriber complaint was also brought on behalf of putative state classes of health plan subscribers in Alabama, Arkansas, California, Florida, Hawaii, Illinois, Louisiana, Michigan, Mississippi, Missouri, New Hampshire, North Carolina, Pennsylvania, Rhode Island, South Carolina, Tennessee, and Texas. Defendants filed motions to dismiss in September 2013. In June 2014, the court denied the majority of the motions, ruling that plaintiffs had alleged sufficient facts at this stage of the litigation to avoid dismissal of their claims. Following the subsequent filing of amended complaints by each of the subscriber and provider plaintiffs, we filed our answer and asserted our affirmative defenses in December 2014. No date has been set for either the pretrial conference or trials in these actions. Since January 2016, subscribers have filed additional actions asserting damage claims in Indiana, Kansas, Kansas City, Minnesota, Montana, Nebraska, North Dakota, Oklahoma, South Dakota, Vermont, and Virginia, all of which have been consolidated into the multi-district lawsuit. In November 2016, subscriber plaintiffs and provider plaintiffs filed new consolidated amended complaints adding new named plaintiffs and new factual allegations. We intend to vigorously defend these suits; however, their ultimate outcome cannot be presently determined.

In July 2013, our California affiliate Blue Cross of California doing business as Anthem Blue Cross, or BCC, has been named as a defendant, along with an unaffiliated entity, in a California taxpayer action filed in Los Angeles County Superior Court, captioned as *Michael D. Myers v. State Board of Equalization, et al.* This action is brought under a California statute that permits an individual taxpayer to sue a governmental agency when the taxpayer believes the agency has failed to enforce

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Notes to Consolidated Financial Statements (continued)

governing law. Plaintiff contends that BCC, a licensed Health Care Service Plan, or HCSP, is an “insurer” for purposes of taxation despite acknowledging it is not an “insurer” under regulatory law. At the time, under California law, “insurers” were required to pay a gross premiums tax, or GPT, calculated as 2.35% on gross premiums. As a licensed HCSP, BCC has paid the California Corporate Franchise Tax, or CFT, the tax paid by California businesses generally. Plaintiff contends that BCC must pay the GPT rather than the CFT. Plaintiff seeks a writ of mandate directing the taxing agencies to collect the GPT, and seeks an order requiring BCC to pay GPT back taxes, interest, and penalties, for a period dating to eight years prior to the July 2013 filing of the complaint. In February 2014, the Superior Court sustained BCC’s demurrer to the complaint, without leave to amend, ruling that BCC is not an “insurer” for purposes of taxation. Plaintiff appealed. In September 2015, the Court of Appeal reversed the Superior Court’s ruling, and remanded. The Court of Appeal held that a HCSP could be an insurer for purposes of taxation if it wrote predominantly “indemnity” products. In October 2015, BCC filed a petition for rehearing in the Court of Appeal which was denied. In November 2015, BCC filed a petition for review with the California Supreme Court which was denied in December 2015. This lawsuit is being coordinated with similar lawsuits filed against other entities. The parties were recently assigned a new judge, but no court dates have been set. BCC intends to vigorously defend this suit; however, its ultimate outcome cannot be presently determined.

In March 2016, we filed a lawsuit against Express Scripts, Inc., or Express Scripts, our vendor for pharmacy benefit management, or PBM, services, captioned *Anthem, Inc. v. Express Scripts, Inc.*, in the U.S. District Court for the Southern District of New York. The lawsuit seeks to recover damages for pharmacy pricing that is higher than competitive benchmark pricing, damages related to operational breaches and seeks various declarations under the pharmacy benefit management agreement, or PBM Agreement, between the parties. Our suit asserts that Express Scripts’ pricing exceeds the competitive benchmark pricing required by the PBM Agreement by approximately \$13,000.0 over the remaining term of the PBM Agreement, and by approximately \$1,800.0 through the post-termination transition period. Further, we assert that Express Scripts’ excessive pricing has caused us to lose existing customers and prevented us from gaining new business. In addition to the amounts associated with competitive benchmark pricing, we are seeking over \$158.0 in damages associated with operational breaches incurred, together with a declaratory judgment that Express Scripts: (i) breached its obligation to negotiate in good faith and to agree in writing to new pricing terms; (ii) is required to provide competitive benchmark pricing to us through the term of the PBM Agreement; (iii) has breached the PBM Agreement, and that we can terminate the PBM Agreement either due to Express Scripts’ breaches or because we have determined that Express Scripts’ performance with respect to the delegated Medicare Part D functions has been unsatisfactory; and (iv) is required under the PBM Agreement to provide post-termination services, at competitive benchmark pricing, for one year following any termination. In April 2016, Express Scripts filed an answer to the lawsuit disputing our contractual claims and alleging various defenses and counterclaims. Express Scripts contends that we breached the PBM Agreement by failing to negotiate proposed new pricing terms in good faith and that we breached the implied covenant of good faith and fair dealing by disregarding the terms of the transaction. In addition, Express Scripts is seeking declaratory judgments: (i) regarding the timing of the periodic pricing review under the PBM Agreement; (ii) that it has no obligation to ensure that we receive any specific level of pricing, that we have no contractual right to any change in pricing under the PBM Agreement and that its sole obligation is to negotiate proposed pricing terms in good faith; and (iii) that we do not have the right to terminate the PBM Agreement. In the alternative, Express Scripts claims that we have been unjustly enriched by its payment of \$4,675.0 at the time of the PBM Agreement. We believe that Express Scripts’ defenses and counterclaims are without merit. We filed a motion to dismiss Express Scripts’ counterclaims, which is pending. We intend to vigorously pursue our claims and defend against any counterclaims; however, the ultimate outcome cannot be presently determined.

Anthem, Inc. and Express Scripts were named as defendants in a purported class action lawsuit filed in June 2016 in the Southern District of New York by three members of ERISA plans alleging ERISA violations captioned *Karen Burnett, Brendan Farrell, and Robert Shullich, individually and on behalf of all others similarly situated v. Express Scripts, Inc. and Anthem, Inc.* The lawsuit was then consolidated with a similar lawsuit that was previously filed against Express Scripts. A first amended consolidated complaint was filed in the consolidated lawsuit, which is captioned *In Re Express Scripts/Anthem ERISA Litigation*. The first amended consolidated complaint was filed by six individual plaintiffs against Anthem and Express Scripts on behalf of all persons who are participants in or beneficiaries of any ERISA or non-ERISA health care plan from December 1, 2009 to the present in which Anthem provided prescription drug benefits through a PBM Agreement with Express Scripts and who paid a percentage based co-insurance payment in the course of using that prescription drug benefit. As to the ERISA members, the plaintiffs allege that Anthem breached its duties under ERISA (i) by failing to adequately monitor Express Scripts’ pricing under the PBM Agreement and (ii) by placing its own pecuniary interest above the best interests of Anthem insureds for its own pecuniary interest by allegedly agreeing to higher pricing in the PBM Agreement in

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exchange for the \$4,675.0 purchase price for our NextRx PBM business. As to the non-ERISA members, the plaintiffs assert that Anthem breached the implied covenant of good faith and fair dealing implied in the health plans under which the non-ERISA members are covered by (i) negotiating and entering into the PBM Agreement with Express Scripts that was detrimental to the interests of the such non-ERISA members, (ii) failing to adequately monitor the activities of Express Scripts, including failing to timely monitor and correct the prices charged by Express Scripts for prescription medications, and (iii) acting in Anthem's self-interests instead of the interests of the non-ERISA members when it accepted the \$4,675.0 purchase price for NextRx. Plaintiffs seek to hold Anthem and Express Scripts jointly and severally liable and to recover all losses suffered by the proposed class, equitable relief, disgorgement of alleged ill-gotten gains, injunctive relief, attorney's fees and costs and interest. We filed a motion to dismiss all of the claims brought against Anthem, which is pending. ESI filed a motion to transfer the case to a federal court in Missouri, and we intend to oppose the transfer. We intend to vigorously defend this suit; however, its ultimate outcome cannot be presently determined.

As discussed in Note 3, Business Acquisitions - *Pending Acquisition of Cigna Corporation*, in July 2016, the DOJ, along with certain state attorneys general, filed a civil antitrust lawsuit in the District Court seeking to block the Acquisition, which is captioned *United States of America, et al., v. Anthem, Inc. and Cigna Corp.* Trial commenced in November 2016 and concluded in January 2017. On January 18, 2017, we provided notice to Cigna that we had elected to extend the termination date under the Merger Agreement from January 31, 2017 until April 30, 2017. On February 8, 2017, the District Court ruled in favor of the DOJ, and following our motion to expedite the appeal, which was granted on February 17, 2017, we promptly appealed the District Court's ruling to the Appellate Court. On February 14, 2017, Cigna purported to terminate the Merger Agreement and commenced litigation against us in the Delaware Court, seeking damages and a declaratory judgment that its purported termination of the Merger Agreement was lawful, among other claims, which is captioned *Cigna Corp. v. Anthem Inc.* We believe Cigna's allegations are without merit. Also on February 14, 2017, we initiated our own litigation against Cigna in the Delaware Court seeking a temporary restraining order to enjoin Cigna from terminating the Merger Agreement, specific performance compelling Cigna to comply with the Merger Agreement and damages, which is captioned *Anthem Inc. v. Cigna Corp.* On February 15, 2017, the Delaware Court granted our motion for a temporary restraining order and issued an order enjoining Cigna from terminating the Merger Agreement. The temporary restraining order became effective immediately and will remain in place pending any further order from the Delaware Court. A hearing is expected to be scheduled the week of April 10, 2017. We intend to vigorously defend the Acquisition in this litigation and remain committed to completing the Acquisition as soon as practicable.

Where available information indicates that it is probable that a loss has been incurred as of the date of the consolidated financial statements and we can reasonably estimate the amount of that loss, we accrue the estimated loss by a charge to income. In many proceedings, however, it is difficult to determine whether any loss is probable or reasonably possible. In addition, even where loss is possible or an exposure to loss exists in excess of the liability already accrued with respect to a previously identified loss contingency, it is not always possible to reasonably estimate the amount of the possible loss or range of loss.

With respect to many of the proceedings to which we are a party, we cannot provide an estimate of the possible losses, or the range of possible losses in excess of the amount, if any, accrued, for various reasons, including but not limited to some or all of the following: (i) there are novel or unsettled legal issues presented, (ii) the proceedings are in early stages, (iii) there is uncertainty as to the likelihood of a class being certified or decertified or the ultimate size and scope of the class, (iv) there is uncertainty as to the outcome of pending appeals or motions, (v) there are significant factual issues to be resolved, and/or (vi) in many cases, the plaintiffs have not specified damages in their complaint or in court filings. For those legal proceedings where a loss is probable, or reasonably possible, and for which it is possible to reasonably estimate the amount of the possible loss or range of losses, we currently believe that the range of possible losses, in excess of established reserves, for all of those proceedings is from \$0 to approximately \$250.0 at December 31, 2016. This estimated aggregate range of reasonably possible losses is based upon currently available information taking into account our best estimate of such losses for which such an estimate can be made.

Cyber Attack Incident

In February 2015, we reported that we were the target of a sophisticated external cyber attack. The attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many individuals and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that

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credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that we will not identify additional information that was accessed or obtained.

Upon discovery of the cyber attack, we took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate our systems and identify solutions based on the evolving landscape. We are providing credit monitoring and identity protection services to those who have been affected by this cyber attack. We have continued to implement security enhancements since this incident. We have incurred expenses subsequent to the cyber attack to investigate and remediate this matter and expect to continue to incur expenses of this nature in the foreseeable future. We recognize these expenses in the periods in which they are incurred.

Actions have been filed in various federal and state courts and other claims have been or may be asserted against us on behalf of current or former members, current or former employees, other individuals, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber attack. Federal and state agencies, including state insurance regulators, state attorneys general, the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigation, are investigating events related to the cyber attack, including how it occurred, its consequences and our responses. In December 2016, the National Association of Insurance Commissioners, or NAIC, concluded its multistate targeted market conduct and financial exam. In connection with the resolution of the matter, the NAIC requested we provide, and we agreed, a customized credit protection program, equivalent to a credit freeze, for our members who were under the age of eighteen on January 27, 2015. No fines or penalties were imposed on us. Although we are cooperating in these investigations, we may be subject to fines or other obligations, which may have an adverse effect on how we operate our business and our results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation in February 2015 and was subsequently heard by the Panel in May 2015. In June 2015, the Panel entered its order transferring the consolidated matter to the U.S. District Court for the Northern District of California. The U.S. District Court entered its case management order in September 2015. We filed a motion to dismiss ten of the counts that are before the U.S. District Court. In February 2016, the court issued an order granting in part and denying in part our motion, dismissing three counts with prejudice, four counts without prejudice and allowing three counts to proceed. Plaintiffs filed a second amended complaint in March 2016, and we subsequently filed a second motion to dismiss. In May 2016, the court issued an order granting in part and denying in part our motion, dismissing one count with prejudice, dismissing certain counts asserted by specific named plaintiffs with or without prejudice depending on their individualized facts, and allowing the remaining counts to proceed. In July 2016, plaintiffs filed a third amended complaint which we answered in August 2016. Fact discovery was completed in December 2016. There remain two state court cases that are presently proceeding outside of the Multidistrict Litigation.

We have contingency plans and insurance coverage for certain expenses and potential liabilities of this nature. While a loss from these matters is reasonably possible, we cannot reasonably estimate a range of possible losses because our investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved. We intend to vigorously defend these suits; however, their ultimate outcome cannot be presently determined.

Other Contingencies

From time to time, we and certain of our subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. We, like HMOs and health insurers generally, exclude certain health care and other services from coverage under our HMO, PPO and other plans. We are, in the ordinary course of business, subject to the claims of our enrollees arising out of decisions to restrict or deny reimbursement for uncovered services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on us. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable settlements of coverage claims.

In addition to the lawsuits described above, we are also involved in other pending and threatened litigation of the character incidental to our business, and are from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits, reviews and administrative proceedings include routine and special inquiries by state insurance departments, state attorneys general, the U.S. Attorney General and subcommittees of the U.S. Congress. Such investigations, audits, reviews and administrative proceedings could result in the

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imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on our business operations. Any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on our consolidated financial position or results of operations.

The National Organization of Life & Health Insurance Guaranty Associations, or NOLHGA, is a voluntary organization consisting of the state life and health insurance guaranty associations located throughout the U.S. Such associations, working together with NOLHGA, provide a safety net for their state's policyholders, ensuring that they continue to receive coverage, subject to state maximum limits, even if their insurer is declared insolvent. In 2009, the Pennsylvania Insurance Commissioner placed Penn Treaty Network America Insurance Company and its subsidiary American Network Insurance Company, or collectively Penn Treaty, in rehabilitation, an intermediate action before insolvency. After failing to develop a viable rehabilitation plan, the Pennsylvania Insurance Commissioner filed a petition to convert the rehabilitation to a liquidation, with the liquidation expected to commence following the coordination of certain scheduling matters. When Penn Treaty is placed in liquidation, we and other insurers will be obligated to pay a portion of their policyholder claims through state guaranty association assessments in future periods. At December 31, 2016, we estimate our portion of the assessments for the Penn Treaty insolvency will approximate \$190.0 to \$220.0. In accordance with FASB guidance, the ultimate amount of the assessments will be recognized as an expense in the period in which a court ordered liquidation is entered. Payment of the assessments will be largely recovered through premium billing surcharges and premium tax credits over future years.

Contractual Obligations and Commitments

Express Scripts, through our PBM Agreement, is the exclusive provider of certain PBM services to our plans, excluding our CareMore subsidiary and certain self-insured members, who have exclusive agreements with different PBM service providers. The initial term of this PBM Agreement expires on December 31, 2019. Under the PBM Agreement, the Express Scripts PBM services include, but are not limited to, pharmacy network management, mail order and specialty drug fulfillment, claims processing, rebate management and specialty pharmaceutical management services. Accordingly, the PBM Agreement contains certain financial and operational requirements obligating both Express Scripts and us. Express Scripts' primary obligations relate to the performance of such services in a compliant manner and meeting certain pricing guarantees and performance standards. Our primary responsibilities relate to formulary management, product and benefit design, provision of data, payment for services, certain minimum volume requirements and oversight. The failure by either party to meet the respective requirements could potentially serve as a basis for financial penalties or early termination of the PBM Agreement. In March 2016, we filed a lawsuit against Express Scripts seeking to recover damages for pharmacy pricing that is higher than competitive benchmark pricing, damages related to operational breaches and seeking various declarations under the PBM Agreement between the parties. For additional information regarding this lawsuit, refer to the Litigation section above. We believe we have appropriately recognized all rights and obligations under this PBM Agreement at December 31, 2016.

During November 2015, we entered into an amended and restated agreement with Accenture LLP to provide business process outsourcing services. This new agreement supersedes certain prior agreements, converts certain services to transaction based pricing and also includes provisions for additional services. Our remaining commitment under this agreement at December 31, 2016 was \$168.0 through December 31, 2019. We have the ability to terminate this agreement upon the occurrence of certain events, subject to early termination fees.

During December 2014, we entered into an agreement with International Business Machines Corporation to provide information technology infrastructure services. Our remaining commitment under this agreement at December 31, 2016 was \$349.0 through March 31, 2020. We have the ability to terminate this agreement upon the occurrence of certain events, subject to early termination fees.

Vulnerability from Concentrations

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash equivalents, investment securities, premium receivables and instruments held through hedging activities. All investment securities are managed by professional investment managers within policies authorized by our Board of Directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. Concentrations of credit risk with respect to premium receivables are limited due to the large number of employer groups that constitute our customer base.

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in the states in which we conduct business. As of December 31, 2016, there were no significant concentrations of financial instruments in a single investee, industry or geographic location.

14. Capital Stock

Stock Incentive Plans

Our Board of Directors has adopted the Anthem Incentive Compensation Plan, or Incentive Compensation Plan, which has been approved by our shareholders. The term of the Incentive Compensation Plan is such that no awards may be granted on or after May 20, 2019. The Incentive Compensation Plan gives authority to the Compensation Committee of the Board of Directors to make incentive awards to our non-employee directors, employees and consultants, consisting of stock options, stock, restricted stock, restricted stock units, cash-based awards, stock appreciation rights, performance shares and performance units. The Incentive Compensation Plan, as amended and restated, limits the number of available shares for issuance to 60.1 shares, subject to adjustment as set forth in the Incentive Compensation Plan.

Stock options are granted for a fixed number of shares with an exercise price at least equal to the fair value of the shares at the grant date. Stock options vest over three years in equal semi-annual installments and generally have a term of ten years from the grant date.

Certain option grants contain provisions whereby the employee continues to vest in the award subsequent to termination due to retirement. Our attribution method for newly granted awards considers all vesting and other provisions, including retirement eligibility, in determining the requisite service period over which the fair value of the awards will be recognized.

Awards of restricted stock or restricted stock units are issued at the fair value of the stock on the grant date and may also include one or more performance measures that must be met for the award to vest. The restrictions lapse in three equal annual installments. Performance units issued in 2015 will vest in 2018, based on earnings targets over the three year period of 2015 to 2017. Performance units issued in 2016 will vest in 2019, based on earnings targets over the three year period of 2016 to 2018.

For the years ended December 31, 2016, 2015 and 2014, we recognized share-based compensation expense of \$164.6, \$148.2 and \$168.9, respectively, as well as related tax benefits of \$60.5, \$53.7 and \$60.7, respectively.

A summary of stock option activity for the year ended December 31, 2016 is as follows:

	Number of Shares	Weighted-Average Option Price per Share	Weighted-Average Remaining Contractual Life (Years)	Aggregate Intrinsic Value
Outstanding at January 1, 2016	6.0	\$ 87.23		
Granted	1.4	131.84		
Exercised	(1.5)	64.39		
Forfeited or expired	(0.3)	118.58		
Outstanding at December 31, 2016	5.6	102.80	5.19	\$ 234.0
Exercisable at December 31, 2016	3.7	88.04	3.62	\$ 207.8

The intrinsic value of options exercised during the years ended December 31, 2016, 2015 and 2014 amounted to \$103.0, \$188.1 and \$156.7, respectively. We recognized tax benefits of \$37.9, \$68.0 and \$53.2 in 2016, 2015 and 2014, respectively, from option exercises and disqualifying dispositions. During the years ended December 31, 2016, 2015 and 2014 we received cash of \$95.4, \$162.2 and \$283.6, respectively, from exercises of stock options.

The total fair value of restricted stock awards that vested during the years ended December 31, 2016, 2015 and 2014 was \$184.9, \$257.2 and \$174.0, respectively.

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Notes to Consolidated Financial Statements (continued)

A summary of the status of nonvested restricted stock activity, including restricted stock units, for the year ended December 31, 2016 is as follows:

	Restricted Stock Shares and Units	Weighted-Average Grant Date Fair Value per Share
Nonvested at January 1, 2016	2.7	\$ 101.66
Granted	1.1	131.81
Vested	(1.4)	82.26
Forfeited	(0.3)	119.94
Nonvested at December 31, 2016	2.1	127.68

During the year ended December 31, 2016, we granted approximately 0.5 restricted stock units that are contingent upon us achieving earning targets over the three year period of 2016 to 2018. These grants have been included in the activity shown above, but will be subject to adjustment at the end of 2018, based on results in the three year period.

As of December 31, 2016, the total remaining unrecognized compensation expense related to nonvested stock options and restricted stock amounted to \$17.7 and \$111.7, respectively, which will be amortized over the weighted-average remaining requisite service periods of 11 months and 15 months, respectively.

As of December 31, 2016, there were approximately 15.0 shares of common stock available for future grants under the Incentive Compensation Plan.

Fair Value

We use a binomial lattice valuation model to estimate the fair value of all stock options granted. Expected volatility assumptions used in the binomial lattice model are based on an analysis of implied volatilities of publicly traded options on our stock and historical volatility of our stock price. The risk-free interest rate is derived from the U.S. Treasury strip rates at the time of the grant. The expected term of the options was derived from the outputs of the binomial lattice model, which incorporates post-vesting forfeiture assumptions based on an analysis of historical data. The dividend yield was based on our estimate of future dividend yields. Similar groups of employees that have dissimilar exercise behavior are considered separately for valuation purposes. We utilize the "multiple-grant" approach for recognizing compensation expense associated with each separately vesting portion of the share-based award.

The following weighted-average assumptions were used to estimate the fair values of options granted during the years ended December 31:

	2016	2015	2014
Risk-free interest rate	1.76%	1.96%	2.16%
Volatility factor	32.00%	31.00%	35.00%
Dividend yield (annual)	2.00%	1.70%	2.00%
Weighted-average expected life (years)	4.10	4.00	3.75

The following weighted-average fair values were determined for the years ending December 31:

	2016	2015	2014
Options granted during the year	\$ 30.56	\$ 33.97	\$ 22.41
Restricted stock awards granted during the year	131.81	147.00	90.53

The binomial lattice option-pricing model requires the input of highly subjective assumptions including the expected stock price volatility. Because our stock option grants have characteristics significantly different from those of traded options,

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Notes to Consolidated Financial Statements (continued)

and because changes in the subjective input assumptions can materially affect the fair value estimate, in our opinion, existing models do not necessarily provide a reliable single measure of the fair value of our stock option grants.

Employee Stock Purchase Plan

We have registered 14.0 shares of common stock for the Employee Stock Purchase Plan, or the Stock Purchase Plan, which is intended to provide a means to encourage and assist employees in acquiring a stock ownership interest in Anthem. Pursuant to terms of the Stock Purchase Plan, an employee is permitted to purchase no more than \$25,000 (actual dollars) worth of stock in any calendar year, based on the fair value of the stock at the end of each plan quarter. Employees become participants by electing payroll deductions from 1% to 15% of gross compensation. Once purchased, the stock is accumulated in the employee's investment account. The Stock Purchase Plan allows participants to purchase shares of our common stock at a price per share of 95% of the fair value of a share of common stock on the last trading day of the plan quarter. The employee stock purchase plan discount is not recognized as compensation expense based on GAAP guidance. There were 0.2 shares issued during the year ended December 31, 2016. As of December 31, 2016, 5.6 shares were available for issuance under the Stock Purchase Plan.

Use of Capital and Stock Repurchase Program

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors.

A summary of the cash dividend activity for the years ended December 31, 2016 and 2015 is as follows:

Declaration Date	Record Date	Payment Date	Cash Dividend per Share	Total
Year ended December 31, 2016				
February 18, 2016	March 10, 2016	March 25, 2016	\$ 0.6500	\$ 170.7
April 26, 2016	June 10, 2016	June 24, 2016	0.6500	170.9
July 26, 2016	September 9, 2016	September 26, 2016	0.6500	171.1
November 1, 2016	December 5, 2016	December 21, 2016	0.6500	171.3
Year ended December 31, 2015				
January 27, 2015	March 10, 2015	March 25, 2015	\$ 0.6250	\$ 166.6
April 28, 2015	June 10, 2015	June 25, 2015	0.6250	163.9
July 28, 2015	September 10, 2015	September 25, 2015	0.6250	163.0
October 27, 2015	December 4, 2015	December 21, 2015	0.6250	163.1

On February 22, 2017, our Board of Directors declared a quarterly cash dividend to shareholders of \$0.6500 per share on the outstanding shares of our common stock. This quarterly dividend is payable on March 24, 2017 to the shareholders of record as of March 10, 2017.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. On October 2, 2014, the Board of Directors authorized a \$5,000.0 increase to the common stock repurchase program. Repurchases may be made from time to time at prevailing market prices, subject to certain restrictions on volume, pricing and timing. The repurchases are effected from time to time in the open market, through negotiated transactions, including accelerated share repurchase agreements, and through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. Our stock repurchase program is discretionary as we are under no obligation to repurchase shares. We repurchase shares under the program when we believe it is a prudent use of capital. The excess cost of the repurchased shares over par value is charged on a pro rata basis to additional paid-in capital and retained earnings.

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Notes to Consolidated Financial Statements (continued)

There were no common stock repurchases during 2016. Total authorization remaining at December 31, 2016 was \$4,175.9.

A summary of common stock repurchases for the year ended December 31, 2015 is as follows:

	2015
Shares repurchased	10.4
Average price per share	\$ 145.50
Aggregate cost	\$ 1,515.8
Authorization remaining at end of year	\$ 4,175.9

During the year ended December 31, 2015, we entered into a series of call and put options with certain counterparties to repurchase shares of our common stock. We exercised call options that enabled us to repurchase 2.1 shares of our common stock at an average strike price of \$135.03. In order to set the call option strike prices below our market price at inception on certain of these options, we sold 5.3 put options, the majority containing an average strike price equal to the call options. During the year ended December 31, 2015, 4.6 put options expired unexercised, while the remaining 0.7 put options were assigned to us, resulting in our repurchase of 0.7 shares of our common stock at an average share price of \$143.89. Based on GAAP guidance, the initial value of the call options was recognized as a reduction of shareholders' equity and the initial value of the put options was recognized as a liability.

For additional information regarding the use of capital for debt security repurchases, see Note 12, "Debt."

Equity Units

On May 12, 2015, we issued 25.0 Equity Units, pursuant to an underwriting agreement dated May 6, 2015, in an aggregate principal amount of \$1,250.0. For additional information relating to the Equity Units, see Note 12, "Debt."

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15. Accumulated Other Comprehensive Loss

A reconciliation of the components of accumulated other comprehensive loss at December 31 is as follows:

	2016	2015
Investments:		
Gross unrealized gains	\$ 748.6	\$ 815.0
Gross unrealized losses	(180.9)	(447.5)
Net pretax unrealized gains	567.7	367.5
Deferred tax liability	(206.5)	(124.2)
Net unrealized gains on investments	361.2	243.3
Non-credit components of OTTI on investments:		
Gross unrealized losses	(7.2)	(15.4)
Deferred tax asset	2.6	5.4
Net unrealized non-credit component of OTTI on investments	(4.6)	(10.0)
Cash flow hedges:		
Gross unrealized losses	(259.1)	(124.8)
Deferred tax asset	90.7	43.7
Net unrealized losses on cash flow hedges	(168.4)	(81.1)
Defined benefit pension plans:		
Deferred net actuarial loss	(655.8)	(635.0)
Deferred prior service credits	(0.5)	0.1
Deferred tax asset	257.2	250.4
Net unrecognized periodic benefit costs for defined benefit pension plans	(399.1)	(384.5)
Postretirement benefit plans:		
Deferred net actuarial loss	(146.6)	(162.7)
Deferred prior service credits	59.7	73.5
Deferred tax asset	34.0	35.1
Net unrecognized periodic benefit costs for postretirement benefit plans	(52.9)	(54.1)
Foreign currency translation adjustments:		
Gross unrealized losses	(6.3)	(9.5)
Deferred tax asset	2.2	3.3
Net unrealized losses on foreign currency translation adjustments	(4.1)	(6.2)
Accumulated other comprehensive loss	\$ (267.9)	\$ (292.6)

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Notes to Consolidated Financial Statements (continued)

Other comprehensive income (loss) reclassification adjustments for the years ended December 31 are as follows:

	2016	2015	2014
Investments:			
Net holding gain (loss) on investment securities arising during the period, net of tax (expense) benefit of (\$118.9), \$180.4, and (\$107.9), respectively	\$ 186.0	\$ (336.1)	\$ 201.8
Reclassification adjustment for net realized gain on investment securities, net of tax expense of \$36.6, \$25.9, and \$44.8, respectively	(68.1)	(48.2)	(83.2)
Total reclassification adjustment on investments	117.9	(384.3)	118.6
Non-credit component of OTTI on investments:			
Non-credit component of OTTI on investments, net of tax (expense) benefit of (\$2.8), \$3.0, and \$2.1, respectively	5.4	(5.6)	(3.9)
Cash flow hedges:			
Holding loss, net of tax benefit of \$47.0, \$24.4, and \$1.9, respectively	(87.3)	(45.2)	(3.6)
Other:			
Net change in unrecognized periodic benefit costs for defined benefit pension and postretirement benefit plans, net of tax benefit of \$5.7, \$13.4, and \$75.2, respectively	(13.4)	(26.0)	(118.1)
Foreign currency translation adjustment, net of tax (expense) benefit of (\$1.1), \$1.8, and \$2.2, respectively	2.1	(3.4)	(4.3)
Net gain (loss) recognized in other comprehensive loss, net of tax (expense) benefit of (\$33.5), \$248.9, and \$18.3, respectively	\$ 24.7	\$ (464.5)	\$ (11.3)

16. Reinsurance

We reinsure certain risks with other companies and assume risk from other companies. We remain primarily liable to policyholders under ceded insurance contracts and are contingently liable for amounts recoverable from reinsurers in the event that such reinsurers do not meet their contractual obligations. We evaluate the financial condition of our reinsurers and monitor concentrations of credit risk arising from similar geographic regions, activities, or economic characteristics of the reinsurers to minimize our exposure to significant losses from reinsurer insolvencies. In conjunction with the Health Care Reform temporary reinsurance premium stabilization program that was effective for 2014 through 2016, we recognized assessments upon our fully-insured non-grandfathered individual market plans that were eligible for reinsurance recoveries as ceded premiums and estimated reinsurance recoveries as a reduction to benefit expense. Assessments upon all other lines of business that were not eligible for reinsurance recoveries were recognized in general and administrative expense.

A summary of direct, assumed and ceded premiums written and earned for the years ended December 31 is as follows:

	2016		2015		2014	
	Written	Earned	Written	Earned	Written	Earned
Direct	\$ 78,200.4	\$ 78,726.2	\$ 72,925.5	\$ 73,259.2	\$ 68,628.6	\$ 68,304.3
Assumed	217.4	217.3	221.8	221.9	192.3	194.0
Ceded	(79.8)	(83.4)	(95.8)	(96.0)	(108.5)	(108.5)
Net premiums	\$ 78,338.0	\$ 78,860.1	\$ 73,051.5	\$ 73,385.1	\$ 68,712.4	\$ 68,389.8
Percentage—assumed to net premiums	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%

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

A summary of net premiums written and earned by segment (see Note 19, "Segment Information") for the years ended December 31 is as follows:

	2016		2015		2014	
	Written	Earned	Written	Earned	Written	Earned
Reportable segments:						
Commercial and Specialty Business	\$ 33,355.6	\$ 33,831.5	\$ 33,016.9	\$ 33,078.0	\$ 35,084.7	\$ 35,045.2
Government Business	44,982.4	45,028.6	40,034.6	40,307.1	33,627.7	33,344.6
Net premiums	<u>\$ 78,338.0</u>	<u>\$ 78,860.1</u>	<u>\$ 73,051.5</u>	<u>\$ 73,385.1</u>	<u>\$ 68,712.4</u>	<u>\$ 68,389.8</u>

The effect of reinsurance on benefit expense for the years ended December 31 is as follows:

	2016	2015	2014
Direct	\$ 67,221.7	\$ 61,674.0	\$ 57,496.6
Assumed	184.9	192.2	182.4
Ceded	(572.2)	(749.3)	(824.1)
Net benefit expense	<u>\$ 66,834.4</u>	<u>\$ 61,116.9</u>	<u>\$ 56,854.9</u>

The effect of reinsurance on certain assets and liabilities at December 31 is as follows:

	2016	2015
Policy liabilities, assumed	\$ 47.2	\$ 56.7
Unearned income, assumed	0.6	0.5
Premiums payable, ceded	5.2	9.3
Premiums receivable, assumed	25.9	23.2

17. Leases

We lease office space and certain computer and related equipment using noncancelable operating leases. At December 31, 2016, future lease payments for operating leases with initial or remaining noncancelable terms of one year or more consist of the following:

2017	\$ 149.7
2018	137.1
2019	121.4
2020	91.3
2021	69.9
Thereafter	201.1
Total minimum payments required	<u>\$ 770.5</u>

We have certain lease agreements that contain contingent payment provisions. Under these provisions, we pay contingent amounts in addition to base rent, primarily based upon annual changes in the consumer price index. The schedule above contains estimated amounts for potential future increases in lease payments based on the contingent payment provisions.

Lease expense for 2016, 2015 and 2014 was \$207.5, \$212.9 and \$192.5, respectively.

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

18. Earnings per Share

The denominator for basic and diluted earnings per share at December 31 is as follows:

	2016	2015	2014
Denominator for basic earnings per share—weighted-average shares	262.9	263.0	275.9
Effect of dilutive securities—employee stock options, non-vested restricted stock awards and convertible debentures	5.2	9.9	10.0
Denominator for diluted earnings per share	268.1	272.9	285.9

During the years ended December 31, 2016, 2015 and 2014, weighted-average shares related to certain stock options of 2.2, 1.0 and 0.5, respectively, were excluded from the denominator for diluted earnings per share because the stock options were anti-dilutive.

During the years ended December 31, 2016, 2015 and 2014, we issued approximately 0.5, 0.4 and 0.7 restricted stock units, respectively, of which vesting was contingent upon meeting certain earnings targets. Contingent restricted stock units are excluded from the denominator for diluted earnings per share and are included only if and when the contingency is met. The 2016 contingent restricted stock units are being measured over the three year period of 2016 through 2018 and the 2015 contingent restricted stock units are being measured over the three year period of 2015 through 2017. The 2016 and 2015 contingent restricted stock units remain contingent as of December 31, 2016. The 2014 contingent restricted stock units were based on annual targets and were subsequently included in the denominator for diluted earnings per share for the year ended December 31, 2015.

The Equity Units are potentially dilutive securities but were excluded from the denominator for diluted earnings per share for each of the years presented as the dilutive stock price threshold was not met. For additional information relating to the Equity Units, see Note 12, "Debt."

19. Segment Information

Our organizational structure is comprised of three reportable segments: Commercial and Specialty Business; Government Business; and Other.

Our Commercial and Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial and Specialty Business segment offer fully-insured health products; provide a broad array of managed care services to self-funded customers including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services; and provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal health care guidance.

Our Government Business segment includes Medicare and Medicaid businesses, National Government Services, or NGS, and services provided to the federal government in connection with FEP. Medicare business includes services such as Medicare Advantage, Medicare Part D, and Medicare Supplement. Medicaid business includes our managed care alternatives through publicly funded health care programs, including Medicaid, Temporary Assistance for Needy Family programs, programs for seniors and people with disabilities, programs for long-term services and support, Children's Health Insurance Programs and ACA-related Medicaid expansion programs. NGS acts as a Medicare contractor for the federal government in several regions across the nation.

Our Other segment includes other businesses that do not individually meet the quantitative thresholds for an operating segment as defined by FASB guidance, as well as corporate expenses not allocated to the other reportable segments.

We define operating revenues, a non-GAAP measure, to include premium income, administrative fees and other revenues. Operating revenues are derived from premiums and fees received primarily from the sale and administration of health benefit products. Operating gain, a non-GAAP measure, is calculated as total operating revenue less benefit expense and selling, general and administrative expense.

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

Through our participation in various federal government programs, we generated approximately 18.2%, 18.8% and 21.0% of our total consolidated revenues from agencies of the U.S. government for the years ended December 31, 2016, 2015, and 2014, respectively. These revenues are contained in the Government Business segment.

The accounting policies of the segments are consistent with those described in the summary of significant accounting policies in Note 2, "Basis of Presentation and Significant Accounting Policies," except that certain shared administrative expenses for each segment are recognized on a pro rata allocated basis, which in aggregate approximates the consolidated expense. Any difference between the allocated expenses and actual consolidated expense is included in other expenses not allocated to reportable segments. Intersegment sales and expenses are recorded at cost and eliminated in the consolidated financial statements. We evaluate performance of the reportable segments based on operating gain or loss as defined above. We evaluate net investment income, net realized gains on financial instruments, OTTI losses recognized in income, interest expense, amortization expense, gain or loss on extinguishment of debt, income taxes, assets and liabilities on a consolidated basis as these items are managed in a corporate shared service environment and are not the responsibility of segment operating management.

Financial data by reportable segment for the years ended December 31 is as follows:

	Commercial and Specialty Business	Government Business	Other	Total
Year ended December 31, 2016				
Operating revenue	\$ 38,692.1	\$ 45,477.7	\$ 24.2	\$ 84,194.0
Operating gain (loss)	3,195.2	1,784.3	(177.8)	4,801.7
Depreciation and amortization of property and equipment	—	—	576.0	576.0
Year ended December 31, 2015				
Operating revenue	\$ 37,570.8	\$ 40,813.0	\$ 21.0	\$ 78,404.8
Operating gain (loss)	2,854.0	1,978.5	(79.4)	4,753.1
Depreciation and amortization of property and equipment	—	—	515.6	515.6
Year ended December 31, 2014				
Operating revenue	\$ 39,199.6	\$ 33,796.4	\$ 25.7	\$ 73,021.7
Operating gain (loss)	3,260.9	1,191.9	(34.4)	4,418.4
Depreciation and amortization of property and equipment	—	—	474.3	474.3

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

The major product revenues for each of the reportable segments for the years ended December 31 are as follows:

	2016	2015	2014
Commercial and Specialty Business			
Managed care products	\$ 32,369.8	\$ 31,676.9	\$ 33,755.6
Managed care services	4,710.1	4,344.8	3,997.8
Dental/Vision products and services	1,182.3	1,111.7	1,037.3
Other	429.9	437.4	408.9
Total Commercial and Specialty Business	38,692.1	37,570.8	39,199.6
Government Business			
Managed care products	45,028.5	40,307.0	33,344.6
Managed care services	449.2	506.0	451.8
Total Government Business	45,477.7	40,813.0	33,796.4
Other			
Other	24.2	21.0	25.7
Total product revenues	<u>\$ 84,194.0</u>	<u>\$ 78,404.8</u>	<u>\$ 73,021.7</u>

The classification between managed care products and managed care services in the above table primarily distinguishes between the level of risk assumed. Managed care products represent insurance products where we bear the insurance risk, whereas managed care services represent product offerings where we provide claims adjudication and other administrative services to the customer, but the customer principally bears the insurance risk.

Asset, liability and equity details by reportable segment have not been disclosed, as we do not internally report such information.

A reconciliation of reportable segment operating revenues to the amounts of total revenues included in the consolidated statements of income for the years ended December 31 is as follows:

	2016	2015	2014
Reportable segments operating revenues	\$ 84,194.0	\$ 78,404.8	\$ 73,021.7
Net investment income	779.5	677.6	724.4
Net realized gains on financial instruments	4.9	157.5	177.0
Other-than-temporary impairment losses recognized in income	(115.4)	(83.4)	(49.0)
Total revenues	<u>\$ 84,863.0</u>	<u>\$ 79,156.5</u>	<u>\$ 73,874.1</u>

A reconciliation of reportable segment operating gain to income from continuing operations before income taxes included in the consolidated statements of income for the years ended December 31 is as follows:

	2016	2015	2014
Reportable segments operating gain	\$ 4,801.7	\$ 4,753.1	\$ 4,418.4
Net investment income	779.5	677.6	724.4
Net realized gains on financial instruments	4.9	157.5	177.0
Other-than-temporary impairment losses recognized in income	(115.4)	(83.4)	(49.0)
Interest expense	(723.0)	(653.0)	(600.7)
Amortization of other intangible assets	(192.3)	(230.1)	(220.9)
Gain (loss) on extinguishment of debt	—	9.3	(81.1)
Income from continuing operations before income tax expense	<u>\$ 4,555.4</u>	<u>\$ 4,631.0</u>	<u>\$ 4,368.1</u>

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

20. Related Party Transactions

We have a 19.50% equity investment in National Accounts Service Company, LLC, or NASCO, which processes National Accounts claims and provides other administrative services for us and certain other Blue Cross Blue Shield plans. Administrative expenses incurred related to NASCO services totaled \$79.7, \$83.6 and \$85.3, for the years ended December 31, 2016, 2015 and 2014, respectively. Amounts due to NASCO were \$6.2 and \$5.4 at December 31, 2016 and 2015, respectively.

21. Statutory Information

The majority of our insurance and HMO subsidiaries report their accounts in conformity with accounting practices prescribed or permitted by state insurance regulatory authorities, or statutory, which vary in certain respects from GAAP. However, certain of our insurance and HMO subsidiaries, including BCC, Blue Cross of California Partnership Plan, Inc., Golden West Health Plan, Inc. and CareMore Health Plan are regulated by the California Department of Managed Health Care, or DMHC, and report their accounts in conformity with GAAP (these entities are collectively referred to as the "DMHC regulated entities"). Typical differences of GAAP reporting as compared to statutory reporting are the inclusion of unrealized gains or losses relating to fixed maturity securities in shareholders' equity, recognition of all assets including those that are non-admitted for statutory purposes and recognition of all deferred tax assets without regard to statutory limits. The National Association of Insurance Commissioners, or NAIC, developed a codified version of the statutory accounting principles, designed to foster more consistency among the states for accounting guidelines and reporting. Prescribed statutory accounting practices are set forth in a variety of publications of the NAIC as well as state laws, regulations and general administrative rules.

Our ability to pay dividends and credit obligations is significantly dependent on receipt of dividends from our subsidiaries. The payment of dividends to us by our insurance and HMO subsidiaries without prior approval of the insurance departments of each subsidiary's domiciliary jurisdiction is limited by formula. Dividends in excess of these amounts are subject to prior approval by the respective state insurance departments or the DMHC.

Our statutory basis insurance and HMO subsidiaries are subject to risk-based capital requirements. Risk-based capital is a method developed by the NAIC to determine the minimum amount of statutory capital appropriate for an insurance company or HMO to support its overall business operations in consideration of its size and risk profile. The formula for determining the amount of risk-based capital specifies various factors, weighted based on the perceived degree of risk, which are applied to certain financial balances and financial activity. Below minimum risk-based capital requirements are classified within certain levels, each of which requires specified corrective action. Additionally, the DMHC regulated entities are subject to capital and solvency requirements as prescribed by the DMHC. As of December 31, 2016 and 2015, all of our regulated subsidiaries exceeded the minimum risk-based capital requirements and/or capital and solvency requirements of their applicable governmental regulator. The statutory risk-based capital necessary to satisfy regulatory requirements of our statutory basis insurance and HMO subsidiaries was approximately \$4,300.0 and \$3,900.0 as of December 31, 2016 and 2015, respectively. The tangible net equity required for the DMHC regulated entities was approximately \$650.0 and \$560.0 as of December 31, 2016 and 2015, respectively.

Statutory-basis capital and surplus of our insurance and HMO subsidiaries and capital and surplus of our other regulated subsidiaries, excluding the DMHC regulated entities, was \$10,580.2 and \$9,676.7 at December 31, 2016 and 2015, respectively. Statutory-basis net income of our insurance and HMO subsidiaries and net income of our other regulated subsidiaries, excluding the DMHC regulated entities, was \$2,613.2, \$2,359.9 and \$2,403.8 for 2016, 2015 and 2014, respectively. GAAP equity of the DMHC regulated entities was \$2,225.7 and \$1,838.1 at December 31, 2016 and 2015, respectively. GAAP net income of the DMHC regulated entities was \$774.5, \$477.5 and \$453.6 for the years ended December 31, 2016, 2015 and 2014, respectively.

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

22. Selected Quarterly Financial Data (Unaudited)

Selected quarterly financial data is as follows:

	For the Quarter Ended			
	March 31	June 30	September 30	December 31
2016				
Total revenues	\$ 20,288.5	\$ 21,456.2	\$ 21,403.9	\$ 21,714.4
Income before income taxes	1,312.0	1,448.3	1,136.5	658.6
Net income	703.0	780.6	617.8	368.4
Basic net income per share	\$ 2.69	\$ 2.97	\$ 2.35	\$ 1.40
Diluted net income per share	2.63	2.91	2.30	1.37
2015				
Total revenues	\$ 19,051.5	\$ 20,015.5	\$ 19,901.6	\$ 20,187.9
Income before income taxes	1,569.1	1,558.0	1,129.6	374.3
Net income	865.2	859.1	654.8	180.9
Basic net income per share	\$ 3.25	\$ 3.27	\$ 2.51	\$ 0.69
Diluted net income per share	3.09	3.13	2.43	0.68

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE.

There have been no changes in or disagreements with our independent registered public accounting firm on accounting or financial disclosures.

ITEM 9A. CONTROLS AND PROCEDURES.

Evaluation of Disclosure Controls and Procedures

We carried out an evaluation as of December 31, 2016, under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures as defined in Rule 13a-15(e) of the Exchange Act. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures are effective in timely alerting them to material information relating to us (including our consolidated subsidiaries) required to be disclosed in our reports under the Exchange Act. In addition, based on that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective in ensuring that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is accumulated and communicated to our management, including our Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosures.

Management's Report on Internal Control Over Financial Reporting

Management, under the supervision and with the participation of the principal executive officer and principal financial officer, of Anthem, Inc., or the Company, is responsible for establishing and maintaining effective internal control over financial reporting, or Internal Control, as such term is defined in the Exchange Act. The Company's Internal Control is designed to provide reasonable assurance regarding the reliability of the Company's financial reporting and the preparation of financial statements for external reporting purposes in accordance with U.S. generally accepted accounting principles, or GAAP. The Company's Internal Control includes those policies and procedures that (i) pertain to the maintenance of records that in reasonable detail accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in

accordance with GAAP, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the financial statements.

Because of inherent limitations in any Internal Control, no matter how well designed, misstatements due to error or fraud may occur and not be detected. Accordingly, even effective Internal Control can provide only reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with GAAP.

Management, under the supervision and with the participation of the principal executive officer and principal financial officer, assessed the effectiveness of the Company's Internal Control as of December 31, 2016. Management's assessment was based on criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission.

Based on management's assessment, management has concluded that the Company's Internal Control was effective as of December 31, 2016 to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external reporting purposes in accordance with GAAP.

Ernst & Young LLP, the Company's independent registered public accounting firm, has audited the consolidated financial statements of the Company for the year ended December 31, 2016, and has also issued an audit report dated February 22, 2017, on the effectiveness of the Company's internal control over financial reporting as of December 31, 2016, which is included in this Annual Report on Form 10-K.

/S/ JOSEPH R. SWEDISH
Chairman, President and Chief Executive Officer

/S/ JOHN E. GALLINA
Executive Vice President and Chief Financial Officer

Changes in Internal Control over Financial Reporting

There have been no changes in our internal control over financial reporting that occurred during the three months ended December 31, 2016 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders of Anthem, Inc.

We have audited Anthem, Inc.'s internal control over financial reporting as of December 31, 2016, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). Anthem, Inc.'s management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and

dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, Anthem, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2016, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Anthem, Inc. as of December 31, 2016 and 2015, and the related consolidated statements of income, comprehensive income, shareholders' equity, and cash flows for each of the three years in the period ended December 31, 2016 of Anthem, Inc. and our report dated February 22, 2017 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Indianapolis, Indiana
February 22, 2017

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ITEM 9B. OTHER INFORMATION.

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE.

The information required by this Item concerning our Executive Officers, Directors and nominees for Director, Audit Committee members and financial expert(s) and concerning disclosure of delinquent filers under Section 16(a) of the Exchange Act and our Standards of Business Conduct is incorporated herein by reference from our definitive Proxy Statement for our 2017 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 11. EXECUTIVE COMPENSATION.

The information required by this Item concerning remuneration of our Executive Officers and Directors, material transactions involving such Executive Officers and Directors and Compensation Committee interlocks, as well as the Compensation Committee Report, are incorporated herein by reference from our definitive Proxy Statement for our 2017 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS.

The information required by this Item concerning the stock ownership of management and five percent beneficial owners and securities authorized for issuance under equity compensation plans is incorporated herein by reference from our definitive Proxy Statement for our 2017 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE.

The information required by this Item concerning certain relationships and related person transactions and director independence is incorporated herein by reference from our definitive Proxy Statement for our 2017 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES.

The information required by this Item concerning principal accounting fees and services is incorporated herein by reference from our definitive Proxy Statement for our 2017 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES.

(a) 1. Financial Statements:

The following consolidated financial statements of the Company are set forth in Part II, Item 8

Report of Independent Registered Public Accounting Firm

Consolidated Balance Sheets as of December 31, 2016 and 2015

Consolidated Statements of Income for the years ended December 31, 2016, 2015, and 2014

Consolidated Statements of Comprehensive Income for the years ended December 31, 2016, 2015, and 2014

Consolidated Statements of Shareholders' Equity for the years ended December 31, 2016, 2015 and 2014

Consolidated Statements of Cash Flows for the years ended December 31, 2016, 2015 and 2014

Notes to Consolidated Financial Statements

2. Financial Statement Schedule:

The following financial statement schedule of the Company is included in Item 15(c):

Schedule II—Condensed Financial Information of Registrant (Parent Company Only).

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore, have been omitted.

3. Exhibits:

A list of exhibits required to be filed as part of this report is set forth in the Index to Exhibits, which immediately precedes such exhibits, and is incorporated herein by reference.

(b) Exhibits

The response to this portion of Item 15 is submitted as a separate section of this report.

(c) Financial Statement Schedule

Schedule II—Condensed Financial Information of Registrant (Parent Company Only).

ITEM 16. FORM 10-K SUMMARY.

None.

Schedule II—Condensed Financial Information of Registrant

**Anthem, Inc. (Parent Company Only)
Balance Sheets**

<i>(In millions, except share data)</i>	December 31, 2016	December 31, 2015
Assets		
Current assets:		
Cash and cash equivalents	\$ 882.7	\$ 492.3
Investments available-for-sale, at fair value:		
Fixed maturity securities (amortized cost of \$463.4 and \$889.6)	477.6	794.0
Equity securities (cost of \$35.7 and \$53.0)	85.5	82.0
Other invested assets, current	4.6	5.9
Other receivables	47.8	77.0
Income taxes receivable	69.0	236.5
Net due from subsidiaries	1,394.6	—
Securities lending collateral	39.7	130.6
Other current assets	277.0	394.0
Total current assets	3,278.5	2,212.3
Long-term investments available-for-sale, at fair value:		
Equity securities (cost of \$6.4 and \$6.5)	6.4	6.5
Other invested assets, long-term	632.4	630.1
Property and equipment, net	142.8	116.8
Deferred tax assets, net	107.5	146.6
Investments in subsidiaries	37,378.8	36,524.4
Other noncurrent assets	87.6	129.8
Total assets	\$ 41,634.0	\$ 39,766.5
Liabilities and shareholders' equity		
Liabilities		
Current liabilities:		
Accounts payable and accrued expenses	\$ 690.2	\$ 615.5
Security trades pending payable	18.2	13.4
Securities lending payable	39.7	130.6
Net due to subsidiaries	—	93.2
Current portion of long-term debt	928.4	—
Other current liabilities	301.4	278.1
Total current liabilities	1,977.9	1,130.8
Long-term debt, less current portion	14,333.6	15,299.6
Other noncurrent liabilities	222.1	292.0
Total liabilities	16,533.6	16,722.4
Commitments and contingencies—Note 5		
Shareholders' equity		
Preferred stock, without par value, shares authorized - 100,000,000; shares issued and outstanding - none	—	—
Common stock, par value \$0.01, shares authorized - 900,000,000; shares issued and outstanding - 263,747,395 and 261,238,188	2.6	2.6
Additional paid-in capital	8,805.1	8,555.6
Retained earnings	16,560.6	14,778.5
Accumulated other comprehensive loss	(267.9)	(292.6)
Total shareholders' equity	25,100.4	23,044.1
Total liabilities and shareholders' equity	\$ 41,634.0	\$ 39,766.5

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Income

(In millions)	Years ended December 31		
	2016	2015	2014
Revenues			
Net investment income	\$ 74.7	\$ 99.7	\$ 87.4
Net realized losses on financial instruments	(195.0)	(3.8)	(27.1)
Other-than-temporary impairment losses on investments:			
Total other-than-temporary impairment losses on investments	(65.0)	(49.2)	(35.5)
Portion of other-than-temporary impairment losses recognized in other comprehensive income	17.2	10.0	7.0
Other-than-temporary impairment losses recognized in income	(47.8)	(39.2)	(28.5)
Other revenue	—	3.5	4.8
Total (losses) revenues	(168.1)	60.2	36.6
Expenses			
General and administrative expense	270.0	77.9	20.3
Interest expense	719.3	649.7	597.8
(Gain) loss on extinguishment of debt	—	(9.3)	81.1
Total expenses	989.3	718.3	699.2
Loss before income tax credits and equity in net income of subsidiaries	(1,157.4)	(658.1)	(662.6)
Income tax credits	(438.5)	(270.1)	(255.4)
Equity in net income of subsidiaries	3,188.7	2,948.0	2,976.9
Net income	\$ 2,469.8	\$ 2,560.0	\$ 2,569.7

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Comprehensive Income

<i>(in millions)</i>	Years ended December 31		
	2016	2015	2014
Net income	\$ 2,469.8	\$ 2,560.0	\$ 2,569.7
Other comprehensive income (loss), net of tax:			
Change in net unrealized gains/losses on investments	117.9	(384.3)	118.6
Change in non-credit component of other-than-temporary impairment losses on investments	5.4	(5.6)	(3.9)
Change in net unrealized gains/losses on cash flow hedges	(87.3)	(45.2)	(3.6)
Change in net periodic pension and postretirement costs	(13.4)	(26.0)	(118.1)
Foreign currency translation adjustments	2.1	(3.4)	(4.3)
Other comprehensive income (loss)	24.7	(464.5)	(11.3)
Total comprehensive income	<u>\$ 2,494.5</u>	<u>\$ 2,095.5</u>	<u>\$ 2,558.4</u>

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Cash Flows

(In millions)	Years ended December 31		
	2016	2015	2014
Operating activities			
Net income	\$ 2,469.8	\$ 2,560.0	\$ 2,569.7
Adjustments to reconcile net income to net cash provided by operating activities:			
(Undistributed) distributed earnings of subsidiaries	(502.4)	(287.8)	244.3
Net realized losses on financial instruments	195.0	3.8	27.1
Other-than-temporary impairment losses recognized in income	47.8	39.2	28.5
(Gain) loss on extinguishment of debt	—	(9.3)	81.1
Loss on disposal of assets	2.3	0.2	3.9
Deferred income taxes	(7.0)	55.0	52.7
Amortization, net of accretion	33.5	40.8	17.5
Depreciation expense	70.4	68.1	67.4
Share-based compensation	164.6	148.2	168.9
Excess tax benefits from share-based compensation	(53.5)	(95.8)	(46.4)
Changes in operating assets and liabilities:			
Receivables, net	17.5	(17.9)	(16.6)
Other invested assets, current	1.3	(0.2)	(3.8)
Other assets	213.2	(106.9)	55.6
Amounts due from/to subsidiaries	(1,487.8)	420.5	566.1
Accounts payable and accrued expenses	(21.8)	7.5	(111.4)
Other liabilities	(30.7)	(231.4)	(113.8)
Income taxes	198.4	47.2	(36.0)
Other, net	5.1	(10.2)	—
Net cash provided by operating activities	1,315.7	2,631.0	3,554.8
Investing activities			
Purchases of investments	(2,874.9)	(2,130.7)	(1,819.3)
Proceeds from sales, maturities, calls and redemptions of investments	3,309.8	3,076.6	820.7
Changes in collateral and settlement of non-hedging derivatives	(34.5)	(36.5)	(67.4)
Capitalization of subsidiaries	(295.0)	(939.7)	(321.8)
Changes in securities lending collateral	91.8	94.0	(178.8)
Purchases of property and equipment, net of sales	(98.7)	(51.1)	(57.0)
Other, net	(7.9)	1.5	(38.0)
Net cash provided by (used in) investing activities	90.6	14.1	(1,661.6)
Financing activities			
Net (repayments of) proceeds from commercial paper borrowings	(53.2)	682.2	(379.2)
Proceeds from long-term borrowings	—	1,226.5	2,700.0
Repayments of long-term borrowings	—	(2,697.2)	(1,730.1)
Changes in securities lending payable	(90.9)	(94.2)	178.6
Changes in bank overdrafts	30.8	(89.3)	55.5
Premiums paid on equity call options	—	(16.7)	—
Proceeds from sale of put options	—	16.6	—
Repurchase and retirement of common stock	—	(1,515.8)	(2,998.8)
Change in collateral and settlements of debt-related derivatives	(360.4)	—	—
Cash dividends	(715.1)	(686.5)	(501.6)
Proceeds from issuance of common stock under employee stock plans	119.4	186.0	301.3
Excess tax benefits from share-based compensation	53.5	95.8	46.4
Net cash used in financing activities	(1,015.9)	(2,892.6)	(2,327.9)
Change in cash and cash equivalents	390.4	(247.5)	(434.7)
Cash and cash equivalents at beginning of year	492.3	739.8	1,174.5
Cash and cash equivalents at end of year	\$ 882.7	\$ 492.3	\$ 739.8

See accompanying notes.

Anthem, Inc.
(Parent Company Only)
Notes to Condensed Financial Statements
December 31, 2016
(In Millions, Except Per Share Data)

1. Basis of Presentation and Significant Accounting Policies

In the parent company only financial statements of Anthem, Inc., or Anthem, Anthem's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. Anthem's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting.

Certain amounts presented in the parent company only financial statements are eliminated in the consolidated financial statements of Anthem.

Anthem's parent company only financial statements should be read in conjunction with Anthem's audited consolidated financial statements and the accompanying notes included in this Annual Report on Form 10-K.

2. Subsidiary Transactions

Dividends from Subsidiaries

Anthem received cash dividends from subsidiaries of \$2,688.8, \$2,672.3 and \$3,234.5 during 2016, 2015 and 2014, respectively.

Dividends to Subsidiaries

Certain subsidiaries of Anthem own shares of Anthem common stock. Anthem paid cash dividends to subsidiaries related to these shares of common stock in the amount of \$31.1, \$29.9 and \$20.9 during 2016, 2015 and 2014, respectively.

Investments in Subsidiaries

Capital contributions to subsidiaries were \$295.0, \$939.7 and \$321.8 during 2016, 2015 and 2014, respectively.

Amounts Due to and From Subsidiaries

At December 31, 2016 and 2015, Anthem reported \$1,394.6 due from subsidiaries and \$93.2 due to subsidiaries, respectively. The amounts due to or from subsidiaries primarily include amounts for allocated administrative expenses or cash held overnight at the parent level resulting from daily cash management activities. These items are routinely settled, and as such, are classified as current assets or liabilities.

3. Derivative Financial Instruments

The information regarding derivative financial instruments contained in Note 5, "Derivative Financial Instruments," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries is incorporated herein by reference.

4. Long-Term Debt

The information regarding long-term debt contained in Note 12, "Debt," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries is incorporated herein by reference.

5. Commitments and Contingencies

The information regarding commitments and contingencies contained in Note 13, "Commitments and Contingencies," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries is incorporated herein by reference.

6. Capital Stock

The information regarding capital stock contained in Note 14, “Capital Stock,” of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries is incorporated herein by reference.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

ANTHEM, INC.

By: /s/ JOSEPH R. SWEDISH
Joseph R. Swedish
Chairman, President and Chief Executive Officer

Dated: February 22, 2017

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

<u>Signature</u>	<u>Title</u>	<u>Date</u>
<u>/s/ JOSEPH R. SWEDISH</u> Joseph R. Swedish	Chairman, President and Chief Executive Officer (Principal Executive Officer)	February 22, 2017
<u>/s/ JOHN E. GALLINA</u> John E. Gallina	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 22, 2017
<u>/s/ RONALD W. PENCZEK</u> Ronald W. Penczek	Senior Vice President and Chief Accounting Officer (Principal Accounting Officer)	February 22, 2017
<u>/s/ GEORGE A. SCHAEFER, JR.</u> George A. Schaefer, Jr.	Director	February 22, 2017
<u>/s/ R. KERRY CLARK</u> R. Kerry Clark	Director	February 22, 2017
<u>/s/ ROBERT L. DIXON, JR.</u> Robert L. Dixon, Jr.	Director	February 22, 2017
<u>/s/ LEWIS HAY III</u> Lewis Hay III	Director	February 22, 2017
<u>/s/ JULIE A. HILL</u> Julie A. Hill	Director	February 22, 2017
<u>/s/ RAMIRO G. PERU</u> Ramiro G. Peru	Director	February 22, 2017
<u>/s/ WILLIAM J. RYAN</u> William J. Ryan	Director	February 22, 2017
<u>/s/ ELIZABETH E. TALLETT</u> Elizabeth E. Tallett	Director	February 22, 2017

INDEX TO EXHIBITS

<u>Exhibit Number</u>	<u>Exhibit</u>
2.1	Stock and Interest Purchase Agreement dated April 9, 2009, by and between the Company and Express Scripts, Inc., incorporated by reference to Exhibit 2.1 of the Company's Current Report on Form 8-K filed on April 13, 2009, SEC File No. 001-16751.
2.2	Agreement and Plan of Merger, dated as of July 23, 2015 among Anthem, Inc., Anthem Merger Sub. Corp. and Cigna Corporation, incorporated by reference to Exhibit 2.1 to the Company's Current Report on Form 8-K filed on July 27, 2015.
3.1	Amended and Restated Articles of Incorporation of the Company, as amended effective December 2, 2014, incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on December 2, 2014.
3.2	By-Laws of the Company, as amended effective February 18, 2016, incorporated by reference to Exhibit 3.2 to the Company's Current Report on Form 8-K filed on February 23, 2016.
4.1	Indenture, dated as of December 9, 2004, between the Company and The Bank of New York Trust Company, N.A., as trustee, including the Form of the Company's 5.950% Notes due 2034, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on December 15, 2004, SEC File No. 001-16751.
4.2	Indenture, dated as of January 10, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. (formerly known as The Bank of New York Trust Company, N.A.), as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on January 11, 2006, SEC File No. 001-16751.
(a)	Form of 5.85% Notes due 2036, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on January 11, 2006, SEC File No. 001-16751.
(b)	Form of 5.875% Notes due 2017, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on June 8, 2007, SEC File No. 001-16751.
(c)	Form of 6.375% Notes due 2037, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on June 8, 2007, SEC File No. 001-16751.
(d)	Form of 7.000% Notes due 2019, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on February 5, 2009, SEC File No. 001-16751.
(e)	Form of 4.350% Notes due 2020, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on August 12, 2010, SEC File No. 001-16751.
(f)	Form of 5.800% Notes due 2040, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 12, 2010, SEC File No. 001-16751.
(g)	Form of 2.375% Notes due 2017, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on August 15, 2011, SEC File No. 001-16751.
(h)	Form of 3.700% Notes due 2021, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 15, 2011, SEC File No. 001-16751.
(i)	Form of 3.125% Notes due 2022, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on May 7, 2012.
(j)	Form of 4.625% Notes due 2042, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on May 7, 2012.
(k)	Form of 1.875% Notes due 2018, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on September 10, 2012.
(l)	Form of 3.300% Notes due 2023, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on September 10, 2012.

**Exhibit
Number**

Exhibit

- (m) Form of 4.650% Notes due 2043, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on September 10, 2012.
- (n) Form of 2.300% Notes due 2018, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on July 31, 2013.
- (o) Form of 5.100% Notes due 2044, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on July 31, 2013.
- (p) Form of 2.250% Notes due 2019, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on August 12, 2014.
- (q) Form of 3.500% Notes due 2024, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 12, 2014.
- (r) Form of 4.650% Notes due 2044, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on August 12, 2014.
- (s) Form of 4.850% Notes due 2054, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on August 12, 2014.
- 4.3 Indenture dated as of October 9, 2012 between the Company and The Bank of New York Mellon Trust Company, N.A. as trustee, including the Form of the 2.750% Senior Convertible Debentures due 2042, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on October 9, 2012.
- 4.4 Subordinated Indenture, dated as of May 12, 2015, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on May 12, 2015.
 - (a) First Supplemental Indenture to the Subordinated Indenture, dated as of May 12, 2015, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee, including the Form of 1.90% Remarketable Subordinated Notes due 2028, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on May 12, 2015.
- 4.5 Purchase Contract and Pledge Agreement, dated as of May 12, 2015, between the Company and The Bank of New York Mellon Trust Company, N.A., as Purchase Contract Agent, Collateral Agent, Custodial Agent and Securities Intermediary, including the Form of Remarketing Agreement, Form of Corporate Units Certificate and Form of Treasury Units Certificate, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on May 12, 2015.
- 4.6 Upon the request of the Securities and Exchange Commission, the Company will furnish copies of any other instruments defining the rights of holders of long-term debt of the Company or its subsidiaries.
- 10.1 * Anthem Incentive Compensation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed on December 2, 2014.
 - (a) Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement, incorporated by reference to Exhibit 10.2(o) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2010, SEC File No. 001-16751.
 - (b) Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2013, incorporated by reference to Exhibit 10.2(s) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2013.
 - (c) Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2014, incorporated by reference to Exhibit 10.2(p) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014.
 - (d) Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2014, incorporated by reference to Exhibit 10.2(q) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014.

**Exhibit
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Exhibit

- (e) Form of Incentive Compensation Plan Performance Share Award Agreement for 2014, incorporated by reference to Exhibit 10.2(r) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014.
- (f) Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2015, incorporated by reference to Exhibit 10.2(n) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015.
- (g) Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2015, incorporated by reference to Exhibit 10.2(o) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015.
- (h) Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for 2015, incorporated by reference to Exhibit 10.2(p) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015.
- (i) Form of Amendment, dated March 9, 2016, to Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2014, incorporated by reference to Exhibit 10.2(m) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
- (j) Form of Amendment, dated March 9, 2016, to Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2014, incorporated by reference to Exhibit 10.2(n) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
- (k) Form of Amendment, dated March 9, 2016, to Incentive Compensation Plan Performance Share Award Agreement for 2014, incorporated by reference to Exhibit 10.2(o) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
- (l) Form of Amendment, dated March 9, 2016, to Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2015, incorporated by reference to Exhibit 10.2(p) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
- (m) Form of Amendment, dated March 9, 2016, to Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2015, incorporated by reference to Exhibit 10.2(q) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
- (n) Form of Amendment, dated March 9, 2016, to Incentive Compensation Plan Performance Stock Unit Award Agreement for 2015, incorporated by reference to Exhibit 10.2(r) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
- (o) Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2016, incorporated by reference to Exhibit 10.2(s) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
- (p) Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2016, incorporated by reference to Exhibit 10.2(t) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
- (q) Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for 2016, incorporated by reference to Exhibit 10.2(u) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.
- 10.2 * Anthem, Inc. Comprehensive Nonqualified Deferred Compensation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.3 to the Company's Annual Report on Form 10-K for the year ended December 31, 2014.
- 10.3 * Anthem, Inc. Executive Agreement Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.4 to the Company's Annual Report on Form 10-K for the year ended December 31, 2014.
- (a) First Amendment, dated March 9, 2016, to Executive Agreement Plan, incorporated by reference to Exhibit 10.4(a) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016.

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Exhibit

- (b) Second Amendment, dated January 6, 2017, to Executive Agreement Plan.
- 10.4 * Anthem, Inc. Executive Salary Continuation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.5 to the Company's Annual Report on Form 10-K for the year ended December 31, 2015.
- 10.5 * Anthem, Inc. Directed Executive Compensation Plan amended effective January 1, 2014, incorporated by reference to Exhibit 10.6 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2013.
- 10.6 * Anthem, Inc. Board of Directors Compensation Program, as amended effective December 9, 2015, incorporated by reference to Exhibit 10.7 to the Company's Annual Report on Form 10-K for the year ended December 31, 2015.
- 10.7 * Anthem Board of Directors' Deferred Compensation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.8 to the Company's Annual Report on Form 10-K for the year ended December 31, 2014.
- 10.8 * (a) Form of Employment Agreement between the Company and each of the following: John E. Gallina, Brian T. Griffin, Peter D. Haytaian, Gloria McCarthy, Jose D. Tomas and Thomas C. Zielinski, incorporated by reference to Exhibit A to Exhibit 10.41 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2007, SEC File No. 001-16751.
- (b) Form of Employment Agreement between the Company and Joseph R. Swedish, incorporated by reference to Exhibit A to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on February 12, 2013.
- (c) Form of Employment Agreement between the Company and Craig E. Sammit, incorporated by reference to Exhibit A to Exhibit 10.4 to the Company's Annual Report on Form 10-K for the year ended December 31, 2014.
- 10.9 * Offer Letter, by and between WellPoint, Inc. and Joseph R. Swedish, dated as of February 6, 2013, incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on February 12, 2013.
- 10.10 Blue Cross License Agreement by and between Blue Cross Blue Shield Association and the Company, including revisions, if any, adopted by the Member Plans through November 18, 2016.
- 10.11 Blue Shield License Agreement by and between Blue Cross Blue Shield Association and the Company, including revisions, if any, adopted by the Member Plans through November 18, 2016.
- 10.12 Undertakings to California Department of Managed Health Care, dated October 15, 2012, delivered by Blue Cross of California, incorporated by reference to Exhibit 10.19 to the Company's Annual Report on Form 10-K for the year ended December 31, 2012.
- 10.13 Commitment letter, dated as of July 23, 2015, by and among Anthem, Inc., Bank of America, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Credit Suisse Securities (USA) LLC, Credit Suisse AG, UBS AG and UBS Securities LLC, incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on July 27, 2015.
- (a) Bridge Facility Joinder Agreement, dated as of August 25, 2015, among Anthem, Inc. and the other parties thereto, incorporated by reference to Exhibit 10.2 to the Company's Registration Statement on Form S-4 filed on September 30, 2015 (Registration No. 333-207218).
- 21 Subsidiaries of the Company.
- 23 Consent of Independent Registered Public Accounting Firm.
- 31.1 Certification of Chief Executive Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
- 31.2 Certification of Chief Financial Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.

**Exhibit
Number**

Exhibit

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|------|--|
| 32.1 | Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002. |
| 32.2 | Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002. |
| 101 | The following materials from Anthem, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2016, formatted in XBRL (Extensible Business Reporting Language): (i) the Consolidated Balance Sheets; (ii) the Consolidated Statements of Income; (iii) the Consolidated Statements of Comprehensive Income; (iv) the Consolidated Statements of Cash Flows; (v) the Consolidated Statements of Shareholders' Equity; (vi) the Notes to Consolidated Financial Statements and (vii) Financial Statement Schedule II. |

* Indicates management contracts or compensatory plans or arrangements.

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SECOND AMENDMENT TO THE
ANTHEM, INC. EXECUTIVE AGREEMENT PLAN

Pursuant to rights reserved under Section 7.3 of the Anthem, Inc. Executive Agreement Plan (as restated effective December 2, 2014 and amended March 9, 2016) (the “Plan”), Anthem, Inc. hereby amends the Plan, as follows:

1. Section 3.6(a) is amended in its entirety to read as follows effective November 30, 2016, except as noted therein:

3.6 Restrictive Covenants. As a condition of participation in this Plan each Participant agrees as follows:

(a) Confidentiality.

(i) The Participant recognizes that the Company derives substantial economic value from information created and used in its business which is not generally known by the public, including, but not limited to, plans, designs, concepts, computer programs, formulae, and equations; product fulfillment and supplier information; customer and supplier lists, and confidential business practices of the Company, its affiliates and any of its customers, vendors, business partners or suppliers; profit margins and the prices and discounts the Company obtains or has obtained or at which it sells or has sold or plans to sell its products or services (except for public pricing lists); manufacturing, assembling, labor and sales plans and costs; business and marketing plans, ideas, or strategies; confidential financial performance and projections; employee compensation; employee staffing and recruiting plans and employee personal information; and other confidential concepts and ideas related to the Company’s business (collectively, “Confidential Information”). The Participant expressly acknowledges and agrees that by virtue of his or her employment with the Company, the Participant will have access and will use in the course of the Participant’s duties certain Confidential Information and that Confidential Information constitutes trade secrets and confidential and proprietary business information of the Company, all of which is the exclusive property of the Company. For purposes of this Agreement, Confidential Information includes the foregoing and other information protected under the Indiana Uniform Trade Secrets Act (the “Act”), or to any comparable protection afforded by applicable law, but does not include information that the Participant establishes by clear and convincing evidence is or may become known to the Participant or to the public from sources outside the Company and through means other than a breach of this Agreement. Notwithstanding the foregoing, effective May 12, 2016 and in accordance with the Defend Trade Secrets Act of 2016, the Participant will not be held criminally or civilly liable under any federal or state trade secret law for the disclosure of a trade secret that: (a) is made (i) in confidence to a federal, state, or local

government official, either directly or indirectly, or to an attorney; and (ii) solely for the purpose of reporting or investigating a suspected violation of law; or (b) is made in a complaint or other document that is filed under seal in a lawsuit or other proceeding. If the Participant files a lawsuit for retaliation by the Company for reporting a suspected violation of law, the Participant may disclose the Company's trade secrets to his or her attorney and use the trade secret information in the court proceeding if the Participant (a) files any document containing the trade secret under seal; and (b) does not disclose the trade secret, except pursuant to court order.

(ii) The Participant agrees that the Participant will not for himself or herself or for any other person or entity, directly or indirectly, without the prior written consent of the Company, while employed by the Company and thereafter: (i) use Confidential Information for the benefit of any person or entity other than the Company or its affiliates; (ii) remove, copy, duplicate or otherwise reproduce any document or tangible item embodying or pertaining to any of the Confidential Information, except as required to perform the Participant's duties for the Company or its affiliates; or (iii) while employed and thereafter, publish, release, disclose or deliver or otherwise make available to any third party any Confidential Information by any communication, including oral, documentary, electronic or magnetic information transmittal device or media. Upon termination of employment, the Participant shall return all Confidential Information and all other property of the Company. This obligation of non-disclosure and non-use of information shall continue to exist for so long as such information remains Confidential Information. Provided, however, nothing in this Agreement prohibits or limits the Participant from (i) reporting possible violations of federal securities law or regulation to any governmental agency or entity or (ii) receiving a monetary award from the governmental agency or entity for the information reported.

2. Section 3.10 is amended, in its entirety, effective November 30, 2016 to read as follows:

3.10 Cooperation. Upon the receipt of reasonable notice from the Company (including from outside counsel to the Company), the Participant agrees that while employed by the Company and for two years (or, if longer, for so long as any claim referred to in this Section remains pending) after the termination of Participant's employment for any reason, the Participant will respond and provide information with regard to matters in which the Participant has knowledge as a result of the Participant's employment with the Company, and will provide reasonable assistance to the Company, its affiliates and their respective representatives in defense of any claims that may be made against the Company or its affiliates, and will assist the Company and its affiliates in the prosecution of any claims that may be made by the Company or its affiliates, to the extent that such claims may relate to the period of the Participant's employment with the Company (or any predecessor); provided, that with respect to periods after the termination of the Participant's employment, the Company shall reimburse the Participant for any out-of-pocket expenses incurred in providing such assistance and if the

Participant is required to provide more than ten (10) hours of assistance per week after his termination of employment then the Company shall pay the Participant a reasonable amount of money for his services at a rate agreed to between the Company and the Participant; and provided further that after the Participant's termination of employment with the Company such assistance shall not unreasonably interfere with the Participant's business or personal obligations. The Participant agrees to promptly inform the Company if the Participant becomes aware of any lawsuits involving such claims that may be filed or threatened against the Company or its affiliates. The Participant also agrees to promptly inform the Company (to the extent the Participant is legally permitted to do so) if the Participant is asked to assist in any investigation of the Company or its affiliates (or their actions), regardless of whether a lawsuit or other proceeding has then been filed against the Company or its affiliates with respect to such investigation, and shall not do so unless legally required. Provided, however, the Participant is not required to inform the Company of any investigation by a governmental agency or entity resulting from the reporting of possible violations of federal securities law or regulation to any governmental agency or entity, and the Participant may participate in such investigation, without informing the Company.

* * *

IN WITNESS WHEREOF, the following authorized officer has executed this First Amendment to evidence its adoption by Anthem, Inc. this 6th day of January, 2017.

ANTHEM, INC.

By: /s/ Joseph R. Swedish
Joseph R. Swedish
Chairman, President & Chief Executive Officer

BLUE CROSS LICENSE AGREEMENT

(Includes revisions, if any, adopted by Member Plans through their November 18, 2016 meeting)

This agreement by and between Blue Cross and Blue Shield Association ("BCBSA") and the Blue Cross Plan, known as _____ (the "Plan").

Preamble

WHEREAS, the Plan and/or its predecessor(s) in interest (collectively the "Plan") had the right to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") for health care plans in its service area, which was essentially local in nature;

WHEREAS, the Plan was desirous of assuring nationwide protection of the Licensed Marks, maintaining uniform quality controls among Plans, facilitating the provision of cost effective health care services to the public and otherwise benefiting the public;

WHEREAS, to better attain such ends, the Plan and the predecessor of BCBSA in 1972 simultaneously executed the BCA License Agreement (s) and the Ownership Agreement; and

WHEREAS, BCBSA and the Plan desire to supercede said Agreement(s) and to revise certain provisions of the Ownership Agreement to reflect their current practices and to assure the continued integrity of the Licensed Marks and of the BLUE CROSS system;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

Agreement

1. BCBSA hereby grants to the Plan, upon the terms and conditions of this License Agreement (“Agreement” or “Primary License Agreement”, the right to use BLUE CROSS in its trade and/or corporate name (the “Licensed Name”), and the right to use the Licensed Marks, in the sale, marketing and administration of health care plans and related services in the Service Area set forth and defined in paragraph 5 below. As used herein, health care plans and related services shall include acting as a nonprofit health care plan, a for-profit health care plan, or mutual health insurer operating on a not-for-profit or for-profit basis, under state law; financing access to health care services; when working with a bank that holds the relevant license to use the Licensed Name and Marks, offering: (i) tax-favored savings accounts for medical expenses and means for accessing such accounts, such as debit cards or checks, that are provided solely to support access to such tax-favored savings accounts, all pursuant to such license, or (ii) prepaid rewards cards that are provided for completion of a wellness program, all pursuant to such license; providing health care management and administration; administering, but not underwriting, non-health portions of Worker’s Compensation insurance; delivering health care services, except hospital services (as defined in the Guidelines to Membership Standards Applicable to Regular Members); and performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by a group account to its members, including benefit plans not provided by the Plan, provided that the Plan has contracted to provide Health Coverage under the Licensed Marks to the account (as the terms “Health Coverage,” “Eligibility” and “Enrollment” are defined in Exhibit 4, Paragraph 2.t.).

2. The Plan may use the Licensed Marks and Name in connection with the offering of: i) health care plans and related services in the Service Area through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit I hereto (the “Controlled Affiliate License Agreement”); and: ii) insurance coverages offered by life insurers under the applicable law in the Service Area, other than those which the Plan may offer in its own name, provided through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1A hereto (the “Controlled Affiliate License Agreement Applicable to Life Insurance Companies”) or the Agreement attached as Exhibit 1A1 hereto (the “Controlled Affiliate Trademark License Agreement for Life and Disability Insurance Products”) and further provided that the offering of such services does not and will not dilute or tarnish the unique value of the Licensed Marks and Name; and iii) administration and underwriting of Workers’ Compensation Insurance Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit I hereto (the “Controlled Affiliate License.”); and iv) regional Medicare Advantage PPO products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1B hereto (the “Controlled Affiliate License Agreement Applicable to Regional Medicare Advantage PPO Products”); and v) regional Medicare Part D Prescription Drug Plan products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1C hereto (the “Controlled Affiliate License Agreement Applicable to Regional Medicare Part D Prescription Drug Plan Products”). As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans and, if the entity meets the standards of Paragraph 2a.B but not Paragraph 2a.A, the entity, its owners, and persons

Amended as of September 19, 2014

with authority to select or appoint members or board members, other than a Plan or Plans, have received written approval of BCBSA. Absent written approval by BCBSA of an alternative method of control, bona fide control shall have the meaning set forth in Paragraphs 2a. and 2b.

2a. With respect to the Controlled Affiliate Licenses authorized in clauses i) through iii) of Paragraph 2, bona fide control shall mean that a Plan (the "Sponsoring Plan") authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to this Primary License Agreement with BCBSA must have:

- A. The legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; (b) to exercise control over the policy and operations of the Controlled Affiliate; (c) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or
- B. The legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; (c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan. Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:
 - 1. Change its legal and/or trade name;
 - 2. Change the geographic area in which it operates;
 - 3. Change any of the types of businesses in which it engages;
 - 4. Create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;
 - 5. Sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;
 - 6. Make any loans or advances except in the ordinary course of business;

Amended as of March 26, 2015

7. Enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners of the Controlled Affiliate or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);
8. Conduct any business other than under the Licensed Marks and Name;
9. Take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks or Names.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or

- C. With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid products and services, the legal authority together with such other Plans (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B-1 to Exhibit 1 attached hereto; or
 - D. With respect to a Controlled Affiliate that is 100% controlled by a Sponsoring Plan which on a Blue-branded basis offers solely a Basic Medicare Part D Prescription Drug product, the legal authority (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by the Plan shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and Participating Plan as defined on the
-

Controlled Affiliate License Agreement shall execute the “Addendum to Controlled Affiliate License” attached as Exhibit B-2 to Exhibit 1 attached hereto.

2b. With respect to the Controlled Affiliate License Agreements authorized in clauses iv) and v) of Paragraph 2, bona fide control shall mean that the Controlled Affiliate is organized and operated in such a manner that it meets the following requirements:

A. The Controlled Affiliate is owned or controlled by two or more Plans authorized to use the Licensed Marks pursuant to this License Agreement with BCBSA (for purposes of this subparagraph A. through subparagraph C., the “Controlling Plans”); and

Amended as of March 17, 2016

- B. Each Controlling Plan is authorized pursuant to this Agreement to use the Licensed Marks in a geographic area in the Region (as that term is defined in such Controlled Affiliate License Agreements) and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
- C. The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur; and (c) to exercise control over the policy and operations of the Controlled Affiliate. Notwithstanding anything to the contrary in (a) through (c) of this subparagraph E., the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:
1. Change its legal and/or trade names;
 2. Change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
 3. Change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
 4. Take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Amended as of June 19, 2014

3. With respect to a Controlled Affiliate that is not licensed to use the Licensed Marks and Name, the Plan may, in communications that contain the Licensed Marks or Name, indicate its corporate relationship to the Affiliate and permit such Affiliate to indicate its corporate relationship to the Plan, solely in the circumstances, style and manner specified by BCBSA from time-to-time in regulations of general application consistent with the avoidance of confusion or mistake or the dilution or tarnishment of the Licensed Marks and Name. No rights are hereby created in any Controlled Affiliate to use the Licensed Marks or Name in its own name or otherwise.

4. The Plan recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Plan further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide. The Plan agrees (a) to maintain in good standing its membership in BCBSA; (b) promptly to pay its dues to BCBSA, said dues to represent the royalties for this License Agreement; (c) materially to comply with all applicable laws; (d) to comply with the Membership Standards Applicable to Regular Members of BCBSA, a current copy of which is attached as Exhibit 2 hereto; and (e) reasonably to permit BCBSA, upon a written, good faith request and during reasonable business hours, to inspect the Plan's books and records necessary to ascertain compliance herewith. As to other Plans and third parties, BCBSA shall maintain the confidentiality of all documents and information furnished by the Plan pursuant hereto, or pursuant to the Membership Standards, and clearly designated by the Plan as containing proprietary information of the Plan.

5. The rights hereby granted are exclusive to the Plan within the geographical area(s) served by the Plan on June 30, 1972, and/or as to which the Plan has been granted a subsequent license, which is hereby defined as the "Service Area," except that BCBSA reserves the right to use the Licensed Marks in said Service Area, and except to the extent that said Service Area may overlap areas served by one or more other licensed Blue Cross Plans as of said date or subsequent license, as to which overlapping areas the rights hereby granted are nonexclusive as to such other Plan or Plans only.

Amended as of June 19, 2014

6. Except as expressly provided by BCBSA with respect to National Accounts, Government Programs and certain other necessary and collateral uses, the current rules and regulations governing which are attached as Exhibit 3 and Exhibit 4 hereto, and are contained in other documents referenced herein, or as expressly provided herein, the Plan may not use the Licensed Marks and Name outside the Service Area or in connection with other goods and services, nor may the Plan use the Licensed Marks or Name in a manner which is intended to transfer in the Service Area the goodwill associated therewith to another mark or name. Nothing herein shall be construed to prevent the Plan from engaging in lawful activity anywhere under other marks and names not confusingly similar to the Licensed Marks and Name, provided that engaging in such activity does and will not dilute or tarnish the unique value of the Licensed Marks and Name. In addition to any and all remedies available hereunder, BCBSA may impose monetary fines on the Plan for the Plan's use of the Licensed Marks and Names outside the Service Area, and provided that the procedure used in imposing a fine is consistent with procedures specifically prescribed by BCBSA from time to time in regulations of general application. In the case of regional Medicare Advantage PPO and regional Medicare Part D Prescription Drug Plan products offered by consenting and participating Plans in a region that includes the Service Areas, or portions thereof, of more than one Plan, such fine may be imposed jointly on the consenting and participating Plans for use of the Licensed Marks and Name in any geographic area of the region in which a Plan having exclusive rights to the Licensed Marks and Name does not consent to and participate in such offering, provided that the basis for imposition of such fine is consistent with rules specifically prescribed by BCBSA from time to time in regulations of general application.

7. The Plan agrees that it will display the Licensed Marks and Name only in such form, style and manner as shall be specifically prescribed by BCBSA from time-to-time in regulations of general application in order to prevent impairment of the distinctiveness of the Licensed Marks and Name and the goodwill pertaining thereto. The Plan shall cause to appear on all materials on or in connection with which the Licensed Marks or Name are used such legends, markings and notices as BCBSA may reasonably request in order to give appropriate notice of service mark or other proprietary rights therein or pertaining thereto.

8. BCBSA agrees that: (a) it will not grant any other license effective during the term of this License Agreement for the use of the Licensed Marks or Name which is inconsistent with the rights granted to the Plan hereunder; and (b) it will not itself use the Licensed Marks in derogation of the rights of the Plan or in a manner to deprive the Plan of the full benefits of this License Agreement, provided that BCBSA shall have the right to use the Licensed Marks in conjunction with any national offering under the Federal Employees Health Benefits Program in the manner set forth in Exhibit 4, Paragraph 4 (including subparagraphs) to this License Agreement. The Plan agrees that it will not attack the title of BCBSA in and to the Licensed Marks or Name or attack the validity of the Licensed Marks or of this License Agreement. The Plan further agrees that all use by it of the Licensed Marks and Name or any similar mark or name shall inure to the benefit of BCBSA, and the Plan shall cooperate with BCBSA in effectuating the assignment to BCBSA of any service mark or trademark registrations of the Licensed Marks or any similar mark or name held by the Plan or a Controlled Affiliate of the Plan, all or any portion of which registration consists of the Licensed Marks.

Amended as of November 16, 2006

9. (a). Should the Plan fail to comply with the provisions of paragraphs 2-4, 6, 7 and/or 12, and not cure such failure within thirty (30) days of receiving written notice thereof (or commence curing such failure within such thirty day period and continue diligent efforts to complete the curing of such failure if such curing cannot reasonably be completed within such thirty day period), BCBSA shall have the right to issue a notice that the Plan is in a state of noncompliance. Except as to the termination of a Plan's License Agreement or the merger of two or more Plans, disputes as to noncompliance, and all other disputes between or among BCBSA, the Plan, other Plans and/or Controlled Affiliates, shall be submitted promptly to mediation and mandatory dispute resolution pursuant to the rules and regulations of BCBSA, a current copy of which is attached as Exhibit 5 hereto, and shall be timely presented and resolved. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. If a state of noncompliance as aforesaid is undisputed by the Plan or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the License Agreement. Except, however, as provided in paragraphs 9(d)(iii), 15(a)(i)-(viii), and 15(a)(x) below, no Plan's license to use the Licensed Marks and Name may be finally terminated for any reason without the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

(b). Notwithstanding any other provision of this License Agreement, a Plan's license to use the Licensed Marks and Name may be forthwith terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to Member Plans for: (i) failure to comply with any minimum capital or liquidity requirement under the Membership Standard on Financial Responsibility; or (ii) impending financial insolvency; or (iii) the pendency of any action instituted against the Plan seeking its dissolution or liquidation or its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property of business, unless this License Agreement has been earlier terminated under paragraph 15(a); or (iv) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans and/or the Licensed Marks.

Amended as of November 16, 2006

(c). To the extent not otherwise provided therein, neither: (i) the Membership Standards Applicable to Regular Members of BCBSA; nor (ii) the rules and regulations governing Government Programs and certain other uses; nor (iii) the rules and regulations governing mediation and mandatory dispute resolution, may be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans. The rules and regulations governing National Accounts and other national programs required by the Membership Standards Applicable to Regular Members of BCBSA (Exhibit 2) are contained, in addition to those set forth in Exhibit 3, in the following documents, as amended from time to time: (1) the Inter-Plan Programs Policies and Provisions; (2) Inter-Plan Medicare Advantage Program Policies and Provisions. The voting requirements specified in rules and regulations governing such national programs may not be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans.

Amended as of November 21, 2014

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

(i) The Plan shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement and the Plan's membership in BCBSA.

(ii) The Plan shall not use the licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Plan in any securities market. The Plan shall use the licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(iii) Plan's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Plan knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Plan ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Plan knows, or there is an SEC filing indicating that, any Noninstitutional Investor has become the Beneficial Owner of securities representing 5% or more of the voting power of the Plan ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Plan knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner of 20% or more of the Plan's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 9(d)(iv) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Plan went public constituted the Board of Directors of the Plan (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Plan went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Plan consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Plan in a writing received by BCBSA prior to such automatic termination becoming effective, the provisions of this paragraph 9(d)(iii) may be waived, in whole or in part,

Amended as of September 17, 1997

upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 9(d)(iii)(a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Plan's license to use the Licensed Marks and Name is terminated pursuant to this Paragraph 9(d)(iii), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Plan demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(iv) The Plan shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities or (iii) such other securities as the Plan may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(v) For purposes of paragraph 9(d)(iii), the following definitions shall apply:

(a) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(b) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(i) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

Amended as of September 17, 1997

(ii) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(iii) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (b)(ii)(B) above) or disposing of any securities of the Plan.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Plan, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(c) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

(d) "Noninstitutional Investor" means any Person who is not an Institutional Investor.

(e) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

Amended as of September 17, 1997

10. This License Agreement shall remain in effect: (a) until terminated as provided herein; or (b) until this and all such other License Agreements are terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans; or (c) until termination of aforesaid Ownership Agreement; or (d) until terminated by the Plan upon eighteen (18) months written notice to BCBSA or upon a shorter notice period approved by BCBSA in writing at its sole discretion.

11. Except as otherwise provided in paragraph 15 below or by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans, or unless this and all such other License Agreements are simultaneously terminated by force of law, the termination of this License Agreement for any reason whatsoever shall cause the reversion to BCBSA of all rights in and to the Licensed Marks and Name, and the Plan agrees that it will promptly discontinue all use of the Licensed Marks and Name, will not use them thereafter, and will promptly, upon written notice from BCBSA, change its corporate name so as to eliminate the Licensed Name therefrom.

12. The license hereby granted to Plan to use the Licensed Marks and Name is and shall be personal to the Plan so licensed and shall not be assignable by any act of the Plan, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Plan mortgage or part with possession or control of this license or any right hereunder, and the Plan shall have no right to grant any sublicense to use the Licensed Marks and Name.

13. BCBSA shall maintain appropriate service mark registrations of the Licensed Marks and BCBSA shall take such lawful steps and proceedings as may be necessary or proper to prevent use of the Licensed Marks by any person who is not authorized to use the same. Any actions or proceedings undertaken by BCBSA under the provisions of this paragraph shall be at BCBSA's sole cost and expense. BCBSA shall have the sole right to determine whether or not any legal action shall be taken on account of unauthorized use of the Licensed Marks, such right not to be unreasonably exercised. The Plan shall report any unlawful usage of the Licensed Marks to BCBSA in writing and agrees, free of charge, to cooperate fully with BCBSA's program of enforcing and protecting the service mark rights, trade name rights and other rights in the Licensed Marks.

14. The Plan hereby agrees to save, defend, indemnify and hold BCBSA and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of the activities of the Plan or of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan. BCBSA hereby agrees to save, defend, indemnify and hold the Plan and any other Plan(s) harmless from and against all claims, damages, liabilities And costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of BCBSA.

Amended as of June 21, 2012

15. (a). This Agreement shall automatically terminate upon the occurrence of any of the following events: (i) a voluntary petition shall be filed by the Plan or by BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against the Plan or BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Plan or BCBSA respectively, or (iii) an order for relief is entered against the Plan or BCBSA in any case under the bankruptcy laws of the United States, or the Plan or BCBSA is adjudged bankrupt or insolvent (as that term is defined in the Uniform Commercial Code as enacted in the state of Illinois) by any court of competent jurisdiction, or (iv) the Plan or BCBSA makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of the Plan or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Plan or BCBSA respectively, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of the Plan's or BCBSA's property or business is appointed, or the Plan or BCBSA is ordered dissolved or liquidated, or (ix) the Plan shall fail to pay its dues and shall not cure such failure within thirty (30) days of receiving written notice thereof, or (x) if, due to regulatory action, the Plan together with any applicable Controlled Affiliate becomes unable to do business using the Names and Marks in any State or portion thereof included in its Service Area, provided that: (i) automatic termination shall not occur prior to the exhaustion by any such Plan of its rights to appeal or challenge such regulatory action; and (ii) in the event the Plan is licensed to do business using the Names and Marks in multiple States or portions of States, the termination of its License Agreement shall be solely limited to the State(s) or portions thereof in which the regulatory action applies. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Plan's or BCBSA's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 15(a)(vii) and (viii) of this Agreement.

Amended as of March 26, 2015

(b). BCBSA, or the Plans (as provided and in addition to the rights conferred in Paragraph 10(b) above), may terminate this Agreement immediately upon written notice upon the occurrence of either of the following events: (a) the Plan or BCBSA becomes insolvent (as that term is defined in the Uniform Commercial Code enacted in the state of Illinois), or (b) any final judgment against the Plan or BCBSA remains unsatisfied or unbonded of record for a period of sixty (60) days or longer.

(c). If this License Agreement is terminated as to BCBSA for any reason stated in subparagraphs 15(a) and (b) above, the ownership of the Licensed Marks shall revert to each of the Plans as provided in the Ownership Agreement.

(d). Upon termination of this License Agreement or any Controlled Affiliate License Agreement of a Larger Controlled Affiliate, as defined in Exhibit 1 to this License Agreement, the following conditions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 15 (a)(x)(ii) of this Agreement, the notices, national account listing, payment and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

- (i) The terminated entity shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the terminated entity or its Controlled Affiliates under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination or, if termination is pursuant to paragraph 10(d) of this Agreement, within 15 days after the written notice to BCBSA described in paragraph 10(d).
- (ii) The terminated entity shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the terminated entity is involved (in a Control, Participating or Servicing capacity), identifying the national account and the terminated entity's role therein. For those accounts where the terminated entity is the Control Plan, the Plan must also indicate the Participating and Servicing Plans in the national account syndicate.

Amended as of June 16, 2005

(iii) Unless the cause of termination is an event stated in paragraph

15(a) or (b) above respecting BCBSA, the Plan and its Licensed Controlled Affiliates shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. The Re-Establishment Fee shall be indexed to a base fee of \$80. The Re-Establishment Fee through December 31, 2005 shall be \$80. The Re-Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was \$278.60, \$285.00 and \$290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be \$83.27 (100% of the base fee plus \$1.84 for calendar year 2005 and \$1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (a) the end of the last fiscal year of the terminated entity which ended prior to termination or (b) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph (d)(iii) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Plan to fall below 100% of the Health Risk-Based Capital formula or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and

Amended as of June 16, 2005

three-fourths of the total then current weighted vote of all the Plans), measured as of the date of termination and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plan or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue;

provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Plan (and/or its Licensed Controlled Affiliates, as the case may be) for

payments made under this subparagraph only to the extent that such payments exceed the amounts due to BCBSA pursuant to subparagraph 15(d)(vi) and any costs associated with

reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the terminated entity.

(iv) The terminated entity shall comply with all financial settlement

procedures set forth in BCBSA's License Termination Contingency Plan, as amended from time to time and shall work diligently and in good faith with BCBSA, any Alternative Control Licensee or Replacement Licensee and any existing or potential new account for Blue-branded products and services to minimize the disruption of termination, and honor, to the fullest extent possible, the desire of accounts to continue to receive or obtain Blue-branded products and services through a new Licensee ("Transition"). Such diligence and good faith on the part of the terminated entity shall include, but not be limited to:

(a) working cooperatively with BCBSA to protect the Names and Marks from potential harm; (b) cooperating with BCBSA's use of the Names and Marks in the terminated entity's former service area during the termination and Transition; (c) transmitting, upon the request of an

Amended as of June 16, 2005

existing Blue account or of BCBSA with consent and on behalf of an existing Blue account, all member and account-data relating to the Federal Employee Program to BCBSA, and all member and account data relating to other programs to an Alternative Control Licensee or Replacement Licensee; (d) working with BCBSA and the Alternative Control or Replacement Licensee with respect to potential new Blue accounts headquartered in the terminated entity's former service area; (e) continuing to service Blue accounts during the Transition; (f) continuing to comply with National Programs, Federal Employee Program and NASCO policies and procedures and all voluntary BCBSA programs, policies and performance standards, such as Away From Home Care, including being responsible for payment of all penalties for non-compliance duly levied in conformity with the License Agreements, Membership Standards, or the Federal Employee Program agreements, that may arise during the Transition; (g) maintaining and providing access to its provider networks, as defined by Federal Employee Program agreements and National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and making those networks and discounts available to members and providers who participate in National Programs and the Federal Employee Program during the Transition; (h) maintaining its technical connections and processing capabilities during the Transition; and (i) working diligently to conclude all financial settlements and account reconciliations as negotiated in the termination transition agreement.

- (v) Notwithstanding any other provision in this Agreement, BCBSA shall have the right, with the approval of its Board of Directors, to assess additional fines against the terminated entity during the Transition in the event it fails to maintain and provide access to provider networks as defined by Federal Employee Program agreements, National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and/or pass on applicable discounts. Such fines shall be in addition to any other assessments, fees or liquidated damages payable herein, or under existing policies and programs and shall be imposed to make whole BCBSA and/or the Plans. Terminated entity shall pay any such fines to BCBSA no later than 30 days after they are approved by the Board of Directors.
- (vi) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third-party auditor to examine and audit the books and records of the terminated entity and its Licensed Controlled Affiliates to verify compliance with the terms and requirements this paragraph 15(d).

Amended as of November 16, 2006

- (vii) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.
- (viii) As to a breach of 15 (d) (i), (ii), (iii), (iv), (vi), or (vii) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 15 (d) (i), (ii), (iv), (vi), or (vii) by the Plan, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.
- (ix) In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Plan and its Licensed Controlled Affiliates shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.
- (e). BCBSA shall be entitled to enjoin the Plan or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this License Agreement unless the License Agreement has been terminated pursuant to paragraph 10 (d) of this Agreement upon the required six (6) month written notice.
- (f). BCBSA acknowledges that it is not the owner of assets of the Plan.

Amended as of June 16, 2005

16. This Agreement supersedes any and all other agreements between the parties with respect to the subject matter herein, and contains all of the covenants and agreements of the parties as to the licensing of the Licensed Marks and Name. This Agreement may be amended only by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

17. If any provision or any part of any provision of this Agreement is judicially declared unlawful, each and every other provision, or any part of any provision, shall continue in full force and effect notwithstanding such judicial declaration.

18. No waiver by BCBSA or the Plan of any breach or default in performance on the part of BCBSA or the Plan or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

19a. All notices provided for hereunder shall be in writing and shall be sent in duplicate by regular mail to BCBSA or the Plan at the address currently published for each by BCBSA and shall be marked respectively to the attention of the President and, if any, the General Counsel, of BCBSA or the Plan.

19b. Except as provided in paragraphs 9(b), 9(d)(iii), 15(a), and 15(b) above, this Agreement may be terminated for a breach only upon at least 30 days' written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Member Plans.

19c. For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2006

20. Nothing herein contained shall be construed to constitute the parties hereto as partners or joint venturers, or either as the agent of the other, and Plan shall have no right to bind or obligate BCBSA in any way, nor shall it represent that it has any right to do so. BCBSA shall have no liability to third parties with respect to any aspect of the business, activities, operations, products, or services of the Plan.

21. This Agreement shall be governed, construed and interpreted in accordance with the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By _____

Title _____

Date _____

PLAN:

By _____

Title _____

Date _____

**BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT**

(Includes revisions adopted by Member Plans through their September 18, 2015 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA")
and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan, known as
_____ ("Plan" or "Sponsoring Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non-health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the Sponsoring Plan's net subscription revenue.

This grant of rights is non-exclusive and is limited to the Service Area served by the Plan. Subject to paragraph 3A(3) of this Agreement, Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market, unless such Controlled Affiliate is a not-for-profit company which may use the Licensed Marks and Name, or an approved derivative therefor, to identify itself in debt securities markets. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

Amended as of March 26, 2015

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that the Sponsoring Plan has:

(1) The legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and

(c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

Amended as of September 19, 2014

- (iii) change any of the type(s) of businesses in which it engages;
- (iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;
- (v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;
- (vi) make any loans or advances except in the ordinary course of business;
- (vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);
- (viii) conduct any business other than under the Licensed Marks and Name;
- (ix) take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

- (2) the legal authority directly or indirectly through wholly-owned subsidiaries:
 - (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:

Amended as of March 26, 2015

- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and
- (c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

(3) With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid products and services, the legal authority together with such other Plans:

- (a) to select all members of the Controlled Affiliate's governing body; and
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and
- (c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate with the Sponsoring Plan and such other Plans each having an ownership interest. Such control and ownership by Plans must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License Agreement attached hereto as Exhibit B-1.

Or

(4) With respect to a Controlled Affiliate that is 100% controlled by a Sponsoring Plan which on a Blue-branded basis offers solely a Basic Medicare Part D Prescription Drug product, the legal authority:

- (a) to select all members of the Controlled Affiliate's governing body; and
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and
- (c) to exercise control over the policy and operations of the Controlled Affiliate.

Amended March 17, 2016

In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by Sponsoring Plan must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Participating Plan as defined in Exhibit B-2 and the Sponsoring Plan shall execute the Addendum to Controlled Affiliate License Agreement attached hereto as Exhibit B-2.

3. FOR-PROFIT, PUBLICLY TRADED LICENSEES

A. The Controlled Affiliate may operate as a for-profit publicly traded company on the following conditions:

- (1) The Controlled Affiliate shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement.
 - (2) The Controlled Affiliate shall provide 90 days advance written notice to BCBSA prior to the initial filing with the SEC.
-

(3) The Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Controlled Affiliate in any securities market. The Controlled Affiliate shall use the Licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(4) The Controlled Affiliate's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Controlled Affiliate ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Noninstitutional Investor, other than a Plan or Plans or Controlled Affiliate Licensee or Licensees has become the Beneficial Owner of securities representing 5% or more of the voting power of the Controlled Affiliate ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner, other than a Plan or Plans or Controlled Affiliate Licensee or Licensees, of 20% or more of the Controlled Affiliate's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 3A(4) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Controlled Affiliate went public constituted the Board of Directors of the Controlled Affiliate (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Controlled Affiliate went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Controlled Affiliate consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Sponsoring Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Controlled Affiliate in a writing received by BCBSA prior to such automatic termination becoming effective, the provisions of this paragraph 3A(4) may be waived, in whole or in part, upon the affirmative vote of a majority of the disinterested Plans and majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by

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the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 3A(4) (a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Controlled Affiliate's license, or any other license, to use the Licensed Marks and Name is terminated pursuant to Paragraph 3A(4), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Controlled Affiliate demonstrates that the Person referred to in clause (a), (b), or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(5) The Controlled Affiliate shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities or (iii) such other securities as the Controlled Affiliate may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(6) For purposes of paragraph 3A(4) above, the following definitions shall apply:

(i) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(ii) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(1) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

(2) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to

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beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(3) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (ii)2(B) above) or disposing of any securities of the Controlled Affiliate.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Controlled Affiliate, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(iii) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

(iv) "Noninstitutional Investor" means any Person who is not an Institutional Investor.

(v) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

4. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

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B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this Agreement, Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name.

5. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

6. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

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7. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to: (i) Controlled Affiliate's rendering of services under the Licensed Marks and Name; or (ii) the activities of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan or Controlled Affiliate.

8. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) the Plan ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement the Plan ceases to be authorized to use the Licensed Names and Marks in the geographic area served by the Controlled Affiliate provided, however, that if the Controlled Affiliate is serving more than one State or portions thereof, the termination of this Agreement shall be limited to the State(s) or portions thereof in which the Plan's license to use the Licensed Marks and Names is terminated. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless

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this Controlled Affiliate License Agreement has been earlier terminated under paragraph 8(E); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 8(B), 8(C) or 8(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 8(B), 8(C) or 8(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 8(B) and 8(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Controlled Affiliate shall no longer comply with item 2(E) above;
- (2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 10 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or
- (3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled

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Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 8(E)(3)(vii) and (viii) of this Agreement.

(4) The for-profit, publicly traded Controlled Affiliate is terminated pursuant to Paragraph 3A(4) of this Agreement. In which case, the licenses of any Controlled Affiliates directly or indirectly owned by the terminated for-profit, publicly traded Controlled Affiliate also shall immediately terminate as provided for in paragraph 3A(4) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

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G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 8(B) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 8.G. shall not apply and the following provisions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 8(B)(ii) of this Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated.

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area.

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The Re-Establishment Fee shall be indexed to a base fee of \$80. The Re-Establishment Fee through December 31, 2005 shall be \$80. The Re-establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was \$278.60, \$285.00 and \$290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be \$83.27 (100% of base fee plus \$1.84 for calendar year 2005 and \$1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Plan or its other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 8.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 8.M. and any costs associated with reestablishing the Service Area, including payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the Controlled Affiliate.

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(4) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third party auditor to examine and audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 8.H.

(5) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

(6) As to a breach of 8.H.(1), (2), (3), (4) or (5) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 8.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. This Agreement shall remain in effect until terminated by the Controlled Affiliate or the Plan upon not less than eighteen (18) months written notice to the Association or upon a shorter notice period approved by BCBSA in writing at its sole discretion, or until terminated as otherwise provided herein. The Plan's right to terminate without cause upon such notice is unfettered and may be exercised in the Plan's sole discretion.

J. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3. and M. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

K. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of the Plan's license agreement upon the required 18 months written notice.

L. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

M. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E) (2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 8(C) and 8(D) above shall require the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

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N. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

9. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

10. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit C.

11. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

12. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

13. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

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14. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

15. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question.

Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

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16. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

17. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: __

Date: __

Plan:

By: __

Date: __

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: __

Date: __

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EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS November 2016

PREAMBLE

For purposes of definition:

- A "smaller Controlled Affiliate:" (1) comprises less than fifteen percent (15%) of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers' compensation insurance and has total premium revenue less than 15 percent of the Sponsoring Plan's net subscription revenue.
- A "larger Controlled Affiliate" comprises fifteen percent (15%) or more of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate's status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate's health and workers' compensation administration business reaches or surpasses fifteen percent (15%) of the total member enrollment of the Sponsoring Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

Amended as of September 19, 2014

EXHIBIT A (continued)

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA "Health Risk-Based Capital (HRBC)" as defined by the NAIC and state-established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and
2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers' compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

*For purposes of this calculation, The numerator equals:

Applicant Controlled Affiliate's member enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Sponsoring Plan and all other licensed Controlled Affiliates' member enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

Amended as of September 19, 2002

EXHIBIT A (continued)

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

Each licensed controlled affiliate shall be subject to certain standards as determined below:

1. What percent of the licensed controlled affiliate is controlled by the Sponsoring Plan and other Plans?

More than 50% by Sponsoring Plan ↓ Standard 1A, 4	50% by Sponsoring Plan ↓ Standard 1B, 4	100% Plan Control but less than 50% Sponsoring Plan Control and it offers solely Medicaid products and services ↓ Standard 1C, 4	100% Sponsoring Plan control and on a Blue-branded basis, it only offers a Basic Medicare Part D Prescription Drug Plan product ↓ Standard 1D, 4
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IN ADDITION,

2. Is risk being assumed?

Yes			No	
Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance ↓ Standards 7A-7E, 11	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance ↓ Standard 2 (Guidelines 1.1,1.2) and Standard 11	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance ↓ Standard 6H	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates ↓ Standard 2 (Guidelines 1.1,1.3) and Standard 11	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates ↓ Standard 6H

IN ADDITION,

3. Is medical care being directly provided?

Yes ↓ Standard 3A	No ↓ Standard 3B
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IN ADDITION,

4. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total member enrollment of Plan and its licensed Controlled Affiliates?

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

EXHIBIT A (continued)

Standard 1 - Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA, has the legal authority, directly or indirectly through wholly-owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate.

1B.) The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA, has the legal authority, directly or indirectly through wholly-owned subsidiaries:

- 1) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and
- 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and
- 3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan.

Amended as of March 17, 2016

EXHIBIT A (continued)

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by Sponsoring Plan before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate.

Amended September 19, 2014

1C.) The Standard for a Controlled Affiliate that offers solely Medicaid products and service and has 100% Plan control but less than 50% Sponsoring Plan Control:

A Controlled Affiliate shall be organized and operated in such a manner that (i) it offers solely Medicaid products and services; and (ii) a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA (the “Sponsoring Plan,) has the legal authority together with Other Plans:

- 1) to select all members of the Controlled Affiliate’s governing body; and
- 2) to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; and
- 3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License.

1D.) The Standard for a Controlled Affiliate that on a Blue-branded basis, only offers a Basic Medicare Part D Prescription Drug product and has 100% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that (i) it offers solely a Basic Medicare PDP product; and (ii) the Sponsoring Plan has the legal authority:

- 1) to select all members of the Controlled Affiliate's governing body; and
- 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and
- 3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by Sponsoring Plan must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA.

Further, the Sponsoring Plan and Participating Plan shall execute the Addendum to Controlled Affiliate License.

Amended March 17, 2016

EXHIBIT A (continued)

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk-assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk-assuming Controlled Affiliate ceases operations for any reason, Sponsoring Plan will provide for services to its customers. The requirements of the preceding two sentences shall apply to all lines of business unless a line of business is specially exempted from the requirement(s) by the BCBSA Board of Directors.

Standard 3 - State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Amended as of September 19, 2014

EXHIBIT A (continued)

Standard 5 - Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its Sponsoring licensed Plan shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Other Standards for Larger Controlled Affiliates Standards 6(A) - (I) that follow apply to larger Controlled

Affiliates. Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost-effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Amended as of September 19, 2014

EXHIBIT A (continued)

Such programs are applicable to licensees, and include:

1. BlueCard Program;
2. Inter-Plan Teleprocessing System (ITS);
3. National Account Programs;
4. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
5. Inter-Plan Medicare Advantage Program. Standard Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter-licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Local and National Best Efforts

Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this License Agreement, during each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross Mark.

Amended as of November 21, 2014

EXHIBIT A (continued)

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

- A) BCBSA Controlled Affiliate Licensure Information Request; and
- B) Triennial trade name and service mark usage material, including disclosure material; and
- C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and
- D) Semi-annual "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

Amended as of November 17, 2011

EXHIBIT A (continued)

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 - Other Standards for Risk-Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) - (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

- A. BCBSA Controlled Affiliate Licensure Information Request; and
- B. Triennial trade name and service mark usage materials, including disclosure materials; and
- C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk-Based Capital Worksheets for Property and Casualty Insurers; and
- D. Quarterly Estimated Risk-Based Capital for Property and Casualty Insurers, Insurance Department Examination Report; and

Amended as of November 17, 2011

EXHIBIT A (continued)

- E. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and
- F. Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended as of November 16, 2000

EXHIBIT A (continued)

Standard 8 - Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

A smaller controlled affiliate that formerly was a Primary Licensee shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of November 21, 2014

EXHIBIT A (continued)

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

C. Reporting requirements include:

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

Amended as of June 13, 2002

EXHIBIT A (continued)

Standard 9(B) - Participation in National Programs by Smaller Controlled Affiliates

A smaller controlled affiliate shall participate in national programs in accordance with BlueCard and other relevant Policies and Provisions shall effectively and efficiently participate in national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of June 20, 2013

EXHIBIT A (continued)

Standard 10 - Participation in Inter-Plan Medicare Advantage Program

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

- A. Inter-Plan Medicare Advantage Program.

Standard 11: Participation in Master Business Associate Agreement by Smaller Controlled Affiliate Licensees

Effective April 14, 2003, all smaller controlled affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of September 19, 2014

EXHIBIT B-1

**ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES
LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1C.**

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Cross Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association
("Licensor"), _____ ("Controlled Affiliate Licensee")
and _____ ("Sponsoring Plan")
dated the ____ day of _____, ____ ("Agreement"). The parties to
this Addendum are Licensor, Controlled Affiliate Licensee, Sponsoring Plan, and the undersigned other Plans ("Other Plans"). This
Addendum is made and shall be deemed effective as of the date of the Agreement.

WHEREAS, the Sponsoring Plan asserts that it can serve the Medicaid market in its Service Area more efficiently and with less risk
through a Medicaid enterprise jointly owned and controlled with other Plans than through a wholly owned and controlled Medicaid
enterprise;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1C. permits the licensing of a Controlled Affiliate that is less
than 50% owned and controlled by the Sponsoring Plan but which is 100% owned and controlled by Plans including the Sponsoring
Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan and all such other owning and controlling Plans enter into this Addendum;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as
follows:

1. The Sponsoring Plan shall participate operationally in Controlled Affiliate's business that is conducted under the Licensed
Marks. The parties understand that participation may take many forms, one of which should be providing a network of
providers in the Service Area of the Controlled Affiliate for the Medicaid services being offered under the Agreement and
being involved in network development and provider relations.
2. Each of the Other Plans agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable
Sponsoring Plan and

Amended March 17, 2016

Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it will not take any action, either individually or jointly with any of the Other Plans, that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with any of the Other Plans, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

3. Each of the Other Plans acknowledges that it has reviewed the Agreement and understands that Sponsoring Plan has the right to terminate the Agreement without cause upon notice as provided in Paragraph 8 of the Agreement, and that such right is unfettered and may be exercised by Sponsoring Plan in its sole discretion.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By:___

[Controlled Affiliate Licensee]

By:___

[Sponsoring Plan]

By:___

[Other Plan 1]

By:___

[Other Plan 2]

By:___

Amended March 17, 2016

EXHIBIT B-2

**ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES
LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1D.**

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Cross Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association ("Licensor"), _____ ("Controlled Affiliate Licensee"),
_____, _____ ("Sponsoring Plan") and
_____, _____ ("Participating Plan") dated the _____ day of
_____, _____ ("Agreement").

WHEREAS, the Participating Plan is defined as the Plan that holds the Primary License with BCBSA to use the Service Marks in the Service Area where the Controlled Affiliate will use the Service Marks;

WHEREAS, the Participating Plan asserts that it can offer a lower cost Basic Medicare Part D Prescription Drug Plan product more efficiently in the Participating Plan's Service Area through the Controlled Affiliate Licensee;

WHEREAS, the Controlled Affiliate shall only use the Service Marks inside of the Participating Plan(s) Service Area subject to each Participating Plan signing a separate Addendum;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1D permits the licensing of a Controlled Affiliate that is 100% owned and controlled by a Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan, Controlled Affiliate and the Participating Plan enter into this Addendum;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. The Participating Plan shall participate in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that the Participating Plan shall conduct sales support and marketing of the Controlled Affiliate's Basic Medicare Part D Prescription Drug Plan product offered in the Participating Plan's Service Area. Any other form of participation shall require BCBSA's written approval.
2. Participating Plan agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it will not take any

action that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with the Sponsoring Plan or Controlled Affiliate Licensee, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

3. The Controlled Affiliate Licensee shall only use the Licensed Marks authorized by the Participating Plan in connection with the Basic Medicare Part D Prescription Drug Plan product offered in the Participating Plan's Service Area.
4. The Sponsoring Plan and Controlled Affiliate acknowledge that it has reviewed the Agreement and understands that Participating Plan has the right to terminate this Agreement: (i) immediately upon the expiration or termination of the Plan Participation Agreement by and between Participating Plan and Controlled Affiliate upon written notice to the Sponsoring Plan, Controlled Affiliate Licensee and Licensor, or (ii) without cause upon 18 months written notice to the Sponsoring Plan, Controlled Affiliate Licensee and Licensor, and that such right is unfettered and may be exercised by Participating Plan in its sole discretion. In the event that Participating Plan and Controlled Affiliate fail to execute the Plan Participation Agreement by _____ (Date), Participating Plan may terminate this Agreement immediately upon notice to Sponsoring Plan, Controlled Affiliate Licensee and Licensor.
5. This Agreement and all of Controlled Affiliate Licensee's rights hereunder shall immediately terminate without any further action by any party or entity in the event that the Sponsoring Plan or Participating Plan ceases to be authorized to use the Licensed Marks and Name.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By:___

[Controlled Affiliate Licensee]

By:___

[Sponsoring Plan]

By:___

[Participating Plan]

By:___

Amended March 17, 2016

EXHIBIT C

ROYALTY FORMULA FOR SECTION 9 OF THE CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of \$5,000 per license for a Controlled Affiliate subject to Standard 7.

Amended as of September 19, 2014

EXHIBIT C (continued)

FOR NONRISK PRODUCTS:

For third-party administrative business, an amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For non-third party administrative business (e.g., case management, provider networks, etc.), an amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

- 1) An annual fee of \$5,000 per license for a Controlled Affiliate subject to Standard 6 D.
- 2) An annual fee of \$2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Amended as of September 19, 2014

CONTROLLED AFFILIATE LICENSE AGREEMENT APPLICABLE TO LIFE INSURANCE COMPANIES

(Includes revisions adopted by Member Plans through their November 18, 2016 meeting)

This agreement by and among Blue Cross and Blue Shield Association

("BCBSA") _____ ("Controlled Affiliate"), a
Controlled Affiliate of the Blue Cross Plan(s), known as
_____ ("Plan").

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, the Plan and the Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Controlled Affiliate the exclusive right to use the licensed Marks and Names in connection with and only in connection with those life insurance and related services authorized by applicable state law, other than health care plans and related services (as defined in the Plan's License Agreements with BCBSA) which services are not separately licensed to Controlled Affiliate by BCBSA, in the Service Area served by the Plan, except that BCBSA reserves the right to use the Licensed Marks and Name in said Service Area, and except to the extent that said Service Area may overlap the area or areas served by one or more other licensed Blue Cross Plans as of the date of this License as to which overlapping areas the rights hereby granted are non-exclusive as to such other Plan or Plans and their respective Licensed Controlled Affiliates only. Controlled Affiliate cannot use the Licensed Marks or Name outside the Service Area or in its legal or trade name; provided, however, that if and only for so long as Controlled Affiliate also holds a Blue Cross Controlled Affiliate License Agreement applicable to health care plans and related services, Controlled Affiliate may use the Licensed Marks and Name in its legal and trade name according to the terms of such license agreement.

Amended as of June 12, 2003

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in relation to the sale, marketing and rendering of authorized products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A as it may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having not less than 51% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Plan or Plans shall own at least 51% of any for-profit Controlled Affiliate. If the Controlled Affiliate is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items (a) and (c) above, proxies representing 51% of the votes at any meeting of the policyholders and shall demonstrate that there is no reason to believe this such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

3. SERVICE MARK USE

Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks, and shall comply with such rules (applicable to all Controlled Affiliates licensed to use the Marks) relative to service mark use, as are issued from time-to-time by BCBSA. If there is any public reference to the affiliation between the Plan and the Controlled Affiliate, all of the Controlled Affiliate's licensed services in the Service Area of the Plan shall be rendered under the Licensed Marks. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENTS

Controlled Affiliate shall promptly notify Plan and BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate hereby agrees to save, defend, indemnify and hold Plan and BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Controlled Affiliate's rendering of health care services under the Licensed Marks.

7. LICENSE TERM

The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods upon evidence satisfactory to the Plan and BCBSA that Controlled Affiliate meets the then applicable quality control standards, unless one of the parties hereto notifies the other party of the termination hereof at least sixty (60) days prior to expiration of any license period.

This Agreement may be terminated by the Plan or by BCBSA for cause at any time provided that Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Controlled Affiliate's failure to abide by the quality control provisions of Paragraph 2, above, shall be considered a proper ground for cancellation of this Agreement.

This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

A. Controlled Affiliate shall no longer comply with Standard No. 1 (Organization and Governance) of Exhibit A or, following an opportunity to cure, with the remaining quality control provisions of Exhibit A, as it may be amended from time-to-time; or

B. Plan ceases to be authorized to use the Licensed Marks; or

C. Appropriate dues for Controlled Affiliate pursuant to item 8 hereof, which are the royalties for this License Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks including any use in its trade name.

In the event of any disagreement between Plan and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of the Blue Cross and Blue Shield Association and provide instruction on how the customer can contact the Blue Cross and Blue Shield Association or a designated licensee to obtain further information on securing coverage. The written notification required by this paragraph shall be in writing and in a form approved by the Association. The Association shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. DUES

Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars (\$5,000) per license, plus
- .05% of gross revenue per year from branded group products, plus
- .5% of gross revenue per year from branded individual products plus
- .14% of gross revenue per year from branded individual annuity products.

The foregoing percentages shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® license are issued to the same entity. In the event that any License period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Plan will promptly and timely transmit to BCBSA all dues owed by Controlled Affiliate as determined by the above formula and if Plan shall fail to do so, Controlled Affiliate shall pay such dues directly.

Amended as of November 20, 1997

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

9A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

10. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

Amended as of June 16, 2005

11. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by a writing executed by all parties.

12. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way effect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

13. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: __

Date: __

Controlled Affiliate:

By: __

Date: __

Plan:

By: __

Date: __

EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES
Page 1 of 2

PREAMBLE

The standards for licensing Life Insurance Companies (Life and Health Insurance companies, as defined by state statute) are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote of all Plans. Each Licensed Plan is required to use a standard controlled affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Life Insurance Company maintains compliance with the license standards.

An organization meeting the following standards shall be eligible for a license to use the Licensed Marks within the service area of its sponsoring Licensed Plan to the extent and the manner authorized under the Controlled Affiliate License applicable to Life Insurance Companies and the principal license to the Plan.

Standard 1 - Organization and Governance

The LIC shall be organized and operated in such a manner that it is controlled by a licensed Plan or Plans which have, directly or indirectly: 1) not less than 51% of the voting control of the LIC; and 2) the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the LIC with which it does not concur; and 3) operational control of the LIC.

If the LIC is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items 1 and 2 above, proxies representing at least 51% of the votes at any policyholder meeting and shall demonstrate that there is no reason to believe such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

Standard 2 - State Licensure

The LIC must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life and health insurance company in each state in which the LIC does business.

EXHIBIT A

**CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES**

Page 2 of 2

Standard 3 - Records and Examination

The LIC and its sponsoring licensed Plan(s) shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the LIC as may be required in order to establish compliance with the license agreement. The LIC and its sponsoring licensed Plan(s) shall permit BCBSA to examine the affairs of the LIC and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the sponsoring Plan(s).

Standard 4 - Mediation

The LIC and its sponsoring Plan(s) shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed controlled affiliate, a licensed Plan or BCBSA.

Standard 5 - Financial Responsibility

The LIC shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with Affiliate License Performance Response Process Protocol

The LIC and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing LIC compliance problems identified thereunder.

**CONTROLLED AFFILIATE
TRADEMARK LICENSE AGREEMENT
FOR LIFE AND DISABILITY INSURANCE PRODUCTS**

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____, ("Life and Disability Controlled Affiliate") which is a company offering life and disability insurance products owned and controlled by _____, _____, _____ (individually, "Sponsoring Plan" and when referred to collectively, "Sponsoring Plans").

Whereas, BCBSA is the owner of the BLUE CROSS and BLUE SHIELD word and design service marks and any derivatives thereof ("Licensed Marks");

Whereas, each Sponsoring Plan is licensed separately by BCBSA to use one or more of the Licensed Marks in a particular Service Area;

Whereas, the Sponsoring Plans and the Life and Disability Controlled Affiliate desire that the latter be entitled to use the appropriate Licensed Marks in connection with life and disability insurance products in some or all of such Sponsoring Plans' Service Areas and in the Service Areas of other Regular Member Plans, as defined in the BCBSA By-laws, ("Blue Plans") consistent with the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

A. Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Life and Disability Controlled Affiliate the limited right to use the Licensed Marks in connection with and only in connection with the following life and disability insurance products authorized by state law: (1) Group: Term Life, Long Term Disability, Whole Life, Benefit Life, Universal Life; (2) Individual: Term Life, Whole Life, Dependent Life, Spouse Life; (3)

Other: Disability Income, Short Term Disability, Long Term Disability, Income Replacement; and (4) such other life and disability products approved by BCBSA in writing ("Licensed Products") in the Service Areas served by the Sponsoring Plans or in the Service Area or Areas of one or more other licensed Blue Plans, provided that such Blue Plans have consented to such use as authorized by this Agreement. Life and Disability Controlled Affiliate may not use the Licensed Marks in its legal or trade name.

B. Notwithstanding that the license granted to Life and Disability Controlled Affiliate is a license to use all of the Licensed Marks, Life and Disability Controlled Affiliate may only use those of the Licensed Marks in

the Service Area of a Sponsoring Plan or other consenting Blue Plan as described below that such Plan is authorized to use as a Blue Plan pursuant to its separate license agreements with BCBSA.

C. Life and Disability Controlled Affiliate may use the Licensed Marks in the Service Areas of Sponsoring Plans or in the Service Area of a Blue Plan that is not a signatory to this Agreement only after such Sponsoring Plan(s) or non-signatory Blue Plan consents to such use by executing a written consent in substantially the same form as the Consent Agreement attached as Exhibit B.

D. The following provisions apply with respect to Consent Agreements once such agreements have been fully and properly executed:

(1) All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in the Service Area of Sponsoring Plan or consenting Blue Plan (hereinafter, such consenting Sponsoring Plan or consenting Blue Plan collectively referred to "Consenting Plan(s)") must clearly identify the Consenting Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");

(2) To the extent the Consenting Plan has separate divisions or other Affiliates that use the Licensed Marks in distinct geographic areas within its Service Area, consent obtained under this Agreement may be limited to one or more of such specific geographic areas as specified by the Consenting Plan in its signed Consent Agreement. For purposes of this entire Agreement, all references to the Service Area of a Sponsoring Plan, Blue Plan or Consenting Plan may include the entire Service Area or a distinct geographic area within such Service Area as specified in this Section 1 D (2);

(3) Where BCBSA has licensed two or more Blue Plans to use the same Licensed Marks in the same Service Area, in addition to the requirements set forth in Section D (1) above, the sales, marketing and advertising materials referenced in such section above must be communicated to the Consenting Plan's existing and prospective accounts through or with the approval of such Consenting Plan, and the personnel of such Consenting Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the Consenting Plan;

(4) Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the Consenting Plan has been granted by BCBSA the license to use under its Blue Plan license

(5) agreements (for example, if a Consenting Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

(6) If a Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless BCBSA and the Consenting Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

2. QUALITY CONTROL

A. Life and Disability Controlled Affiliate agrees to use the Licensed Marks only in relation to the sale, marketing and administration of the Licensed Products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A and the Guidelines to Administer the Standards for Trademark License Agreement for Life and Disability Insurance Products attached thereto.

B. Life and Disability Controlled Affiliate agrees that BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Life and Disability Controlled Affiliate's rendering of service and use of the Licensed Marks.

C. Life and Disability Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by BCBSA) a report to BCBSA demonstrating Life and Disability Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Life and Disability Controlled Affiliate is defined as: An entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

3. SERVICE MARK USE

Life and Disability Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and shall ensure all uses of the Licensed Marks comply with the BCBSA Brand Regulations, as amended by BCBSA from time to time. Life and Disability Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Life and Disability Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

The license hereby granted to Life and Disability Controlled Affiliate to use the Licensed Marks is and shall be personal to Life and Disability Controlled Affiliate and shall not be assignable by any act of the Life and Disability Controlled Affiliate, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Life and Disability Controlled Affiliate mortgage or part with possession or control of this license or any right hereunder, and the Life and Disability Controlled Affiliate shall have no right to grant any sublicense to use the Licensed Marks.

5. INFRINGEMENTS

Life and Disability Controlled Affiliate shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Life and Disability Controlled Affiliate shall not be entitled to require BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Life and Disability Controlled Affiliate agrees to render to BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA. BCBSA shall have sole control of the defense and resolution of any claim of infringement brought or threatened by others.

6. LIABILITY INDEMNIFICATION

Life and Disability Controlled Affiliate hereby agrees to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Life and Disability Controlled Affiliate's conduct.

7. LICENSE TERM

A. The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods, unless either BCBSA or Life and Disability Controlled Affiliate notifies the other party in writing of the termination hereof at least sixty (60) days prior to expiration of any license period.

B. This Agreement may be terminated by BCBSA for cause at any time provided that Life and Disability Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Life and Disability Controlled Affiliate's failure to abide by the conditions regarding use of the Licensed Marks set forth in Section 1 of this Agreement or the quality control provisions of Section 2 (other than with respect to Section 2 D which is subject to immediate termination as stated in Section 7 C (1) below) shall be considered proper grounds for termination of this Agreement.

C. This Agreement and all of Life and Disability Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Life and Disability Controlled Affiliate shall no longer comply with Section 2 D (or Standard No. 1 (Organization and Governance) of Exhibit A); or
- (2) Any Sponsoring Plan ceases to be authorized to use the Licensed Marks; or
- (3) Appropriate fees for Life and Disability Controlled Affiliate pursuant to Section 8 of this Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Life and Disability Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks.

In the event of any disagreement between Life and Disability Controlled Affiliate and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Life and Disability Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. ROYALTIES

Life and Disability Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars (\$5,000) per license, plus
- .05% of gross revenue per year from group products sold under the Licensed Marks, plus
- .5% of gross revenue per year from individual products sold under the Licensed Marks

In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Life and Disability Controlled Affiliate will promptly and timely transmit to BCBSA all fees owed by Life and Disability Controlled Affiliate as determined by the above formula.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between any Sponsoring Plan and Life and Disability Controlled Affiliate or between among them and/or BCBSA.

10. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by: (a) a writing signed by all parties; or (b) a writing approved by the affirmative vote of three-fourths of the Blue Plans and three-fourths of the total then current weighted vote of all the Blue Plans as officially recorded by the BCBSA Corporate Secretary. Upon such adoption by the Blue Plans, this Agreement and all other Trademark License Agreements for Life and Disability Insurance Products then in effect shall simultaneously be amended.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Life and Disability Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: __

Date: __

Life and Disability Controlled Affiliate:

By: __

Date: __

Sponsoring Plan:

By: __

Date: __

Name: _____

Sponsoring Plan:

By: __

Date: __

Name: _____

[Add other Sponsoring Plans as necessary]

EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS Page 1 of 2

Standard 1 - Organization and Governance

Any Life and Disability Controlled Affiliate licensed under the Trademark License Agreement for Life and Disability Insurance Products ("licensee") shall be organized and operated in such a manner that it is an entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

Standard 2 - State Licensure

The licensee must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life company in each state in which the licensee does business.

Standard 3 - Records and Examination

The licensee shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the licensee as may be required in order to establish compliance with the Agreement. The licensee shall permit BCBSA to examine the affairs of the licensee and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the Sponsoring Plan(s).

Standard 4 - Mediation

The licensee, its Sponsoring Plan(s) and all consenting Blue Plans shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed Life and Disability Controlled Affiliate, a Sponsoring Plan and or consenting Blue Plan or BCBSA.

EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS Page 2 of 2

Standard 5 - Financial Responsibility

The licensee shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with BCBSA Governance

The licensee shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of and in addressing licensee compliance problems that may be identified in connection with the operation or administration of the Trademark License Agreement for Life and Disability Insurance Products.

EXHIBIT B

CONSENT AGREEMENT

This Consent Agreement is made and entered into by and among the undersigned Blue Plan, and _____ (“Life and Disability Controlled Affiliate”), and the Blue Cross and Blue Shield Association (“BCBSA”) and shall be deemed effective on _____ (“Effective Date”).

Whereas, BCBSA owns the Blue Cross and Blue Shield word and design service marks and any derivative mark thereof (the “Brands”);

Whereas, the undersigned Blue Plan is licensed to use one or more of the Brands within a specific geographic area (“Service Area”);

Whereas Life and Disability Controlled Affiliate is licensed by BCBSA to use one or more of the Brands to offer life and disability insurance products (“Products”) as defined and authorized in the Trademark License Agreement for Life and Disability Insurance Products (“Life and Disability License Agreement”);

Whereas neither the Blue Plan nor its affiliates offer the Products under any of the Brands in such Blue Plan’s Service Area or portion thereof where Blue Plan has consented to sale of the Products by Life and Disability Controlled Affiliate; and

Whereas BCBSA and the undersigned Blue Plan desire to consent to Life and Disability Controlled Affiliate’s use of the Brands in Blue Plan’s Service Area consistent with the terms of the Life and Disability License Agreement and this Consent Agreement.

Now, therefore, in consideration of the obligations and conditions stated in this Agreement, Blue Plan, Life and Disability Controlled Affiliate and BCBSA agree as follows:

1. Life and Disability Controlled Affiliate may market, sell, administer and underwrite the Products in Blue Plan’s Service Area under the Brands licensed to Blue Plan in such Service Area subject to the terms of this Consent Agreement, the Life and Disability License Agreement and Blue Plan’s license agreement(s) with BCBSA. Life and Disability Controlled Affiliate’s rights under the Brands to offer the Products under the Brands are limited to offering the Products only under the Brand(s) licensed to the consenting Blue Plan.
 2. Life and Disability Controlled Affiliate shall work with the undersigned Blue Plan to develop a written sales and marketing agreement that identifies the relationship between it and Blue Plan for the sales, marketing and customer service for the Products. The term of the sales and marketing agreement shall be the same as the term of this Consent Agreement.
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3. All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in a consenting Blue Plan's Service Area must clearly identify the consenting Blue Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");
 4. Life and Disability Controlled Affiliate may use the Brands to sell the Products in the following Service Area or portion thereof as designated by Blue Plan:

 5. If two or more Blue Plans to use the same Licensed Marks in the same Service Area, Life and Disability Controlled Affiliate shall work with the consenting Blue Plan in the following manner: (a) the sales, marketing and advertising materials must be communicated to the consenting Blue Plan's existing and prospective accounts through or with the approval of such Blue Plan, and (b) the personnel of such Blue Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the consenting Blue Plan;
 6. Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the consenting Blue Plan has been granted by BCBSA the license to use under its license agreement (for example, if a consenting Blue Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).
 7. If this Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless each BCBSA and the Blue Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.
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8. The term of this Consent Agreement shall be one year from the Effective Date. Unless either Blue Plan or Life and Disability Controlled Affiliate provides the other party with written notice of its desire not to renew this Consent Agreement at least 60 days prior to expiration of the term or any extended term or unless terminated as provided in Paragraph 9 below, this Consent Agreement shall automatically renew for subsequent one year periods.
9. This Consent Agreement may be terminated as follows:
- A. Upon mutual written consent of Life and Disability Controlled Affiliate and Blue Plan;
 - B. By Blue Plan or Life and Disability Controlled Affiliate upon 60 days advance written notice to the non-terminating party and BCBSA; or
 - C. By Blue Plan immediately if Life and Disability Controlled Affiliate does not comply with this Consent Agreement or the sales protocol agreement.
10. This Consent Agreement shall automatically terminate if Blue Plan's primary licensee agreement terminates for any reason or if the Life and Disability License Agreement terminates for any reason.

Agreed and Accepted by:

[Blue Plan]:

By: ____
Title: ____

BLUE CROSS AND BLUE SHIELD ASSOCIATION:

By: ____
Title: ____

LIFE AND DISABILITY CONTROLLED AFFILIATE:

By: ____
Title: ____

BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS
(Adopted by Member Plans at their November 18, 2016 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Advantage PPO products in geographic regions designated by CMS (hereafter "regional MAPPO products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name") to offer regional MAPPO products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional MAPPO products and related services.

This grant of rights is non-exclusive and is limited to the following states:

_____ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

- A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.
- B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.
- C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.
- D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.
- E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:
- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
 - (2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
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(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

- (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
- (c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
 - (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
 - (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
 - (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.
-

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional MAPPO products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this

Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x) (ii) of the Blue Cross License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to \$25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and

any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last

known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: __

Date: __

Controlling Plan:

By: __

Date: __

Controlling Plan:

By: __

Date: __

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: __

Date: __

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS

November 2016

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Advantage PPO Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
 - (2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
 - (3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:
 - (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
 - (b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
 - (c) exercise control over the policy and operations of the Controlled Affiliate; and
-

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

- a. the structure of the Blue Cross and Blue Shield System; and
- b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross Marks.

Standard 7 - Participation in Certain National Programs

A Controlled Affiliate shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area.

National program requirements include:

- a. Inter-Plan Teleprocessing System (ITS); and
- b. Inter-Plan Medicare Advantage Program.

Standard 8 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of November 15, 2007

EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional MAPPO products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN
PRODUCTS
(Adopted by Member Plans at their November 18, 2016 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Part D Prescription Drug Plan products in geographic regions designated by CMS (hereafter "regional PDP products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name") to offer regional PDP products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional PDP products and related services.

This grant of rights is non-exclusive and is limited to the following states:

_____ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing Body having not less than 100% voting control thereof;

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates

(except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive

national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional PDP products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely

as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that

the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Controlled Affiliate shall no longer comply with item 2(E) above;
 - (2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or
 - (3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its
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dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Cross

License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to \$25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths

of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the

termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: __

Date: __

Controlling Plan:

By:

Date: __

Controlling Plan:

By: __

Date: __

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: __

Date: __

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS June 2016

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Part D Prescription Drug Plan Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
 - (2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
 - (3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:
 - (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
 - (b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
 - (c) exercise control over the policy and operations of the Controlled Affiliate; and
-

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

- a. the structure of the Blue Cross and Blue Shield System; and
- b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross Marks.

Standard 7 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional PDP products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

EXHIBIT 2

Membership Standards Page 1 of 5

Preamble

The Membership Standards apply to all organizations seeking to become or to continue as Regular Members of the Blue Cross and Blue Shield Association. Any organization seeking to become a Regular Member must be found to be in substantial compliance with all Membership Standards at the time membership is granted and the organization must be found to be in substantial compliance with all Membership Standards for a period of two (2) years preceding the date of its application. If Membership is sought by an entity which controls or is controlled by one or more Plans, such compliance shall be determined on the basis of compliance by such Plan or Plans.

The Regular Member Plans shall have authority to interpret these Standards.

A Regular Member Plan that operates as a “Shell Holding Company” is defined as an entity that assumes no underwriting risk and has less than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) and less than 5% of the consolidated enterprise net general and administrative expenses.

A Regular Member Plan that operates as a “Hybrid Holding Company” is defined as an entity that assumes no underwriting risk and has either more than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) or more than 5% of the consolidated enterprise net general and administrative expenses.

Standard 1: A Plan shall maintain a governing Board, which shall control the Plan and ensure that the Plan follows appropriate practices of corporate governance. A Plan's Board shall not be controlled by any special interest group, shall make an annual determination that a majority of its directors are independent, and shall act in the best interest of its Corporation and its customers. The Board shall be composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Amended as of March 15, 2007

EXHIBIT 2

Membership Standards Page 2 of 5

- Standard 2: A Plan shall furnish to the Association on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between the Association and the Plans. Such reports and records are the following:
- A. BCBSA Membership Information Request;
 - B. Triennial trade name and service mark usage material, including disclosure material under Standard 7;
 - C. Changes in the governance of the Plan, including changes in a Plan's Charter, Articles of Incorporation, or Bylaws, changes in a Plan's Board composition, or changes in the identity of the Plan's Principal Officers;
 - D. Quarterly Financial Report, Semi-annual "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC, Annual Budget, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), Plan, Subsidiary and Affiliate Report; and
 - Plans that are a Shell Holding Company as defined in the Preamble hereto are required to furnish only a calendar year-end "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC.

Amended as of November 17, 2011

EXHIBIT 2

Membership Standards Page 3 of 5

E. Quarterly Enrollment Report, Quarterly Member Touchpoint Measures Index (MTM) through 12/31/2011, and Semi-annual MTM Index starting 1/1/2012 and thereafter.

- For purposes of MTM reporting only, a Plan shall file a separate MTM report for each Geographic Market.

Standard 3: A Plan shall be operated in a manner that provides reasonable financial assurance that it can fulfill its contractual obligations to its customers.

Standard 4: A Plan shall be operated in a manner responsive to customer needs and requirements.

Standard 5: A Plan shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the Plans and ease of claims processing for customers receiving benefits outside of the Plan's Service Area.

Such programs are applicable to Blue Cross and Blue Shield Plans, and include:

- A. Inter-Plan Teleprocessing System (ITS);
- B. BlueCard Program;
- C. National Account Programs;
- D. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
- E. Inter-Plan Medicare Advantage Program.

Amended as of November 21, 2014

EXHIBIT 2

Membership Standards Page 4 of 5

- Standard 6: In addition to requirements under the national programs listed in Standard 5: Participation in National Programs, a Plan shall take such action as required to ensure its financial performance in programs and contracts of an inter-Plan nature or where the Association is a party.
- Standard 7: A Plan shall make adequate disclosure in contracting with third parties and in disseminating public statements of (i) the structure of the Blue Cross and Blue Shield System, (ii) the independent nature of every Plan, and (iii) the Plan's financial condition.
- Standard 8: A Plan shall cooperate with the Association's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Plan performance problems identified thereunder.
- Standard 9: A Plan shall obtain a rating of its financial strength from an independent rating agency approved by the Association's Board of Directors for such purpose.
- Standard 10: Notwithstanding any other provision in this License Agreement, during each year, a Plan and its Controlled Affiliate(s) engaged in providing licensable services (excluding Life Insurance and Charitable Foundation Services) shall use their best efforts to promote and build the value of the Blue Cross Marks.
- Standard 11: Neither a Plan nor any Larger Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Plan or Larger Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Amended as of June 16, 2005

EXHIBIT 2

Membership Standards Page 5 of 5

Standard 12: No provider network, or portion thereof, shall be rented or otherwise made available to a National Competitor if the Licensed Marks or Names are used in any way with such network.

A provider network may be rented or otherwise made available, provided there is no use of the Licensed Marks or Names with respect to the network being rented.

Standard 13: Each Plan shall operate in a manner to reasonably: 1) protect the security and confidentiality of Personally Identifiable Information (PII) and Protected Health Information (PHI); 2) protect the Brands from reputational damage; and 3) cooperate with BCBSA and other Plans if a data security incident or data breach occurs.

Amended as of June 18, 2015

EXHIBIT 3

GUIDELINES WITH RESPECT TO USE OF LICENSED NAME AND MARKS IN CONNECTION WITH NATIONAL ACCOUNTS

Page 1 of 3

1. The strength of the Blue Cross/Blue Cross National Accounts mechanism, and the continued provision of cost effective, quality health care benefits to National Accounts, are predicated on locally managed provider networks coordinated on a national scale in a manner consistent with effective service to National Account customers and consistent with the preservation of the integrity of the Blue Cross/Blue Shield system and the Licensed Marks. These guidelines shall be interpreted in keeping with such ends.
2. A National Account is an entity with employee and/or retiree locations in more than one Plan's Service Area. Unless otherwise agreed, a National Account is deemed located in the Service Area in which the corporate headquarters of the National Account is located. A local plant, office or division headquarters of an entity may be deemed a separate National Account when that local plant, office or division headquarters 1) has employee locations in more than one Service Area, and 2) has independent health benefit decision-making authority for the employees working at such local plant, office or division headquarters and for employees working at other locations outside the Service Area. In such a case, the local plant, office or division headquarters is a National Account that is deemed located in the Service Area in which such local plant, office or division headquarters is located. The Control Plan of a National Account is the Plan in whose Service Area the National Account is located. A participating ("Par") Plan is a Plan in whose Service Area the National Account has employee and/or retiree locations, but in which the National Account is not located. In the event that a National Account parent company consolidates health benefit-decision making for itself and its wholly-owned subsidiary companies, the parent company and the subsidiary companies shall be considered one National Account. The Control Plan for such a National Account shall be the Plan in whose Service Area the parent company headquarters is located.
3. The National Account Guidelines enunciated herein below shall be applicable only with respect to the business of new National Accounts acquired after January 1, 1991.
4. Control Plans shall utilize National Account identification cards complying with then currently effective BCBSA graphic standards in connection with all National Accounts business to facilitate administration thereof, to minimize subscriber and provider confusion, and to reflect a commitment to cooperation among Plans.

Amended as of June 12, 2003

EXHIBIT 3 Page 2 of 3

5. Disputes among Plans and/or BCBSA as to the interpretation or implementation of these Guidelines or as to other National Accounts issues shall be submitted to mediation and mandatory dispute resolution as provided in the License Agreement. For two years from the effective date of the License Agreement, however, such disputes shall be subject to mediation only, with the results of such mediation to be collected and reported in order to establish more definitive operating parameters for National Accounts business and to serve as ground rules for future binding dispute resolution.

6. The Control Plan may use the BlueCard Program (as defined by IPPC) to deliver benefits to employees and non-Medicare eligible retirees in a Participating Plan's service area if an alternative arrangement with the Participating Plan cannot be negotiated. The Participating Plan's minimum servicing requirement for those employees and non-Medicare retirees in its service area is to deliver benefits using the BlueCard Program. Account delivery is subject to the policies, provisions and procedures of the BlueCard Program.

7. For provider payments in a Participating Plan's area (on non-BlueCard claims), payment to the provider may be made by the Participating Plan or the Control Plan at the Participating Plan's option. If the Participating Plan elects to pay the provider, it may not withhold payment of a claim verified by the Control Plan or its designated processor, and payment must be in conformity with service criteria established by the Board of Directors of BCBSA (or an authorized committee thereof) to assure prompt payment, good service and minimum confusion with providers and subscribers. The Control Plan, at the Participating Plan's request, will also assure that measures are taken to protect the confidentiality of the data pertaining to provider reimbursement levels and profiles.

Amended as of June 14, 1996

EXHIBIT 3 Page 3 of 3

8. The Control Plan, in its financial agreements with a National Account, is expected to reasonably reflect the aggregate amount of differentials passed along to the Control Plan by all Participating Plans in a National Account.

9. Other than in contracting with health care providers or soliciting such contracts in areas contiguous to a Plan's Service Area in order to serve its subscribers or those of its licensed Controlled Affiliate residing or working in its Service Area, a Control Plan may not use the Licensed Marks and/or Name, as a tag line or otherwise, to negotiate directly with providers outside its Service Area.

Amended as of March 13, 2003

EXHIBIT 4

GOVERNMENT PROGRAMS AND CERTAIN OTHER USES

Page 1 of 14

1. A Plan and its licensed Controlled Affiliate may use the Licensed Marks and Name in bidding on and executing a contract to serve a Government Program, and in thereafter communicating with the Government concerning the Program. With respect, however, to such contracts entered into after the 1st day of January, 1991, the Licensed Marks and Name will not be used in communications or transactions with beneficiaries or providers in the Government Program located outside a Plan's Service Area, unless the Plan can demonstrate to the satisfaction of BCBSA's governing body that such a restriction on use of the Licensed Marks and Name will jeopardize its ability to procure the contract for the Government Program. As to both existing and future contracts for Government Programs, Plans will discontinue use of the Licensed Marks and Name as to beneficiaries and Providers outside their Service Area as expeditiously as circumstances reasonably permit. Effective January 1, 1995, except as provided in the first sentence above, all use by a Plan of the Licensed Marks and Name in Government Programs outside of the Plan's Service Area shall be discontinued. Incidental communications outside a Plan's Service Area with resident or former resident beneficiaries of the Plan, and other categories of necessary incidental communications approved by BCBSA, are not prohibited. For purposes of this Paragraph 1, the term "Government Programs" shall mean Medicare Part A, Medicare Part B and other non-risk government programs.

2. In connection with activity otherwise in furtherance of the License Agreement, a Plan and its Controlled Affiliates that are licensed to use the Licensed Marks and Name in its Service Area pursuant to the Controlled Affiliate License Agreements authorized in clauses a) through c) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Plan's Service Area in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

2.1 Common Business Communications

- a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);
- b. distributing business cards other than in marketing and selling;
- c. advertising in publications or electronic media solely to persons for employment;

Amended as of June 19, 2014

EXHIBIT 4 Page 2 of 14

2.2 Marketing Spillover

- a. advertising in print, electronic or other media which serve, as a substantial market, the Service Area of the Plan or licensed Controlled Affiliate, provided that no Plan or Controlled Affiliate may advertise outside its Service Area on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Service Area;
- b. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Plan's Service Area or that of a licensed Controlled Affiliate;

2.3 Provider Contracting

- a. contracting with health care providers or soliciting such contracts in areas contiguous to the Plan's Service Area in order to serve its subscribers or those of such licensed Controlled Affiliates residing or working in its service area;
- b. issuing a small sign containing the legal name or trade name of the Plan or such licensed Controlled Affiliates for display by a provider to identify the latter as a participating provider of the Plan or Controlled Affiliate;
- c. negotiating rates with a health care provider for services to a specific member, provided that all of the following conditions are met:
 - (1) the health care provider does not have a contract, applicable to the services rendered or to be rendered, with the Licensee (or any of the Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located; and
 - (2) the Plan or Controlled Affiliate reasonably determines that the member did/does not have a reasonable opportunity to access a participating provider whose contract applies to the services rendered or to be rendered; and
 - (3) at least one of the following circumstances exists:

Amended as of June 19, 2014

EXHIBIT 4

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- (i) the member received emergency services and the Plan or Controlled Affiliate knows or reasonably anticipates that the charges on the claim will meet or exceed \$5,000; or
 - (ii) a provider, in consultation pre- or post- treatment with the Plan or Controlled Affiliate, makes/made a treatment recommendation or referral to a non-par provider or to a par provider whose contract does not apply to the services to be rendered; or
 - (iii) the member inadvertently accessed a non-par provider or non-contracted services in the course of receiving services from a par provider (e.g., the member sees a non-par consulting specialist in a participating hospital); and
 - (4) the Licensee (and in the case of overlapping Service Areas, all of the Licensees) in whose Service Area the health care provider is located consent(s) in advance.
- d. contracting with a pharmacy management organization (“Pharmacy Intermediary”) to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan’s or licensed Controlled Affiliate’s members nationwide, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;

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EXHIBIT 4

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- e. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided that (1) the Plan and the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Plan's Service Area, and (2) neither the Plan's or the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Plan's Service Area;
 - f. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;
 - g. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;
 - h. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Plan's Service Area;
 - i. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Plan's Service Area;
 - j. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Plan's Service Area;
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EXHIBIT 4 Page 5 of 14

- k. contracting with a company that operates provider sites in the Plan's Service Area, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Plan's Service Area;
- l. contracting with a company that makes health care professionals available in the Plan's Service Area (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Plan's Service Area.

2.4 Services to National Accounts

- a. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee (as those terms are defined in the Inter-Plan Programs Policies and Provisions ("IP Policies")) to offer Blue-branded Health Coverage to the National Account, offering Blue-branded Health and Wellness Programs to all members of the National Account, including members who have not enrolled in the Blue-branded Health Coverage ("non-Blue Health Coverage members"), provided that:
 - (i) the Plan and/or licensed Controlled Affiliate has no contact or interaction with providers outside of the Plan's Service Area, except as specifically provided in the IP Policies and in 2.4 (b); and
 - (ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not offer Blue-branded Health and Wellness Programs to any employees working at such local plant, office or division without the consent of such other Licensee; and
 - (iii) if the Plan and/or licensed Controlled Affiliate provides an information card to the non-Blue Health Coverage members, the card may not display the Symbols in the masthead, must contain a prominent disclosure conveying that it is not a health insurance card, and otherwise must be designed so that it is dissimilar to a Blue member identification card.

Amended as of March 26, 2015

EXHIBIT 4 Page 6 of 14

For purposes of this subparagraph a, the following definitions apply:

“Health and Wellness Program” shall mean a program that includes at least one of the following elements or a related element:

- Health Risk Assessment and/or Preventive Screenings
- Exercise and Fitness Programs
- Health and Wellness Events (e.g., attendance at a health fair, a 5K walk)
- Nutrition and Weight Management
- Health Education (e.g., smoking cessation classes)
- Prenatal and Parenting Education
- Disease or Chronic Condition Management

The above listing is intended to represent examples of the types of programs that may be offered, and other programs, including those offered through different media such as the internet or telephonically, may also be deemed Health and Wellness programs.

“Health Coverage” shall mean providing or administering medical, surgical, hospital, major medical, or catastrophic coverage, or any HMO, PPO, POS or other managed care plan for the foregoing services.

2.4 Services to National Accounts (continued)

- b. as part of a Health and Wellness Program that is otherwise compliant with Brand Regulation 4.11.4(a), contracting with a health and wellness organization to gain access to providers to deliver a discrete health and wellness event (“Event”) held at a National Account’s worksite outside of the Licensee’s Service Area, provided that:
 - (i) the services delivered at the Event are limited to fingerstick screenings for cholesterol and glucose, seasonal flu immunizations, blood pressure measurements, body mass index measurements, and other routine screenings, immunizations and measurements; and
 - (ii) neither such services nor their costs are applied as claims against any benefit plan; and
 - (iii) the Event is presented during one or more limited periods during a benefit year and is available to all employees at the worksite.

Amended as of June 19, 2014

EXHIBIT 4 Page 7 of 14

- c. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee to offer Blue-branded Health Coverage to the National Account, performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by the National Account to its members, including benefit plans that are not underwritten or administered by the Plan, provided that:
- (i) in performing such functions, the Plan and/or licensed Controlled Affiliate does not use the Brands in any communications with health care providers outside of the Plan's Service Area, and otherwise limits its use of the Brands outside of the Service Area to communications with the account's members, the other benefit plan providers with which the account has contracted and other reasonably necessary communications to perform such functions; and
 - (ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not perform Eligibility and Enrollment functions for employees working at such local plant, office or division without the consent of such other Licensee;

For purposes of this subparagraph b, the following definitions apply: "Health Coverage" has the meaning set forth in subparagraph

2.4.a.

Amended as of March 26, 2015

EXHIBIT 4 Page 8 of 14

“Eligibility” means services that manage the account’s eligibility data and determine or process determinations relating to eligibility for benefit plans offered by the account to its employees, including such services as:

- monitoring and auditing data to ensure that only entitled individuals are enrolled in each such benefit plan;
- review of eligibility documentation (e.g. marriage licenses, birth certificates, student status verification letters, employment records);
- identification of key member segments such as over-age dependents, part-time employees, employees reaching certain milestones (e.g. Medicare-eligible, retirees);
- termination of coverage for those individuals found to be ineligible for coverage under a benefit plan, and, if applicable, generation of a COBRA event; and
- management of “hour-banking” for union environments in which union members can bank hours to remain eligible for benefits.

“Enrollment” means services that enroll eligible individuals and their spouses/dependents or terminate or change their enrollment in the account’s benefit plans on an ongoing basis and during open enrollment periods, including such services as:

- the coordination of each step in open enrollment process from project planning and system set-up to the generation of confirmation statements;
- ongoing enrollment support for new hires and changes due to life events and work status adjustments;
- evidence of insurability (EOI) administration for life and disability coverage;
- transmission of eligibility/enrollment information to the account’s benefit plan providers;
- review and reconciliation of error reports received from the account’s benefit plan providers; and
- transmission of information to the account’s payroll system (e.g., benefit deductions, employee demographic data).

Amended as of November 18, 2010

EXHIBIT 4 Page 9 of 14

2.5 Knowledge Sharing

- a. submitting scholarly articles authored or co-authored by the Plan or Controlled Affiliate or its respective employees for publication in peer-reviewed journals;
- b. permitting an internal representative of the Licensee (e.g., officer, employee) to speak or present at a conference or symposium outside of the Licensee's Service Area regarding either (i) healthcare financing, administration, delivery or policy, or (ii) topics within the representative's functional discipline or expertise at the Licensee, for which the event sponsor will issue communications to promote, administer, and/or recap the event that will identify the Licensee's representative as a participant. The communications outside of the Licensee's Service Area that mention the Licensee's representative shall be limited to materials and digital media provided to attendees, on-site signage, advertising in relevant trade publications, direct mail and email to attendees and prospective attendees, and the sponsor's website. Participation in any conference or symposium outside of the Licensee's Service Area may not be for the purpose of marketing or selling products or services.

If the Licensee's representative wishes to use the Brands in any manner, including use in his/her title, when participating as a speaker or presenter outside of the Licensee's Service Area about a topic that is not related to healthcare financing, administration, delivery, or policy, or to topics within the representative's functional discipline or expertise at the Licensee, the Licensee must notify BCBSA and receive prior approval from BCBSA before participating;

Amended as of March 26, 2015

EXHIBIT 4

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2.6 Other Uses

- a. entering into a license agreement between and among BCBSA, the Plan and a debit card issuer located outside the Plan's Service Area, and entering into a corresponding operating agreement or agreements, in order to offer a debit card bearing the Licensed Marks and Name to eligible persons as defined by the aforementioned license agreement;
- b. appearing in communications issued by an independent third party to recognize outstanding performance of the Plan or Controlled Affiliate or a member of the Plan's or Controlled Affiliate's senior management as part of an established program of the third party for which the Plan has provided information to be considered for the recognition, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;
- c. to identify itself as being a joint sponsor of an event, program or activity along with other Plans or such Plans' licensed Controlled Affiliates, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;
- d. hosting meetings or events (collectively, "events") in Washington, D.C. related to policy and business issues in the Licensee's Service Area, or hosting events in conjunction with the assemblies or conventions of national political parties. Such events may not involve marketing or selling products or services. Use of the Brands outside the Licensee's Service Area in connection with such events shall be limited to materials and digital media provided to attendees and prospective attendees and onsite signage. For any such events in Washington, D.C. that are open to attendees other than government officials or their staffs, or are briefings open to all Congressional staff, or are otherwise likely to receive media coverage, the Licensee is required to provide advance notice to BCBSA. For events hosted outside of Washington, D.C. in conjunction with the assemblies or conventions of national political parties, the Licensee is required to provide advance notice to BCBSA and to the local Plan;

Amended as of March 26, 2015

EXHIBIT 4 Page 11 of 14

- e. permitting an affiliate that is not licensed to use the Licensed Marks to identify its corporate relationship with the Plan, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time.

3. In connection with activity otherwise in furtherance of the License

Agreement, a Controlled Affiliate that is licensed to use the Licensed Marks and Name pursuant to a Controlled Affiliate License Agreement authorized in clauses d) or e) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Region (as that term is defined in such respective Controlled Affiliate License Agreements) in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

- a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);
- b. distributing business cards other than in marketing and selling;
- c. contracting with health care providers or soliciting such contracts in areas contiguous to the Region in order to serve its subscribers residing in the Region, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans in connection with such contracting unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;
- d. issuing a small sign containing the legal name or trade name of the Controlled Affiliate for display by a provider to identify the latter as a participating provider of the Controlled Affiliate, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans on such signs unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;
- e. advertising in publications or electronic media solely to persons for employment;

Amended as of June 19, 2014

EXHIBIT 4

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- f. advertising in print, electronic or other media which serve, as a substantial market, the Region, provided that the Controlled Affiliate may not advertise outside its Region on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Region, and provided further that any such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to advertise in such media;
 - g. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Region, provided that such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to send direct mail to such zip code plus 4.
 - h. [Intentionally left blank, pending review by the Inter-Plan Programs Committee of the applicability of the case management rule to such Controlled Affiliates.]
 - i. contracting with a pharmacy management organization ("Pharmacy Intermediary") to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for the Controlled Affiliate's regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective Controlled Affiliate License Agreements, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;
 - j. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit to the Controlled Affiliate's regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective
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EXHIBIT 4

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Controlled Affiliate License Agreements, provided that (1) the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Region, and (2) neither the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Region;

- k. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for the Controlled Affiliate's regional Medicare Advantage PPO members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;
 - l. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for the Controlled Affiliate's regional Medicare Advantage members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;
 - m. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Controlled Affiliate's Region;
 - n. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Controlled Affiliate's Region;
 - o. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Region;
 - p. contracting with a company that operates provider sites in the Region, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Region;
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- q. contracting with a company that makes health care professionals

available in the Region (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health

care professionals who are located within the Region.

4. BCBSA shall retain the right to use the Licensed Marks in conjunction with the Federal Employee Program and with any other national offering made to federal employees pursuant to the Federal Employees Health Benefits Program (FEHBP), including the right to license such use to its vendors, but only in the following manner.
- a. the Licensed Marks may only be used by BCBSA with the term “Federal Employee Program”, “Federal”, “FEP”, or similar language identifying the program as a benefit program for federal employees;
 - b. the Licensed Marks may not be used by BCBSA with the name(s) of a specific Plan or Plans and;
 - c. any use by BCBSA in conjunction with a new national FEHBP program proposed after the enactment of this amendment will require the approval of the BCBSA Board of Directors.
5. Where required by applicable state or local law or regulation, a Plan or its licensed Controlled Affiliate may submit documents that contain the Brands to, and file forms that contain the Brands with, state or local regulators in a state not included in its Service Area, provided that it gives reasonable advance notice to the local Plan of its intent to submit such documents or file such forms. Notwithstanding, in no event may a Plan or its licensed Controlled Affiliate use the Brands to register, or to obtain or maintain a license, a certificate of authority, or an equivalent document authorizing it to act as a risk-bearing entity or third party administrator in a state not included in its Service Area. If the local Plan advises BCBSA that it believes its License Agreement has been or would be violated by any submission or filing, BCBSA shall determine whether such submission or filing is required by state or local law or regulation and violates the License Agreement, subject to the Plan’s or licensed Controlled Affiliate’s rights to obtain an independent review of such determination under Paragraph 9(a) and Exhibit 5 of its License Agreement or Paragraph 8 of the Controlled Affiliate License. For purposes of this paragraph, “local Plan” is defined as each Plan whose Service Area includes all or part of the state in which the foregoing applicable state or local law or regulation has been enacted.

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MEDIATION AND MANDATORY DISPUTE RESOLUTION (MMDR) RULES

The Blue Cross and Blue Shield Plans ("Plans") and the Blue Cross Blue Shield Association ("BCBSA") recognize and acknowledge that the Blue Cross and Blue Shield system is a unique nonprofit and for-profit system offering cost effective health care financing and services. The Plans and BCBSA desire to utilize Mediation and Mandatory Dispute Resolution ("MMDR") to avoid expensive and time-consuming litigation that may otherwise occur in the federal and state judicial systems. Even MMDR should be viewed, however, as methods of last resort, all other procedures for dispute resolution having failed. Except as otherwise provided in the License Agreements, the Plans, their Controlled Affiliates and BCBSA agree to submit all disputes to MMDR pursuant to these Rules and in lieu of litigation.

1. Initiation of Proceedings

A. Pre-MMDR Efforts

Before filing a Complaint to invoke the MMDR process, the CEO of a complaining party, or his/her designated representative, shall undertake good faith efforts with the other side(s) to try to resolve any dispute.

B. Complaint

To commence a proceeding, the complaining party (or parties) shall provide by certified mail, return receipt requested, a written Complaint to the BCBSA Corporate Secretary (which shall also constitute service on BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) named therein. The Complaint shall contain:

- i. identification of the complaining party (or parties) requesting the proceeding;
- ii. identification of the respondent(s);
- iii. identification of any other persons or entities who are interested in a resolution of the dispute;
- iv. a full statement describing the nature of the dispute;
- v. identification of all of the issues that are being submitted for resolution;

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- vi. the remedy sought;
- vii. a statement as to whether the complaining party (or parties) elect(s) first to pursue Mediation;
- viii. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor; and
- ix. a statement signed by the CEO of the complaining party affirming that the CEO has undertaken efforts, or has directed efforts to be undertaken, to resolve the dispute before resorting to the MMDR process.

The complaining party (or parties) shall file and serve with the Complaint copies of all documents which the party (or parties) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

C. Answer

Within twenty (20) days after receipt of the Complaint, each respondent shall serve on BCBSA and on the complaining party (or parties);

- i. a full Answer to the aforesaid Complaint;
- ii. a statement of any Counterclaims against the complaining party (or parties), providing with respect thereto the information specified in Paragraph 1.B., above;
- iii. a statement as to whether the respondent elects to first pursue Mediation; and
- iv. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor.

The respondent(s) shall file and serve with the Answer or by the date of the Initial Conference set forth in Paragraph 3.C., below, copies of all documents which the respondent(s) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

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D. Reply To Counterclaim

Within ten (10) days after receipt of any Counterclaim, the complaining party (or parties) shall serve on BCBSA and on the responding party (or parties), a Reply to the Counterclaim. Such Reply must provide the same information required by Paragraph 1.C., above.

2. Mediation

To facilitate the mediation of disputes between or among BCBSA, the Plans and/or their Controlled Affiliates, the BCBSA Board has provided for Mediation under these Rules. Mediation may be pursued in lieu of or in an effort to obviate the Mandatory Dispute Resolution process, and all parties are strongly urged, but not required, to exhaust the mediation procedure provided for herein. In the event any party refuses to proceed with Mediation, the parties shall proceed immediately to Mandatory Dispute Resolution, as provided in Section 3.

A. Selection of Mediators

If all parties agree to pursue Mediation, they shall promptly attempt to agree upon: (i) the number of mediators desired, not to exceed three mediators; and (ii) the selection of experienced mediator(s) from an independent entity to mediate all disputes set forth in the Complaint and Answer (and Counterclaim and Reply, if any). In the event the parties are unable to agree upon the selection or number of mediators, both within five (5) days of the service of the Answer or Reply to Counterclaim, whichever is later, the BCBSA Corporate Secretary shall immediately refer the matter to a nationally recognized professional ADR organization (such as CPR or JAMS) for mediation by a single mediator to be selected by the ADR organization.

B. Binding Decision

Before the Mediation Hearing described below, the BCBSA Corporate Secretary shall contact the parties to determine whether they wish to be bound by any recommendation of the selected mediator(s) for resolution of the disputes. If all wish to be bound, the Corporate Secretary will send appropriate documentation to them for their signatures before the Mediation Hearing begins.

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C. Mediation Procedure

The Mediator(s) shall apply the mediation procedures and processes provided for herein (not the rules of the ADR organization with which they are affiliated) and shall promptly advise the parties of a scheduled Mediation Hearing date. Unless a party requests an expedited procedure, or unless all parties to the proceeding agree to one or more extensions of time, the Mediation Hearing set forth below shall be completed within forty (40) days of BCBSA's receipt of the Complaint. The selected mediator(s), unless the parties otherwise agree, shall adhere to the following procedure:

- i. Each party must be represented by its CEO or other representative who has been delegated full authority to resolve the dispute. However, parties may send additional representatives as they see fit.
- ii. Each party will be given one-half hour to present its case, beginning with the complaining party (or parties), followed by the other party or parties. The parties are free to structure their presentations as they see fit, using oral statements or direct examination of witnesses. However, neither cross-examination nor questioning of opposing representatives will be permitted. At the close of each presentation, the selected mediator(s) will be given an opportunity to ask questions of the presenters and witnesses. All parties must be present throughout the Mediation Hearing. The selected mediator(s) may extend the time allowed for each party's presentation at the Mediation Hearing. The selected mediator(s) may meet in executive session, outside the presence of the parties, or may meet with the parties separately, to discuss the controversy.
- iii. After the close of the presentations, the parties will attempt to negotiate a settlement of the dispute. If the parties desire, the selected mediator(s), or any one or more of the selected mediators, will sit in on the negotiations.

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- iv. After the close of the presentations, the selected mediator(s) may meet privately to agree upon a recommendation for resolution of the dispute which would be submitted to the parties for their consideration and approval. If the parties have previously agreed to be bound by the results of this procedure, this recommendation shall be binding upon the parties.
- v. The purpose of the Mediation Hearing is to assist the parties to settle their grievances short of mandatory dispute resolution. As a result, the Mediation Hearing has been designed to be as informal as possible. Rules of evidence shall not apply. There will be no transcript of the proceedings, and no party may make a tape recording of the Mediation Hearing.
- vi. In order to facilitate a free and open discussion, the Mediation proceeding shall remain confidential. A "Stipulation to Confidentiality" which prohibits future use of settlement offers, all position papers or other statements furnished to the selected mediator(s), and decisions or recommendations in any Mediation proceeding shall be executed by each party.
- vii. Upon request of the selected mediator(s), or one of the parties, BCBSA staff may also submit documentation at any time during the proceedings.

D. Notice of Termination of Mediation

If the Mediation cannot be completed within the prescribed or agreed time period due to the lack of cooperation of any party, as determined by the selected mediator(s), or if the Mediation does not result in a final resolution of all disputes at the Mediation Hearing or within ten (10) days after the Mediation Hearing, any party or any one of the selected mediators shall so notify the BCBSA Corporate Secretary, who shall promptly issue a Notice of Termination of Mediation to all parties, to the selected mediator(s), and to the MDR Administrator. Such notice shall serve to bring the Mediation to an end and to initiate Mandatory Dispute Resolution. Upon agreement of all parties and the mediator(s), the Mediation process may continue at the same time the MDR process is invoked. In such case, the Notice of Termination of Mediation described above serves to initiate the MDR proceeding, but does not terminate mediation proceedings, which may proceed simultaneous with the MDR proceeding.

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3. Mandatory Dispute Resolution (MDR)

If any party elects not to first pursue Mediation, or if a Notice of Termination of Mediation is issued as set forth in Paragraph 2.D., above, then the unresolved disputes set forth in any Complaint and Answer (and Counterclaim and Reply, if any) shall be subject to mandatory binding arbitration (herein referred to as “MDR”).

A. MDR Administrator

The Administrator for purposes of Mandatory Arbitration shall be an independent nationally recognized entity such as CPR or JAMS, specializing in alternative dispute resolution. In the event the parties pursued Mediation with CPR, JAMS or a similar organization, that organization also shall serve as the MDR Administrator, unless all parties notify the BCBSA Corporate Secretary in writing within two (2) days of receiving the Notice of Termination of Mediation that they wish to pursue MDR with another nationally recognized organization serving as MDR Administrator.

In the event the parties (i) did not pursue Mediation, (ii) pursued mediation with a Mediator not affiliated with an ADR organization that offers a panel of arbitrators, or (iii) all parties that pursued Mediation notified the BCBSA Corporate Secretary that they wish to have an MDR Administrator that is different from the organization with which their mediator was affiliated, they shall promptly attempt to agree on a nationally recognized ADR entity that supplies a panel of arbitrators. If they reach such agreement within five (5) days of the Notice of Termination of Mediation or receipt of the Answer or Reply to Counterclaim (whichever is later), the parties shall promptly inform the BCBSA Corporate Secretary of their agreed upon ADR organization. In the event the parties are unable to reach agreement on an MDR Administrator within that timeframe, the BCBSA Corporate Secretary shall immediately refer the matter to CPR, JAMS or a similar organization for MDR.

Any person who served as a Mediator shall not serve as an arbitrator for the same or similar dispute for purposes of MDR.

B. Rules for MDR

The rules controlling all aspects of MDR shall be exclusively those provided for herein. The rules promulgated or otherwise used by the MDR Administrator organization shall not apply.

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C. Initial Conference

Within seven (7) days after a Notice of Termination has issued or the matter has otherwise been referred to an MDR Administrator, or within five (5) days after the time for filing and serving the Answer or Reply to any Counterclaim (whichever is later) if the parties elect first not to mediate, the parties shall confer with the Administrator to discuss selecting a dispute resolution panel ("the Panel"). This conference (the "Initial Conference") may be by telephone. The parties are encouraged to agree to the composition of the Panel and to present that agreement to the Administrator at the Initial Conference. If the parties do not agree on the composition of the Panel by the time of the Initial Conference, or by any extension thereof agreed to by all parties and the Administrator, then the Panel Selection Process set forth in subparagraph D, below, shall be followed.

D. Panel Selection Process

The Administrator shall designate, prior to the Initial Conference, at least seven potential arbitrators. Each party shall be permitted to strike any designee for cause and the Administrator shall determine the sufficiency thereof in its sole discretion. The Administrator will designate a replacement for any designee so stricken. Each party shall then be permitted one peremptory strike from the list of designees. The Administrator shall set the dates for exercising all strikes, which shall be set to encourage the prompt selection of arbitrators.

After the parties exercise any designee strikes for cause and their peremptory strike against any designee of their choice, the parties shall each rank the remaining panel members in order of preference and provide the Administrator, without serving on any other party, their ranked list. The Administrator shall not disclose any party's ranked list to members of the panel or to other parties.

From the remaining designees, and after considering opportunities to maximize, so far as possible, the collectively stated arbitrator preferences provided by the parties on their ranked lists, the Administrator shall select a three member Panel. The Panel Selection Process shall be completed no later than ten (10) days after the Initial Conference.

Each Arbitrator shall be compensated at his or her normal hourly rate or, in the absence of an established rate, at a reasonable hourly rate to be promptly fixed by the Administrator for all time spent in connection with the proceedings and shall be reimbursed for any travel and other reasonable expenses.

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E. Duties Of The Arbitrators

The Panel shall promptly designate a Presiding Arbitrator for the purposes reflected below, but shall retain the power to review and modify any ruling or other action of said Presiding Arbitrator. Each Arbitrator shall be an independent Arbitrator, shall be governed by the Code of Ethics for Arbitrators in Commercial Disputes and shall at or prior to the commencement of any Arbitration Hearing take an oath to that effect. Each Arbitrator shall promptly disclose in writing to the Panel and to the parties any circumstances, whenever arising, that might cause doubt as to such Arbitrator's compliance, or ability to comply, with said Code of Ethics, and, absent resignation by such Arbitrator, the remaining Arbitrators shall determine in their sole discretion whether the circumstances so disclosed constitute grounds for disqualification and for replacement. With respect to such circumstances arising or coming to the attention of a party after an Arbitrator's selection, a party may likewise request the Arbitrator's resignation or a determination as to disqualification by the remaining Arbitrators. With respect to a sole Arbitrator, the determination as to disqualification shall be made by the Administrator.

There shall be no ex parte communication between the parties or their counsel and any member of the Panel.

F. Panel's Jurisdiction And Authority

The Panel's jurisdiction and authority shall extend to all disputes between or among the Plans, their Controlled Affiliates, and/or BCBSA, except for those disputes excepted from these MMDR procedures as set forth in the License Agreements.

With the exception of punitive or treble damages, the Panel shall have full authority to award the relief it deems appropriate to resolve the parties' disputes, including monetary awards and injunctions, mandatory or prohibitory. The Panel has no authority to award punitive or treble damages except that the Panel may allocate or assess responsibility for punitive or treble damages assessed by another tribunal. Subject to the above limitations, the Panel may, by way of example, but not of limitation:

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- i. interpret or construe the meaning of any terms, phrase or provision in any license between BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.
- ii. determine whether BCBSA, a Plan or a Controlled Affiliate has violated the terms or conditions of any license between the BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.
- iii. decide challenges as to its own jurisdiction.
- iv. issue such orders for interim relief as it deems appropriate pending Hearing and Award in any Arbitration.

It is understood that the Panel is expected to resolve issues based on governing principles of law, preserving to the maximum extent legally possible the continued integrity of the Licensed Marks and the BLUE CROSS/BLUE SHIELD system. The Panel shall apply federal law to all issues which, if asserted in the United States District Court, would give rise to federal question jurisdiction, 28 U.S.C. § 1331. The Panel shall apply Illinois law to all issues involving interpretation, performance or construction of any License Agreement or Controlled Affiliate License Agreement unless the agreement otherwise provides. As to other issues, the Panel shall choose the applicable law based on conflicts of law principles of the State of Illinois.

G. Administrative Conference

Within five (5) days of the Panel being selected, the Presiding Arbitrator shall confer with the parties and the other members of the Panel and shall schedule, in writing, a conference in which the parties and the Panel shall participate (the “Administrative Conference”). The Administrative Conference shall take place no later than fifteen (15) days after the Panel is selected. At the Administrative Conference the parties and the Panel shall discuss the scheduling of the Arbitration Hearing and any other matter appropriate to be considered, including but not limited to: any written discovery in the form of requests for production of documents or requests to admit facts; the identity of any witness whose deposition a party may desire and a showing of exceptional good cause for the taking of any such deposition; the desirability of bifurcation or other separation of the issues; the need for and the type of record of conferences and hearings, including the need for transcripts; the need for expert witnesses and

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how expert testimony should be presented; the appropriateness of motions to dismiss and/or for full or partial summary judgment; consideration of stipulations; the desirability of presenting any direct testimony in writing; and the necessity for any on-site inspection by the Panel. If the parties agree, the Administrative Conference may be by telephone.

H. Discovery

- i. Requests for Production of Documents:* All requests for the production of documents must be served no later than five (5) days after the date of the Initial Conference. Within twenty (20) days after receipt of a request for production of documents, a party shall (a) serve responses and objections to the request, (b) produce all responsive, non-privileged documents to the requesting party, and (c) to the extent any responsive documents are withheld on the grounds of attorney-client privilege or work product, produce a log identifying such documents in the manner specified in Fed. R. Civ. P. 26(b)(5). If, after reviewing a privilege log, the requesting party believes attorney-client privilege or work product protection was improperly claimed by the producing party with respect to any document, the requesting party may ask the Presiding Arbitrator to conduct an in-camera inspection of the same. With respect to documentary and other discovery produced in any MDR proceeding by BCBSA, the fact that a party's CEO or other senior officers may serve on the BCBSA Board of Directors, BCBSA Board Committees or other BCBSA work groups, task forces and the like, shall not be a basis for defeating an otherwise valid claim of attorney-client privilege or work product protection over such documentary or other discovery materials by BCBSA.
- ii. Requests for Admissions:* Requests for Admissions may be served up to twenty-one (21) days prior to the discovery cut-off set by the Presiding Arbitrator. A party served with Requests For Admissions must respond within twenty (20) days of receipt of said request. The good faith use of and response to Requests for Admissions is encouraged, and the Panel shall have full discretion, with reference to the Federal Rules of Civil Procedure, in awarding appropriate sanctions with respect to abuse of the procedure.

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- iii. Depositions:** As a general rule, the parties will not be permitted to take party or non-party deposition testimony for discovery purposes. The Presiding Arbitrator, in his or her sole discretion, shall have the authority to permit a party to take such deposition testimony upon a showing of exceptional good cause. The parties will be permitted to take de bene esse deposition¹ testimony to the fullest extent permitted by law of any witness who cannot be compelled to testify at the Arbitration Hearing. No deposition, for discovery purposes or otherwise, shall exceed three (3) hours, excluding objections and colloquy of counsel. Depositions may be recorded in any manner recognized by the Federal Rules of Civil Procedure and the parties shall specify in each notice of deposition or request for permission to take deposition testimony the manner in which such deposition shall be recorded.
- iv. Expert witness(es):** If a party intends to present the testimony of an expert witness during the oral hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2) (B) ten (10) days prior to the discovery cut-off set by the Presiding Arbitrator. If a party intends to present the testimony of a rebuttal expert witness during the Arbitration Hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)(B) within twenty (20) days after the date on which the written statement of the expert witness whose testimony is to be rebutted was produced.
- v. Discovery cut-off:** The Presiding Arbitrator shall determine the date on which the discovery period will end, but the discovery period shall not exceed thirty (30) days from the date of the Administrative Conference without the agreement of all parties.

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¹As used in these Rules, “de bene esse deposition” means a deposition that is not taken for discovery purposes, but is taken for the purpose of reading part or all of the deposition transcript into the record at the Arbitration Hearing, to the extent permitted by the Panel, because the witness cannot be compelled to testify at the Arbitration Hearing or has exercised a right provided under these Rules to provide deposition testimony in lieu of testimony at the Arbitration Hearing.

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vi. Additional discovery: Any additional discovery will be at the discretion of the Presiding Arbitrator.

vii. Discovery Disputes: Any discovery disputes shall be raised by motion to the Presiding Arbitrator, who is authorized to resolve all such disputes, and whose resolution will be binding on the parties unless modified by the Arbitration Panel. Prior to raising any discovery dispute with the Presiding Arbitrator, the parties shall meet and confer, telephonically or in person, in an attempt to resolve or narrow the dispute. If a party refuses to comply with a decision resolving a discovery dispute, the Panel, in keeping with Fed. R. Civ. P. 37, may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for resolution adversely to that party.

viii. Extensions: The time for responding to discovery requests may be extended by the Presiding Arbitrator for good and sufficient cause shown. Any request for such an extension shall be made in writing.

I. Panel Suggested Settlement/Mediation

At any point during the proceedings, the Panel at the request of any party or on its own initiative, may suggest that the parties explore settlement and that they do so at or before the conclusion of the Arbitration Hearing, and the Panel shall give such assistance in settlement negotiations as the parties may request and the Panel may deem appropriate. Alternatively, the Panel may direct the parties to endeavor to mediate their disputes as provided above, or to explore a mini-trial proceeding, or to have an independent party render a neutral evaluation of the parties' respective positions. The Panel shall enter such sanctions as it deems appropriate with respect to any party failing to pursue in good faith such Mediation or other alternate dispute resolution methods.

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J. Subpoenas on Third Parties

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq.*, and subject to Paragraph 3.G(iii) above, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan or any officer, employee or director of a third party Blue Plan, to compel deposition testimony or the production of documents, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena.

K. Arbitration Hearing

An Arbitration Hearing will be held within thirty (30) days after the Administrative Conference if no discovery is taken, or within thirty (30) days after the close of discovery, unless all parties and the Panel agree to extend the Arbitration Hearing date, or unless the parties agree in writing to waive the Arbitration Hearing. The parties may mutually agree on the location of the Arbitration Hearing. If the parties fail to agree, the Arbitration Hearing shall be held in Chicago, Illinois, or at such other location determined by the Presiding Arbitrator to be most convenient to the participants. The Panel will determine the date(s) and time(s) of the Arbitration Hearing(s) after consultation with all parties and shall provide reasonable notice thereof to all parties or their representatives.

L. Arbitration Hearing Memoranda

Twenty (20) days prior to the Arbitration Hearing, each party shall submit to the other party (or parties) and to the Panel an Arbitration Hearing Memorandum which sets forth the applicable law and any argument as to any relevant issue. The Arbitration Hearing Memorandum will supplement, and not repeat, the allegations, information and documents contained in or with the Complaint, Answer, Counterclaim and Reply, if any. Ten (10) days prior to the Arbitration Hearing, each party shall submit to each other party a list of all expert and fact witnesses (but not including rebuttal fact witness) that such party intends to have testify at the Arbitration Hearing and a brief summary of the testimony each such witness is expected to give. In addition, no later than five (5) days prior to the Arbitration, each party may submit to each other party and to the Panel a Response Arbitration Hearing Memorandum which sets forth any response to another party's Arbitration Hearing Memorandum.

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M. Notice For Testimony

Ten (10) days prior to the Arbitration Hearing, any party may serve a Notice on any other party (or parties) requesting the attendance at the Arbitration Hearing of any officer, employee or director of the other party (or parties) for the purpose of providing noncumulative testimony. If a party fails to produce one of its officers, employees or directors whose noncumulative testimony during the Arbitration Hearing is reasonably requested by an adverse party, the Panel may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for mandatory dispute resolution adversely to that party; provided, however, that a party may refuse to produce a director to testify if, within two (2) days of receiving a notice requesting the attendance of such director at the Arbitration Hearing, the party agrees to make the director available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. This Rule may not be used for the purpose of burdening or harassing any party, and the Presiding Arbitrator may impose such orders as are appropriate so as to prevent or remedy any such burden or harassment.

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq.*, twenty (20) days or more prior to the Arbitration Hearing, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan, BCBSA or any officer, employee or director of a third party Blue Plan or BCBSA for the purpose of providing noncumulative testimony at the Arbitration Hearing, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena; provided however, that a director of a third party Blue Plan or BCBSA may refuse to testify if, within two (2) days of receiving a subpoena requesting the attendance of such director at the Arbitration Hearing, the director agrees to make him/herself available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. Each Blue Plan agrees to waive, on its own behalf and on behalf of its directors and officers, any objection it otherwise might have to any such subpoena based on service, venue or extraterritoriality.

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N. Arbitration Hearing Procedures

- i. Attendance at Arbitration Hearing:* Any person having a direct interest in the proceeding is entitled to attend the Arbitration Hearing. The Presiding Arbitrator shall otherwise have the power to require the exclusion of any witness, other than a party or other essential person, during the testimony of any other witness. It shall be discretionary with the Presiding Arbitrator to determine the propriety of the attendance of any other person.
- ii. Confidentiality:* The Panel and all parties shall maintain the privacy of the Arbitration Proceeding. The parties and the Panel shall treat the Arbitration Hearing and any discovery or other proceedings or events related thereto, including any award resulting therefrom, as confidential except as otherwise necessary in connection with a judicial challenge to or enforcement of an award or unless otherwise required by law.
- iii. Stenographic Record:* Any party, or if the parties do not object, the Panel, may request that a stenographic or other record be made of any Arbitration Hearing or portion thereof. The costs of the recording and/or of preparing the transcript shall be borne by the requesting party and by any party who receives a copy thereof. If the Panel requests a recording and/or a transcript, the costs thereof shall be borne equally by the parties.
- iv. Oaths:* The Panel may require witnesses to testify under oath or affirmation administered by any duly qualified person and, if requested by any party, shall do so.
- v. Order of Arbitration Hearing:* An Arbitration Hearing shall be opened by the recording of the date, time, and place of the Arbitration Hearing, and the presence of the Panel, the parties, and their representatives, if any. The Panel may, at the beginning of the Arbitration Hearing, ask for statements clarifying the issues involved.

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Unless otherwise agreed, the complaining party (or parties) shall then present evidence to support their claim(s). The respondent(s) shall then present evidence supporting their defenses and Counterclaims, if any. The complaining party (or parties) shall then present evidence supporting defenses to the Counterclaims, if any, and rebuttal.

Witnesses for each party shall submit to questions by adverse parties and/or the Panel.

The Panel has the discretion to vary these procedures, but shall afford a full and equal opportunity to all parties for the presentation of any material and relevant evidence.

- vi. **Evidence:** The parties may offer such evidence as is relevant and material to the dispute and shall produce such evidence as the Panel may deem necessary to an understanding and resolution of the dispute. Unless good cause is shown, as determined by the Panel or agreed to by all other parties, no party shall be permitted to offer evidence at the Arbitration Hearing which was not disclosed prior to the Arbitration Hearing by that party. The Panel may receive and consider the

evidence of witnesses by affidavit upon such terms as the Panel deems appropriate.

The Panel shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence, other than enforcement of the attorney-client privilege and the work product protection, shall not be necessary. The Federal Rules of Evidence shall be considered by the Panel in conducting the Arbitration Hearing but those rules shall not be controlling. All evidence shall be taken in the presence of the Panel and all of the parties, except where any party is in default or has waived the right to be present.

Settlement offers by any party in connection with Mediation or MDR proceedings, decisions or recommendations of the selected mediators, and a party's position papers or statements furnished to the selected mediators shall not be admissible evidence or considered by the Panel without the consent of all parties.

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vii. ***Closing of Arbitration Hearing:*** The Presiding Arbitrator shall specifically inquire of all parties whether they have any further proofs to offer or witnesses to be heard. Upon receiving negative replies or if he or she is satisfied that the record is complete, the Presiding Arbitrator shall declare the Arbitration Hearing closed with an appropriate notation made on the record. Subject to being reopened as provided below, the time within which the Panel is required to make the award shall commence to run, in the absence of contrary agreement by the parties, upon the closing of the Arbitration Hearing.

With respect to complex disputes, the Panel may, in its sole discretion, defer the closing of the Arbitration Hearing for a period of up to thirty (30) days after the presentation of proofs in order to permit the parties to submit post-hearing briefs and argument, as the Panel deems appropriate, prior to making an award.

For good cause, the Arbitration Hearing may be reopened for up to thirty (30) days on the Panel's initiative, or upon application of a party, at any time before the award is made

O. Awards

An Award must be in writing and shall be made promptly by the Panel and, unless otherwise agreed by the parties or specified by law, no later than thirty (30) days from the date of closing the Arbitration Hearing. If all parties so request, the Award shall contain findings of fact and conclusions of law. The Award, and all other rulings and determinations by the Panel, may be by a majority vote.

Parties shall accept as legal delivery of the Award the placing of the Award or a true copy thereof in the mail addressed to a party or its representative at its last known address or personal service of the Award on a party or its representative.

Awards are binding only on the parties to the Arbitration and are not binding on any non-parties to the Arbitration and may not be used or cited as precedent in any other proceeding.

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After the expiration of twenty (20) days from initial delivery, the Award (with corrections, if any) shall be final and binding on the parties, and the parties shall undertake to carry out the Award without delay.

Proceedings to confirm, modify or vacate an Award shall be conducted in conformity with and controlled by the Federal Arbitration Act. 9 U.S.C. § 1, *et seq.*

P. Return of Documents

Within sixty (60) days after the Award and the conclusion of any judicial proceedings with respect thereto, each party and the Panel shall return any documents produced by any other party, including all copies thereof. If a party receives a discovery request in any other proceeding which would require it to produce any documents produced to it by any other party in a proceeding hereunder, it shall not produce such documents without first notifying the producing party and giving said party reasonable time to respond, if appropriate, to the discovery request.

4. Miscellaneous

A. Expedited Procedures

Any party to a Mediation may direct a request for an expedited Mediation Hearing to the Chairman of the Mediation Committee, to the selected Mediators, and to all other parties at any time. The Chairman of the Mediation Committee, or at his or her direction, the then selected Mediators, shall grant any request which is supported by good and sufficient reasons. If such a request is granted, the Mediation shall be completed within as short a period as practicable, as determined by the Chairman of the Mediation Committee or, at his or her direction, the then selected Mediators.

Any party to an Arbitration may direct a request for expedited proceedings to the Administrator, to the Panel, and to all other parties at any time. The Administrator, or the Presiding Arbitrator if the Panel has been selected, shall grant any such request which is supported by good and sufficient reasons. If such a request is granted, the Arbitration shall be completed within as short a time as practicable, as determined by the Administrator and/or the Presiding Arbitrator.

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B. Temporary or Preliminary Injunctive Relief

Any party may seek temporary or preliminary injunctive relief with the filing of a Complaint or at any time thereafter. If such relief is sought prior to the time that an Arbitration Panel has been selected, then the Administrator shall select a single Arbitrator who is a lawyer who has no interest in the subject matter of the dispute, and no connection to any of the parties, to hear and determine the request for temporary or preliminary injunction. If such relief is sought after the time that an Arbitration Panel has been selected, then the Arbitration Panel will hear and determine the request. The request for temporary or preliminary injunctive relief will be determined with reference to the temporary or preliminary injunction standards set forth in Fed. R. Civ. P. 65.

C. Defaults and Proceedings in the Absence of a Party

Whenever a party fails to comply with the MDR Rules in a manner deemed material by the Panel, the Panel shall fix a reasonable time for compliance and, if the party does not comply within said period, the Panel may enter an Order of default or afford such other relief as it deems appropriate. Arbitration may proceed in the event of a default or in the absence of any party who, after due notice, fails to be present or fails to obtain an extension. An Award shall not be made solely on the default or absence of a party, but the Panel shall require the party who is present to submit such evidence as the Panel may require for the making of findings, determinations, conclusions, and Awards.

D. Notice

Each party shall be deemed to have consented that any papers, notices, or process necessary or proper for the initiation or continuation of a proceeding under these rules or for any court action in connection therewith may be served on a party by mail addressed to the party or its representative at its last known address or by personal service, in or outside the state where the MDR proceeding is to be held.

The Corporate Secretary and the parties may also use facsimile transmission, telex, telegram, or other written forms of electronic communication to give the notices required by these rules.

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E. Expenses

The expenses of witnesses shall be paid by the party causing or requesting the appearance of such witnesses. All expenses of the MDR proceeding, including compensation, required travel and other reasonable expenses of the Panel, and the cost of any proof produced at the direct request of the Panel, shall be borne equally by the parties and shall be paid periodically on a timely basis, unless they agree otherwise or unless the Panel in the Award assesses such expenses, or any part thereof against any party (or parties). In exceptional cases, the Panel may award reasonable attorneys' fees as an item of expense, and the Panel shall promptly determine the amount of such fees based on affidavits or such other proofs as the Panel deems sufficient.

F. Disqualification or Disability of A Panel Member

In the event that any Arbitrator of a Panel with more than one Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the remaining Panel member(s):

- i. shall designate a replacement, subject to the right of any party to challenge such replacement for cause.
- ii. shall decide the extent to which previously held hearings shall be repeated.

If the remaining Panel members consider the proceedings to have progressed to a stage as to make replacement impracticable, the parties may agree, as an alternative to the recommencement of the Mandatory Dispute Resolution process, to resolution of the dispute by the remaining Panel members.

In the event that a single Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the Administrator shall appoint a successor, subject to the right of any party to challenge such successor for cause, and the successor shall decide the extent to which previously held proceedings shall be repeated.

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G. Extensions of Time

Subject to the provisions of Paragraph 3.H.(viii.), any time limit set forth in these Rules may be extended upon agreement of the parties and approval of: (1) the Mediator if the proceeding is then in Mediation; (2) the Administrator if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (3) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected.

H. Intervention

The Plans, their Controlled Affiliates, and BCBSA, to the extent subject to MMDR pursuant to their License Agreements, shall have the right to move to intervene in any pending Arbitration. A written motion for intervention shall be made to: (1) the Administrator, if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (2) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected. The written motion for intervention shall be delivered to the BCBSA Corporate Secretary (which shall also constitute service on the BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) which are parties to the proceeding. Any party to the proceeding can submit written objections to the motion to intervene. The motion for intervention shall be granted upon good cause shown. Intervention also may be allowed by stipulation of the parties to the Arbitration proceeding. Intervention shall be allowed upon such terms as the Arbitration Panel decides.

I. BCBSA Assistance in Resolution of Disputes

The resources and personnel of the BCBSA may be requested by any member Plan at any time to try to resolve disputes with another Plan.

J. Neutral Evaluation

The parties can voluntarily agree at any time to have an independent party render a neutral evaluation of the parties' respective positions.

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K. Recovery of Attorney Fees and Expenses

i. Motions to Compel

Notwithstanding any other provisions of these Rules, any Party subject to the License Agreements (for purposes of this Section K and all of its subsections only hereinafter referred to collectively and individually as a “Party”) that initiates a court action or administrative proceeding solely to compel adherence to these Rules shall not be determined to have violated these Rules by initiating such action or proceeding.

ii Recovery of Fees, Expenses and Costs

The Arbitration Panel may, in its sole discretion, award a Party its reasonable attorneys’ fees, expenses and costs associated with a filing to compel adherence to these Rules and/or reasonable attorneys’ fees, expenses and costs incurred in responding to an action filed in violation of these Rules; provided, however, that neither fees, expenses, nor costs shall be awarded by the Arbitration Panel if the Party from which the award is sought can demonstrate to the Arbitration panel, in its sole discretion, that it did not violate these Rules or that it had reasonable grounds for believing that its action did not violate these Rules.

iii Requests for Reimbursement

For purposes of this Section K, any Party may request reimbursement of fees, expenses and/or costs by submitting said request in writing to the Arbitration Panel at any time before an award is delivered pursuant Paragraph to 3.O above with a copy to the Party from which reimbursement is sought, explaining why it is entitled to such reimbursement. The Party from which reimbursement is sought shall have twenty (20) days to submit a response to such request to the Arbitration Panel with a copy to the Party seeking reimbursement.

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L. Calculation of Time and Deadlines

In computing any period of time prescribed or allowed under these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not one of the aforementioned days. When the period of time prescribed is less than six (6) days, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation. As used in this rule, "legal holiday" includes New Year's Day, Martin Luther King, Jr. Day, Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day and any other day appointed as a holiday by the President or the Congress of the United States.

Amended as of September 20, 2007

BLUE SHIELD LICENSE AGREEMENT

(Includes revisions, if any, adopted by Member Plans through their November 18, 2016 meeting)

This agreement by and between Blue Cross and Blue Shield Association ("BCBSA") and The Blue Shield Plan, known as _____ (the "Plan").

Preamble

WHEREAS, the Plan and/or its predecessor(s) in interest (collectively the "Plan") had the right to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") for health care plans in its service area, which was essentially local in nature;

WHEREAS, the Plan was desirous of assuring nationwide protection of the Licensed Marks, maintaining uniform quality controls among Plans, facilitating the provision of cost effective health care services to the public and otherwise benefiting the public;

WHEREAS, to better attain such ends, the Plan and the predecessor of BCBSA executed the Agreement(s) Relating to the Collective Service Mark "Blue Shield"; and

WHEREAS, BCBSA and the Plan desire to supercede said Agreement(s) to reflect their current practices and to assure the continued integrity of the Licensed Marks and of the BLUE SHIELD system;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

Agreement

1. BCBSA hereby grants to the Plan, upon the terms and conditions of this License Agreement (“Agreement” or “Primary License Agreement”, the right to use BLUE SHIELD in its trade and/or corporate name (the “Licensed Name”), and the right to use the Licensed Marks, in the sale, marketing and administration of health care plans and related services in the Service Area set forth and defined in paragraph 5 below. As used herein, health care plans and related services shall include acting as a nonprofit health care plan, a for-profit health care plan, or mutual health insurer operating on a not-for-profit or for-profit basis, under state law; financing access to health care services; when working with a bank that holds the relevant license to use the Licensed Name and Marks, offering: (i) tax-favored savings accounts for medical expenses and means for accessing such accounts, such as debit cards or checks, that are provided solely to support access to such tax-favored savings accounts, all pursuant to such license, or (ii) prepaid rewards cards that are provided for completion of a wellness program, all pursuant to such license; providing health care management and administration; administering, but not underwriting, non-health portions of Worker’s Compensation insurance; delivering health care services, except hospital services (as defined in the Guidelines to Membership Standards Applicable to Regular Members); and performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by a group account to its members, including benefit plans not provided by the Plan, provided that the Plan has contracted to provide Health Coverage under the Licensed Marks to the account (as the terms “Health Coverage,” “Eligibility” and “Enrollment” are defined in Exhibit 4, Paragraph 2.t.).

2. The Plan may use the Licensed Marks and Name in connection with the offering of: i) health care plans and related services in the Service Area through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the “Controlled Affiliate License Agreement”); and ii) insurance coverages offered by life insurers under the applicable law in the Service Area, other than those which the Plan may offer in its own name, provided through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1A hereto (the “Controlled Affiliate License Agreement Applicable to Life Insurance Companies”) or the Agreement attached as Exhibit 1A1 hereto (the “Controlled Affiliate Trademark License Agreement for Life and Disability Insurance Products”) and further provided that the offering of such services does not and will not dilute or tarnish the unique value of the Licensed Marks and Name; and iii) administration and underwriting of Workers’ Compensation Insurance Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the “Controlled Affiliate License.”); and iv) regional Medicare Advantage PPO Products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1B hereto (the “Controlled Affiliate License Agreement Applicable to Regional Medicare Advantage PPO Products”); and v) regional Medicare Part D Prescription Drug Plan products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1C hereto (the “Controlled Affiliate License Agreement Applicable to Regional Medicare Part D Prescription Drug Plan Products”). As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans and, if the entity meets the standards of Paragraph 2a.B but not Paragraph 2a.A, the entity, its owners, and persons authority to select or appoint members or board members, other than a Plan or Plans, have received written approval of BCBSA. Absent written approval by BCBSA of an alternative method of control, bona fide control shall have the meaning set forth in

Paragraphs 2a. and 2b.

2a. With respect to the Controlled Affiliate Licenses authorized in clauses

i)through iii) of Paragraph 2, bona fide control shall mean that a Plan (the “Sponsoring Plan”) authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to this Primary License Agreement with BCBSA must have:

- A. The legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; (b) to exercise control over the policy and operations of the Controlled Affiliate; (c) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or
- B. The legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; (c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan. Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:
1. Change its legal and/or trade name;
 2. Change the geographic area in which it operates;
 3. Change any of the types of businesses in which it engages;
 4. Create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;
 5. Sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;
 6. Make any loans or advances except in the ordinary course of business;

Amended as of March 26, 2015

7. Enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners of the Controlled Affiliate or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);
8. Conduct any business other than under the Licensed Marks and Name;
9. Take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks or Names.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or

- C. With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid products and services, the legal authority together with such other Plans (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B-1 to Exhibit 1 attached hereto; or
- D. With respect to a Controlled Affiliate that is 100% controlled by a Sponsoring Plan which on a Blue-branded basis, offers solely a Basic Medicare Part D Prescription Drug product, the legal authority (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan shall own 100% of

Amended as of March 17, 2016

any for-profit Controlled Affiliate. Such 100% control and ownership by the Plan shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and Participating Plan as defined on the Controlled Affiliate License Agreement shall execute the “Addendum to Controlled Affiliate License” attached as Exhibit B-2 to Exhibit 1 attached hereto.

2b. With respect to the Controlled Affiliate License Agreements authorized in clauses iv) and v) of Paragraph 2, bona fide control shall mean that the Controlled Affiliate is organized and operated in such a manner that it meets the following requirements:

- A. The Controlled Affiliate is owned or controlled by two or more Plans authorized to use the Licensed Marks pursuant to this License

Amended as of March 26, 2015

Agreement with BCBSA (for purposes of this subparagraph A. through subparagraph C., the “Controlling Plans”); and

- B. Each Controlling Plan is authorized pursuant to this Agreement to use the Licensed Marks in a geographic area in the Region (as that term is defined in such Controlled Affiliate License Agreements) and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
- C. The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate’s governing body having not less than 100% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur; and (c) to exercise control over the policy and operations of the Controlled Affiliate. Notwithstanding anything to the contrary in (a) through (c) of this subparagraph E., the Controlled Affiliate’s establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:
 - 1. Change its legal and/or trade names;
 - 2. Change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

Amended as of March 26, 2015

3. Change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
4. Take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly- owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. With respect to a Controlled Affiliate that is not licensed to use the Licensed Marks and Name, the Plan may, in communications that contain the Licensed Marks or Name, indicate its corporate relationship to the Affiliate and permit such Affiliate to indicate its corporate relationship to the Plan, solely in the circumstances, style and manner specified by BCBSA from time-to-time in regulations of general application consistent with the avoidance of confusion or mistake or the dilution or tarnishment of the Licensed Marks and Name. No rights are hereby created in any Controlled Affiliate to use the Licensed Marks or Name in its own name or otherwise.

4. The Plan recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Plan further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide. The Plan agrees (a) to maintain in good standing its membership in BCBSA; (b) promptly to pay its dues to BCBSA, said dues to represent the royalties for this License Agreement; (c) materially to comply with all applicable laws; (d) to comply with the Membership Standards Applicable to Regular Members of BCBSA, a current copy of which is attached as Exhibit 2 hereto; and (e) reasonably to permit BCBSA, upon a written, good faith request and during reasonable business hours, to inspect the Plan's books and records necessary to ascertain compliance herewith. As to other Plans and third parties, BCBSA shall maintain the confidentiality of all documents and information furnished by the Plan pursuant hereto, or pursuant to the Membership Standards, and clearly designated by the Plan as containing proprietary information of the Plan.

5. The rights hereby granted are exclusive to the Plan within the geographical area(s) served by the Plan on June 30, 1972, and/or as to which the Plan has been granted a subsequent license, which is hereby defined as the "Service Area," except that BCBSA reserves the right to use the Licensed Marks in said Service Area, and except to the extent that said Service Area may overlap areas served by one or more other licensed Blue Shield Plans as of said date or subsequent license, as to which overlapping areas the rights hereby granted are nonexclusive as to such other Plan or Plans only.

Amended as of June 19, 2014

6. Except as expressly provided by BCBSA with respect to National Accounts, Government Programs and certain other necessary and collateral uses, the current rules and regulations governing which are attached as Exhibit 3 and Exhibit 4 hereto, and are contained in other documents referenced herein, or as expressly provided herein, the Plan may not use the Licensed Marks and Name outside the Service Area or in connection with other goods and services, nor may the Plan use the Licensed Marks or Name in a manner which is intended to transfer in the Service Area the goodwill associated therewith to another mark or name. Nothing herein shall be construed to prevent the Plan from engaging in lawful activity anywhere under other marks and names not confusingly similar to the Licensed Marks and Name, provided that engaging in such activity does and will not dilute or tarnish the unique value of the Licensed Marks and Name. In addition to any and all remedies available hereunder, BCBSA may impose monetary fines on the Plan for the Plan's use of the Licensed Marks and Names outside the Service Area, and provided that the procedure used in imposing a fine is consistent with procedures specifically prescribed by BCBSA from time to time in regulations of general application. In the case of regional Medicare Advantage PPO and regional Medicare Part D Prescription Drug Plan products offered by consenting and participating Plans in a region that includes the Service Areas, or portions thereof, of more than one Plan, such fine may be imposed jointly on the consenting and participating Plans for use of the Licensed Marks and Name in any geographic area of the region in which a Plan having exclusive rights to the Licensed Marks and Name does not consent to and participate in such offering, provided that the basis for imposition of such fine is consistent with rules specifically prescribed by BCBSA from time to time in regulations of general application.

7. The Plan agrees that it will display the Licensed Marks and Name only in such form, style and manner as shall be specifically prescribed by BCBSA from time-to-time in regulations of general application in order to prevent impairment of the distinctiveness of the Licensed Marks and Name and the goodwill pertaining thereto. The Plan shall cause to appear on all materials on or in connection with which the Licensed Marks or Name are used such legends, markings and notices as BCBSA may reasonably request in order to give appropriate notice of service mark or other proprietary rights therein or pertaining thereto.

8. BCBSA agrees that: (a) it will not grant any other license effective during the term of this License Agreement for the use of the Licensed Marks or Name which is inconsistent with the rights granted to the Plan hereunder; and (b) it will not itself use the Licensed Marks in derogation of the rights of the Plan or in a manner to deprive the Plan of the full benefits of this License Agreement, provided that BCBSA shall have the right to use the Licensed Marks in conjunction with any national offering under the Federal Employees Health Benefits Program in the manner set forth in Exhibit 4, Paragraph 4 (including subparagraphs) to this License Agreement. The Plan agrees that it will not attack the title of BCBSA in and to the Licensed Marks or Name or attack the validity of the Licensed Marks or of this License Agreement. The Plan further agrees that all use by it of the Licensed Marks and Name or any similar mark or name shall inure to the benefit of BCBSA, and the Plan shall cooperate with BCBSA in effectuating the assignment to BCBSA of any service mark or trademark registrations of the Licensed Marks or any similar mark or name held by the Plan or a Controlled Affiliate of the Plan, all or any portion of which registration consists of the Licensed Marks.

Amended as of November 16, 2006

9. (a). Should the Plan fail to comply with the provisions of paragraphs 2-4, 6, 7 and/or 12, and not cure such failure within thirty (30) days of receiving written notice thereof (or commence curing such failure within such thirty day period and continue diligent efforts to complete the curing of such failure if such curing cannot reasonably be completed within such thirty day period), BCBSA shall have the right to issue a notice that the Plan is in a state of noncompliance. Except as to the termination of a Plan's License Agreement or the merger of two or more Plans, disputes as to noncompliance, and all other disputes between or among BCBSA, the Plan, other Plans and/or Controlled Affiliates, shall be submitted promptly to mediation and mandatory dispute resolution pursuant to the rules and regulations of BCBSA, a current copy of which is attached as Exhibit 5 hereto, and shall be timely presented and resolved. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. If a state of noncompliance as aforesaid is undisputed by the Plan or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the License Agreement. Except, however, as provided in paragraphs 9(d)(iii), 15(a)(i)-(viii), and 15(a)(x) below, no Plan's license to use the Licensed Marks and Name may be finally terminated for any reason without the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

(b). Notwithstanding any other provision of this License Agreement, a Plan's license to use the Licensed Marks and Name may be forthwith terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to Member Plans for: (i) failure to comply with any minimum capital or liquidity requirement under the Membership Standard on Financial Responsibility; or (ii) impending financial insolvency; or (iii) the pendency of any action instituted against the Plan seeking its dissolution or liquidation or its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property of business, unless this License Agreement has been earlier terminated under paragraph 15(a); or (iv) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans and/or the Licensed Marks.

Amended as of March 16, 2006

(c). To the extent not otherwise provided therein, neither: (i) the Membership Standards Applicable to Regular Members of BCBSA; nor (ii) the rules and regulations governing Government Programs and certain other uses; nor (iii) the rules and regulations governing mediation and mandatory dispute resolution, may be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans. The rules and regulations governing National Accounts and other national programs required by the Membership Standards Applicable to Regular Members of BCBSA (Exhibit 2) are contained, in addition to those set forth in Exhibit 3, in the following documents, as amended from time to time: (1) the Inter-Plan Programs Policies and Provisions; (2) Inter-Plan Medicare Advantage Program Policies and Provisions. The voting requirements specified in rules and regulations governing such national programs may not be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans.

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

(i) The Plan shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement and the Plan's membership in BCBSA.

(ii) The Plan shall not use the licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Plan in any securities market. The Plan shall use the Licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(iii) The Plan's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Plan knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Plan ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Plan knows, or there is an SEC filing indicating that, any Noninstitutional Investor has become the Beneficial Owner of securities representing 5% or more of the voting power of the Plan ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Plan knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner of 20% or more of the Plan's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 9(d)(iv) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Plan went public constituted the Board of Directors of the Plan (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Plan went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Plan consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Plan in a writing received by BCBSA prior to such automatic termination

Amended as of September 17, 1997

becoming effective, the provisions of this paragraph 9(d)(iii) may be waived, in whole or in part, upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 9(d)(iii)(a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Plan's license to use the Licensed Marks and Name is terminated pursuant to this Paragraph 9(d)(iii), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Plan demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(iv) The Plan shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities or (iii) such other securities as the Plan may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(v) For purposes of paragraph 9(d)(iii), the following definitions shall apply:

(a) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(b) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

Amended as of September 17, 1997

(i) which such Person or any of such

Person's Affiliates or Associates beneficially owns, directly or indirectly;

(ii) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(iii) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (b)(ii)(B) above) or disposing of any securities of the Plan.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Plan, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(c) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

(d) "Noninstitutional Investor" means any Person who is not an Institutional Investor.

(e) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

(The next page is page 6)

Amended as of September 17, 1997

10. This License Agreement shall remain in effect: (a) until terminated as provided herein; or (b) until this and all such other License Agreements are terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans; (c) until terminated by the Plan upon eighteen (18) months written notice to BCBSA or upon a shorter notice period approved by BCBSA in writing at its sole discretion.

11. Except as otherwise provided in paragraph 15 below or by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans, or unless this and all such other License Agreements are simultaneously terminated by force of law, the termination of this License Agreement for any reason whatsoever shall cause the reversion to BCBSA of all rights in and to the Licensed Marks and Name, and the Plan agrees that it will promptly discontinue all use of the Licensed Marks and Name, will not use them thereafter, and will promptly, upon written notice from BCBSA, change its corporate name so as to eliminate the Licensed Name therefrom.

12. The license hereby granted to Plan to use the Licensed Marks and Name is and shall be personal to the Plan so licensed and shall not be assignable by any act of the Plan, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Plan mortgage or part with possession or control of this license or any right hereunder, and the Plan shall have no right to grant any sublicense to use the Licensed Marks and Name.

13. BCBSA shall maintain appropriate service mark registrations of the Licensed Marks and BCBSA shall take such lawful steps and proceedings as may be necessary or proper to prevent use of the Licensed Marks by any person who is not authorized to use the same. Any actions or proceedings undertaken by BCBSA under the provisions of this paragraph shall be at BCBSA's sole cost and expense. BCBSA shall have the sole right to determine whether or not any legal action shall be taken on account of unauthorized use of the Licensed Marks, such right not to be unreasonably exercised. The Plan shall report any unlawful usage of the Licensed Marks to BCBSA in writing and agrees, free of charge, to cooperate fully with BCBSA's program of enforcing and protecting the service mark rights, trade name rights and other rights in the Licensed Marks.

14. The Plan hereby agrees to save, defend, indemnify and hold BCBSA And any other Plan(s) harmless from and against all claims, damages, liabilities and Costs of every kind, nature and description which may arise as a result of the activities of the Plan or of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan. BCBSA hereby agrees to save, defend, indemnify and hold the Plan and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of BCBSA.

Amended as of June 21, 2012

15. (a). This Agreement shall automatically terminate upon the occurrence of any of the following events: (i) a voluntary petition shall be filed by the Plan or by BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against the Plan or BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Plan or BCBSA respectively, or (iii) an order for relief is entered against the Plan or BCBSA in any case under the bankruptcy laws of the United States, or the Plan or BCBSA is adjudged bankrupt or insolvent (as that term is defined in the Uniform Commercial Code as enacted in the state of Illinois) by any court of competent jurisdiction, or (iv) the Plan or BCBSA makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of the Plan or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Plan or BCBSA respectively, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of the Plan's or BCBSA's property or business is appointed, or the Plan or BCBSA is ordered dissolved or liquidated, or (ix) the Plan shall fail to pay its dues and shall not cure such failure within thirty (30) days of receiving written notice thereof, or (x) if, due to regulatory action, the Plan together with any applicable Controlled Affiliate becomes unable to do business using the Names and Marks in any State or portion thereof included in its Service Area, provided that: (i) automatic termination shall not occur prior to the exhaustion by any such Plan of its rights to appeal or challenge such regulatory action; and (ii) in the event the Plan is licensed to do business using the Names and Marks in multiple States or portions of States, the termination of its License Agreement shall be solely limited to the State(s) or portions thereof in which the regulatory action applies. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Plan's or BCBSA's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 15(a)(vii) and (viii) of this Agreement.

Amended as of September 14, 2004

(b). BCBSA, or the Plans (as provided and in addition to the rights conferred in Paragraph 10(b) above), may terminate this Agreement immediately upon written notice upon the occurrence of either of the following events: (a) the Plan or BCBSA becomes insolvent (as that term is defined in the Uniform Commercial Code enacted in the state of Illinois), or (b) any final judgment against the Plan or BCBSA remains unsatisfied or unbonded of record for a period of sixty (60) days or longer.

(c). If this License Agreement is terminated as to BCBSA for any reason stated in subparagraphs 15(a) and (b) above, the ownership of the Licensed Marks shall revert to each of the Plans.

(d). Upon termination of this License Agreement or any Controlled Affiliate License Agreement of a Larger Controlled Affiliate, as defined in Exhibit 1 to this License Agreement, the following conditions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 15 (a)(x)(ii) of this Agreement, the notices, national account listing, payment and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

- (i) The terminated entity shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the terminated entity or its Controlled Affiliates under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination or, if termination is pursuant to paragraph 10(d) of this Agreement, within 15 days after the written notice to BCBSA described in paragraph 10(d).
- (ii) The terminated entity shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the terminated entity is involved (in a Control, Participating or Servicing capacity), identifying the national account and the terminated entity's role therein. For those accounts where the terminated entity is the Control Plan, the Plan must also indicate the Participating and Servicing Plans in the national account syndicate.

Amended as of June 16, 2005

- (iii) Unless the cause of termination is an event stated in paragraph 15(a) or (b) above respecting BCBSA, the Plan and its Licensed Controlled Affiliates shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. The Re-Establishment Fee shall be indexed to a base fee of \$80. The Re-Establishment Fee through December 31, 2005 shall be \$80. The Re-Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was \$278.60, \$285.00 and \$290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be \$83.27 (100% of the base fee plus \$1.84 for calendar year 2005 and \$1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (a) the end of the last fiscal year of the terminated entity which ended prior to termination or (b) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph (d)(iii) shall be due only

Amended as of June 16, 2005

to the extent that, in BCBSA's opinion, it does not cause the net worth of the Plan to fall below 100% of the Health Risk-Based Capital formula or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans), measured as of the date of termination and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plan or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Plan (and/or its Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph only to the extent that such payments exceed the amounts due to BCBSA pursuant to subparagraph 15(d)(vi) and any costs associated with reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the terminated entity.

- (iv) The terminated entity shall comply with all financial settlement procedures set forth in BCBSA's License Termination Contingency Plan, as amended from time to time and shall work diligently and in good faith with

Amended as of June 16, 2005

BCBSA, any Alternative Control Licensee or Replacement Licensee and any existing or potential new account for Blue-branded products and services to minimize the disruption of termination, and honor, to the fullest extent possible, the desire of accounts to continue to receive or obtain Blue-branded products and services through a new Licensee ("Transition"). Such diligence and good faith on the part of the terminated entity shall include, but not be limited to: (a) working cooperatively with BCBSA to protect the Names and Marks from potential harm; (b) cooperating with BCBSA's use of the Names and Marks in the terminated entity's former service area during the termination and Transition; (c) transmitting, upon the request of an existing Blue account or of BCBSA with consent and on behalf of an existing Blue account, all member and account-data relating to the Federal Employee Program to BCBSA, and all member and account data relating to other programs to an Alternative Control Licensee or Replacement Licensee; (d) working with BCBSA and the Alternative Control or Replacement Licensee with respect to potential new Blue accounts headquartered in the terminated entity's former service area; (e) continuing to service Blue accounts during the Transition; (f) continuing to comply with National Programs, Federal Employee Program and NASCO policies and procedures and all voluntary BCBSA programs, policies and performance standards, such as Away From Home Care, including being responsible for payment of all penalties for non-compliance duly levied in conformity with the License Agreements, Membership Standards, or the Federal Employee Program agreements, that may arise during the Transition; (g) maintaining and providing access to its provider networks, as defined by Federal Employee Program agreements and National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and making those networks and discounts available to members and providers who participate in National Programs and the Federal Employee Program during the Transition; (h) maintaining its technical connections and processing capabilities during the Transition; and (i) working diligently to conclude all financial settlements and account reconciliations as negotiated in the termination transition agreement.

Amended as of November 16, 2006

- (v) Notwithstanding any other provision in this Agreement, BCBSA shall have the right, with the approval of its Board of Directors, to assess additional fines against the terminated entity during the Transition in the event it fails to maintain and provide access to provider networks as defined by Federal Employee Program agreements, National Account Program Policies and Provisions, and Inter-Plans Programs Policies and Provisions, and/or pass on applicable discounts. Such fines shall be in addition to any other assessments, fees or liquidated damages payable herein, or under existing policies and programs and shall be imposed to make whole BCBSA and/or the Plans. Terminated entity shall pay any such fines to BCBSA no later than 30 days after they are approved by the Board of Directors.
- (vi) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third-party auditor to examine and audit the books and records of the terminated entity and its Licensed Controlled Affiliates to verify compliance with the terms and requirements of this paragraph 15(d).
- (vii) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.
- (viii) As to a breach of 15 (d) (i), (ii), (iii), (iv), (vi), or (vii) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 15 (d) (i), (ii), (iv), (vi), or (vii) by the Plan, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

Amended as of November 16, 2006

- (ix) In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Plan and its Licensed Controlled Affiliates shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

(e). BCBSA shall be entitled to enjoin the Plan or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this License Agreement unless the License Agreement has been terminated pursuant to paragraph 10 (d) of this Agreement upon the required six (6) month written notice.

- (f). BCBSA acknowledges that it is not the owner of assets of the Plan.

Amended as of June 16, 2006

16. This Agreement supersedes any and all other agreements between the parties with respect to the subject matter herein, and contains all of the covenants and agreements of the parties as to the licensing of the Licensed Marks and Name. This Agreement may be amended only by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.
17. If any provision or any part of any provision of this Agreement is judicially declared unlawful, each and every other provision, or any part of any provision, shall continue in full force and effect notwithstanding such judicial declaration.
18. No waiver by BCBSA or the Plan of any breach or default in performance on the part of BCBSA or the Plan or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.
- 19a. All notices provided for hereunder shall be in writing and shall be sent in duplicate by regular mail to BCBSA or the Plan at the address currently published for each by BCBSA and shall be marked respectively to the attention of the President and, if any, the General Counsel, of BCBSA or the Plan.

- 19b Except as provided in paragraphs 9(b), 9(d)(iii), 15(a), and 15(b) above, this Agreement may be terminated for a breach only upon at least 30 days' written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Member Plans.
- 19c For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2006

20. Nothing herein contained shall be construed to constitute the parties hereto as partners or joint venturers, or either as the agent of the other, and Plan shall have no right to bind or obligate BCBSA in any way, nor shall it represent that it has any right to do so. BCBSA shall have no liability to third parties with respect to any aspect of the business, activities, operations, products, or services of the Plan.
21. This Agreement shall be governed, construed and interpreted in accordance with the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By _____

Title _____

Date _____

Plan:

By _____

Title _____

Date _____

BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT
(Includes revisions adopted by Member Plans through their June 16, 2016 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Shield Plan, known as _____ ("Plan" or "Sponsoring Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non-health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the Sponsoring Plan's net subscription revenue.

This grant of rights is non-exclusive and is limited to the Service Area served by the Plan. Subject to Paragraph 3A(3) of this Agreement, Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market, unless such Controlled Affiliate is a not-for-profit company which may use the Licensed Marks and Name, or an approved derivative therefor, to identify itself in debt securities markets. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

Amended as of March 26, 2015

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that the Sponsoring Plan has:

(1) The legal authority directly or indirectly through wholly-owned subsidiaries:

- (a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and
- (c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates;
- (iii) change any of the type(s) of businesses in which it engages;

Amended as of September 19, 2014

- (iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;
- (v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;
- (vi) make any loans or advances except in the ordinary course of business;
- (vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);
- (viii) conduct any business other than under the Licensed Marks and Name;
- (ix) take any action that Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

- (2) The legal authority directly or indirectly through wholly-owned subsidiaries;
 - (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:
 - (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; and
 - (c) to exercise control over the policy and operations of the Controlled Affiliate.

Amended as of March 26, 2015

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

(3) With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid products and services, the legal authority together with such other Plans:

- (a) to select all members of the Controlled Affiliate's governing body; and
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and
- (c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such control and ownership by Plans must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License Agreement attached hereto as Exhibit B-1.

Or

(4) With respect to a Controlled Affiliate that is 100% controlled by a Sponsoring Plan which on a Blue-branded basis offers solely a Basic Medicare Part D Prescription Drug product, the legal authority:

- (a) to select all members of the Controlled Affiliate's governing body; and
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and
- (c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by Sponsoring Plan must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Participating Plan as defined in Exhibit B-2 and the Sponsoring Plan shall execute the Addendum to Controlled Affiliate License Agreement attached hereto as Exhibit B-2.

Amended March 17, 2016

3. FOR-PROFIT, PUBLICLY TRADED LICENSEES

A. The Controlled Affiliate may operate as a for-profit publicly traded company on the following conditions:

- (1) The Controlled Affiliate shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement.
- (2) The Controlled Affiliate shall provide 90 days advance written notice to BCBSA prior to the initial filing with the SEC.
- (3) The Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Controlled Affiliate in any securities market. The Controlled Affiliate shall use the Licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

Amended as of March 26, 2015

(4) The Controlled Affiliate's license to use the Licensed Marks and Name

shall automatically terminate effective: (a) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Controlled Affiliate ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Noninstitutional Investor, other than a Plan or Plans or Controlled Affiliate licensee or licensees has become the Beneficial Owner of securities representing 5% or more of the voting power of the Controlled Affiliate ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner, other than a Plan or Plans or Controlled Affiliate licensee or licensees, of 20% or more of the Controlled Affiliate's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under Paragraph 3A(4) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Controlled Affiliate went public constituted the Board of Directors of the Controlled Affiliate (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Controlled Affiliate went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Controlled Affiliate consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Sponsoring Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Controlled Affiliate in a writing received by BCBSA prior to such automatic termination becoming effective, the provision of this paragraph 3A(4) may be waived, in whole or in part, upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 3A(4)(a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

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In the event that the Controlled Affiliate's license, or any other license, to use the Licensed Marks and Name is terminated pursuant to Paragraph 3A(4), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Controlled Affiliate demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(5) The Controlled Affiliate shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities, or (iii) such other securities as the Controlled Affiliate may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(6) For purposes of paragraph 3(A) above, the following definitions shall apply:

(i) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(ii) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(1) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

(2) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

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(3) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (ii)2(B) above) or disposing of any securities of the Controlled Affiliate.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding", when used with reference to a Person's Beneficial Ownership of securities of the Controlled Affiliate, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(iii) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 1 of SEC Schedule 13G as constituted on June 1, 1997.

(iv) "Noninstitutional Investor" means any Person who is not an Institutional Investor.

(v) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

4. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed

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Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this Agreement, Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name.

5. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

6. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

Amended as of September 19, 2014

7. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to: (i) Controlled Affiliate's rendering of services under the Licensed Marks and Name; or (ii) the activities of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan or Controlled Affiliate.

8. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) the Plan ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement the Plan ceases to be authorized to use the Licensed Names and Marks in the geographic area served by the Controlled Affiliate provided, however, that if the Controlled Affiliate is serving more than one State or portions thereof, the termination of this Agreement shall be limited to the State(s) or portions thereof in which the Plan's license to use the Licensed Marks and Names is terminated. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph

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8(E); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 8(B), 8(C) or 8(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 8(B), 8(C) or 8(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 8(B) and 8(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Controlled Affiliate shall no longer comply with item 2(E) above;
- (2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 10 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or
- (3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of

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the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 8(E)(3)(vii) and (viii) of this Agreement.

(4) The for-profit, publicly traded Controlled Affiliate is terminated pursuant to Paragraph 3A(4) of this Agreement. In which case, the licenses of any controlled Affiliates directly or indirectly owned by the terminated for profit, publicly traded Controlled Affiliate also shall immediately terminate as provided for in paragraph 3A(4) of this Agreement

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

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H. In the event this Agreement terminates pursuant to 8(b) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 8.G. shall not apply and the following provisions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 8(B)(ii) of this Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area.

The Re-Establishment Fee shall be indexed to a base fee of \$80. The Re-Establishment Fee through December 31, 2005 shall be \$80. The Re-Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was \$278.60, \$285.00 and \$290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be \$83.27 (100% of base fee plus \$1.84 for calendar

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year 2005 and \$1.43 for calendar year 2006. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Plan or its other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 8.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 8.M. and any cost associated with reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third party auditor to examine and audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 8.H.

(5) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

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(6) As to a breach of 8.H.(1), (2), (3), (4) or (5) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 8.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. This Agreement shall remain in effect until terminated by the Controlled Affiliate or the Plan upon not less than eighteen (18) months written notice to the Association or upon a shorter notice period approved by BCBSA in writing at its sole discretion, or until terminated as otherwise provided herein. The Plan's right to terminate without cause upon such notice is unfettered and may be exercised in the Plan's sole discretion.

J. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3. and M. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

K. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of the Plan's license agreement upon the required 18 months written notice.

L. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

M. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E) (2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 8(C) and 8(D) above shall require the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

N. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

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9. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

10. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit C.

11. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

12. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

13. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

14. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

Amended as March 26, 2015

15. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

Amended as of March 26, 2015

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16. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

17. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: _____

Date: _____

Plan:

By: _____

Date: _____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: _____

Date: _____

Amended as of March 26, 2015

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS November 2016

PREAMBLE

For purposes of definition:

- A "smaller Controlled Affiliate:" (1) comprises less than fifteen percent (15%) of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers' compensation insurance and has total premium revenue less than 15 percent of the Sponsoring Plan's net subscription revenue.
- A "larger Controlled Affiliate" comprises fifteen percent (15%) or more of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate's status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate's health and workers' compensation administration business reaches or surpasses fifteen percent (15%) of the total member enrollment of the Sponsoring Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

Amended as of September 19, 2014

EXHIBIT A (continued)

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA "Health Risk-Based Capital (HRBC)" as defined by the NAIC and state-established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and
2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers' compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

*For purposes of this calculation, The numerator equals:

Applicant Controlled Affiliate's member enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Sponsoring Plan and all other licensed Controlled Affiliates' member enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

Amended as of September 19, 2014

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

Each licensed controlled affiliate shall be subject to certain standards as determined below:

1. What percent of the licensed controlled affiliate is controlled by the Sponsoring Plan and other Plans?

More than 50% by Sponsoring Plan ↓ Standard 1A, 4	50% by Sponsoring Plan ↓ Standard 1B, 4	100% Plan Control but less than 50% Sponsoring Plan Control and it offers solely Medicaid products and services ↓ Standard 1C, 4	100% Sponsoring Plan control and on a Blue-branded basis, it only offers Basic Medicare Part D Prescription Drug Plan product ↓ Standard 1D, 4
---	---	--	--

IN ADDITION,

2. Is risk being assumed?

Yes			No	
Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance ↓ Standards 7A-7E, 11	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance ↓ Standard 2 (Guidelines 1.1,1.2) and Standard 11	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance ↓ Standard 6H	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates ↓ Standard 2 (Guidelines 1.1,1.3) and Standard 11	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates ↓ Standard 6H

IN ADDITION,

3. Is medical care being directly provided?

Yes	No
↓ Standard 3A	↓ Standard 3B

IN ADDITION,

4. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total member enrollment of Plan and its licensed Controlled Affiliates?

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

EXHIBIT A (continued)

Standard 1 - Organization and Governance

1A.)The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA, Sponsoring Plan”), has the legal authority, directly or indirectly through wholly-owned subsidiaries: 1) to select members of the Controlled Affiliate’s governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate.

1B.)The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA, has the legal authority, directly or indirectly through wholly-owned subsidiaries:

- 1) to select members of the Controlled Affiliate’s governing body having not less than 50% voting control thereof; and
- 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; and
- 3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan.

Amended September 19, 2014

EXHIBIT A (continued)

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate.

1C.) The Standard for a Controlled Affiliate that offers solely Medicaid products and service and has 100% Plan control but less than 50% Sponsoring Plan Control:

A Controlled Affiliate shall be organized and operated in such a manner that (i) it offers solely Medicaid products and services; and (ii) a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA (the "Sponsoring Plan,") has the legal authority together with Other Plans:

Amended September 19, 2014

- 1) to select all members of the Controlled Affiliate's governing body; and
- 2) to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; and
- 3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License.

1D). The Standard for a Controlled Affiliate that on a Blue-branded basis, only offers a Basic Medicare Part D Prescription Drug product and has 100% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that (i) on a Blue-branded basis, it only offers a Basic Medicare Part D Prescription Drug product; and (ii) the Sponsoring Plan has the legal authority:

- 1) to select all members of the Controlled Affiliate's governing body; and
- 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and
- 3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan shall own 100% of any for-profit Controlled Affiliate. Such 100% control and ownership by Sponsoring Plan must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA.

Further, the Sponsoring Plan and Participating Plan shall execute the Addendum to Controlled Affiliate License.

Amended March 17, 2016

EXHIBIT A (continued)

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk-assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk-assuming Controlled Affiliate ceases operations for any reason, Sponsoring Plan will provide for services to its customers. The requirements of the preceding two sentences shall apply to all lines of business unless a line of business is specially exempted from the requirement(s) by the BCBSA Board of Directors.

Standard 3 - State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Amended as of September 19, 2014

EXHIBIT A (continued)

Standard 5 - Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its Sponsoring licensed Plan shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Other Standards for Larger Controlled Affiliates Standards 6(A) - (I) that follow apply to larger Controlled

Affiliates. Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost-effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Amended as of September 19, 2014

EXHIBIT A (continued)

Such programs are applicable to licensees, and include:

1. BlueCard Program;
2. Inter-Plan Teleprocessing System (ITS);
3. National Account Programs;
4. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
5. Inter-Plan Medicare Advantage Program.

Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter-licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Local and National Best Efforts

Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this License Agreement, during each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Shield Mark.

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Amended as of November 21, 2014

EXHIBIT A (continued)

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

- A) BCBSA Controlled Affiliate Licensure Information Request; and
- B) Triennial trade name and service mark usage material, including disclosure material; and
- C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and
- D) Semi-annual "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

Amended as of November 17, 2011

EXHIBIT A (continued)

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 - Other Standards for Risk-Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) - (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

- A. BCBSA Controlled Affiliate Licensure Information Request; and
- B. Triennial trade name and service mark usage materials, including disclosure materials; and
- C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk-Based Capital Worksheets for Property and Casualty Insurers; and
- D. Quarterly Estimated Risk-Based Capital for Property and Casualty Insurers, Insurance Department Examination Report; and

Amended as of November 17, 2011

EXHIBIT A (continued)

- E. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and
- F. Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended as of November 16, 2000

EXHIBIT A (continued)

Standard 8 - Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

A smaller controlled affiliate that formerly was a Primary Licensee shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of November 21, 2014

EXHIBIT A (continued)

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

C. Reporting requirements include:

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

Amended as of June 13, 2002

Exhibit A (continued)

Standard 9(B) - Participation in National Programs by Smaller Controlled Affiliates

A smaller controlled affiliate shall participate in national programs in accordance with BlueCard and other relevant Policies and Provisions shall effectively and efficiently participate in national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of June 20, 2013

EXHIBIT A (continued)

Standard 10 - Participation in Inter-Plan Medicare Advantage Program

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

A. Inter-Plan Medicare Advantage Program.

Standard 11: Participation in Master Business Associate Agreement by Smaller Controlled Affiliate Licensees

Effective April 14, 2003, all smaller controlled affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of September 19, 2014

EXHIBIT B-1

**ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES
LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1C.**

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Shield Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association

("Licensor"), _____ ("Controlled Affiliate Licensee")

and _____ ("Sponsoring Plan")

dated the ____ day of _____, ____ ("Agreement"). The parties to this Addendum are Licensor, Controlled Affiliate Licensee, Sponsoring Plan, and the undersigned other Plans ("Other Plans"). This Addendum is made and shall be deemed effective as of the date of the Agreement.

WHEREAS, the Sponsoring Plan asserts that it can serve the Medicaid market in its Service Area more efficiently and with less risk through a Medicaid enterprise jointly owned and controlled with other Plans than through a wholly owned and controlled Medicaid enterprise;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1C. permits the licensing of a Controlled Affiliate that is less than 50% owned and controlled by the Sponsoring Plan but which is 100% owned and controlled by Plans including the Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan and all such other owning and controlling Plans enter into this Addendum.;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. The Sponsoring Plan shall participate operationally in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that participation may take many forms, one of which should be providing a network of providers in the Service Area of the Controlled Affiliate for the Medicaid services being offered under the Agreement and being involved in network development and provider relations.
2. Each of the Other Plans agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it will not take any action, either individually or

Amended March 17, 2016

3. jointly with any of the Other Plans, that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with any of the Other Plans, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.
4. Each of the Other Plans acknowledges that it has reviewed the Agreement and understands that Sponsoring Plan has the right to terminate the Agreement without cause upon notice as provided in Paragraph 7 of the Agreement, and that such right is unfettered and may be exercised by Sponsoring Plan in its sole discretion.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By: _____

[Controlled Affiliate Licensee]

By: _____

[Sponsoring Plan]

By: _____

[Other Plan 1]

By: _____

[Other Plan 2]

By: _____

Amended as of September 19, 2014

EXHIBIT B-2

**ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES
LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1D.**

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Shield Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association ("Licensor"), _____ ("Controlled Affiliate Licensee"),
_____, _____ ("Sponsoring Plan") and
_____, _____ ("Participating Plan") dated the _____ day of
_____, _____ ("Agreement").

WHEREAS, the Participating Plan is defined as the Plan that holds the Primary License with BCBSA to use the Service Marks in the Service Area where the Controlled Affiliate will use the Service Marks;

WHEREAS, the Participating Plan asserts that it can offer a lower cost Basic Medicare Part D Prescription Drug Plan product more efficiently in the Participating Plan's Service Area through the Controlled Affiliate Licensee;

WHEREAS, the Controlled Affiliate shall only use the Service Marks inside of the Participating Plan(s) Service Area subject to each Participating Plan signing a separate Addendum;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1D permits the licensing of a Controlled Affiliate that is 100% owned and controlled by a Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan, Controlled Affiliate and the Participating Plan enter into this Addendum;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. The Participating Plan shall participate in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that the Participating Plan shall conduct sales support and marketing of the Controlled Affiliate's Basic Medicare Part D Prescription Drug Plan product offered in the Participating Plan's Service Area. Any other form of participation shall require BCBSA's written approval.
2. Participating Plan agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and

Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it will not take any action that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with the Sponsoring Plan or Controlled Affiliate Licensee, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

3. The Controlled Affiliate Licensee shall only use the Licensed Marks authorized by the Participating Plan in connection with the Basic Medicare Part D Prescription Drug Plan product offered in the Participating Plan's Service Area.
4. The Sponsoring Plan and Controlled Affiliate acknowledge that it has reviewed the Agreement and understands that Participating Plan has the right to terminate this Agreement: (i) immediately upon the expiration or termination of the Plan Participation Agreement by and between Participating Plan and Controlled Affiliate upon written notice to the Sponsoring Plan, Controlled Affiliate Licensee and Licensor, or (ii) without cause upon 18 months written notice to the Sponsoring Plan, Controlled Affiliate Licensee and Licensor, and that such right is unfettered and may be exercised by Participating Plan in its sole discretion. In the event that Participating Plan and Controlled Affiliate fail to execute the Plan Participation Agreement by _____ (Date), Participating Plan may terminate this Agreement immediately upon notice to Sponsoring Plan, Controlled Affiliate Licensee and Licensor.
5. This Agreement and all of Controlled Affiliate Licensee's rights hereunder shall immediately terminate without any further action by any party or entity in the event that the Sponsoring Plan or Participating Plan ceases to be authorized to use the Licensed Marks and Name.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By: _____

[Controlled Affiliate Licensee]

By: _____

[Sponsoring Plan]

By: _____

[Participating Plan]

By: _____

Amended March 17, 2016

EXHIBIT C

ROYALTY FORMULA FOR SECTION 9 OF THE CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of \$5,000 per license for a Controlled Affiliate subject to Standard 7.

Amended as of September, 19, 2014

EXHIBIT C (continued)

FOR NONRISK PRODUCTS:

For third-party administrative business, an amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For non-third party administrative business (e.g., case management, provider networks, etc.), an amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

- 1) An annual fee of \$5,000 per license for a Controlled Affiliate subject to Standard 6 D.
- 2) An annual fee of \$2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Amended as of September 19, 2014

CONTROLLED AFFILIATE LICENSE AGREEMENT APPLICABLE TO LIFE INSURANCE COMPANIES

(Includes revisions adopted by Member Plans through their November 18, 2016 meeting)

This agreement by and among Blue Cross and Blue Shield Association
("BCBSA") _____ ("Controlled Affiliate"), a
Controlled Affiliate of the Blue Shield Plan(s), known as
_____ ("Plan").

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, the Plan and the Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name");

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Controlled Affiliate the exclusive right to use the licensed Marks and Names in connection with and only in connection with those life insurance and related services authorized by applicable state law, other than health care plans and related services (as defined in the Plan's License Agreements with BCBSA) which services are not separately licensed to Controlled Affiliate by BCBSA, in the Service Area served by the Plan, except that BCBSA reserves the right to use the Licensed Marks and Name in said Service Area, and except to the extent that said Service Area may overlap the area or areas served by one or more other licensed Blue Shield Plans as of the date of this License as to which overlapping areas the rights hereby granted are non-exclusive as to such other Plan or Plans and their respective Licensed Controlled Affiliates only. Controlled Affiliate cannot use the Licensed Marks or Name outside the Service Area or in its legal or trade name; provided, however, that if and only for so long as Controlled Affiliate also holds a Blue Shield Affiliate License Agreement applicable to health care plans and related services, Controlled Affiliate may use the Licensed Marks and Name in its legal and trade name according to the terms of such license agreement.

Amended as of June 12, 2003

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in relation to the sale, marketing and rendering of authorized products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A as it may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having not less than 51% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Plan or Plans shall own at least 51% of any for-profit Controlled Affiliate. If the Controlled Affiliate is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items (a) and (c) above, proxies representing 51% of the votes at any meeting of the policyholders and shall demonstrate that there is no reason to believe this such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

3. SERVICE MARK USE

Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks, and shall comply with such rules (applicable to all Controlled Affiliates licensed to use the Marks) relative to service mark use, as are issued from time-to-time by BCBSA. If there is any public reference to the affiliation between the Plan and the Controlled Affiliate, all of the Controlled Affiliate's licensed services in the Service Area of the Plan shall be rendered under the Licensed Marks. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENTS

Controlled Affiliate shall promptly notify Plan and BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate hereby agrees to save, defend, indemnify and hold Plan and BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Controlled Affiliate's rendering of health care services under the Licensed Marks.

7. LICENSE TERM

The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods upon evidence satisfactory to the Plan and BCBSA that Controlled Affiliate meets the then applicable quality control standards, unless one of the parties hereto notifies the other party of the termination hereof at least sixty (60) days prior to expiration of any license period.

This Agreement may be terminated by the Plan or by BCBSA for cause at any time provided that Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Controlled Affiliate's failure to abide by the quality control provisions of Paragraph 2, above, shall be considered a proper ground for cancellation of this Agreement.

This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- A. Controlled Affiliate shall no longer comply with Standard No. 1 (Organization and Governance) of Exhibit A or, following an opportunity to cure, with the remaining quality control provisions of Exhibit A, as it may be amended from time-to-time; or
- B. Plan ceases to be authorized to use the Licensed Marks; or
- C. Appropriate dues for Controlled Affiliate pursuant to item 8 hereof, which are the royalties for this License Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks including any use in its trade name.

In the event of any disagreement between Plan and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of the Blue Cross and Blue Shield Association and provide instruction on how the customer can contact the Blue Cross and Blue Shield Association or a designated licensee to obtain further information on securing coverage. The written notification required by this paragraph shall be in writing and in a form approved by the Association. The Association shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. DUES

Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars (\$5,000) per license, plus
 - .05% of gross revenue per year from branded group products, plus
 - .5% of gross revenue per year from branded individual products plus
 - .14% of gross revenue per year from branded individual annuity products.
-

The foregoing percentages shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® license are issued to the same entity. In the event that any License period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Plan will promptly and timely transmit to BCBSA all dues owed by Controlled Affiliate as determined by the above formula and if Plan shall fail to do so, Controlled Affiliate shall pay such dues directly.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

9A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

10. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

Amended as of November 20, 1997

11. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by a writing executed by all parties.

12. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way effect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

13. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

Amended as of June 16, 2005

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: ____

Date: ____

Controlled Affiliate

By: _____

Date: _____

Plan

By: _____

Date: _____

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS LIFE INSURANCE COMPANIES

Page 1 of 2

PREAMBLE

The standards for licensing Life Insurance Companies (Life and Health Insurance companies, as defined by state statute) are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote of all Plans. Each Licensed Plan is required to use a standard controlled affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Life Insurance Company maintains compliance with the license standards.

An organization meeting the following standards shall be eligible for a license to use the Licensed Marks within the service area of its sponsoring Licensed Plan to the extent and the manner authorized under the Controlled Affiliate License applicable to Life Insurance Companies and the principal license to the Plan.

Standard 1 - Organization and Governance

The LIC shall be organized and operated in such a manner that it is controlled by a licensed Plan or Plans which have, directly or indirectly: 1) not less than 51% of the voting control of the LIC; and 2) the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the LIC with which it does not concur; and 3) operational control of the LIC.

If the LIC is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items 1 and 2 above, proxies representing at least 51% of the votes at any policyholder meeting and shall demonstrate that there is no reason to believe such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

Standard 2 - State Licensure

The LIC must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life and health insurance company in each state in which the LIC does business.

Standard 3 - Records and Examination

The LIC and its sponsoring licensed Plan(s) shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the LIC as may be required in order to establish compliance with the license agreement.

EXHIBIT A

**CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES**

Page 2 of 2

LIC and its sponsoring licensed Plan(s) shall permit BCBSA to examine the affairs of the LIC and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the sponsoring Plan(s).

Standard 4 - Mediation

The LIC and its sponsoring Plan(s) shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed controlled affiliate, a licensed Plan or BCBSA.

Standard 5 - Financial Responsibility

The LIC shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with Affiliate License Performance Response Process Protocol

The LIC and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing LIC compliance problems identified thereunder.

**CONTROLLED AFFILIATE
TRADEMARK LICENSE AGREEMENT
FOR LIFE AND DISABILITY INSURANCE PRODUCTS**

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____, ("Life and Disability Controlled Affiliate") which is a company offering life and disability insurance products owned and controlled by _____, _____ (individually, "Sponsoring Plan" and when referred to collectively, "Sponsoring Plans").

Whereas, BCBSA is the owner of the BLUE CROSS and BLUE SHIELD word and design service marks and any derivatives thereof ("Licensed Marks");

Whereas, each Sponsoring Plan is licensed separately by BCBSA to use one or more of the Licensed Marks in a particular Service Area;

Whereas, the Sponsoring Plans and the Life and Disability Controlled Affiliate desire that the latter be entitled to use the appropriate Licensed Marks in connection with life and disability insurance products in some or all of such Sponsoring Plans' Service Areas and in the Service Areas of other Regular Member Plans, as defined in the BCBSA By-laws, ("Blue Plans") consistent with the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

A. Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Life and Disability Controlled Affiliate the limited right to use the Licensed Marks in connection with and only in connection with the following life and disability insurance products authorized by state law: (1) Group: Term Life, Long Term Disability, Whole Life, Benefit Life, Universal Life; (2) Individual: Term Life, Whole Life, Dependent Life, Spouse Life; (3) Other: Disability Income, Short Term Disability, Long Term Disability, Income Replacement; and (4) such other life and disability products approved by BCBSA in writing ("Licensed Products") in the Service Areas served by the Sponsoring Plans or in the Service Area or Areas of one or more other licensed Blue Plans, provided that such Blue Plans have consented to such use as authorized by this Agreement. Life and Disability Controlled Affiliate may not use the Licensed Marks in its legal or trade name.

B. Notwithstanding that the license granted to Life and Disability Controlled Affiliate is a license to use all of the Licensed Marks, Life and Disability Controlled Affiliate may only use those of the Licensed Marks in the Service Area of a Sponsoring Plan or other consenting Blue Plan as described below that such Plan is authorized to use as a Blue Plan pursuant to its separate license agreements with BCBSA.

C. Life and Disability Controlled Affiliate may use the Licensed Marks in the Service Areas of Sponsoring Plans or in the Service Area of a Blue Plan that is not a signatory to this Agreement only after such Sponsoring Plan(s) or non-signatory Blue Plan consents to such use by executing a written consent in substantially the same form as the Consent Agreement attached as Exhibit B.

D. The following provisions apply with respect to Consent Agreements once such agreements have been fully and properly executed:

(1) All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in the Service Area of Sponsoring Plan or consenting Blue Plan (hereinafter, such consenting Sponsoring Plan or consenting Blue Plan collectively referred to "Consenting Plan(s)") must clearly identify the Consenting Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");

(2) To the extent the Consenting Plan has separate divisions or other Affiliates that use the Licensed Marks in distinct geographic areas within its Service Area, consent obtained under this Agreement may be limited to one or more of such specific geographic areas as specified by the Consenting Plan in its signed Consent Agreement. For purposes of this entire Agreement, all references to the Service Area of a Sponsoring Plan, Blue Plan or Consenting Plan may include the entire Service Area or a distinct geographic area within such Service Area as specified in this Section 1 D (2);

(3) Where BCBSA has licensed two or more Blue Plans to use the same Licensed Marks in the same Service Area, in addition to the requirements set forth in Section D (1) above, the sales, marketing and advertising materials referenced in such section above must be communicated to the Consenting Plan's existing and prospective accounts through or with the approval of such Consenting Plan, and the personnel of such Consenting Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the Consenting Plan;

(4) Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the Consenting Plan has been granted by BCBSA the license to use under its Blue Plan license agreements (for example, if a Consenting Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

(5) If a Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless BCBSA and the Consenting Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

2. QUALITY CONTROL

A. Life and Disability Controlled Affiliate agrees to use the Licensed Marks only in relation to the sale, marketing and administration of the Licensed Products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A and the Guidelines to Administer the Standards for Trademark License Agreement for Life and Disability Insurance Products attached thereto.

B. Life and Disability Controlled Affiliate agrees that BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Life and Disability Controlled Affiliate's rendering of service and use of the Licensed Marks.

C. Life and Disability Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by BCBSA) a report to BCBSA demonstrating Life and Disability Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Life and Disability Controlled Affiliate is defined as: An entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance

thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

3. SERVICE MARK USE

Life and Disability Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and shall ensure all uses of the Licensed Marks comply with the BCBSA Brand Regulations, as amended by BCBSA from time to time. Life and Disability Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Life and Disability Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

The license hereby granted to Life and Disability Controlled Affiliate to use the Licensed Marks is and shall be personal to Life and Disability Controlled Affiliate and shall not be assignable by any act of the Life and Disability Controlled Affiliate, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Life and Disability Controlled Affiliate mortgage or part with possession or control of this license or any right hereunder, and the Life and Disability Controlled Affiliate shall have no right to grant any sublicense to use the Licensed Marks.

5. INFRINGEMENTS

Life and Disability Controlled Affiliate shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Life and Disability Controlled Affiliate shall not be entitled to require BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Life and Disability Controlled Affiliate agrees to render to BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA. BCBSA shall have sole control of the defense and resolution of any claim of infringement brought or threatened by others.

6. LIABILITY INDEMNIFICATION

Life and Disability Controlled Affiliate hereby agrees to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Life and Disability Controlled Affiliate's conduct.

7. LICENSE TERM

A. The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods, unless either BCBSA or Life and Disability Controlled Affiliate notifies the other party in writing of the termination hereof at least sixty (60) days prior to expiration of any license period.

B. This Agreement may be terminated by BCBSA for cause at any time provided that Life and Disability Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Life and Disability Controlled Affiliate's failure to abide by the conditions regarding use of the Licensed Marks set forth in Section 1 of this Agreement or the quality control provisions of Section 2 (other than with respect to Section 2 D which is subject to immediate termination as stated in Section 7 C (1) below) shall be considered proper grounds for termination of this Agreement.

C. This Agreement and all of Life and Disability Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Life and Disability Controlled Affiliate shall no longer comply with Section 2 D (or Standard No. 1 (Organization and Governance) of Exhibit A); or
- (2) Any Sponsoring Plan ceases to be authorized to use the Licensed Marks; or
- (3) Appropriate fees for Life and Disability Controlled Affiliate pursuant to Section 8 of this Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Life and Disability Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks.

In the event of any disagreement between Life and Disability Controlled Affiliate and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Life and Disability Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. ROYALTIES

Life and Disability Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars (\$5,000) per license, plus
- .05% of gross revenue per year from group products sold under the Licensed Marks, plus
- .5% of gross revenue per year from individual products sold under the Licensed Marks

In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Life and Disability Controlled Affiliate will promptly and timely transmit to BCBSA all fees owed by Life and Disability Controlled Affiliate as determined by the above formula.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between any Sponsoring Plan and Life and Disability Controlled Affiliate or between among them and/or BCBSA.

10. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the

Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by: (a) a writing signed by all parties; or (b) a writing approved by the affirmative vote of three-fourths of the Blue Plans and three-fourths of the total then current weighted vote of all the Blue Plans as officially recorded by the BCBSA Corporate Secretary. Upon such adoption by the Blue Plans, this Agreement and all other Trademark License Agreements for Life and Disability Insurance Products then in effect shall simultaneously be amended.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Life and Disability Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: __

Date: __

Life and Disability Controlled Affiliate:

By: __

Date: __

Sponsoring Plan:

By: __

Date: __

Name: __

Sponsoring Plan:

By: __

Date: __

Name: __

[Add other Sponsoring Plans as necessary]

EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS Page 1 of 2

Standard 1 - Organization and Governance

Any Life and Disability Controlled Affiliate licensed under the Trademark License Agreement for Life and Disability Insurance Products ("licensee") shall be organized and operated in such a manner that it is an entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

Standard 2 - State Licensure

The licensee must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life company in each state in which the licensee does business.

Standard 3 - Records and Examination

The licensee shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the licensee as may be required in order to establish compliance with the Agreement. The licensee shall permit BCBSA to examine the affairs of the licensee and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the Sponsoring Plan(s).

Standard 4 - Mediation

The licensee, its Sponsoring Plan(s) and all consenting Blue Plans shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed Life and Disability Controlled Affiliate, a Sponsoring Plan and or consenting Blue Plan or BCBSA.

EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS Page 2 of 2

Standard 5 - Financial Responsibility

The licensee shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with BCBSA Governance

The licensee shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of and in addressing licensee compliance problems that may be identified in connection with the operation or administration of the Trademark License Agreement for Life and Disability Insurance Products.

EXHIBIT B

CONSENT AGREEMENT

This Consent Agreement is made and entered into by and among the undersigned Blue Plan, and _____ (“Life and Disability Controlled Affiliate”), and the Blue Cross and Blue Shield Association (“BCBSA”) and shall be deemed effective on _____ (“Effective Date”).

Whereas, BCBSA owns the Blue Cross and Blue Shield word and design service marks and any derivative mark thereof (the “Brands”);

Whereas, the undersigned Blue Plan is licensed to use one or more of the Brands within a specific geographic area (“Service Area”);

Whereas Life and Disability Controlled Affiliate is licensed by BCBSA to use one or more of the Brands to offer life and disability insurance products (“Products”) as defined and authorized in the Trademark License Agreement for Life and Disability Insurance Products (“Life and Disability License Agreement”);

Whereas neither the Blue Plan nor its affiliates offer the Products under any of the Brands in such Blue Plan’s Service Area or portion thereof where Blue Plan has consented to sale of the Products by Life and Disability Controlled Affiliate; and

Whereas BCBSA and the undersigned Blue Plan desire to consent to Life and Disability Controlled Affiliate’s use of the Brands in Blue Plan’s Service Area consistent with the terms of the Life and Disability License Agreement and this Consent Agreement.

Now, therefore, in consideration of the obligations and conditions stated in this Agreement, Blue Plan, Life and Disability Controlled Affiliate and BCBSA agree as follows:

1. Life and Disability Controlled Affiliate may market, sell, administer and underwrite the Products in Blue Plan’s Service Area under the Brands licensed to Blue Plan in such Service Area subject to the terms of this Consent Agreement, the Life and Disability License Agreement and Blue Plan’s license agreement(s) with BCBSA. Life and Disability Controlled Affiliate’s rights under the Brands to offer the Products under the Brands are limited to offering the Products only under the Brand(s) licensed to the consenting Blue Plan.
2. Life and Disability Controlled Affiliate shall work with the undersigned Blue Plan to develop a written sales and marketing agreement that identifies the relationship between it and Blue Plan for the sales,

marketing and customer service for the Products. The term of the sales and marketing agreement shall be the same as the term of this Consent Agreement.

3. All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in a consenting Blue Plan's Service Area must clearly identify the consenting Blue Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");
 4. Life and Disability Controlled Affiliate may use the Brands to sell the Products in the following Service Area or portion thereof as designated by Blue Plan:

 5. If two or more Blue Plans to use the same Licensed Marks in the same Service Area, Life and Disability Controlled Affiliate shall work with the consenting Blue Plan in the following manner: (a) the sales, marketing and advertising materials must be communicated to the consenting Blue Plan's existing and prospective accounts through or with the approval of such Blue Plan, and (b) the personnel of such Blue Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the consenting Blue Plan;
 6. Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the consenting Blue Plan has been granted by BCBSA the license to use under its license agreement (for example, if a consenting Blue Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).
 7. If this Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless each BCBSA and the Blue Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.
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8. The term of this Consent Agreement shall be one year from the Effective Date. Unless either Blue Plan or Life and Disability Controlled Affiliate provides the other party with written notice of its desire not to renew this Consent Agreement at least 60 days prior to expiration of the term or any extended term or unless terminated as provided in Paragraph 9 below, this Consent Agreement shall automatically renew for subsequent one year periods.
9. This Consent Agreement may be terminated as follows:
- A. Upon mutual written consent of Life and Disability Controlled Affiliate and Blue Plan;
 - B. By Blue Plan or Life and Disability Controlled Affiliate upon 60 days advance written notice to the non-terminating party and BCBSA; or
 - C. By Blue Plan immediately if Life and Disability Controlled Affiliate does not comply with this Consent Agreement or the sales protocol agreement.
10. This Consent Agreement shall automatically terminate if Blue Plan's primary licensee agreement terminates for any reason or if the Life and Disability License Agreement terminates for any reason.

Agreed and Accepted by:

[Blue Plan]:

By: _____

Title: _____

BLUE CROSS AND BLUE SHIELD ASSOCIATION:

By: _____

Title: _____

LIFE AND DISABILITY CONTROLLED AFFILIATE:

By: _____

Title: _____

Exhibit 1B

BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS
(Adopted by Member Plans at their November 18, 2016)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Advantage PPO products in geographic regions designated by CMS (hereafter "regional MAPPO products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name") to offer regional MAPPO products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional MAPPO products and related services.

This grant of rights is non-exclusive and is limited to the following states:

_____ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

- A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.
- B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.
- C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.
- D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.
- E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:
- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
 - (2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
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(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

- (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
- (c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional MAPPO products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Shield License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking

appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Controlled Affiliate shall no longer comply with item 2(E) above;
 - (2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or
 - (3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or
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proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall

have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x) (ii) of the Blue Shield License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to \$25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the

foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other

Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the

Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: _____

Date: _____

Controlling Plan:

By: __

Date: __

Controlling Plan:

By: __

Date: __

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: __

Date: __

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS November 2016

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Advantage PPO Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
 - (2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
 - (3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:
 - (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
 - (b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
 - (c) exercise control over the policy and operations of the Controlled Affiliate; and
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EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

- a. the structure of the Blue Cross and Blue Shield System; and
- b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Shield Marks.

Standard 7 - Participation in Certain National Programs

A Controlled Affiliate shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area.

National program requirements include:

- a. Inter-Plan Teleprocessing System (ITS); and
- b. Inter-Plan Medicare Advantage Program.

Standard 8 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of November 15, 2007

EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional MAPPO products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

Exhibit 1C

BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN
PRODUCTS
(Adopted by Member Plans at their November 18, 2016 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Part D Prescription Drug Plan products in geographic regions designated by CMS (hereafter "regional PDP products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name") to offer regional PDP products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional PDP products and related services.

This grant of rights is non-exclusive and is limited to the following states:

_____ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

- A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.
- B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.
- C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.
- D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.
- E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:
- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
 - (2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
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- (3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

- (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
- (c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional PDP products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Shield License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to

complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Controlled Affiliate shall no longer comply with item 2(E) above;
 - (2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or
 - (3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim
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trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Shield License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to \$25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license

termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: __

Date: __

Controlling Plan:

By: __

Date: __

Controlling Plan:

By: __

Date: __

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: __

Date: __

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS November 2016

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Part D Prescription Drug Plan Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
 - (2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
 - (3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:
 - (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
 - (b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
 - (c) exercise control over the policy and operations of the Controlled Affiliate; and
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EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

- a. the structure of the Blue Cross and Blue Shield System; and
- b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Shield Marks.

Standard 7 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional PDP products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

EXHIBIT 2

Membership Standards Page 1 of 5

Preamble

The Membership Standards apply to all organizations seeking to become or to continue as Regular Members of the Blue Cross and Blue Shield Association. Any organization seeking to become a Regular Member must be found to be in substantial compliance with all Membership Standards at the time membership is granted and the organization must be found to be in substantial compliance with all Membership Standards for a period of two (2) years preceding the date of its application. If Membership is sought by an entity which controls or is controlled by one or more Plans, such compliance shall be determined on the basis of compliance by such Plan or Plans.

The Regular Member Plans shall have authority to interpret these Standards.

A Regular Member Plan that operates as a “Shell Holding Company” is defined as an entity that assumes no underwriting risk and has less than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) and less than 5% of the consolidated enterprise net general and administrative expenses.

A Regular Member Plan that operates as a “Hybrid Holding Company” is defined as an entity that assumes no underwriting risk and has either more than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) or more than 5% of the consolidated enterprise net general and administrative expenses.

Standard 1: A Plan shall maintain a governing Board, which shall control the

Plan and ensure that the Plan follows appropriate practices of corporate governance. A Plan's Board shall not be controlled by any special interest group, shall make an annual determination that a majority of its directors are independent, and shall act in the best interest of its Corporation and its customers. The Board shall be composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Amended as of March 15, 2007

EXHIBIT 2

Membership Standards

Page 2 of 5

- Standard 2: A Plan shall furnish to the Association on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between the Association and the Plans. Such reports and records are the following:
- A. BCBSA Membership Information Request;
 - B. Triennial trade name and service mark usage material, including disclosure material under Standard 7;
 - C. Changes in the governance of the Plan, including changes in a Plan's Charter, Articles of Incorporation, or Bylaws, changes in a Plan's Board composition, or changes in the identity of the Plan's Principal Officers;
 - D. Quarterly Financial Report, Semi-annual "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC, Annual Budget, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), Plan, Subsidiary and Affiliate Report; and
 - Plans that are a Shell Holding Company as defined in the Preamble hereto are required to furnish only a calendar year-end "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC.

Amended as of November 17, 2011

EXHIBIT 2

Membership Standards Page 3 of 5

- E. Quarterly Enrollment Report, Quarterly Member Touchpoint Measures Index (MTM) through 12/31/2011, and Semiannual MTM Index starting 1/1/2012 and thereafter.
 - For purposes of MTM reporting only, a Plan shall file a separate MTM report for each Geographic Market.

Standard 3: A Plan shall be operated in a manner that provides reasonable financial assurance that it can fulfill its contractual obligations to its customers.

Standard 4: A Plan shall be operated in a manner responsive to customer needs and requirements.

Standard 5: A Plan shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the Plans and ease of claims processing for customers receiving benefits outside of the Plan's Service Area.

Such programs are applicable to Blue Cross and Blue Shield Plans, and include:

- A. Inter-Plan Teleprocessing System (ITS);
- B. BlueCard Program;
- C. National Account Programs;
- D. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
- E. Inter-Plan Medicare Advantage Program.

Amended as of November 21, 2014

EXHIBIT 2

Membership Standards Page 4 of 5

- Standard 6: In addition to requirements under the national programs listed in Standard 5: Participation in National Programs, a Plan shall take such action as required to ensure its financial performance in programs and contracts of an inter-Plan nature or where the Association is a party.
- Standard 7: A Plan shall make adequate disclosure in contracting with third parties and in disseminating public statements of (i) the structure of the Blue Cross and Blue Shield System, (ii) the independent nature of every Plan, and (iii) the Plan's financial condition.
- Standard 8: A Plan shall cooperate with the Association's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Plan performance problems identified thereunder.
- Standard 9: A Plan shall obtain a rating of its financial strength from an independent rating agency approved by the Association's Board of Directors for such purpose.
- Standard 10: Notwithstanding any other provision in this License Agreement, during each year, a Plan and its Controlled Affiliate(s) engaged in providing licensable services (excluding Life Insurance and Charitable Foundation Services) shall use their best efforts to promote and build the value of the Blue Shield Marks.
- Standard 11: Neither a Plan nor any Larger Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Plan or Larger Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.
- Amended as of June 16, 2005**
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EXHIBIT 2

Membership Standards Page 5 of 5

Standard 12: No provider network, or portion thereof, shall be rented or otherwise made available to a National Competitor if the Licensed Marks or Names are used in any way with such network.

A provider network may be rented or otherwise made available, provided there is no use of the Licensed Marks or Names with respect to the network being rented.

Standard 13: Each Plan shall operate in a manner to reasonably: 1) protect the security and confidentiality of Personally Identifiable Information (PII) and Protected Health Information (PHI); 2) protect the Brands from reputational damage; and 3) cooperate with BCBSA and other Plans if a data security incident or data breach occurs.

Amended as of June 18, 2015

EXHIBIT 3

GUIDELINES WITH RESPECT TO USE OF LICENSED NAME AND MARKS IN CONNECTION WITH NATIONAL ACCOUNTS

Page 1 of 3

1. The strength of the Blue Cross/Blue Shield National Accounts mechanism, and the continued provision of cost effective, quality health care benefits to National Accounts, are predicated on locally managed provider networks coordinated on a national scale in a manner consistent with effective service to National Account customers and consistent with the preservation of the integrity of the Blue Cross/Blue Shield system and the Licensed Marks. These guidelines shall be interpreted in keeping with such ends.
2. A National Account is an entity with employee and/or retiree locations in more than one Plan's Service Area. Unless otherwise agreed, a National Account is deemed located in the Service Area in which the corporate headquarters of the National Account is located. A local plant, office or division headquarters of an entity may be deemed a separate National Account when that local plant, office or division headquarters 1) has employee locations in more than one Service Area, and 2) has independent health benefit decision-making authority for the employees working at such local plant, office or division headquarters and for employees working at other locations outside the Service Area. In such a case, the local plant, office or division headquarters is a National Account that is deemed located in the Service Area in which such local plant, office or division headquarters is located. The Control Plan of a National Account is the Plan in whose Service Area the National Account is located. A participating ("Par") Plan is a Plan in whose Service Area the National Account has employee and/or retiree locations, but in which the National Account is not located. In the event that a National Account parent company consolidates health benefit-decision making for itself and its wholly-owned subsidiary companies, the parent company and the subsidiary companies shall be considered one National Account. The Control Plan for such a National Account shall be the Plan in whose Service Area the parent company headquarters is located.
3. The National Account Guidelines enunciated herein below shall be applicable only with respect to the business of new National Accounts acquired after January 1, 1991.
4. Control Plans shall utilize National Account identification cards complying with then currently effective BCBSA graphic standards in connection with all National Accounts business to facilitate administration thereof, to minimize subscriber and provider confusion, and to reflect a commitment to cooperation among Plans.

Amended as of June 12, 2003

Exhibit 3 Page 2 of 3

5. Disputes among Plans and/or BCBSA as to the interpretation or implementation of these Guidelines or as to other National Accounts issues shall be submitted to mediation and mandatory dispute resolution as provided in the License Agreement. For two years from the effective date of the License Agreement, however, such disputes shall be subject to mediation only, with the results of such mediation to be collected and reported in order to establish more definitive operating parameters for National Accounts business and to serve as ground rules for future binding dispute resolution.

6. The Control Plan may use the BlueCard Program (as defined by IPPC) to deliver benefits to employees and non-Medicare eligible retirees in a Participating Plan's service area if an alternative arrangement with the Participating Plan cannot be negotiated. The Participating Plan's minimum servicing requirement for those employees and non-Medicare retirees in its service area is to deliver benefits using the BlueCard Program. Account delivery is subject to the policies, provisions and procedures of the BlueCard Program.

7. For provider payments in a Participating Plan's area (on non-BlueCard claims), payment to the provider may be made by the Participating Plan or the Control Plan at the Participating Plan's option. If the Participating Plan elects to pay the provider, it may not withhold payment of a claim verified by the Control Plan or its designated processor, and payment must be in conformity with service criteria established by the Board of Directors of BCBSA (or an authorized committee thereof) to assure prompt payment, good service and minimum confusion with providers and subscribers. The Control Plan, at the Participating Plan's request, will also assure that measures are taken to protect the confidentiality of the data pertaining to provider reimbursement levels and profiles.

Amended as of June 14, 1996

Exhibit 3 Page 3 of 3

8. The Control Plan, in its financial agreements with a National Account, is expected to reasonably reflect the aggregate amount of differentials passed along to the Control Plan by all Participating Plans in a National Account.

9. Other than in contracting with health care providers or soliciting such contracts in areas contiguous to a Plan's Service Area in order to serve its subscribers or those of its licensed Controlled Affiliate residing or working in its Service Area, a Control Plan may not use the Licensed Marks and/or Name, as a tag line or otherwise, to negotiate directly with providers outside its Service Area.

Amended as of March 13, 2003

EXHIBIT 4

GOVERNMENT PROGRAMS AND CERTAIN OTHER USES

Page 1 of 14

1. A Plan and its licensed Controlled Affiliate may use the Licensed Marks and Name in bidding on and executing a contract to serve a Government Program, and in thereafter communicating with the Government concerning the Program. With respect, however, to such contracts entered into after the 1st day of January, 1991, the Licensed Marks and Name will not be used in communications or transactions with beneficiaries or providers in the Government Program located outside a Plan's Service Area, unless the Plan can demonstrate to the satisfaction of BCBSA's governing body that such a restriction on use of the Licensed Marks and Name will jeopardize its ability to procure the contract for the Government Program. As to both existing and future contracts for Government Programs, Plans will discontinue use of the Licensed Marks and Name as to beneficiaries and Providers outside their Service Area as expeditiously as circumstances reasonably permit. Effective January 1, 1995, except as provided in the first sentence above, all use by a Plan of the Licensed Marks and Name in Government Programs outside of the Plan's Service Area shall be discontinued. Incidental communications outside a Plan's Service Area with resident or former resident beneficiaries of the Plan, and other categories of necessary incidental communications approved by BCBSA, are not prohibited. For purposes of this Paragraph 1, the term "Government Programs" shall mean Medicare Part A, Medicare Part B and other non-risk government programs.

2. In connection with activity otherwise in furtherance of the License Agreement, a Plan and its Controlled Affiliates that are licensed to use the Licensed Marks and Name in its Service Area pursuant to the Controlled Affiliate License Agreements authorized in clauses a) through c) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Plan's Service Area in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

2.1 Common Business Communications

- a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);
- b. distributing business cards other than in marketing and selling;
- c. advertising in publications or electronic media solely to persons for employment;

Amended as of June 19, 2014

EXHIBIT 4 Page 2 of 14

2.2 Marketing Spillover

- a. advertising in print, electronic or other media which serve, as a substantial market, the Service Area of the Plan or licensed Controlled Affiliate, provided that no Plan or Controlled Affiliate may advertise outside its Service Area on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Service Area;
- b. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Plan's Service Area or that of a licensed Controlled Affiliate;

2.3 Provider Contracting

- a. contracting with health care providers or soliciting such contracts in areas contiguous to the Plan's Service Area in order to serve its subscribers or those of such licensed Controlled Affiliates residing or working in its service area;
- b. issuing a small sign containing the legal name or trade name of the Plan or such licensed Controlled Affiliates for display by a provider to identify the latter as a participating provider of the Plan or Controlled Affiliate;
- c. negotiating rates with a health care provider for services to a specific member, provided that all of the following conditions are met:
 - (1) the health care provider does not have a contract, applicable to the services rendered or to be rendered, with the Licensee (or any of the Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located; and
 - (2) the Plan or Controlled Affiliate reasonably determines that the member did/does not have a reasonable opportunity to access a participating provider whose contract applies to the services rendered or to be rendered; and
 - (3) at least one of the following circumstances exists:

Amended as of June 19, 2014

EXHIBIT 4

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- (i) the member received emergency services and the Plan or Controlled Affiliate knows or reasonably anticipates that the charges on the claim will meet or exceed \$5,000; or
 - (ii) a provider, in consultation pre- or post- treatment with the Plan or Controlled Affiliate, makes/made a treatment recommendation or referral to a non-par provider or to a par provider whose contract does not apply to the services to be rendered; or
 - (iii) the member inadvertently accessed a non-par provider or non-contracted services in the course of receiving services from a par provider (e.g., the member sees a non-par consulting specialist in a participating hospital); and
 - (4) the Licensee (and in the case of overlapping Service Areas, all of the Licensees) in whose Service Area the health care provider is located consent(s) in advance.
- d. contracting with a pharmacy management organization (“Pharmacy Intermediary”) to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan’s or licensed Controlled Affiliate’s members nationwide, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;

Amended as of June 19, 2014

EXHIBIT 4

Page 4 of 14

- e. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided that (1) the Plan and the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Plan's Service Area, and (2) neither the Plan's or the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Plan's Service Area;
 - f. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;
 - g. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;
 - h. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Plan's Service Area;
 - i. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Plan's Service Area;
 - j. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Plan's Service Area;
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EXHIBIT 4 Page 5 of 14

- k. contracting with a company that operates provider sites in the Plan's Service Area, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Plan's Service Area;
- l. contracting with a company that makes health care professionals available in the Plan's Service Area (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Plan's Service Area.

2.4 Services to National Accounts

- a. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee (as those terms are defined in the Inter-Plan Programs Policies and Provisions ("IP Policies")) to offer Blue-branded Health Coverage to the National Account, offering Blue-branded Health and Wellness Programs to all members of the National Account, including members who have not enrolled in the Blue-branded Health Coverage ("non-Blue Health Coverage members"), provided that:
 - (i) the Plan and/or Licensed Controlled Affiliate has no contact or interaction with providers outside of the Plan's Service Area, except as specifically provided in the IP Policies and in 2.4(b); and
 - (ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not offer Blue-branded Health and Wellness Programs to any employees working at such local plant, office or division without the consent of such other Licensee; and
 - (iii) if the Plan and/or licensed Controlled Affiliate provides an information card to the non-Blue Health Coverage members, the card may not display the Symbols in the masthead, must contain a prominent disclosure conveying that it is not a health insurance card, and otherwise must be designed so that it is dissimilar to a Blue member identification card.

Amended as of March 26, 2015

EXHIBIT 4 Page 6 of 14

For purposes of this subparagraph a, the following definitions apply:

“Health and Wellness Program” shall mean a program that includes at least one of the following elements or a related element:

- Health Risk Assessment and/or Preventive Screenings
- Exercise and Fitness Programs
- Health and Wellness Events (e.g., attendance at a health fair, a 5K walk)
- Nutrition and Weight Management
- Health Education (e.g., smoking cessation classes)
- Prenatal and Parenting Education
- Disease or Chronic Condition Management

The above listing is intended to represent examples of the types of programs that may be offered, and other programs, including those offered through different media such as the internet or telephonically, may also be deemed Health and Wellness programs.

“Health Coverage” shall mean providing or administering medical, surgical, hospital, major medical, or catastrophic coverage, or any HMO, PPO, POS or other managed care plan for the foregoing services.

2.4 Services to National Accounts (continued)

- b. as part of a Health and Wellness Program that is otherwise compliant with Brand Regulation 4.11.4(a), contracting with a health and wellness organization to gain access to providers to deliver a discrete health and wellness event (“Event”) held at a National Account’s worksite outside of the Licensee’s Service Area, provided that:
 - (i) the services delivered at the Event are limited to fingerstick screenings for cholesterol and glucose, seasonal flu immunizations, blood pressure measurements, body mass index measurements, and other routine screenings, immunizations and measurements; and
 - (ii) neither such services nor their costs are applied as claims against any benefit plan; and
 - (iii) the Event is presented during one or more limited periods during a benefit year and is available to all employees at the worksite.

Amended as of March 26, 2015

EXHIBIT 4 Page 7 of 14

- c. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee to offer Blue-branded Health Coverage to the National Account, performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by the National Account to its members, including benefit plans that are not underwritten or administered by the Plan, provided that:
- (i) in performing such functions, the Plan and/or licensed Controlled Affiliate does not use the Brands in any communications with health care providers outside of the Plan's Service Area, and otherwise limits its use of the Brands outside of the Service Area to communications with the account's members, the other benefit plan providers with which the account has contracted and other reasonably necessary communications to perform such functions; and
 - (ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not perform Eligibility and Enrollment functions for employees working at such local plant, office or division without the consent of such other Licensee;

For purposes of this subparagraph b, the following definitions apply: "Health Coverage" has the meaning set forth in subparagraph

2.4.a.

Amended as of March 26, 2015

EXHIBIT 4

Page 8 of 14

“Eligibility” means services that manage the account’s eligibility data and determine or process determinations relating to eligibility for benefit plans offered by the account to its employees, including such services as:

- monitoring and auditing data to ensure that only entitled individuals are enrolled in each such benefit plan;
- review of eligibility documentation (e.g. marriage licenses, birth certificates, student status verification letters, employment records);
- identification of key member segments such as over-age dependents, part-time employees, employees reaching certain milestones (e.g. Medicare-eligible, retirees);
- termination of coverage for those individuals found to be ineligible for coverage under a benefit plan, and, if applicable, generation of a COBRA event; and
- management of “hour-banking” for union environments in which union members can bank hours to remain eligible for benefits.

“Enrollment” means services that enroll eligible individuals and their spouses/dependents or terminate or change their enrollment in the account’s benefit plans on an ongoing basis and during open enrollment periods, including such services as:

- the coordination of each step in open enrollment process from project planning and system set-up to the generation of confirmation statements;
- ongoing enrollment support for new hires and changes due to life events and work status adjustments;
- evidence of insurability (EOI) administration for life and disability coverage;
- transmission of eligibility/enrollment information to the account’s benefit plan providers;
- review and reconciliation of error reports received from the account’s benefit plan providers; and
- transmission of information to the account’s payroll system (e.g., benefit deductions, employee demographic data).

Amended as of March 26, 2015

EXHIBIT 4 Page 9 of 14

2.5 Knowledge Sharing

- a. submitting scholarly articles authored or co-authored by the Plan or Controlled Affiliate or its respective employees for publication in peer-reviewed journals;
- b. permitting an internal representative of the Licensee (e.g., officer, employee) to speak or present at a conference or symposium outside of the Licensee's Service Area regarding either (i) healthcare financing, administration, delivery or policy, or (ii) topics within the representative's functional discipline or expertise at the Licensee, for which the event sponsor will issue communications to promote, administer, and/or recap the event that will identify the Licensee's representative as a participant. The communications outside of the Licensee's Service Area that mention the Licensee's representative shall be limited to materials and digital media provided to attendees, on-site signage, advertising in relevant trade publications, direct mail and email to attendees and prospective attendees, and the sponsor's website, Participation in any conference or symposium outside of the Licensee's Service Area may not be for the purpose of marketing or selling products or services.

If the Licensee's representative wishes to use the Brands in any manner, including use in his/her title, when participating as a speaker or presenter outside of the Licensee's Service Area about a topic that is not related to healthcare financing, administration, delivery, or policy, or to topics within the representative's functional discipline or expertise at the Licensee, the Licensee must notify BCBSA and receive prior approval from BCBSA before participating.

Amended as of March 26, 2015

EXHIBIT 4 Page 10 of 14

2.6 Other Uses

- a. entering into a license agreement between and among BCBSA, the Plan and a debit card issuer located outside the Plan's Service Area, and entering into a corresponding operating agreement or agreements, in order to offer a debit card bearing the Licensed Marks and Name to eligible persons as defined by the aforementioned license agreement;
- b. appearing in communications issued by an independent third party to recognize outstanding performance of the Plan or Controlled Affiliate or a member of the Plan's or Controlled Affiliate's senior management as part of an established program of the third party for which the Plan has provided information to be considered for the recognition, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;
- c. to identify itself as being a joint sponsor of an event, program or activity along with other Plans or such Plans' licensed Controlled Affiliates, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;
- d. hosting meetings or events (collectively, "events") in Washington, D.C. related to policy and business issues in the Licensee's Service Area, or hosting events in conjunction with the assemblies or conventions of national political parties. Such events may not involve marketing or selling products or services. Use of the Brands outside the Licensee's Service Area in connection with such events shall be limited to materials and digital media provided to attendees and prospective attendees and onsite signage. For any such events in Washington, D.C. that are open to attendees other than government officials or their staffs, or are briefings open to all Congressional staff, or are otherwise likely to receive media coverage, the Licensee is required to provide advance notice to BCBSA. For events hosted outside of Washington, D.C. in conjunction with the assemblies or conventions of national political parties, the Licensee is required to provide advance notice to BCGSA and to the local Plan;

Amended as of March 26, 2015

EXHIBIT 4 Page 11 of 14

- e. permitting an affiliate that is not licensed to use the Licensed Marks to identify its corporate relationship with the Plan, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time.

3. In connection with activity otherwise in furtherance of the License Agreement, a Controlled Affiliate that is licensed to use the Licensed Marks and Name pursuant to a Controlled Affiliate License Agreement authorized in clauses d) or e) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Region (as that term is defined in such respective Controlled Affiliate License Agreements) in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

- a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);
- b. distributing business cards other than in marketing and selling;
- c. contracting with health care providers or soliciting such contracts in areas contiguous to the Region in order to serve its subscribers residing in the Region, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans in connection with such contracting unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;
- d. issuing a small sign containing the legal name or trade name of the Controlled Affiliate for display by a provider to identify the latter as a participating provider of the Controlled Affiliate, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans on such signs unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;
- e. advertising in publications or electronic media solely to persons for employment;

Amended as of March 26, 2015

EXHIBIT 4

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- f. advertising in print, electronic or other media which serve, as a substantial market, the Region, provided that the Controlled Affiliate may not advertise outside its Region on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Region, and provided further that any such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to advertise in such media;
 - g. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Region, provided that such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to send direct mail to such zip code plus 4.
 - h. [Intentionally left blank, pending review by the Inter-Plan Programs Committee of the applicability of the case management rule to such Controlled Affiliates.]
 - i. contracting with a pharmacy management organization ("Pharmacy Intermediary") to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for the Controlled Affiliate's regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective Controlled Affiliate License Agreements, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;
 - j. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit to the Controlled Affiliate's regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective
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Controlled Affiliate License Agreements, provided that (1) the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Region, and (2) neither the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Region;

- k. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for the Controlled Affiliate's regional Medicare Advantage PPO members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;
 - l. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for the Controlled Affiliate's regional Medicare Advantage members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;
 - m. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Controlled Affiliate's Region;
 - n. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Controlled Affiliate's Region;
 - o. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Region;
 - p. contracting with a company that operates provider sites in the Region, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Region;
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- q. contracting with a company that makes health care professionals

available in the Region (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Region.

4. BCBSA shall retain the right to use the Licensed Marks in conjunction with the Federal Employee Program and with any other national offering made to federal employees pursuant to the Federal Employees Health Benefits Program (FEHBP), including the right to license such use to its vendors, but only in the following manner.

- a. the Licensed Marks may only be used by BCBSA with the term “Federal Employee Program”, “Federal”, “FEP”, or similar language identifying the program as a benefit program for federal employees;
- b. the Licensed Marks may not be used by BCBSA with the name(s) of a specific Plan or Plans and;
- c. any use by BCBSA in conjunction with a new national FEHBP

program proposed after the enactment of this amendment will require the approval of the BCBSA Board of Directors.

5. Where required by applicable state or local law or regulation, a Plan or its licensed Controlled Affiliate may submit documents that contain the Brands to, and file forms that contain the Brands with, state or local regulators in a state not included in its Service Area, provided that it gives reasonable advance notice to the local Plan of its intent to submit such documents or file such forms. Notwithstanding, in no event may a Plan or its licensed Controlled Affiliate use the Brands to register, or to obtain or maintain a license, a certificate of authority, or an equivalent document authorizing it to act as a risk-bearing entity or third party administrator in a state not included in its Service Area. If the local Plan advises BCBSA that it believes its License Agreement has been or would be violated by any submission or filing, BCBSA shall determine whether such submission or filing is required by state or local law or regulation and violates the License Agreement, subject to the Plan’s or licensed Controlled Affiliate’s rights to obtain an independent review of such determination under Paragraph 9(a) and Exhibit 5 of its License Agreement or Paragraph 8 of the Controlled Affiliate License. For purposes of this paragraph, “local Plan” is defined as each Plan whose Service Area includes all or part of the state in which the foregoing applicable state or local law or regulation has been enacted.

Amended as of March 26, 2015

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MEDIATION AND MANDATORY DISPUTE RESOLUTION (MMDR) RULES

The Blue Cross and Blue Shield Plans ("Plans") and the Blue Cross Blue Shield Association ("BCBSA") recognize and acknowledge that the Blue Cross and Blue Shield system is a unique nonprofit and for-profit system offering cost effective health care financing and services. The Plans and BCBSA desire to utilize Mediation and Mandatory Dispute Resolution ("MMDR") to avoid expensive and time-consuming litigation that may otherwise occur in the federal and state judicial systems. Even MMDR should be viewed, however, as methods of last resort, all other procedures for dispute resolution having failed. Except as otherwise provided in the License Agreements, the Plans, their Controlled Affiliates and BCBSA agree to submit all disputes to MMDR pursuant to these Rules and in lieu of litigation.

1. Initiation of Proceedings

A. Pre-MMDR Efforts

Before filing a Complaint to invoke the MMDR process, the CEO of a complaining party, or his/her designated representative, shall undertake good faith efforts with the other side(s) to try to resolve any dispute.

B. Complaint

To commence a proceeding, the complaining party (or parties) shall provide by certified mail, return receipt requested, a written Complaint to the BCBSA Corporate Secretary (which shall also constitute service on BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) named therein. The Complaint shall contain:

- i. identification of the complaining party (or parties) requesting the proceeding;
- ii. identification of the respondent(s);
- iii. identification of any other persons or entities who are interested in a resolution of the dispute;
- iv. a full statement describing the nature of the dispute;
- v. identification of all of the issues that are being submitted for resolution;

Amended as of November 21, 1996

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- vi. the remedy sought;
- vii. a statement as to whether the complaining party (or parties) elect(s) first to pursue Mediation;
- viii. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor; and
- ix. a statement signed by the CEO of the complaining party affirming that the CEO has undertaken efforts, or has directed efforts to be undertaken, to resolve the dispute before resorting to the MMDR process.

The complaining party (or parties) shall file and serve with the Complaint copies of all documents which the party (or parties) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

C. Answer

Within twenty (20) days after receipt of the Complaint, each respondent shall serve on BCBSA and on the complaining party (or parties):

- i. a full Answer to the aforesaid Complaint;
- ii. a statement of any Counterclaims against the complaining party (or parties), providing with respect thereto the information specified in Paragraph 1.B., above;
- iii. a statement as to whether the respondent elects to first pursue Mediation; and
- iv. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor.

The respondent(s) shall file and serve with the Answer or by the date of the Initial Conference set forth in Paragraph 3.C., below, copies of all documents which the respondent(s) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

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D. Reply To Counterclaim

Within ten (10) days after receipt of any Counterclaim, the complaining party (or parties) shall serve on BCBSA and on the responding party (or parties) a Reply to the Counterclaim. Such Reply must provide the same information required by Paragraph 1.C., above.

2. Mediation

To facilitate the mediation of disputes between or among BCBSA, the Plans and/or their Controlled Affiliates, the BCBSA Board has provided for Mediation under these Rules. Mediation may be pursued in lieu of or in an effort to obviate the Mandatory Dispute Resolution process, and all parties are strongly urged, but not required, to exhaust the mediation procedure provided for herein. In the event any party refuses to proceed with Mediation, the parties shall proceed immediately to Mandatory Dispute Resolution, as provided in Section 3.

A. Selection of Mediators

If all parties agree to pursue Mediation, they shall promptly attempt to agree upon: (i) the number of mediators desired, not to exceed three mediators; and (ii) the selection of experienced mediator(s) from an independent entity to mediate all disputes set forth in the Complaint and Answer (and Counterclaim and Reply, if any). In the event the parties are unable to agree upon the selection or number of mediators, both within five (5) days of the service of the Answer or Reply to Counterclaim, whichever is later, the BCBSA Corporate Secretary shall immediately refer the matter to a nationally recognized professional ADR organization (such as CPR or JAMS) for mediation by a single mediator to be selected by the ADR organization.

B. Binding Decision

Before the Mediation Hearing described below, the BCBSA Corporate Secretary shall contact the parties to determine whether they wish to be bound by any recommendation of the selected mediator(s) for resolution of the disputes. If all wish to be bound, the Corporate Secretary will send appropriate documentation to them for their signatures before the Mediation Hearing begins.

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C. Mediation Procedure

The Mediator(s) shall apply the mediation procedures and processes provided for herein (not the rules of the ADR organization with which they are affiliated) and shall promptly advise the parties of a scheduled Mediation Hearing date. Unless a party requests an expedited procedure, or unless all parties to the proceeding agree to one or more extensions of time, the Mediation Hearing set forth below shall be completed within forty (40) days of BCBSA's receipt of the Complaint. The selected mediator(s), unless the parties otherwise agree, shall adhere to the following procedure:

- i. Each party must be represented by its CEO or other representative who has been delegated full authority to resolve the dispute. However, parties may send additional representatives as they see fit.
- ii. Each party will be given one-half hour to present its case, beginning with the complaining party (or parties), followed by the other party or parties. The parties are free to structure their presentations as they see fit, using oral statements or direct examination of witnesses. However, neither cross-examination nor questioning of opposing representatives will be permitted. At the close of each presentation, the selected mediator(s) will be given an opportunity to ask questions of the presenters and witnesses. All parties must be present throughout the Mediation Hearing. The selected mediator(s) may extend the time allowed for each party's presentation at the Mediation Hearing. The selected mediator(s) may meet in executive session, outside the presence of the parties, or may meet with the parties separately, to discuss the controversy.
- iii. After the close of the presentations, the parties will attempt to negotiate a settlement of the dispute. If the parties desire, the selected mediators, or any one or more of the selected mediator(s), will sit in on the negotiations.

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- iv. After the close of the presentations, the selected mediator(s) may meet privately to agree upon a recommendation for resolution of the dispute which would be submitted to the parties for their consideration and approval. If the parties have previously agreed to be bound by the results of this procedure, this recommendation shall be binding upon the parties.
- v. The purpose of the Mediation Hearing is to assist the parties to settle their grievances short of mandatory dispute resolution. As a result, the Mediation Hearing has been designed to be as informal as possible. Rules of evidence shall not apply. There will be no transcript of the proceedings, and no party may make a tape recording of the Mediation Hearing.
- vi. In order to facilitate a free and open discussion, the Mediation proceeding shall remain confidential. A "Stipulation to Confidentiality" which prohibits future use of settlement offers, all position papers or other statements furnished to the selected mediator(s), and decisions or recommendations in any Mediation proceeding shall be executed by each party.
- vii. Upon request of the selected mediator(s), or one of the parties, BCBSA staff may also submit documentation at any time during the proceedings.

D. Notice of Termination of Mediation

If the Mediation cannot be completed within the prescribed or agreed time period due to the lack of cooperation of any party, as determined by the selected mediator(s), or if the Mediation does not result in a final resolution of all disputes at the Mediation Hearing or within ten (10) days after the Mediation Hearing, any party or any one of the selected mediator(s) shall so notify the BCBSA Corporate Secretary, who shall promptly issue a Notice of Termination of Mediation to all parties, to the selected mediator(s), and to the MDR Administrator. Such notice shall serve to bring the Mediation to an end and to initiate Mandatory Dispute Resolution. Upon agreement of all parties and the mediator(s), the Mediation process may continue at the same time the MDR process is invoked. In such case, the Notice of Termination of Mediation described above serves to initiate the MDR proceeding, but does not terminate mediation proceedings, which may proceed simultaneous with the MDR proceeding.

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3. Mandatory Dispute Resolution (MDR)

If any party elects not to first pursue Mediation, or if a Notice of Termination of Mediation is issued as set forth in Paragraph 2.D., above, then the unresolved disputes set forth in any Complaint and Answer (and Counterclaim and Reply, if any) shall be subject to mandatory binding arbitration (herein referred to as “MDR”).

A. MDR Administrator

The Administrator for purposes of Mandatory Arbitration shall be an independent nationally recognized entity such as CPR or JAMS, specializing in alternative dispute resolution. In the event the parties pursued Mediation with CPR, JAMS or a similar organization, that organization also shall serve as the MDR Administrator, unless all parties notify the BCBSA Corporate Secretary in writing within two (2) days of receiving the Notice of Termination of Mediation that they wish to pursue MDR with another nationally recognized organization serving as MDR Administrator.

In the event the parties (i) did not pursue Mediation, (ii) pursued mediation with a Mediator not affiliated with an ADR organization that offers a panel of arbitrators, or (iii) all parties that pursued Mediation notified the BCBSA Corporate Secretary that they wish to have an MDR Administrator that is different from the organization with which their mediator was affiliated, they shall promptly attempt to agree on a nationally recognized ADR entity that supplies a panel of arbitrators. If they reach such agreement within five (5) days of the Notice of Termination of Mediation or receipt of the Answer or Reply to Counterclaim (whichever is later), the parties shall promptly inform the BCBSA Corporate Secretary of their agreed upon ADR organization. In the event the parties are unable to reach agreement on an MDR Administrator within that timeframe, the BCBSA Corporate Secretary shall immediately refer the matter to CPR, JAMS or a similar organization for MDR.

Any person who served as a Mediator shall not serve as an arbitrator for the same or similar dispute for purposes of MDR.

B. Rules for MDR

The rules controlling all aspects of MDR shall be exclusively those provided for herein. The rules promulgated or otherwise used by the MDR Administrator organization shall not apply.

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C. Initial Conference

Within seven (7) days after a Notice of Termination has issued, or the matter has otherwise been referred to an MDR Administrator, or within five (5) days after the time for filing and serving the Answer or Reply to any Counterclaim (whichever is later) if the parties elect first not to mediate, the parties shall confer with the Administrator to discuss selecting a dispute resolution panel ("the Panel"). This conference (the "Initial Conference") may be by telephone. The parties are encouraged to agree to the composition of the Panel and to present that agreement to the Administrator at the Initial Conference. If the parties do not agree on the composition of the Panel by the time of the Initial Conference, or by any extension thereof agreed to by all parties and the Administrator, then the Panel Selection Process set forth in subparagraph D, below, shall be followed.

D. Panel Selection Process

The Administrator shall designate, prior to the Initial Conference, at least seven potential arbitrators. Each party shall be permitted to strike any designee for cause and the Administrator shall determine the sufficiency thereof in its sole discretion. The Administrator will designate a replacement for any designee so stricken. Each party shall then be permitted one preemptory strike from the list of designees. The Administrator shall set the dates for exercising all strikes, which shall be set to encourage the prompt selection of arbitrators.

After the parties exercise any designee strikes for cause and their preemptory strike against any designee of their choice, the parties shall each rank the remaining panel members in order of preference and provide the Administrator, without serving on any other party, their ranked list. The Administrator shall not disclose any party's ranked list to members of the panel or to other parties.

From the remaining designees, and after considering opportunities to maximize, so far as possible, the collectively stated arbitrator preferences provided by the parties on their ranked lists, the Administrator shall select a three member Panel. The Panel Selection Process shall be completed no later than ten (10) days after the Initial Conference.

Each Arbitrator shall be compensated at his or her normal hourly rate or, in the absence of an established rate, at a reasonable hourly rate to be promptly fixed by the Administrator for all time spent in connection with the proceedings and shall be reimbursed for any travel and other reasonable expenses.

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E. Duties Of The Arbitrators

The Panel shall promptly designate a Presiding Arbitrator for the purposes reflected below, but shall retain the power to review and modify any ruling or other action of said Presiding Arbitrator. Each Arbitrator shall be an independent Arbitrator, shall be governed by the Code of Ethics for Arbitrators in Commercial Disputes, and shall at or prior to the commencement of any Arbitration Hearing take an oath to that effect. Each Arbitrator shall promptly disclose in writing to the Panel and to the parties any circumstances, whenever arising, that might cause doubt as to such Arbitrator's compliance, or ability to comply, with said Code of Ethics, and, absent resignation by such Arbitrator, the remaining Arbitrators shall determine in their sole discretion whether the circumstances so disclosed constitute grounds for disqualification and for replacement. With respect to such circumstances arising or coming to the attention of a party after an Arbitrator's selection, a party may likewise request the Arbitrator's resignation or a determination as to disqualification by the remaining Arbitrators. With respect to a sole Arbitrator, the determination as to disqualification shall be made by the Administrator.

There shall be no ex parte communication between the parties or their counsel and any member of the Panel.

F. Panel's Jurisdiction And Authority

The Panel's jurisdiction and authority shall extend to all disputes between or among the Plans, their Controlled Affiliates, and/or BCBSA, except for those disputes excepted from these MMDR procedures as set forth in the License Agreements.

With the exception of punitive or treble damages, the Panel shall have full authority to award the relief it deems appropriate to resolve the parties' disputes, including monetary awards and injunctions, mandatory or prohibitory. The Panel has no authority to award punitive or treble damages except that the Panel may allocate or assess responsibility for punitive or treble damages assessed by another tribunal. Subject to the above limitations, the Panel may, by way of example, but not of limitation:

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- i. interpret or construe the meaning of any terms, phrase or provision in any license between BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.
- ii. determine whether BCBSA, a Plan or a Controlled Affiliate has violated the terms or conditions of any license between the BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.
- iii. decide challenges as to its own jurisdiction.
- iv. issue such orders for interim relief as it deems appropriate pending Hearing and Award in any Arbitration.

It is understood that the Panel is expected to resolve issues based on governing principles of law, preserving to the maximum extent legally possible the continued integrity of the Licensed Marks and the BLUE CROSS/BLUE SHIELD system. The Panel shall apply federal law to all issues which, if asserted in the United States District Court, would give rise to federal question jurisdiction, 28 U.S.C. § 1331. The Panel shall apply Illinois law to all issues involving interpretation, performance or construction of any License Agreement or Controlled Affiliate License Agreement unless the agreement otherwise provides. As to other issues, the Panel shall choose the applicable law based on conflicts of law principles of the State of Illinois.

G. Administrative Conference

Within five (5) days of the Panel being selected, the Presiding Arbitrator shall confer with the parties and the other members of the Panel and shall schedule, in writing, a conference in which the parties and the Panel shall participate (the “Administrative Conference”). The Administrative Conference shall take place no later than fifteen (15) days after the Panel is selected. At the Administrative Conference the parties and the Panel shall discuss the scheduling of the Arbitration Hearing and any other matter appropriate to be considered, including but not limited to: any written discovery in the form of requests for production of documents or requests to admit facts; the identity of any witness whose deposition a party may desire and a showing of exceptional good cause for the taking

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of any such deposition; the desirability of bifurcation or other separation of the issues; the need for and the type of record of conferences and hearings, including the need for transcripts; the need for expert witnesses and how expert testimony should be presented; the appropriateness of motions to dismiss and/or for full or partial summary judgment; consideration of stipulations; the desirability of presenting any direct testimony in writing; and the necessity for any on-site inspection by the Panel. If the parties agree, the Administrative Conference may be by telephone.

H. Discovery

- i. Requests for Production of Documents:* All requests for the production of documents must be served no later than five (5) days after the date of the Initial Conference. Within twenty (20) days after receipt of a request for production of documents, a party shall (a) serve responses and objections to the request, (b) produce all responsive, non-privileged documents to the requesting party, and (c) to the extent any responsive documents are withheld on the grounds of attorney-client privilege or work product, produce a log identifying such documents in the manner specified in Fed. R. Civ. P. 26(b)(5). If, after reviewing a privilege log, the requesting party believes attorney-client privilege or work product protection was improperly claimed by the producing party with respect to any document, the requesting party may ask the Presiding Arbitrator to conduct an in-camera inspection of the same. With respect to documentary and other discovery produced in any MDR proceeding by BCBSA, the fact that a party's CEO or other senior officers may serve on the BCBSA Board of Directors, BCBSA Board Committees or other BCBSA work groups, task forces and the like, shall not be a basis for defeating an otherwise valid claim of attorney-client privilege or work product protection over such documentary or other discovery materials by BCBSA.
- ii. Requests for Admissions:* Requests for Admissions may be served up to twenty-one (21) days prior to the discovery cut-off set by the Presiding Arbitrator. A party served with Requests For Admissions must respond within twenty (20) days of receipt of said request. The good faith use of and response to Requests for Admissions is encouraged, and the Panel shall have full discretion, with reference to the Federal Rules of Civil Procedure, in awarding appropriate sanctions with respect to abuse of the procedure.

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iii. Depositions: As a general rule, the parties will not be permitted to take party or non-party deposition testimony for discovery

purposes. The Presiding Arbitrator, in his or her sole discretion, shall have the authority to permit a party to take such deposition testimony upon a showing of exceptional good cause. The parties will be permitted to take de bene esse deposition¹ testimony to the fullest extent permitted by law of any witness who cannot be compelled to testify at the Arbitration Hearing. No deposition, for discovery purposes or otherwise, shall exceed three (3) hours, excluding objections and colloquy of counsel. Depositions may be recorded in any manner recognized by the Federal Rules of Civil Procedure and the parties shall specify in each notice of deposition or request for permission to take deposition testimony the manner in which such deposition shall be recorded.

iv. Expert witness(es): If a party intends to present the testimony of an expert witness during the oral hearing, it shall provide all other parties with a written statement setting forth the information

required to be provided by Fed. R. Civ. P. 26(a)(2)(B) ten (10) days prior to the discovery cut-off set by the Presiding Arbitrator. If a party intends to present the testimony of a rebuttal expert witness during the Arbitration Hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)(B) within twenty (20) days after the date on which the written statement of the expert witness whose testimony is to be rebutted was produced.

v. Discovery cut-off: The Presiding Arbitrator shall determine the date on which the discovery period will end, but the discovery period shall not exceed thirty (30) days from the date of the Administrative Conference without the agreement of all parties.

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¹ As used in these Rules, "de bene esse deposition" means a deposition that is not taken for discovery purposes, but is taken for the purposes of reading part or all of the deposition transcript into the record at the Arbitration Hearing, to the extent permitted by the Panel, because the witness cannot be compelled to testify at the Arbitration Hearing or has exercised a right provided under these Rules to provide deposition testimony in lieu of testimony at the Arbitration Hearing.

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vi. *Additional discovery:* Any additional discovery will be at the discretion of the Presiding Arbitrator.

vii. *Discovery Disputes:* Any discovery disputes shall be raised by motion to the Presiding Arbitrator, who is authorized to resolve all such disputes, and whose resolution will be binding on the parties unless modified by the Arbitration Panel. Prior to raising any discovery dispute with the Presiding Arbitrator, the parties shall meet and confer, telephonically or in person, in an attempt to resolve or narrow the dispute. If a party refuses to comply with a decision resolving a discovery dispute, the Panel, in keeping with Fed. R. Civ. P. 37, may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for resolution adversely to that party.

viii. *Extensions:* The time for responding to discovery requests may be extended by the Presiding Arbitrator for good and sufficient cause shown. Any request for such an extension shall be made in writing.

I. Panel Suggested Settlement/Mediation

At any point during the proceedings, the Panel at the request of any party or on its own initiative, may suggest that the parties explore settlement and that they do so at or before the conclusion of the Arbitration Hearing, and the Panel shall give such assistance in settlement negotiations as the parties may request and the Panel may deem appropriate. Alternatively, the Panel may direct the parties to endeavor to mediate their disputes as provided above, or to explore a mini-trial proceeding, or to have an independent party render a neutral evaluation of the parties' respective positions. The Panel shall enter such sanctions as it deems appropriate with respect to any party failing to pursue in good faith such Mediation or other alternate dispute resolution methods.

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J. Subpoenas on Third Parties

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq.*, and subject to Paragraph 3.G(iii) above, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan or any officer, employee or director of a third party Blue Plan, to compel deposition testimony or the production of documents, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena.

K. Arbitration Hearing

An Arbitration Hearing will be held within thirty (30) days after the Administrative Conference if no discovery is taken, or within thirty (30) days after the close of discovery, unless all parties and the Panel agree to extend the Arbitration Hearing date, or unless the parties agree in writing to waive the Arbitration Hearing. The parties may mutually agree on the location of the Arbitration Hearing. If the parties fail to agree, the Arbitration Hearing shall be held in Chicago, Illinois, or at such other location determined by the Presiding Arbitrator to be most convenient to the participants. The Panel will determine the date(s) and time(s) of the Arbitration Hearing(s) after consultation with all parties and shall provide reasonable notice thereof to all parties or their representatives.

L. Arbitration Hearing Memoranda

Twenty (20) days prior to the Arbitration Hearing, each party shall submit to the other party (or parties) and to the Panel an Arbitration Hearing Memorandum which sets forth the applicable law and any argument as to any relevant issue. The Arbitration Hearing Memorandum will supplement, and not repeat, the allegations, information and documents contained in or with the Complaint, Answer, Counterclaim and Reply, if any. Ten (10) days prior to the Arbitration Hearing, each party shall submit to each other party a list of all expert and fact witnesses (but not including rebuttal fact witness) that such party intends to have testify at the Arbitration Hearing and a brief summary of the testimony each such witness is expected to give. In addition, no later than five (5) days prior to the Arbitration, each party may submit to each other party and to the Panel a Response Arbitration Hearing Memorandum which sets forth any response to another party's Arbitration Hearing Memorandum.

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M. Notice For Testimony

Ten (10) days prior to the Arbitration Hearing, any party may serve a Notice on any other party (or parties) requesting the attendance at the Arbitration Hearing of any officer, employee or director of the other party (or parties) for the purpose of providing noncumulative testimony. If a party fails to produce one of its officers, employees or directors whose noncumulative testimony during the Arbitration Hearing is reasonably requested by an adverse party, the Panel may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for mandatory dispute resolution adversely to that party; provided, however, that a party may refuse to produce a director to testify if, within two (2) days of receiving a notice requesting the attendance of such director at the Arbitration Hearing, the party agrees to make the director available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. This Rule may not be used for the purpose of burdening or harassing any party, and the Presiding Arbitrator may impose such orders as are appropriate so as to prevent or remedy any such burden or harassment.

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq.*, twenty (20) days or more prior to the Arbitration Hearing, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan, BCBSA or any officer, employee or director of a third party Blue Plan or BCBSA for the purpose of providing noncumulative testimony at the Arbitration Hearing, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena; provided however, that a director of a third party Blue Plan or BCBSA may refuse to testify if, within two (2) days of receiving a subpoena requesting the attendance of such director at the Arbitration Hearing, the director agrees to make him/herself available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. Each Blue Plan agrees to waive, on its own behalf and on behalf of its directors and officers, any objection it otherwise might have to any such subpoena based on service, venue or extraterritoriality.

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N. Arbitration Hearing Procedures

- i. Attendance at Arbitration Hearing:* Any person having a direct interest in the proceeding is entitled to attend the Arbitration Hearing. The Presiding Arbitrator shall otherwise have the power to require the exclusion of any witness, other than a party or other essential person, during the testimony of any other witness. It shall be discretionary with the Presiding Arbitrator to determine the propriety of the attendance of any other person.
- ii. Confidentiality:* The Panel and all parties shall maintain the privacy of the Arbitration Proceeding. The parties and the Panel shall treat the Arbitration Hearing and any discovery or other proceedings or events related thereto, including any award resulting therefrom, as confidential except as otherwise necessary in connection with a judicial challenge to or enforcement of an award or unless otherwise required by law.
- iii. Stenographic Record:* Any party, or if the parties do not object, the Panel, may request that a stenographic or other record be made of any Arbitration Hearing or portion thereof. The costs of the recording and/or of preparing the transcript shall be borne by the requesting party and by any party who receives a copy thereof. If the Panel requests a recording and/or a transcript, the costs thereof shall be borne equally by the parties.
- iv. Oaths:* The Panel may require witnesses to testify under oath or affirmation administered by any duly qualified person and, if requested by any party, shall do so.
- v. Order of Arbitration Hearing:* An Arbitration Hearing shall be opened by the recording of the date, time, and place of the Arbitration Hearing, and the presence of the Panel, the parties, and their representatives, if any. The Panel may, at the beginning of the Arbitration Hearing, ask for statements clarifying the issues involved.

Amended as of September 20, 2007

EXHIBIT 5

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Unless otherwise agreed, the complaining party (or parties) shall then present evidence to support their claim(s). The respondent(s) shall then present evidence supporting their defenses and Counterclaims, if any. The complaining party (or parties) shall then present evidence supporting defenses to the Counterclaims, if any, and rebuttal.

Witnesses for each party shall submit to questions by adverse parties and/or the Panel.

The Panel has the discretion to vary these procedures, but shall afford a full and equal opportunity to all parties for the presentation of any material and relevant evidence.

- vi. **Evidence:** The parties may offer such evidence as is relevant and material to the dispute and shall produce such evidence as the Panel may deem necessary to an understanding and resolution of the dispute. Unless good cause is shown, as determined by the Panel or agreed to by all other parties, no party shall be permitted to offer evidence at the Arbitration Hearing which was not disclosed prior to the Arbitration Hearing by that party. The Panel may receive and consider the evidence of witnesses by affidavit upon such terms as the Panel deems appropriate.

The Panel shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence, other than enforcement of the attorney-client privilege and the work product protection, shall not be necessary. The Federal Rules of Evidence shall be considered by the Panel in conducting the Arbitration Hearing but those rules shall not be controlling. All evidence shall be taken in the presence of the Panel and all of the parties, except where any party is in default or has waived the right to be present.

Settlement offers by any party in connection with Mediation or MDR proceedings, decisions or recommendations of the selected mediators, and a party's position papers or statements furnished to the selected mediators shall not be admissible evidence or considered by the Panel without the consent of all parties.

EXHIBIT 5 Page 17 of 23

vii. ***Closing of Arbitration Hearing:*** The Presiding Arbitrator shall specifically inquire of all parties whether they have any further proofs to offer or witnesses to be heard. Upon receiving negative replies or if he or she is satisfied that the record is complete, the Presiding Arbitrator shall declare the Arbitration Hearing closed with an appropriate notation made on the record. Subject to being reopened as provided below, the time within which the Panel is required to make the award shall commence to run, in the absence of contrary agreement by the parties, upon the closing of the Arbitration Hearing.

With respect to complex disputes, the Panel may, in its sole discretion, defer the closing of the Arbitration Hearing for a period of up to thirty (30) days after the presentation of proofs in order to permit the parties to submit post-hearing briefs and argument, as the Panel deems appropriate, prior to making an award.

For good cause, the Arbitration Hearing may be reopened for up to thirty (30) days on the Panel's initiative, or upon application of a party, at any time before the award is made

O. Awards

An Award must be in writing and shall be made promptly by the Panel and, unless otherwise agreed by the parties or specified by law, no later than thirty (30) days from the date of closing the Arbitration Hearing. If all parties so request, the Award shall contain findings of fact and conclusions of law. The Award, and all other rulings and determinations by the Panel, may be by a majority vote.

Parties shall accept as legal delivery of the Award the placing of the Award or a true copy thereof in the mail addressed to a party or its representative at its last known address or personal service of the Award on a party or its representative.

Awards are binding only on the parties to the Arbitration and are not binding on any non-parties to the Arbitration and may not be used or cited as precedent in any other proceeding.

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After the expiration of twenty (20) days from initial delivery, the Award (with corrections, if any) shall be final and binding on the parties, and the parties shall undertake to carry out the Award without delay.

Proceedings to confirm, modify or vacate an Award shall be conducted in conformity with and controlled by the Federal Arbitration Act, 9 U.S.C. § 1, *et seq.*

P. Return of Documents

Within sixty (60) days after the Award and the conclusion of any judicial proceedings with respect thereto, each party and the Panel shall return any documents produced by any other party, including all copies thereof. If a party receives a discovery request in any other proceeding which would require it to produce any documents produced to it by any other party in a proceeding hereunder, it shall not produce such documents without first notifying the producing party and giving said party reasonable time to respond, if appropriate, to the discovery request.

4. Miscellaneous

A. Expedited Procedures

Any party to a Mediation may direct a request for an expedited Mediation Hearing to the Chairman of the Mediation Committee, to the selected Mediators, and to all other parties at any time. The Chairman of the Mediation Committee, or at his or her direction, the then selected Mediators, shall grant any request which is supported by good and sufficient reasons. If such a request is granted, the Mediation shall be completed within as short a period as practicable, as determined by the Chairman of the Mediation Committee or, at his or her direction, the then selected Mediators.

Any party to an Arbitration may direct a request for expedited proceedings to the Administrator, to the Panel, and to all other parties at any time. The Administrator, or the Presiding Arbitrator if the Panel has been selected, shall grant any such request which is supported by good and sufficient reasons. If such a request is granted, the Arbitration shall be completed within as short a time as practicable, as determined by the Administrator and/or the Presiding Arbitrator.

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B. Temporary or Preliminary Injunctive Relief

Any party may seek temporary or preliminary injunctive relief with the filing of a Complaint or at any time thereafter. If such relief is sought prior to the time that an Arbitration Panel has been selected, then the Administrator shall select a single Arbitrator who is a lawyer who has no interest in the subject matter of the dispute, and no connection to any of the parties, to hear and determine the request for temporary or preliminary injunction. If such relief is sought after the time that an Arbitration Panel has been selected, then the Arbitration Panel will hear and determine the request. The request for temporary or preliminary injunctive relief will be determined with reference to the temporary or preliminary injunction standards set forth in Fed. R. Civ. P. 65.

C. Defaults and Proceedings in the Absence of a Party

Whenever a party fails to comply with the MDR Rules in a manner deemed material by the Panel, the Panel shall fix a reasonable time for compliance and, if the party does not comply within said period, the Panel may enter an Order of default or afford such other relief as it deems appropriate. Arbitration may proceed in the event of a default or in the absence of any party who, after due notice, fails to be present or fails to obtain an extension. An Award shall not be made solely on the default or absence of a party, but the Panel shall require the party who is present to submit such evidence as the Panel may require for the making of findings, determinations, conclusions, and Awards.

D. Notice

Each party shall be deemed to have consented that any papers, notices, or process necessary or proper for the initiation or continuation of a proceeding under these rules or for any court action in connection therewith may be served on a party by mail addressed to the party or its representative at its last known address or by personal service, in or outside the state where the MDR proceeding is to be held.

The Corporate Secretary and the parties may also use facsimile transmission, telex, telegram, or other written forms of electronic communication to give the notices required by these rules.

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E. Expenses

The expenses of witnesses shall be paid by the party causing or requesting the appearance of such witnesses. All expenses of the MDR proceeding, including compensation, required travel and other reasonable expenses of the Panel, and the cost of any proof produced at the direct request of the Panel, shall be borne equally by the parties and shall be paid periodically on a timely basis, unless they agree otherwise or unless the Panel in the Award assesses such expenses, or any part thereof against any party (or parties). In exceptional cases, the Panel may award reasonable attorneys' fees as an item of expense, and the Panel shall promptly determine the amount of such fees based on affidavits or such other proofs as the Panel deems sufficient.

F. Disqualification or Disability of A Panel Member

In the event that any Arbitrator of a Panel with more than one Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the remaining Panel member(s):

- i. shall designate a replacement, subject to the right of any party to challenge such replacement for cause.
- ii. shall decide the extent to which previously held hearings shall be repeated.

If the remaining Panel members consider the proceedings to have progressed to a stage as to make replacement impracticable, the parties may agree, as an alternative to the recommencement of the Mandatory Dispute Resolution process, to resolution of the dispute by the remaining Panel members.

In the event that a single Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the Administrator shall appoint a successor, subject to the right of any party to challenge such successor for cause, and the successor shall decide the extent to which previously held proceedings shall be repeated.

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G. Extensions of Time

Subject to the provisions of Paragraph 3.H.(viii), any time limit set forth in these Rules may be extended upon agreement of the parties and approval of: (1) the Mediator if the proceeding is then in Mediation; (2) the Administrator if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (3) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected.

H. Intervention

The Plans, their Controlled Affiliates, and BCBSA, to the extent subject to MMDR pursuant to their License Agreements, shall have the right to move to intervene in any pending Arbitration. A written motion for intervention shall be made to: (1) the Administrator, if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (2) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected. The written motion for intervention shall be delivered to the BCBSA Corporate Secretary (which shall also constitute service on the BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) which are parties to the proceeding. Any party to the proceeding can submit written objections to the motion to intervene. The motion for intervention shall be granted upon good cause shown. Intervention also may be allowed by stipulation of the parties to the Arbitration proceeding. Intervention shall be allowed upon such terms as the Arbitration Panel decides.

I. BCBSA Assistance In Resolution of Disputes

The resources and personnel of the BCBSA may be requested by any member Plan at any time to try to resolve disputes with another Plan.

J. Neutral Evaluation

The parties can voluntarily agree at any time to have an independent party render a neutral evaluation of the parties' respective positions.

Amended as of September 20, 2007

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K. Recovery of Attorney Fees and Expenses

i. Motions to Compel

Notwithstanding any other provisions of these Rules, any Party subject to the License Agreements (for purposes of this Section K and all of its subsections only hereinafter referred to collectively and individually as a “Party”) that initiates a court action or administrative proceeding solely to compel adherence to these Rules shall not be determined to have violated these Rules by initiating such action or proceeding.

ii Recovery of Fees, Expenses and Costs

The Arbitration Panel may, in its sole discretion, award a Party its reasonable attorneys’ fees, expenses and costs associated with a filing to compel adherence to these Rules and/or reasonable attorneys’ fees, expenses and costs incurred in responding to an action filed in violation of these Rules; provided, however, that neither fees, expenses, nor costs shall be awarded by the Arbitration Panel if the Party from which the award is sought can demonstrate to the Arbitration panel, in its sole discretion, that it did not violate these Rules or that it had reasonable grounds for believing that its action did not violate these Rules.

iii Requests for Reimbursement

For purposes of this Section K, any Party may request reimbursement of fees, expenses and/or costs by submitting said request in writing to the Arbitration Panel at any time before an award is delivered pursuant to Paragraph 3.O above, with a copy to the Party from which reimbursement is sought, explaining why it is entitled to such reimbursement. The Party from which reimbursement is sought shall have twenty (20) days to submit a response to such request to the Arbitration Panel with a copy to the Party seeking reimbursement.

Amended as of September 20, 2007

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L. Calculation of Time and Deadlines

In computing any period of time prescribed or allowed under these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not one of the aforementioned days. When the period of time prescribed is less than six (6) days, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation. As used in this rule, “legal holiday” includes New Year’s Day, Martin Luther King, Jr. Day, Washington’s Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day and any other day appointed as a holiday by the President or the Congress of the United States.

Amended as of September 20, 2007

<i>Legal Name</i>	<i>State</i>
American Imaging Management, Inc. (d/b/a AIM Specialty Health)	Illinois
AMERIGROUP Community Care of New Mexico, Inc.	New Mexico
AMERIGROUP Corporation (d/b/a AMERIGROUP CORPORATION; AGP Corporation; AMGP; AMGP Corporation; AMGP Missouri, Inc.; Amerigroup)	Delaware
AMERIGROUP District of Columbia, Inc.	Washington D.C.
AMERIGROUP Florida, Inc. (d/b/a AMERIGROUP Community Care)	Florida
Amerigroup Insurance Company	Texas
Amerigroup Iowa, Inc.	Iowa
Amerigroup Kansas, Inc.	Kansas
AMERIGROUP Maryland, Inc. (d/b/a AMERIGROUP Community Care)	Maryland
AMERIGROUP Mississippi, Inc.	Mississippi
AMERIGROUP Nevada, Inc. (d/b/a AMERIGROUP Community Care)	Nevada
AMERIGROUP New Jersey, Inc. (d/b/a AMERIGROUP Community Care)	New Jersey
AMERIGROUP Ohio, Inc. (d/b/a AMERIGROUP Community Care)	Ohio
AMERIGROUP Oklahoma, Inc.	Oklahoma
Amerigroup Partnership Plan, LLC	Illinois
AMERIGROUP Tennessee, Inc. (d/b/a AMERIGROUP Community Care)	Tennessee
AMERIGROUP Texas, Inc. (d/b/a AMERIGROUP Community Care)	Texas
AMERIGROUP Washington, Inc.	Washington
AMGP Georgia Managed Care Company, Inc. (d/b/a AMERIGROUP; AMERIGROUP Community Care; AMERIGROUP Georgia; AMGP Georgia)	Georgia
Anthem Blue Cross Life and Health Insurance Company	California
Anthem Financial, Inc.	Delaware
Anthem Health Insurance Company of Nevada	Nevada
Anthem Health Plans of Kentucky, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Kentucky
Anthem Health Plans of Maine, Inc. (d/b/a Anthem Blue Cross and Blue Shield and Associated Hospital Service)	Maine
Anthem Health Plans of New Hampshire, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	New Hampshire
Anthem Health Plans of Virginia, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Virginia
Anthem Health Plans, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Connecticut
Anthem Holding Corp. (d/b/a Anthem Properties, Inc.)	Indiana
Anthem Insurance Companies, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Indiana
Anthem Kentucky Managed Care Plan, Inc. (d/b/a Anthem Blue Cross and Blue Shield Medicaid)	Kentucky
Anthem Life & Disability Insurance Company	New York
Anthem Life Insurance Company	Indiana
Anthem Partnership Holding Company, LLC	Indiana
Anthem Southeast, Inc.	Indiana
Anthem UM Services, Inc.	Indiana
Anthem Workers' Compensation, LLC	Indiana
Arcus Enterprises, Inc.	Delaware
ARCUS HealthyLiving Services, Inc.	Indiana
Associated Group, Inc.	Indiana
ATH Holding Company, LLC	Indiana
Better Health, Inc.	Florida

<i>Legal Name</i>	<i>State</i>
Blue Cross and Blue Shield of Georgia, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Georgia
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Georgia
Blue Cross Blue Shield of Wisconsin (d/b/a Anthem Blue Cross and Blue Shield)	Wisconsin
Blue Cross of California (d/b/a Anthem Blue Cross)	California
Blue Cross of California Partnership Plan, Inc.(d/b/a Anthem Blue Cross Partnership Plan)	California
CareMore Health Plan	California
CareMore Health Plan of Arizona, Inc.	Arizona
CareMore Health Plan of Nevada	Nevada
CareMore Health Plan of Texas, Inc.	Texas
CareMore Health System	California
CareMore Holdings, Inc.	Delaware
CareMore IPA of New York, LLC	New York
CareMore Services Company, LLC	Indiana
CareMore, LLC	Indiana
Cerulean Companies, Inc.	Georgia
Claim Management Services, Inc.(d/b/a Anthem Blue Cross and Blue Shield)	Wisconsin
Community Care Health Plan of Louisiana, Inc.	Louisiana
Community Insurance Company (d/b/a Anthem Blue Cross and Blue Shield)	Ohio
Compcare Health Services Insurance Corporation (d/b/a Anthem Blue Cross and Blue Shield)	Wisconsin
Crossroads Acquisition Corp.	Delaware
DeCare Analytics, LLC	Minnesota
DeCare Dental Health International, LLC	Minnesota
DeCare Dental Insurance Ireland, Ltd.	Ireland
DeCare Dental Networks, LLC	Minnesota
DeCare Dental, LLC	Minnesota
DeCare Operations Ireland, Limited	Ireland
Designated Agent Company, Inc. (d/b/a Access Insurance Agency, Inc.)	Kentucky
EHC Benefits Agency, Inc.	New York
Empire HealthChoice Assurance, Inc. (d/b/a Empire Blue Cross; Empire Blue Cross Blue Shield)	New York
Empire HealthChoice HMO, Inc. (d/b/a Empire Blue Cross HMO; Empire Blue Cross Blue Shield HMO)	New York
Federal Government Solutions, LLC	Wisconsin
Golden West Health Plan, Inc.	California
Government Health Services, LLC	Wisconsin
Greater Georgia Life Insurance Company (d/b/a Anthem Life)	Georgia
Health Core, Inc.	Delaware
Health Management Corporation (d/b/a LiveHealth Online; HMC of Virginia; Health Management of Virginia)	Virginia
Health Ventures Partner, L.L.C.	Illinois
HealthKeepers, Inc.	Virginia
HealthLink HMO, Inc. (d/b/a HealthLink HMO)	Missouri
HealthLink, Inc.	Illinois
HealthPlus HP, LLC (d/b/a Empire BlueCross BlueShield HealthPlus)	New York
Healthy Alliance Life Insurance Company (d/b/a Anthem Blue Cross and Blue Shield)	Missouri
HMO Colorado, Inc. (d/b/a HMO Colorado; HMO Nevada)	Colorado

<i>Legal Name</i>	<i>State</i>
HMO Missouri, Inc. (d/b/a Amerigroup Missouri; Anthem Blue Cross and Blue Shield)	Missouri
Imaging Management Holdings, LLC	Delaware
Living Complete Technologies, Inc.	Maryland
Matthew Thornton Health Plan, Inc.	New Hampshire
Meridian Resource Company, LLC	Wisconsin
National Government Services, Inc. (d/b/a NGS of Indiana)	Indiana
National Telehealth Network, LLC	Delaware
Park Square Holdings, Inc.	California
Park Square I, Inc.	California
Park Square II, Inc.	California
PHP Holdings, Inc.	Florida
Resolution Health, Inc.	Delaware
RightCHOICE Managed Care, Inc. (d/b/a RightCHOICE Benefit Administrators; Anthem Blue Cross and Blue Shield)	Delaware
Rocky Mountain Hospital and Medical Service, Inc.(d/b/a Anthem Blue Cross and Blue Shield)	Colorado
SellCore, Inc. (d/b/a SellCore Insurance Services, Inc.)	Delaware
Simply Healthcare Holdings, Inc.	Florida
Simply Healthcare Plans, Inc. (d/b/a Clear Health Alliance)	Florida
Southeast Services, Inc.	Virginia
State Sponsored Business UM Services, Inc.	Indiana
The Anthem Companies of California, Inc.	California
The Anthem Companies, Inc.	Indiana
TrustSolutions, LLC	Wisconsin
UNICARE Health Plan of West Virginia, Inc.	West Virginia
UNICARE Illinois Services, Inc.	Illinois
UniCare Life & Health Insurance Company	Indiana
UNICARE National Services, Inc.	Delaware
UniCare Specialty Services, Inc.	Delaware
UtiliMED IPA, Inc.	New York
WellPoint Acquisition, LLC	Indiana
WellPoint Behavioral Health, Inc.	Delaware
WellPoint California Services, Inc.	Delaware
WellPoint Dental Services, Inc.	Delaware
WellPoint Health Solutions, Inc.	Indiana
WellPoint Holding Corp.	Delaware
WellPoint Information Technology Services, Inc.	California
WellPoint Insurance Services, Inc.	Hawaii
WellPoint Military Care Corporation	Indiana
WPMI (Shanghai) Enterprise Service Co., Ltd.	China
WPMI, LLC	Delaware

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the following Registration Statements:

- Form S-8 No. 333-84906 and Form S-8 No. 333-129334 pertaining to the Anthem 401(k) Plan;
- Form S-8 No. 333-159830 pertaining to the Anthem Incentive Compensation Plan;
- Form S-8 No. 333-156099 pertaining to the Anthem, Inc. Employee Stock Purchase Plan;
- Post-Effective Amendment No. 1 to Form S-3 No. 333-200749 pertaining to the Anthem, Inc. registration of senior debt securities, subordinated debt securities, preferred stock, common stock, depositary shares, warrants, rights, stock purchase contracts and stock purchase units; and
- Form S-4 No. 333-207218 pertaining to the Anthem, Inc. registration of shares of common stock and the joint Proxy Statement of Anthem, Inc. and Cigna Corporation

of our report dated February 22, 2017, with respect to the consolidated financial statements and schedule of Anthem, Inc., and the effectiveness of internal control over financial reporting of Anthem, Inc., included in its Annual Report (Form 10-K) for the year ended December 31, 2016.

/S/ ERNST & YOUNG LLP
Indianapolis, Indiana
February 22, 2017

**CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, Joseph R. Swedish, certify that:

1. I have reviewed this report on Form 10-K of Anthem, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):
 - a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 22, 2017

/s/ JOSEPH R. SWEDISH

Chairman, President and
Chief Executive Officer

**CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, John E. Gallina, certify that:

1. I have reviewed this report on Form 10-K of Anthem, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):
 - a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 22, 2017

/s/ JOHN E. GALLINA

Executive Vice President and
Chief Financial Officer

**CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report of Anthem, Inc. (the "Company") on Form 10-K for the period ended December 31, 2016 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Joseph R. Swedish, Chairman, President and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

- (1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
- (2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JOSEPH R. SWEDISH

Joseph R. Swedish
Chairman, President and Chief Executive Officer
February 22, 2017

**CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report of Anthem, Inc. (the "Company") on Form 10-K for the period ended December 31, 2016 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, John E. Gallina, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

- (1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
- (2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JOHN E. GALLINA

John E. Gallina
Executive Vice President and Chief Financial Officer
February 22, 2017

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE
SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2015
OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE
SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____
Commission file number: 001-16751

ANTHEM, INC.

(Exact name of registrant as specified in its charter)

INDIANA

(State or other jurisdiction of
incorporation or organization)

35-2145715

(I.R.S. Employer Identification Number)

**120 MONUMENT CIRCLE
INDIANAPOLIS, INDIANA**
(Address of principal executive offices)

46204
(Zip Code)

Registrant's telephone number, including area code: **(317) 488-6000**
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock, Par Value \$0.01	New York Stock Exchange
Securities registered pursuant to Section 12(g) of the Act: NONE	
Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. <input checked="" type="checkbox"/>	
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer", and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one): Large accelerated filer <input checked="" type="checkbox"/> Accelerated filer <input type="checkbox"/> Non-accelerated filer <input type="checkbox"/> (Do not check if a smaller reporting company) Smaller reporting company <input type="checkbox"/>	
Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all Directors and executive officers of the registrant are "affiliates") as of June 30, 2015 was approximately \$42,815,533,599. As of February 4, 2016, 261,351,781 shares of the Registrant's Common Stock were outstanding.	

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10-K incorporates by reference information from the registrant's Definitive Proxy Statement for the Annual Meeting of Shareholders to be held May 19, 2016.

Anthem, Inc.

Annual Report on Form 10-K
For the Year Ended December 31, 2015

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This Annual Report on Form 10-K, including Management's Discussion and Analysis of Financial Condition and Results of Operations, contains forward-looking statements, within the meaning of the Private Securities Litigation Reform Act of 1995, that reflect our views about future events and financial performance. When used in this report, the words "expect," "feel," "believe," "will," "may," "should," "anticipate," "intend," "estimate," "project," "forecast," "plan," and similar expressions are intended to identify forward-looking statements, which are generally not historical in nature. Forward-looking statements include, but are not limited to, financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Forward-looking statements are subject to known and unknown risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. You are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. You are also urged to carefully review and consider the various disclosures made by us, which attempt to advise interested parties of the factors that affect our business, including "Risk Factors" set forth in Part I, Item 1A hereof and our reports filed with the U.S. Securities and Exchange Commission, or SEC, from time to time. Except to the extent otherwise required by federal securities laws, we do not undertake any obligation to republish revised forward-looking statements to reflect events or circumstances after the date hereof or to reflect the occurrence of unanticipated events.

References in this Annual Report on Form 10-K to the terms "we," "our," "us," "Anthem" or the "Company" refer to Anthem, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries.

PART I

ITEM 1. BUSINESS.

General

We are one of the largest health benefits companies in terms of medical membership in the United States, serving 38.6 million medical members through our affiliated health plans as of December 31, 2015. We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as BCBS in 10 New York City metropolitan and surrounding counties, and as Blue Cross or BCBS in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield, or Empire Blue Cross (in our New York service areas). We also conduct business through an arrangement with another BCBS licensee in South Carolina. We conduct business through our AMERIGROUP Corporation, or Amerigroup, subsidiary, in Florida, Georgia, Kansas, Louisiana, Maryland, Nevada, New Jersey, New Mexico, New York, Tennessee, Texas, Washington and effective January 1, 2016, in Iowa. In addition, we conduct business through our recently acquired Simply Healthcare Holdings, Inc., or Simply Healthcare, subsidiary in Florida. We also serve customers throughout the country as HealthLink, UniCare (including a non-risk arrangement with Massachusetts), and in certain Arizona, California, Nevada and Virginia markets through our CareMore Health Group, Inc., or CareMore, subsidiary. We are licensed to conduct insurance operations in all 50 states through our subsidiaries.

On July 24, 2015, we and Cigna Corporation, or Cigna, announced that we entered into an Agreement and Plan of Merger, or Merger Agreement, dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and our direct wholly-owned subsidiary, pursuant to which we will acquire all outstanding shares of Cigna, or the Acquisition. The Acquisition will further our goal of creating a premier health benefits company with critical diversification and scale to lead the transformation of health care delivery for consumers. Cigna is a global health services organization that delivers affordable and personalized products and services to customers through employer-based, government-sponsored and individual coverage arrangements. All of Cigna's products and services are provided exclusively by or through its operating subsidiaries, including Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Life Insurance Company of North America and Cigna Life Insurance Company of New York. Such products and services include an integrated suite of health services, such as medical, dental, behavioral health, pharmacy, vision, supplemental benefits, and other related products including group life, accident and disability insurance. Cigna maintains sales capability in 30 countries and jurisdictions.

Under the terms of the Merger Agreement, Cigna's shareholders will receive \$103.40 in cash and 0.5152 shares of our common stock for each Cigna common share outstanding. The value of the transaction is estimated to be approximately \$53.0 billion based on the closing price of our common stock on the New York Stock Exchange on July 23, 2015. The final purchase price will be determined based on our closing stock price on the date of closing of the Acquisition. The combined company will reflect a pro forma equity ownership comprised of approximately 67% Anthem shareholders and approximately 33% Cigna shareholders. On December 3, 2015, both our and Cigna's shareholders approved the proposals necessary to proceed with the Acquisition.

We expect to finance the cash portion of the Acquisition through available cash on hand and the issuance of new debt. The Acquisition is expected to close in the second half of 2016 and is subject to certain state regulatory approvals, other standard closing conditions and customary approvals required under the Hart-Scott-Rodino Antitrust Improvements Act. For additional information, see "Risk Factors" included in Part I, Item 1A; "Management's Discussion and Analysis of Financial Condition and Results of Operations - Overview" included in Part II, Item 7; and Note 3, "Business Acquisitions and Divestiture - Pending Acquisition of Cigna Corporation" included in Part II, Item 8 of this Annual Report on Form 10-K.

In February 2015, we reported that we were the target of a sophisticated external cyber attack. The attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many individuals and employees. We have continued to implement security enhancements since this incident and are supporting federal law enforcement efforts to identify the responsible parties. For additional information about the cyber attack, see Note

13, "Commitments and Contingencies - *Cyber Attack Incident*," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

On February 17, 2015, we completed our acquisition of Simply Healthcare, a leading managed care company for people enrolled in Medicaid and Medicare programs in Florida. This acquisition aligns with our strategy for continued growth in our Government Business segment. As a result, we serve more than six hundred thousand members in Florida through our affiliated Amerigroup and Simply Healthcare Medicaid and Medicare plans. For additional information, see Note 3, "Business Acquisitions and Divestiture - *Acquisition of Simply Healthcare*" included in Part II, Item 8 of this Annual Report on Form 10-K.

We have a vision of becoming America's valued health partner. Together we are transforming health care with trusted and caring solutions and as a result, we focus on delivering quality products and services that give members access to the care they need. With an unyielding commitment to meeting the needs of our diverse customers, we are guided by the following values:

- Accountable
- Caring
- Easy to do business with
- Innovative
- Trustworthy

We offer a broad spectrum of network-based managed care plans to large and small employer, individual, Medicaid and Medicare markets. Our managed care plans include: preferred provider organizations, or PPOs; health maintenance organizations, or HMOs; point-of-service, or POS, plans; traditional indemnity plans and other hybrid plans, including consumer-driven health plans, or CDHPs; and hospital only and limited benefit products. In addition, we provide a broad array of managed care services to self-funded customers, including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services. We provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal health care. We also provide services to the federal government in connection with the Federal Employee Program, or FEP.

The increased focus on health care costs by employers, the government and consumers has continued to drive the growth of alternatives to traditional indemnity health insurance. HMO, PPO and hybrid plans, such as POS plans and CDHPs, are among the various forms of managed care products that have been developed. Through these types of products, insurers attempt to contain the cost of health care by negotiating contracts with hospitals, physicians and other providers to deliver high quality health care to members at favorable rates. These products usually feature medical management and other quality and cost optimization measures such as pre-admission review and approval for certain non-emergency services, pre-authorization of outpatient surgical procedures, network credentialing to determine that network doctors and hospitals have the required certifications and expertise, and various levels of care management programs to help members better understand and navigate the health care system. In addition, providers may have incentives to achieve certain quality measures, may share medical cost risk or may have other incentives to deliver quality medical services in a cost-effective manner. Also, certain plans offer members incentives for healthy behaviors, such as smoking cessation and weight management. Members are charged periodic, prepaid premiums and generally pay co-payments, coinsurance and/or deductibles when they receive services. While the distinctions between the various types of plans have lessened over recent years, PPO, POS and CDHP products generally provide reduced benefits for out-of-network services, while traditional HMO products generally provide little to no reimbursement for non-emergency out-of-network utilization, but often offer more generous benefit coverage. An HMO plan may also require members to select one of the network primary care physicians, or PCPs, to coordinate their care and approve any specialist or other services.

Economic factors, greater consumer and employer sophistication, and accountability have resulted in an increased demand for choice in both product/benefit designs and provider network configurations. As a result we continue to offer our broad access PPO networks with multiple benefit designs, but are also focused on leveraging our emerging provider collaboration initiatives with our Accountable Care Organization, or ACO, partnerships to develop both narrow and tiered network offerings. This array of network and product configurations allows both the employer and the employee to design

and select the combination of benefit designs (e.g., traditional PPOs, high deductibles, HRAs, HSAs, PCP based products, tiered copays) and networks (e.g., broad, narrow, tiered, closed and open) that optimize choice, quality and price at the consumer, employer and market level. We believe we are well-positioned in each of our states to respond to these market preferences.

For our fully-insured products, we charge a premium and assume all of the health care risk. Under self-funded and partially-insured products, we charge a fee for services, and the employer or plan sponsor reimburses us for all or most of the health care costs. In addition, we charge a premium to provide administrative services to Large Group and National Account employers that maintain self-funded health plans and we underwrite stop loss insurance for self-funded plans.

Our medical membership includes seven different customer types: Local Group, Individual, National Accounts, BlueCard®, Medicare, Medicaid and FEP.

BCBS-branded business generally refers to members in our service areas licensed by the BCBSA. Non-BCBS-branded business refers to members in our non-BCBS-branded Amerigroup, CareMore and Simply Healthcare plans, as well as HealthLink and UniCare members. In addition to the above medical membership, we also serve customers who purchase one or more of our other products or services that are often ancillary to our health business.

Our products are generally developed and marketed with an emphasis on the differing needs of our customers. In particular, our product development and marketing efforts take into account the differing characteristics between the various customers served by us, as well as the unique needs of educational and public entities, labor groups, federal employee health and benefit programs, national employers and state-run programs servicing low-income, high-risk and under-served markets. Each business unit is responsible for product design, pricing, enrolling, underwriting and servicing customers in specific customer types. Overall, we seek to establish pricing and product designs to provide value for our customers while achieving an appropriate level of profitability for each of our customer categories balanced with the competitive objective to grow market share. We believe that one of the keys to our success has been our focus on these distinct customer types, which better enables us to develop benefit plans and services that meet our customers' unique needs.

We market our products through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships for Individual and Medicare customers, and for certain Local Group customers with a smaller employee base. Products for National Accounts and Local Group customers with a larger employee base are generally sold through independent brokers or consultants retained by the customer and working with industry specialists from our in-house sales force. In the Individual and Small Group markets, we offer on-exchange products through state or federally facilitated marketplaces, referred to as public exchanges, and off-exchange products. Federal premium subsidies are available only for certain members who purchase certain public exchange products.

Being a member of the BCBS companies, of which there were 36 independent primary licensees as of December 31, 2015, creates significant market advantages, especially when competing for very large multi-state employer groups. For example, each BCBS member company is able to take advantage of other BCBS licensees' substantial provider networks and discounts when any BCBS member works or travels outside of the state in which their policy is written. This program is referred to as BlueCard® and is a source of revenue when we provide member services in the states where we are the BCBS licensee to individuals who are customers of BCBS plans not affiliated with us. This program also provides a national provider network for our members when they travel to other states.

For additional information describing each of our customer types, detailed marketing efforts and changes in medical membership over the last three years, see "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in Part II, Item 7 of this Annual Report on Form 10-K.

Our results of operations depend in large part on accurately predicting health care costs and our ability to manage future health care costs through adequate product pricing, medical management, product design and negotiation of favorable provider contracts.

Advances in medical technology, increases in specialty drug costs, the aging of the population and other demographic characteristics continue to contribute to rising health care costs. Our managed care plans and products are designed to encourage providers and members to participate in quality, cost-effective health benefit programs by using the full range of our innovative medical management services, quality initiatives and financial incentives. Our significant market share and

high business retention rates enable us to realize the long-term benefits of investing in preventive and early detection programs. Our ability to provide cost-effective health benefits products and services is enhanced through a disciplined approach to internal cost containment, prudent management of our risk exposure and successful integration of acquired businesses. In addition, our ability to manage selling, general and administrative costs continues to be a driver of our overall profitability.

Our future results of operations will also be impacted by certain external forces and resulting changes in our business model and strategy. In 2010, the Patient Protection and Affordable Care Act, or ACA, as well as the Health Care and Education Reconciliation Act of 2010, or collectively, Health Care Reform, became law, causing significant changes to the U.S. health care system. Since then, significant regulations have been enacted by the U.S. Department of Health and Human Services, or HHS, the Department of Labor and the Department of the Treasury. The legislation and regulations are far-reaching and are intended to expand access to health insurance coverage over time by mandating that most individuals obtain health insurance coverage, increasing the eligibility thresholds for most state Medicaid programs and providing certain other individuals and small businesses with tax credits to subsidize a portion of the cost of health insurance coverage. As a result of the complexity of the law, its impact on health care in the United States and the continuing modification and interpretation of Health Care Reform rules, we continue to analyze and refine our estimates of the ultimate impact of Health Care Reform on our business, cash flows, financial condition and results of operations. Health Care Reform presents us with new growth opportunities, but also introduces new risks, regulatory challenges and uncertainties, and required changes in the way products are designed, underwritten, priced, distributed and administered. For additional discussion, see "Regulation," herein and Part I, Item 1A "Risk Factors" in this Annual Report on Form 10-K.

In addition to the external forces discussed in the preceding paragraph, our results of operations are impacted by levels and mix of membership. In recent years, we have experienced membership growth due to the quality and pricing of our health benefits products and services, improved economic conditions, decreases in unemployment, acquisitions, entry into new markets and expansions in existing markets. In addition, we believe the self-insured portion of our group membership base will continue to increase as a percentage of total group membership. However, these membership trends could be negatively impacted by various factors that could have a material adverse effect on our future results of operations such as general economic downturns that result in business failures, failure to obtain new customers or retain existing customers, premium increases, benefit changes or our exit from a specific market. See Part I, Item 1A "Risk Factors" and Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

Private exchanges have gained visibility in the marketplace based on the promise of helping employers reduce costs, increase consumer engagement and manage the complexities created by the ACA and other market forces. While private exchanges have been a distribution channel in the Medicare and Individual markets for some time, the heightened level of activity and investment among the consulting and broker communities and other health insurance carriers has generated an increasing level of interest among employers in the Commercial market. To date, adoption levels have been lower than analyst predictions. While the ultimate volume, pace of growth and winning business models remain highly uncertain, we believe private exchanges will provide opportunities for growth.

Our approach to the private exchange market has been broad-based and we believe we are well-positioned to adapt with the market as it evolves. In 2011, we jointly acquired Bloom Health with Health Care Service Corporation and Blue Cross Blue Shield of Michigan, and today it offers an advanced consumer experience platform to employers as Anthem Health Marketplace. We also currently participate in four large national consultant-led exchanges, several regional broker-led exchanges and various individual, commercial and Medicare exchanges. We will continue to assess this highly dynamic market, build out internal capabilities and enhance partnerships to ensure we are best positioned to capitalize on future growth.

We continue to believe health care is local and that we have the strong local presence required to understand and meet local customer needs. We believe we are well-positioned to deliver what customers want: innovative, choice-based and affordable products; distinctive service; simplified transactions; and better access to information for quality care. Our local presence, combined with our national expertise, has created opportunities for collaborative programs that reward physicians and hospitals for clinical quality and excellence. We feel that our commitment to health improvement and care management provides added value to customers and health care professionals. We believe that an essential ingredient for practical and sustainable improvements in health care is raising health care quality while managing costs for total cost affordability. We

have identified initiatives that we believe will deliver better health care while reducing costs. These include driving innovation in paying and partnering with providers to compel improved cost, quality and health along with finding new, effective ways to manage risk and engage the member as a consumer. In addition, we seek to achieve efficiencies from our national scale while optimizing service performance for our customers. Finally, we seek to continue to rationalize our portfolio of businesses and products, and align our investments to capitalize on new opportunities to drive growth in both our existing and new markets in the future.

We continue to enhance interactions with customers, providers, brokers, agents, employees and other stakeholders through web-enabled technology and improving internal operations. Our approach includes not only sales and distribution of health benefits products on the Internet, but also implementation of advanced capabilities that improve services benefiting customers, agents, brokers, and providers while optimizing administrative costs. These enhancements can also help improve the quality, coordination and safety of health care through increased communications between patients and their physicians.

We intend to continue pursuing our vision of becoming America's valued health partner by transforming health care with trusted and caring solutions and by delivering quality products and services that give members access to the care they need. At the same time, we will focus on earnings per share, or EPS, growth through organic membership gains, improvements in our operating cost structure, strategic acquisitions and the efficient use of capital.

Significant Transactions

While Health Care Reform has caused significant changes to the U.S. health care system in recent years, the more significant transactions that have occurred over the last five years that have impacted or will impact our capital structure or that have or will influence how we conduct our business operations include:

- Pending acquisition of Cigna expected to close in the second half of 2016;
- Acquisition of Simply Healthcare (2015);
- Use of Capital—Board of Directors declaration of dividends on common stock (2011 through February 2016) and an increase in the quarterly dividend to \$0.6500 per share (February 2016); authorization for repurchases of our common stock (2015 and prior); and debt repurchases and new debt issuance (2015 and prior);
- Acquisition of Amerigroup and the related debt issuance (2012);
- Acquisition of 1-800 CONTACTS (2012) and subsequent divestiture (2014); and
- Acquisition of CareMore (2011).

For additional information regarding certain of these transactions, see Note 3, "Business Acquisitions and Divestiture," Note 12, "Debt," and Note 14, "Capital Stock," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Competition

The managed care industry is highly competitive, both nationally and in our local markets. Competition continues to be intense due to aggressive marketing and pricing, business consolidations, a proliferation of new products, the impact of Health Care Reform, and increased quality awareness and price sensitivity among customers.

We believe that participants in the managed care industry compete for customers based on quality of service, price, access to provider networks, access to care management and wellness programs (including health information), innovation, breadth and flexibility of products and benefits, reputation (including National Committee on Quality Assurance, or NCQA, accreditation status), brand recognition and financial stability. Our ability to attract and retain customers is substantially tied to our ability to distinguish ourselves from our competitors in these areas.

Also, a health plan's ability to interact with employers, members and other third parties (including health care professionals) via the Internet has become a more important competitive factor, and we have made significant investments in technology to enhance our electronic interaction with providers, employers, members and third parties.

We believe our exclusive right to market products under the most recognized brand in the industry, BCBS, in our most significant markets provides us with an advantage over our competition. Our provider networks in our markets enable us to achieve efficiencies and distinctive service levels enabling us to offer a broad range of health benefits to our customers on a more cost-effective basis than many of our competitors. We strive to distinguish our products through provider access, service, care management, product value and brand recognition.

Pricing in our Commercial and Specialty Business segment (defined below), including our Individual and Small Group lines of business, remains competitive and we strive to price our health care benefit products consistent with anticipated underlying medical trends. We believe our pricing strategy, based on predictive modeling, proprietary research and data-driven processes, as well as our overall investments for Health Care Reform, have positioned us to benefit from the potential growth opportunities available in fully-insured commercial products as a result of Health Care Reform. The public exchanges have increased the risk that our products will be selected by individuals who have a higher risk profile or utilization rate than the pool of participants we anticipated when we established the pricing for these public exchange products. We believe that our pricing strategy, brand name and network quality will provide a strong foundation for commercial risk membership growth opportunities in the future.

To build our provider networks, we compete with other health benefits plans for the best contracts with hospitals, physicians and other providers. We believe that physicians and other providers primarily consider member volume, reimbursement rates, timeliness of reimbursement and administrative service capabilities along with the reduction of non-value added administrative tasks when deciding whether to contract with a health benefits plan.

At the sales and distribution level, we compete for qualified agents and brokers to recommend and distribute our products. Strong competition exists among insurance companies and health benefits plans for agents and brokers with demonstrated ability to secure new business and maintain existing accounts. We believe that the quality and price of our products, support services, reputation and prior relationships, along with a reasonable commission structure are the factors agents and brokers consider in choosing whether to market our products. We believe that we have good relationships with our agents and brokers, and that our products, support services and commission structure compare favorably to those of our competitors in all of our markets. Typically, we are the largest competitor in each of our Blue-branded markets and, thus, are a closely watched target by other insurance competitors.

Reportable Segments

We manage our operations through three reportable segments: Commercial and Specialty Business, Government Business and Other. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, merger and acquisition activity and changing laws and regulations. Therefore, these reportable segments may change in the future.

Our Commercial and Specialty Business and Government Business segments both offer a diversified mix of managed care products, including PPOs, HMOs, traditional indemnity benefits and POS plans, as well as a variety of hybrid benefit plans including CDHPs, hospital only and limited benefit products.

Our Commercial and Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial and Specialty Business segment offer fully-insured health products; provide a broad array of managed care services to self-funded customers including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services; and provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal health care guidance.

Our Government Business segment includes Medicare and Medicaid businesses, National Government Services, or NGS, and services provided to the federal government in connection with FEP. Medicare business includes services such as Medicare Advantage, Medicare Part D, and Medicare Supplement. Medicaid business includes our managed care alternatives through publicly funded health care programs, including Medicaid; Temporary Assistance for Needy Family programs, or TANF; programs for seniors and people with disabilities, or SPD; programs for long-term services and support, or LTSS; Children's Health Insurance Programs, or CHIP; and ACA-related Medicaid expansion programs. NGS acts as a Medicare contractor for the federal government in several regions across the nation.

Our Other segment includes other businesses that do not meet the quantitative thresholds for an operating segment as defined by Financial Accounting Standards Board, or FASB, guidance, as well as corporate expenses not allocated to the other reportable segments.

Through our participation in various federal government programs, we generated approximately 18.8%, 21.0% and 20.3% of our total consolidated revenues from agencies of the U.S. government for the years ended December 31, 2015, 2014 and 2013, respectively. These revenues are contained in the Government Business segment. An immaterial amount of our total consolidated revenues is derived from activities outside of the U.S.

For additional information regarding the operating results of our segments, see Part II, Item 7 “Management’s Discussion and Analysis of Financial Condition and Results of Operations” and Note 19, “Segment Information,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Products and Services

A general description of our products and services is provided below:

Preferred Provider Organization: PPO products offer the member an option to select any health care provider, with benefits reimbursed by us at a higher level when care is received from a participating network provider. Coverage is subject to co-payments or deductibles and coinsurance, with member cost sharing usually limited by out-of-pocket maximums.

Consumer-Driven Health Plans: CDHPs provide consumers with increased financial responsibility, choice and control regarding how their health care dollars are spent. Generally, CDHPs combine a high-deductible PPO plan with an employer-funded and/or employee-funded personal care account, which may result in tax benefits to the employee. Some or all of the dollars remaining in the personal care account at year-end can be rolled over to the next year for future health care needs.

Traditional Indemnity: Indemnity products offer the member an option to select any health care provider for covered services. Coverage is subject to deductibles and coinsurance, with member cost sharing usually limited by out-of-pocket maximums.

Health Maintenance Organization: HMO products include comprehensive managed care benefits, generally through a participating network of physicians, hospitals and other providers. A member in one of our HMOs must typically select a PCP from our network. PCPs generally are family practitioners, internists or pediatricians who provide necessary preventive and primary medical care, and are generally responsible for coordinating other necessary health care services. We offer HMO plans with varying levels of co-payments, which result in different levels of premium rates.

Point-of-Service: POS products blend the characteristics of HMO, PPO and indemnity plans. Members can have comprehensive HMO-style benefits through participating network providers with minimum out-of-pocket expenses (co-payments) and also can go directly, without a referral, to any provider they choose, subject to, among other things, certain deductibles and coinsurance. Member cost sharing is limited by out-of-pocket maximums.

ACA Public Exchange and Off-Exchange Products: The ACA required the modification of existing products and development of new products to meet the requirements of the legislation, subject to certain transitional relief. Individual and Small Group products cover essential health benefits as defined in the ACA along with many other requirements and cost sharing features. Individual and Small Group products offered on and off the public exchanges meet the definition of the “metal” product requirements (bronze, silver, gold and platinum) and each metal product must satisfy a specific actuarial value. Health insurers participating on the public exchanges must offer at least one silver and one gold product.

In our Individual markets we offer bronze, silver and gold products, both on and off the public exchanges, in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. Additionally, we offer platinum products, both on and off the public exchanges, in California and New York.

In our Small Group markets, we offer bronze, silver and gold products, off the public exchanges, in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio, Virginia and Wisconsin. We offer bronze, silver and gold products, on the public exchanges, in Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, New Hampshire, Ohio and Virginia. Additionally, we offer platinum products, off the public exchanges, in California, Connecticut, Georgia, Kentucky, Maine, Nevada and Virginia.

Administrative Services: In addition to fully-insured products, we provide administrative services to Large Group employers that maintain self-funded health plans. These administrative services include underwriting, actuarial services, medical cost management, disease management, wellness programs, claims processing and other administrative services for self-funded employers. Self-funded health plans are also able to use our provider networks and to realize savings through our negotiated provider arrangements, while allowing employers the ability to design certain health benefit plans in accordance with their own requirements and objectives. We also underwrite stop loss insurance for self-funded plans.

BlueCard®: BlueCard® is a national program that links participating health care providers and independent BCBS plans. BlueCard® host members are generally members who reside in or travel to a state in which an Anthem subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer sponsored health plan serviced by a non-Anthem controlled BCBS licensee, which is the “home” plan. We perform certain administrative functions for BlueCard® host members, for which we receive administrative fees from the BlueCard® members’ home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan.

Medicare Plans: We offer a wide variety of plans, products and options to individuals age 65 and older such as Medicare supplement plans; Medicare Advantage, including special needs plans; Medicare Part D Prescription Drug Plans, or Medicare Part D; and Medicare-Medicaid Plans, or MMPs. Medicare supplement plans typically pay the difference between health care costs incurred by a beneficiary and amounts paid by Medicare. Medicare Advantage plans provide Medicare beneficiaries with a managed care alternative to traditional Medicare and often include a Medicare Part D benefit. In addition, our Medicare Advantage special needs plans provide tailored benefits to Medicare beneficiaries who have chronic diseases and also cover certain dual eligible customers, who are low-income seniors and persons under age 65 with disabilities. Medicare Part D offers a prescription drug plan to Medicare and MMP beneficiaries. MMP is a demonstration program focused on serving members who are dually eligible for Medicaid and Medicare, which was established as a result of the passage of the ACA. We offer these plans to customers through our health benefit subsidiaries throughout the country, including Amerigroup, CareMore and Simply Healthcare.

Individual Plans: We offer a full range of health insurance plans with a variety of options and deductibles for individuals under age 65 who are not covered by employer-sponsored coverage and are not otherwise eligible for government sponsored plans, such as Medicare and/or Medicaid. Some of our products target certain demographic populations such as uninsured younger individuals between the ages of 19 and 29, families, those transitioning between jobs or early retirees. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the Internet. Individual business is sold on a fully-insured basis. We offer public exchange products and off-exchange products. Federal premium subsidies are available only for certain public exchange products. Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network, and the efficiency of administration.

Medicaid Plans and Other State-Sponsored Programs: We have contracts to serve members enrolled in publicly funded health care programs, including Medicaid, TANF, SPD, LTSS, CHIP, and ACA-related Medicaid expansion programs. The Medicaid program makes federal matching funds available to all states for the delivery of health care benefits for low income and/or high medical risk individuals. These programs are managed by the individual states based on broad federal guidelines. TANF is a state and federally funded program designed for the population consisting primarily of low-income children and their guardians. SPD is a federal income supplement program designed for Supplemental Security Income recipients, however, states can broaden eligibility criteria. This population consists of low-income seniors and people with disabilities. LTSS is a state and federally funded program that offers states a broad and flexible set of program design options and refers to the delivery of long-term services and support for our members who receive home and community- or institution-based services for long-term care. CHIP is a state and federally funded program that provides health care coverage to children not otherwise covered by Medicaid or other insurance programs. Our Medicaid plans also cover certain dual eligible customers, as previously described above, who also receive Medicare benefits. We provide Medicaid and other State-Sponsored services in California, Florida, Georgia, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Nevada, New Jersey, New York, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia and Wisconsin.

Pharmacy Products: We market and sell an integrated prescription drug product to both fully-insured and self-funded customers through our health benefit subsidiaries throughout the country. This comprehensive product includes features such as drug formularies, a pharmacy network and maintenance of a prescription drug database and mail order capabilities. Since December 1, 2009, we have delegated certain functions and administrative services related to our integrated prescription drug

products to Express Scripts, Inc., or Express Scripts, under a ten year contract, excluding our CareMore and Simply Healthcare subsidiaries and certain self-insured members which have exclusive agreements with different pharmacy benefit management, or PBM, service providers. Express Scripts manages the network of pharmacy providers, operates mail order pharmacies and processes prescription drug claims on our behalf, while we sell and support the product for clients, make formulary decisions and set drug benefit design strategy and provide front line member support.

Life Insurance: We offer an array of competitive individual and group life insurance benefit products to both Large Group and Small Group customers in conjunction with our health plans. The life products include term life and accidental death and dismemberment.

Disability: We offer short-term and long-term disability products, usually in conjunction with our health plans.

Radiology Benefit Management: We offer outpatient diagnostic imaging management services to health plans. These services include utilization management for advanced diagnostic imaging procedures, network development and optimization, patient safety, claims adjudication and provider payment.

Personal Health Care Guidance: We offer leading evidence-based and analytics-driven personal health care guidance. These services help improve the quality, coordination and safety of health care, enhance communications between patients and their physicians, and reduce medical costs.

Dental: Our dental plans include networks in certain states in which we operate. Many of the dental benefits are provided to customers enrolled in our health plans and are offered on both a fully-insured and self-funded basis. Our members also have access to additional dental providers through our participation in the National Dental GRID, a national dental network developed by and for BCBS plans. The National Dental GRID includes dentists in all 50 states and provides multi-state customers with a national solution providing in-network discounts across the country. Additionally, we offer managed dental services to other health care plans to assist those plans in providing dental benefits to their customers.

Vision Services and Products: Our vision plans include networks within the states in which we operate. Many of the vision benefits are provided to customers enrolled in our health plans and are offered on both a fully-insured and self-funded basis.

Medicare Administrative Operations: Through our subsidiary, NGS, we serve as a fiscal intermediary, carrier and Medicare administrative contractor for the federal government providing administrative services for the Medicare program, which generally provides coverage for persons who are 65 or older and for persons who are disabled or with end-stage renal disease. Part A of the Medicare program provides coverage for services provided by hospitals, skilled nursing facilities and other health care facilities. Part B of the Medicare program provides coverage for services provided by physicians, physical and occupational therapists and other professional providers, as well as certain durable medical equipment and medical supplies.

Networks and Provider Relations

Our relationships with physicians, hospitals and professionals that render health care services to our members are guided by local, regional and national standards for network development, reimbursement and contract methodologies. While following industry standards, we are simultaneously seeking to lead transformation efforts within our health care system, moving from our current fragmented model premised on episodic intervention to one based on proactive, coordinated care built around the needs of the patient. A key element of this transformation involves a transition from traditional fee-for-service payment models to models where providers are paid based on the value, both in quality and affordability, of the care they deliver.

We establish "market-based" hospital reimbursement payments that we believe are fair, but aggressive, and among the most competitive in the market. We also seek to ensure that physicians in our network are paid in a timely manner at appropriate rates. In many instances, we deploy multi-year contracting strategies, including case rates or fixed rates, to limit our exposure to medical cost inflation and to increase cost predictability. We maintain both broad and narrow provider networks to ensure member choice, based on both price and access needs, while implementing programs designed to improve the quality of care our members receive. Increasingly, we are supplementing our broad based networks with smaller or more

cost-effective networks that are designed to be attractive to a more price-sensitive customer segment, such as public exchange customers.

Our reimbursement strategies vary across markets and depend on the degree of consolidation and integration of physician groups and hospitals. Fee-for-service is currently our predominant reimbursement methodology for physicians, but as noted above, we are transitioning providers to value-based payment contracts. More traditional physician fee schedules are developed at the state level based on an assessment of several factors and conditions, including the Centers for Medicare & Medicaid Services, or CMS, resource-based relative value system, or RBRVS, medical practice cost inflation and physician supply. We utilize CMS RBRVS fee schedules as a reference point for fee schedule development and analysis. The RBRVS structure was developed, maintained, and updated by CMS and is used by the Medicare program and other major payers. In addition, we have implemented and continue to expand physician incentive contracting, or “pay for performance”, which ties physician payment levels to performance on clinical measures.

While we generally do not delegate full financial responsibility to our physician providers in the form of capitation-based reimbursement, there are certain markets where the market dynamics result in this being a useful method to lower costs and reduce underwriting risk, thus we do utilize this payment method in those markets.

Our hospital contracts provide for a variety of reimbursement arrangements depending on local market dynamics and current hospital utilization efficiency. Most hospitals are reimbursed a fixed amount per day or reimbursed a per-case amount, per admission, for inpatient covered services. A small percentage of hospitals, primarily rural, sole community hospitals, are reimbursed on a discount from approved charge basis for covered services. Our “per-case” reimbursement methods utilize many of the same attributes contained in Medicare’s Diagnosis Related Groups, or DRG, methodology. Hospital outpatient services are reimbursed by fixed case rates, fee schedules or percent of approved charges. Our hospital contracts recognize unique hospital attributes, such as academic medical centers or community hospitals, and the volume of care performed for our members. To improve predictability of expected costs, we frequently use a multi-year contracting approach with providers. In addition, the majority of our hospital contracts include a “pay for performance” component where reimbursement levels are linked to improved clinical performance, patient safety and medical error reduction.

Although fee-for-service combined with pay for performance remains our predominant payment model today, our provider engagement and contracting strategies are moving away from “unit price” or volume-based payment models to payment models that align compensation with the value delivered as measured by health care, quality and cost. We launched the most significant of these efforts, our Enhanced Personal Health Care program, in the fourth quarter of 2012. This program augments traditional fee-for-service with shared savings opportunities for providers when actual health care costs are below projected costs, and providers meet specific quality measures. The quality measures are based on nationally accepted, credible standards (e.g. NCQA, the American Diabetes Association and the American Academy of Pediatrics) and span preventive, acute and chronic care. We understand, however, that payment incentives alone are insufficient to create the large-scale, system-wide transformation required to achieve meaningful impacts on cost, quality and member experience. Accordingly, we invested in care delivery transformation and population health management support structures to help providers succeed under value-based payment models. This support includes our web-based population health management technology and teams of dedicated expert consultants who work alongside providers, sharing best practices, and helping them leverage our data to the benefit of their patients. In some of these arrangements, participating physician practices receive a per-member, per-month clinical coordination fee to compensate them for important care management activities that occur outside of the patient visit (e.g. purchasing an electronic health record or hiring care management nurses), all of which have been shown to reduce healthcare costs and improve care outcomes. Since the launch of Enhanced Personal Health Care, we now have arrangements with provider organizations covering 48% of our PCPs and have rolled this program out in each of the fourteen states where we operate as a licensee of the BCBSA.

Medical Management Programs

Our medical management programs include a broad array of activities that facilitate improvements in the quality of care provided to our members and promote cost-effective medical care. These medical management activities and programs are administered and directed by physicians and nurses. The goals of our medical management strategies are to ensure that the care delivered to our members is supported by appropriate medical and scientific evidence, is received on a timely basis and occurs in the most appropriate location.

Precertification: A traditional medical management program involves assessment of the appropriateness of certain hospitalizations and other medical services prior to the services being rendered. For example, precertification is used to determine whether a set of hospital and medical services is being appropriately applied to the member's clinical condition, in accordance with criteria for medical necessity as that term is defined in the member's benefits contract. All of our health plans have implemented precertification programs for common high-tech radiology studies, including cardiac diagnostic testing, addressing an area of historically significant cost trends. Through our AIM Specialty Health, or AIM, subsidiary we promote appropriate, safe and affordable member care in imaging as well as oncology, sleep management and specialty pharmacy benefits. These expanded specialty benefit management solutions leverage clinical expertise and technology to engage our provider communities and members in more effective and efficient use of outpatient services.

Care Coordination: Another traditional medical management strategy we use is care coordination, which is based on nationally recognized criteria developed by third-party medical specialists. With inpatient care coordination, the requirements and intensity of services during a patient's hospital stay are reviewed, at times by an onsite skilled nurse professional in collaboration with the hospital's medical and nursing staff, in order to coordinate care and determine the most effective transition of care from the hospital setting. In addition, guidance for many continued stay cases is reviewed with physician medical directors to ensure appropriate utilization of medical services. We also coordinate care for outpatient services to help ensure that patients with chronic conditions who receive care from multiple physicians are able to manage the exchange of information between physicians and coordinate office visits to their physicians.

Case Management: We have implemented a medical management strategy focused on identifying the small percentage of the membership that will require a high level of intervention to manage their health care needs. The registered nurses and medical directors focus on members likely to be readmitted to the hospital and help them coordinate their care through pharmacy compliance, post-hospital care, follow-up visits to see their physician and support in their home.

Formulary management: We have developed formularies, which are selections of drugs based on clinical quality and effectiveness. A pharmacy and therapeutics committee of physicians uses scientific and clinical evidence to ensure that our members have access to the appropriate drug therapies.

Medical policy: A medical policy group, comprised of physician leaders from various areas of the country, working in cooperation with academic medical centers, practicing community physicians and medical specialty organizations such as the American College of Radiology and national organizations such as the Centers for Disease Control and Prevention and the American Cancer Society, determines our national policy for the application of new medical technologies and treatments.

Quality programs: We are actively engaged with our hospital and physician networks to enable them to improve medical and surgical care and achieve better outcomes for our members. We endorse, encourage and incentivize hospitals and physicians to support national initiatives to improve the quality of clinical care and patient outcomes and to reduce medication errors and hospital infections. We have demonstrated our leadership in developing hospital quality programs.

External review procedures: We work with outside experts through a process of external review to provide our members scientifically and clinically, evidence-based medical care. When we receive member concerns, we have formal appeals procedures that ultimately allow coverage disputes related to medical necessity decisions under the benefits contract to be settled by independent expert physicians.

Service management: In HMO and POS networks, PCPs serve as the overall coordinators of members' health care needs by providing an array of preventive health services and overseeing referrals to specialists for appropriate medical care. In PPO networks, patients have access to network physicians without a PCP serving as the coordinator of care.

Provider Cost Comparison Tools: Through Estimate Your Cost, Anthem Care Comparison and other tools, our members can compare cost estimates and quality data for common services at contracted providers, with cost estimates accounting for facility, professional and ancillary services. These cost estimates bundle related services typically performed at the time of the procedure, not just for the procedure itself. Users can review cost data for over 400 procedures in 49 states. Members can also estimate out-of-pocket costs based on a member's own benefit coverage, deductible, and out of pocket maximum. We also offer information on overall facility ratings and patient experience using trusted third party data. We continue to work on enhancing and evolving our tools to assist members in making informed and value-based health care decisions. In addition, we collaborate with an external independent vendor to support employers wanting to purchase a transparency and consumer engagement web solution with certain additional functionality.

Personal Health Care Guidance: These services help improve the quality, coordination and safety of health care, enhance communications between patients and their physicians, and reduce medical costs. Examples of services include member and physician messaging, providing access to evidence-based medical guidelines, physician quality profiling, and other consulting services.

Anthem Health Guide: Anthem Health Guide integrates customer service with clinical and wellness coaching to provide easier navigation of health care services for our members. Members are supported by a team of nurses, coaches, educators, and social workers using voice, click-to-chat, secure email and mobile technology. Our Smart Engagement Platform supports this integrated team using our smart engagement triggers for speech recognition, preventative and clinical gaps in care and highlighting when we have members who are identified for current health care support.

Care Management Programs

We continue to expand our *360° Health* suite of integrated care management programs and tools. *360° Health* offers the following programs, among others, that have been proven to increase quality and reduce medical costs for our members:

ConditionCare and *FutureMoms* are care management and maternity management programs that serve as adjuncts to physician care. Skilled nurse professionals with added support from our team of dietitians, social workers, pharmacists, health educators and other health professionals help participants understand their condition, their doctor's orders and how to become a better self-manager of their condition. We also offer members infertility consultation through our *SpecialOffers@Anthem* program, a comprehensive and integrated assembly of discounted health and wellness products and services from a variety of the nation's leading retailers.

24/7 NurseLine offers access to qualified, registered nurses anytime. This allows our members to make informed decisions about the appropriate level of care and avoid unnecessary worry. This program also includes a referral process to the nearest urgent care facility, a robust audiotape library, accessible by phone, with more than 600 health and wellness topics, as well as on-line health education topics designed to educate members about symptoms and treatment of many common health concerns.

ComplexCare is an advanced care management program that reaches out to participants with multiple health care issues who are at risk for frequent and high levels of medical care in order to offer support and assistance in managing their health care needs. *ComplexCare* identifies candidates through claims analysis using predictive modeling techniques, the use of health risk assessment data, utilization management reports and referrals from a physician or one of our other programs, such as the *24/7 NurseLine*.

MyHealth Advantage utilizes integrated information systems and sophisticated data analytics to help our members improve their compliance with evidence-based care guidelines, providing personal care notes that alert members to potential gaps in care, enable more prudent health care choices, and assist in the realization of member out-of-pocket cost savings. Key opportunities are also shared with physicians through *Availity®* at the time of membership eligibility verification. *Availity®* is an electronic data interchange system that allows for the exchange of health information among providers over a secure network.

MyHealth Coach provides our members with a professional guide who helps them navigate the health care system and make better decisions about their well-being. *MyHealth Coach* proactively reaches out to people who are at risk for serious health issues or have complex health care needs. Our health coaches help participants understand and manage chronic conditions, handle any health and wellness related services they need and make smart lifestyle choices.

HealthyLifestyles helps employees transform unhealthy habits into positive ones by focusing on behaviors that can have a positive effect on their health and their employer's financial well-being. *HealthyLifestyles* programs include smoking cessation, weight management, stress management, physical activity, and diet and nutrition.

MyHealth@Anthem is our secure web-based solution, complementing other programs by reinforcing telephonic coaching and mail campaigns. The website engages participants in regularly assessing their health status, gives them feedback about their progress, and tracks important health measures such as blood pressure, weight and blood glucose levels.

Behavioral Health Case Management provides oversight of the delivery of mental health and substance abuse services as an integrated component of the health plan. The program assists providers and members with referrals, transitional care, episodic emergency care and other needs.

Autism Spectrum Disorder is a specialized case management program staffed by a dedicated team of clinicians who have been trained on the unique challenges and needs of families with a member who has a diagnosis of autism spectrum disorder. These clinicians provide education, information on community resources to help with care and support, guidance on the appropriate usage of benefits, and assistance in exploring effective treatments, such as medical services, that may help the member and their families.

Employee Assistance Programs provide many resources that allow members to balance work and personal life by providing quick and easy access to confidential resources to help meet the challenges of daily life. Examples of services available in person as well as via telephone or internet are counseling for child care, health and wellness, financial issues, legal issues, adoption and daily living.

Health Care Quality Initiatives

Increasingly, the health care industry is able to define quality health care based on preventive health measurements, outcomes of care and optimal care management for chronic disease. A key to our success has been our ability to work with our network physicians and hospitals to improve the quality and outcomes of the health care services provided to our members. Our ability to promote quality medical care has been recognized by the NCQA, the largest and most respected national accreditation program for managed care health plans.

Several quality health care measures, including the Healthcare Effectiveness Data and Information Set, or HEDIS®, have been incorporated into the NCQA's accreditation processes. HEDIS® measures range from preventive services, such as screening mammography and pediatric immunization, to elements of care, including decreasing the complications of diabetes and improving treatment for patients with heart disease. For health plans, NCQA's highest accreditation status of Excellent is granted only to those plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. Plans earning this accreditation level must also achieve HEDIS® results that are in the highest range of national or regional performance. Details for each of our plans' accreditation levels can be found at www.ncqa.org.

We have created an innovative program called the State Health Index, or SHI, to quantify and track our success in improving the health of our communities. SHI presents a comprehensive picture of a community's health in the 24 states served by our affiliated health plans. It is compiled from public data and includes 14 health indicators in four domains: Maternity Care, Preventive Care, Lifestyle, and Morbidity/Mortality. The metrics are utilized to identify opportunities for health improvement and leverage our strengths to build partnerships with community coalitions, patient advocacy organizations, and local and state public health departments. We analyze states' performance measures and prioritize measures for focused improvement. Together with Anthem Foundation, Inc. and state leadership, we create or enhance programs to improve the health of the entire population in these states - not just for our members.

Our wholly-owned health outcomes research subsidiary, HealthCore, Inc., or HealthCore, generates consistent and actionable evidence to support decision making while helping to guide fresh initiatives for a range of stakeholders in the healthcare industry. By leveraging a rich array of medical and pharmacy utilization data queried from administrative claims, patients surveys, medical charts and laboratory diagnostics, among other health records, HealthCore's multi-disciplinary research teams uncover a broad spectrum of safety, effectiveness, pharmacoepidemiology, and health economics evidence. HealthCore's real world evidence and comparative effectiveness research, among others, have played roles in the product planning and development campaigns of biotechnology and pharmaceutical companies, and today it lists most of the leading biologics and drug manufacturers as clients or alliance partners. Its health plan research has led to better insights into evidence-based treatment approaches, the development of value-based initiatives to drive access and adherence to treatment, and the crafting of incentives to modify patient and provider behavior. One of HealthCore's predominant initiatives is its governmental and academic collaborations that include cooperation with some of the country's top universities and federal agencies, including the Food and Drug Administration and the Centers of Disease Control of the National Institutes of Health, and it is an active contributor to the safety surveillance Sentinel program. As a notable contributor to the health outcomes

evidence base, HealthCore's research findings are broadly disseminated during presentations at national and international medical meetings and are published in a variety of respected peer-reviewed medical and health services journals.

Our AIM subsidiary supports quality by implementing clinical appropriateness and patient safety solutions for advanced imaging procedures, cardiology, sleep medicine, specialty pharmaceuticals and oncology, including drugs covered under medical benefit and radiation therapy. These programs, based on widely accepted and evidence based clinical guidelines, promote the most appropriate use of diagnostic and therapeutic services to improve the quality of overall health care delivered to our members and members of other health plans that are covered under AIM's programs. To provide additional impact to its clinical appropriateness program, AIM has also implemented a provider assessment program, OptiNet®, which promotes more informed selection of diagnostic imaging and testing facilities by providing cost and facility information to physician offices at the point that a procedure is ordered. We have also leveraged AIM's provider network assessment information to proactively engage and educate our members about imaging providers and sleep testing choices based on site capabilities and cost differences. This program is another example of how we facilitate improvements in the quality of care provided to our members and promote cost effective medical care.

Our wholly-owned analytics-driven subsidiary, Resolution Health, Inc., or RHI, delivers programs to improve the safety, quality and coordination of health care for our members. RHI uses evidence-based proprietary rules and algorithms based on established clinical guidelines and standards of independent accreditation organizations, medical specialty societies, and government agencies such as the National Quality Forum, or NQF, and NCQA. RHI analyzes claims and other data to identify actions that can improve health outcomes at the individual member level. When appropriate, RHI delivers personalized confidential messages, or Personalized Health Insights, to members, providers and care managers. RHI's Personalized Health Insights support total population health management and the results of RHI analyses are used across our enterprise to support HEDIS and other clinical quality measures.

Pricing and Underwriting of Our Products

We price our products based on our assessment of current health care claim costs and emerging health care cost trends, combined with charges for administrative expenses, risk and profit, including charges for ACA taxes and fees. We continually review our product designs and pricing guidelines on a national and regional basis so that our products remain competitive and consistent with our profitability goals and strategies.

In applying our pricing to each employer group and customer, we maintain consistent, competitive, disciplined underwriting standards. We employ our proprietary accumulated actuarial data in determining underwriting and pricing parameters. Where allowed by law and regulation, we underwrite large groups based on each group's aggregate claim experience. Also, we employ credit underwriting procedures with respect to our self-funded products.

In most circumstances, our pricing and underwriting decisions follow a prospective rating process in which a fixed premium is determined at the beginning of the contract period. For fully-insured business, any deviation, favorable or unfavorable, from the medical costs assumed in determining the premium is our responsibility. Some of our larger groups employ retrospective rating reviews, where positive experience is partially refunded to the group, and negative experience is charged against a rate stabilization fund established from the group's favorable experience, or charged against future favorable experience.

BCBSA Licenses

We are a party to license agreements with the BCBSA that entitle us to the exclusive, and in certain areas, non-exclusive use of the Blue Cross and Blue Shield names and marks in assigned geographic territories. BCBSA is a national trade association of Blue Cross and Blue Shield licensees, the primary function of which is to promote and preserve the integrity of the BCBS names and marks, as well as provide certain coordination among the member companies. Each BCBSA licensee is an independent legal organization and is not responsible for obligations of other BCBSA member organizations. We have no right to market products and services using the BCBS names and marks outside of the states in which we are licensed to sell BCBS products. We are required to pay an annual license fee to the BCBSA based on enrollment and also to comply with various operational, governance and financial standards set forth in the licenses.

We believe that we and our licensed affiliates are currently in compliance with these standards. The standards under the license agreements may be modified in certain instances by the BCBSA. See Part I, Item 1A "Risk Factors" in this Annual

Report on Form 10-K for additional details of our licensing requirements and the impact if we were not to comply with these license agreements.

Regulation

General

Our operations are subject to comprehensive and detailed state, federal and international regulation throughout the jurisdictions in which we do business. As discussed below, the regulatory aspects of the U.S. health care system have been and will continue to be significantly affected by Health Care Reform. Supervisory agencies, including state health, insurance and corporation departments, have broad authority to:

- grant, suspend and revoke licenses to transact business;
- regulate our products and services in great detail;
- regulate, limit, or suspend our ability to market products, including the exclusion of our plans from participating on public exchanges;
- retroactively adjust premium rates for services;
- monitor our solvency and reserve adequacy;
- scrutinize our investment activities on the basis of quality, diversification and other quantitative criteria; and
- impose monetary and criminal sanctions for non-compliance with regulatory requirements.

To carry out these tasks, these regulators periodically examine our operations and accounts.

Regulation of Insurance Company and HMO Business Activity

The governments of the states in which we conduct business, as well as the federal government, have adopted laws and regulations that govern our business activities in various ways. Further, Health Care Reform has resulted in increased federal regulation that significantly impacts our business. These laws and regulations, which vary significantly from state to state and on the federal level, restrict how we conduct our businesses and result in additional burdens and costs to us. These state and federal laws and regulations are subject to amendments and changing interpretations in each jurisdiction.

States generally require health insurers and HMOs to obtain a certificate of authority prior to commencing operations. If we were to establish a health insurance company or an HMO in any jurisdiction where we do not presently operate, we generally would have to obtain such a certificate or authorization to expand the operations permitted under an existing certificate if we already operate in the state. The time necessary to obtain such a certificate varies from jurisdiction to jurisdiction. Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. The health benefits business also may be adversely impacted by court and regulatory decisions that expand the interpretations of existing statutes and regulations. It is uncertain whether we can recoup, through higher premiums or other measures, the increased costs of mandated benefits or other increased costs caused by potential legislation, regulation or court rulings. See Part I, Item 1A "Risk Factors" in this Annual Report on Form 10-K.

Patient Protection and Affordable Care Act

The ACA has created significant changes and will continue to create significant changes for health insurance markets for the next several years. Specifically, many of the near-term changes were effective for certain groups and individuals in 2010, including a prohibition on lifetime limits, certain annual limits, member cost-sharing on specified preventive benefits, pre-existing condition exclusions for children, increased restrictions on rescinding coverage and extension of coverage of dependents to the age of 26. Certain requirements for insurers were also effective in 2011, including changes to Medicare Advantage payments and the minimum medical loss ratio, or MLR, provision that requires insurers to pay rebates to customers when insurers do not meet or exceed the specified MLR thresholds. Most of the provisions of the ACA with more significant effects on the health insurance marketplace, both state and federal, went into effect on January 1, 2014, including a requirement that insurers guarantee the issuance of coverage to all individuals regardless of health status, strict rules on how

health insurance is rated, the assessment of new taxes and fees (including annual fees on health insurance companies), the creation of public exchanges for Individuals and Small Groups, the availability of premium subsidies for certain Individual products, and substantial expansions in eligibility for Medicaid.

Despite significant preparation for the advent of the public exchanges, there have been many technical difficulties in their implementation, which entail uncertainties associated with mix and volume of business. In addition, CMS has issued transitional policies modifying or extending the deadlines for compliance with certain aspects of Health Care Reform. In March 2014, CMS issued transition relief providing that health insurance coverage in the Individual or Small Group markets that is renewed for a policy year beginning on or before October 1, 2016 that would otherwise have been deemed non-compliant with certain market reforms under Health Care Reform, will not be considered by CMS to be out of compliance with respect to such market reforms, provided certain conditions are met. Some states have adopted these transitional policies, some have not and others have not taken a position.

Due to the impact of the transitional policies, insurers in the ACA compliant Individual market, including Anthem, may be adversely selected by individuals who will have a higher acuity level than the anticipated pool of participants in the public exchange markets. In addition, the risk adjustment, reinsurance, and risk corridor premium stabilization programs of Health Care Reform, or Health Care Reform Premium Stabilization Programs, established to apportion risk amongst insurers, may not be effective in appropriately mitigating the financial risks related to our public exchange products. These factors, along with the limited information about the individuals who have access to these newly established public exchanges that was available when we established premiums, may have a material adverse effect on our results of operations if premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions utilized in setting adequate premium rates could have a material adverse effect on our results of operations, financial position, and cash flows.

In addition, there have been other material changes and delays in the implementation of the ACA that could have a material adverse effect on our results of operations, financial position, and cash flows. These include:

- Proposed network adequacy standards;
- Reduction in the amount available for payments under the risk corridor program;
- Change in Small Group size expansion;
- Increasingly complex and detailed regulation; and
- Other unanticipated regulatory changes and delays.

These delays and changes may have a material and significant impact on anticipated enrollment in public exchange and off-exchange products, thus affecting the risk pools and premium rates. Finally, implementation of the ACA brings with it significant oversight responsibilities by health insurers that may result in increased governmental audits, increased assertions of False Claims Act violations, and an increased risk of other litigation.

The ACA continues to require additional guidance and specificity to be provided by HHS, the Department of Labor, CMS and the Department of the Treasury. These regulatory agencies continue to consider recommendations from external groups, such as the National Association of Insurance Commissioners, or NAIC. Many provisions have final rules available for review while some proposed regulations have been released for comment or have yet to be released and others are in-process. We continue to carefully evaluate each rule as it is issued. Some of the more significant considerations of the ACA are described below:

- MLR regulations were issued by HHS in December 2011. The minimum MLR thresholds by line of business, as defined by HHS, are as follows:

Line of Business	%
Large Group	85
Small Group	80
Individual	80

New York state regulations require us to meet a more restrictive MLR threshold of 82% for both Small Group and Individual lines of business. The minimum MLR thresholds disclosed above are based on definitions of an MLR calculation provided by HHS, or specific states, as applicable, and differ from our calculation of "benefit expense ratio" based on premium revenue and benefit expense as reported in accordance with U.S. generally accepted accounting principles, or GAAP. Furthermore, the definitions of the lines of business differ under the various state and federal regulations and may not correspond to our lines of business. Definitions under the MLR regulation also impact insurers differently depending upon their organizational structure or tax status, which could result in a competitive advantage to some insurance providers that may not be available to us, resulting in an uneven playing field in the industry. Significant changes to the MLR requirements may occur through additional regulatory action by HHS.

Health Care Reform also imposed a separate minimum MLR threshold of 85% for Medicare Advantage and Medicare Part D plans beginning in 2014. Medicare Advantage or Medicare Part D plans that do not meet this threshold will have to pay a minimum MLR rebate. If a plan's MLR is below 85% for three consecutive years beginning with 2014, enrollment will be restricted. A Medicare Advantage or Medicare Part D plan contract will be terminated if the plan's MLR is below 85% for five consecutive years.

Approximately 86.8% and 36.0% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2015. Approximately 67.0% and 32.2% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2014.

- The ACA required states to establish public exchanges by January 1, 2014 through which qualified individuals and qualified small employers may access coverage. If a state failed to establish a public exchange, the federal government established a public exchange in that state. To date sixteen states plus the District of Columbia have elected to operate state-based public exchanges. The remaining states have either a federal partnership public exchange (six states) or a federally operated public exchange (twenty-eight states). In the states in which we offer products on public exchanges, six states have passed legislation or executive orders establishing state-based public exchanges (California, Colorado, Connecticut, Kentucky, Nevada and New York).
- The ACA required the modification of existing products and development of new products to meet the requirements of the legislation, subject to certain transitional relief. Individual and Small Group products must cover essential health benefits as defined in the ACA along with many other requirements and cost sharing features. Individual and Small Group products must meet the definition of the "metal" product requirements (bronze, silver, gold and platinum). Each metal product must satisfy a specific actuarial value. Health insurers participating on public exchanges must offer at least one silver and one gold product. Additionally, effective January 1, 2014, health insurers were required to cancel or discontinue the sale of existing non-ACA-compliant Individual and Small Group products, subject to the conditions of the CMS transitional policies discussed above.
- Regulations became effective in September 2011 that require filings for premium rate increases to be reviewed for Small Group and Individual products above specified thresholds, generally 10%, as may be adjusted from time to time. The regulations provide for state insurance regulators to conduct the reviews, except for cases where a state does not have an "effective" rate review program or in federal enforcement states, in which cases HHS will conduct the reviews for any rate increase filed.
- The Health Care Reform Premium Stabilization Programs introduce new requirements to the MLR calculation, beginning with the 2014 benefit year for the Individual and Small Group markets. The risk adjustment program is a permanent program that transfers dollars from insurers who enroll individuals with lower relative health risk to insurers who enroll individuals with higher relative health risk. Risk adjustment payments/receipts will be determined separately for each state and for Individual and Small Group. The second premium stabilization program is the transitional reinsurance program, a temporary program that runs from 2014 through 2016. The transitional reinsurance program is intended to help stabilize premiums by reimbursing issuers of ACA-compliant non-grandfathered Individual market plans for eligible claims between a defined attachment point and ceiling, at a coinsurance rate defined by HHS. The program will be funded through assessments per covered enrollee upon the commercial health insurance market and sponsors of self-funded health benefit plans of approximately \$12.0 billion,

\$8.0 billion and \$5.0 billion in 2014, 2015 and 2016, respectively. The final premium stabilization program is the temporary risk corridor program, also a three year program through 2016, that protects insurers from inaccurate pricing of Individual and Small Group qualified health plans and substantially similar off-exchange products. Beginning in 2014, MLR rebate calculations are adjusted to reflect the impact of the Health Care Reform Premium Stabilization Programs.

- Through December 31, 2013, and depending on the laws in each state, health insurers were allowed to consider factors such as health status, gender and age in determining the appropriate premium for products in the Individual and Small Group markets. Some states have adopted rules that limit the variation between the highest and lowest premium for the identical insurance policy. The differential in pricing is commonly referred to as “rating bands”. The process of using these rating bands allowed health insurers to appropriately price for products and to spread the risk more broadly across all policyholders. Except for policies issued under the CMS transitional policies, beginning in 2014, the ACA precludes health insurers from using health status and gender in the determination of the appropriate insurance premium. In addition, rating bands for age cannot vary by more than 3 to 1 and the rating bands for tobacco use cannot vary by more than 1.5 to 1. The ongoing use of the 3 to 1 rating bands may have a significant impact on the majority of Individual and Small Group customers and could lead to adverse selection in the market as well as increased variability in projecting future premiums for those customer markets.
- In 2014 significant new taxes and fees became effective for health insurers, some of which may or may not be passed through to customers. The most significant of the taxes and fees is the annual Health Insurance Provider Fee, or HIP Fee, on health insurers that write certain types of health insurance on U.S. risks. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to an adjusted amount of health insurance for all U.S. health risk for those certain lines of business written during the preceding calendar year. The HIP Fee is non-deductible for federal income tax purposes. The total amount collected from allocations to health insurers in 2015 and 2014 was \$11.3 billion and \$8.0 billion, respectively. We record our estimated liability for the HIP Fee in full at the beginning of the year with a corresponding deferred asset that is amortized on a straight-line basis to general and administrative expense. The final calculation and payment of the annual HIP Fee occurs in the third quarter each year and our portion of the HIP Fee for 2015 and 2014 was \$1.2 billion and \$0.9 billion, respectively. The annual HIP Fee to be allocated to all health insurers remains at \$11.3 billion for 2016, has been suspended for 2017 and will resume and be increased to \$14.3 billion for 2018. For 2019 and beyond, the annual HIP Fee will equal the amount for the preceding year increased by the rate of premium growth for the preceding year less the rate of growth in the consumer price index for the preceding calendar year.
- Medicare Advantage reimbursement rates will not increase as much as they would otherwise due to a new payment formula promulgated by the ACA that is expected to significantly reduce reimbursements in the future. We also expect further and ongoing regulatory guidance on a number of issues related to Medicare, evolving methodology for ratings and quality bonus payments, and potential action on an audit methodology to review data submitted under “risk adjuster” programs.

Dodd-Frank Wall Street Reform and Consumer Protection Act

The Dodd-Frank Wall Street Reform and Consumer Protection Act, or the Dodd-Frank Act, includes a number of financial reforms and regulations that may affect our business and financial reporting, including margin requirements, reporting and clearing transactions for our investments in derivative instruments. In addition, the Dodd-Frank Act creates a Federal Insurance Office, with limited powers that include information-gathering and subpoena authority. Although the Federal Insurance Office does not have authority over health insurance, it may have authority over other parts of our business, such as life insurance.

HIPAA and Gramm-Leach-Bliley Act

The federal Health Insurance Portability and Accountability Act of 1996, or HIPAA, imposes obligations for issuers of health insurance coverage and health benefit plan sponsors. This law requires guaranteed renewability of health care coverage for most group health plans and certain individuals. Also, the law limited exclusions based on preexisting medical conditions.

The administrative simplification provisions of HIPAA imposed a number of requirements on covered entities (including insurers, HMOs, group health plans, providers and clearinghouses). These requirements include uniform standards of common electronic health care transactions; privacy and security regulations; and unique identifier rules for employers, health plans and providers. Additional federal privacy and security requirements, including breach notification, improved enforcement and additional limitations on use and disclosure of protected health information were passed through the Health Information Technology for Economic and Clinical Health, or HITECH, Act provisions of the American Recovery and Reinvestment Act of 2009 and corresponding implementing regulations. CMS posted the Interim Final Rule with Comment, or IFC, adopting operating rules for two electronic transactions: eligibility for a health plan and health care claims status. Based on the comments received on the IFC, CMS has decided not to change any of the policies established in the rule. Thus, the interim final rule became the final rule. The rule had a January 1, 2013 compliance date and we believe we have effectively complied with the requirements of the rule.

The federal Gramm-Leach-Bliley Act generally places restrictions on the disclosure of non-public information to non-affiliated third parties, and requires financial institutions, including insurers, to provide customers with notice regarding how their non-public personal information is used, including an opportunity to "opt out" of certain disclosures. State departments of insurance and certain federal agencies adopted implementing regulations as required by federal law. In addition, a number of states have adopted data security laws and/or regulations, regulating data security and/or requiring security breach notification, which may apply to us in certain circumstances.

Employee Retirement Income Security Act of 1974

The provision of services to certain employee welfare benefit plans is subject to the Employee Retirement Income Security Act of 1974, as amended, or ERISA, a complex set of laws and regulations subject to interpretation and enforcement by the Internal Revenue Service and the Department of Labor. ERISA regulates certain aspects of the relationships between us, the employers that maintain employee welfare benefit plans subject to ERISA and participants in such plans. Some of our administrative services and other activities may also be subject to regulation under ERISA. In addition, certain states require licensure or registration of companies providing third party claims administration services for benefit plans. We provide a variety of products and services to employee welfare benefit plans that are covered by ERISA. Plans subject to ERISA can also be subject to state laws and the question of whether and to what extent ERISA preempts a state law has been, and will continue to be, interpreted by many courts.

HMO and Insurance Holding Company Laws, including Risk-Based Capital Requirements

We are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. These holding company laws and regulations generally require insurance companies and HMOs within an insurance holding company system to register with the insurance department of each state where they are domiciled and to file with those states' insurance departments certain reports describing capital structure, ownership, financial condition, certain intercompany transactions, an enterprise risk report and general business operations. In addition, various notice and reporting requirements generally apply to transactions between insurance companies and HMOs and their affiliates within an insurance holding company system, depending on the size and nature of the transactions. Some insurance holding company laws and regulations require prior regulatory approval or, in certain circumstances, prior notice of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other provisions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends.

Additionally, the holding company acts of the states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company, which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would "control" the insurance holding company. "Control" is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person. Dispositions of control generally are also regulated under the state holding company acts.

The states of domicile of our regulated subsidiaries have statutory risk-based capital, or RBC, requirements for health and other insurance companies and HMOs based on the RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. The law requires increasing degrees of regulatory oversight and intervention as a company's RBC declines. As of December 31, 2015, the RBC levels of our insurance and HMO subsidiaries exceeded all RBC thresholds.

Guaranty Fund Assessments

Under insolvency or guaranty association laws in most states, insurance companies can be assessed for amounts paid by guaranty funds for policyholder losses incurred when an insurance company becomes insolvent. Most state insolvency or guaranty association laws currently provide for assessments based upon the amount of premiums received on insurance underwritten within such state (with a minimum amount payable even if no premium is received). Under many of these guaranty association laws, assessments against insurance companies that issue policies of accident or sickness insurance are made retrospectively. Some states permit insurers to recover assessments paid through full or partial premium tax offsets or through future policyholder assessments.

States' adoption of the revised NAIC Model Guaranty Fund Act will tend to decrease our liability for insolvent insurers. The revised act reduces the premium base on which assessments are calculated, by omitting Medicare Parts C and D premium from the assessment base.

While the amount and timing of any future assessments cannot be predicted with certainty, we believe that future guaranty association assessments for insurer insolvencies will not have a material adverse effect on our liquidity and capital resources with the exception of potential exposure related to the Penn Treaty Network America Insurance Company and its subsidiary American Network Insurance Company insolvency as discussed in Note 13, "Commitments and Contingencies", to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Employees

At December 31, 2015, we had approximately 53,000 employees. Our employees are an important asset, and we seek to develop them to their full potential. We believe that our relationship with our employees is good.

Available Information

We are a large accelerated filer (as defined in Rule 12b-2 of the Securities Exchange Act of 1934, as amended, or Exchange Act) and are required, pursuant to Item 101 of Regulation S-K, to provide certain information regarding our website and the availability of certain documents filed with or furnished to the U.S. Securities and Exchange Commission, or SEC. Our Internet website is www.antheminc.com. We have included our Internet website address throughout this Annual Report on Form 10-K as textual reference only. The information contained on, or accessible through, our Internet website is not incorporated into this Annual Report on Form 10-K. We make available, free of charge, by mail or through our Internet website, our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act as soon as reasonably practicable after we electronically file such material with or furnish it to the SEC. We also include on our Internet website our Corporate Governance Guidelines, our Standards of Ethical Business Conduct and the charter of each standing committee of our Board of Directors. In addition, we intend to disclose on our Internet website any amendments to, or waivers from, our Standards of Ethical Business Conduct that are required to be publicly disclosed pursuant to rules of the SEC and the New York Stock Exchange, or NYSE. Anthem, Inc. is an Indiana corporation incorporated on July 17, 2001.

ITEM 1A. RISK FACTORS.

The following is a description of significant factors that could cause actual results to differ materially from those contained in forward-looking statements made in this Annual Report on Form 10-K and presented elsewhere by management from time to time. Such factors may have a material adverse effect on our business, financial condition, and results of operations and you should carefully consider them. It is not possible to predict or identify all such factors. Consequently, you

should not consider any such list to be a complete statement of all our potential risks or uncertainties. Because of these and other factors, past performance should not be considered an indication of future performance.

Federal Health Care Reform, together with the changes in federal and state regulations that have been, and continue to be, enacted to implement it, could adversely affect our business, cash flows, financial condition and results of operations.

The passage of Health Care Reform during 2010 and subsequent regulations represent significant changes to the U.S. health care system. The legislation and regulations are far-reaching and are intended to expand access to health insurance coverage over time by mandating that most individuals obtain health insurance coverage, increasing the eligibility thresholds for most state Medicaid programs and providing certain other individuals and small businesses with tax credits to subsidize a portion of the cost of health insurance coverage. In addition, the new laws impose significant fees, assessments and taxes on us and other health insurers, health plans and other industry participants. Health Care Reform imposes an annual industry-wide HIP Fee. The total amount collected from allocations to health insurers in 2015 and 2014 was \$11.3 billion and \$8.0 billion, respectively and our portion of the HIP Fee for 2015 and 2014 was \$1.2 billion and \$0.9 billion, respectively. The annual HIP Fee remains at \$11.3 billion for 2016, has been suspended for 2017 and will resume and be increased to \$14.3 billion for 2018, with annual adjustments thereafter. The HIP Fee is not deductible for income tax purposes and is allocated pro rata among us and other industry participants based on net premiums written. Health Care Reform also imposes industry-wide reinsurance assessments under a temporary three year program which were \$8.0 billion and \$12.0 billion for 2015 and 2014, respectively, and decrease to \$5.0 billion for 2016. The reinsurance assessments are based on an insurer's total number of insured members. Insurance companies will pay the fees based upon insured members whereas self-insured entities will pay them directly to HHS. As we are one of the nation's largest health benefits companies, we expect our share of the Health Care Reform fees, assessments and taxes will continue to be significant. We may not be able to include or recoup all or a portion of these fees, assessments and taxes in our premium or public program rates.

Health Care Reform also imposes new regulations on the health insurance sector, including, but not limited to, guaranteed coverage and expanded benefit requirements; prohibitions on some annual and all lifetime limits on amounts paid on behalf of or to our members; increased restrictions on rescinding coverage; establishment of minimum MLR and customer rebate requirements; creation of a federal rate review process; a requirement to cover preventive services on a first dollar basis; the establishment of public exchanges and essential benefit packages and greater limitations on how we price certain of our products. In addition, the legislation reduces the reimbursement levels for our health plans participating in the Medicare Advantage program over time and limits the amount of executive compensation that is deductible for income tax purposes.

The legislation also contains risk adjustment provisions applicable to the Individual and Small Group markets that effectively transfer funds from health plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to help protect against adverse selection. Effectively adapting to these risk adjustment provisions has required us to modify our operational and strategic initiatives to focus on and manage different populations of potential members than we have in the past. If we are not able to successfully design and implement operational and strategic initiatives to adapt to these changes in certain of our markets, our financial condition and results of operations may be adversely affected. Further, the Health Care Reform Premium Stabilization programs may not make payments timely, or as expected, due to lower than anticipated collections. For example, in 2015, the risk corridor program fell short of expectations and, as a result, the payments from the program were approximately 12.6% of the amount that was requested by health insurance issuers.

Although the majority of Health Care Reform's provisions have been implemented, as the remaining provisions are phased in, we could be impacted through potential disruption to the employer-based market, potential cost shifting in the health care delivery system to insurance companies and limitations on the ability to increase premiums to meet costs. We have dedicated material resources and incurred material expenses to implement and comply with Health Care Reform at both the state and federal levels, and we expect to dedicate material resources and incur material expenses going forward to implement and comply with future regulations that provide guidance and clarification on significant portions of the legislation. The Health Care Reform law and regulations are likely to have significant effects on our future operations, which, in turn, could impact the value of our business model and results of operations, including potential impairments of our goodwill and other intangible assets.

Finally, federal and state regulatory agencies may further restrict our ability to obtain new product approvals, implement changes in premium rates or impose additional restrictions, under new or existing laws that could adversely affect our business, cash flows, financial condition and results of operations.

We are subject to significant government regulation, and changes in the regulation of our business by state and federal regulators may adversely affect our business, cash flows, financial condition and results of operations.

Our business is subject to regulation at the state and federal level. In addition to Health Care Reform, we face regulation associated with many aspects of our business, including, but not limited to, licensing, premiums, marketing activities, provider contracting, access and payment standards, and corporate governance and financial reporting matters.

Our insurance, managed health care and HMO subsidiaries are subject to extensive regulation and supervision by regulatory authorities in each state in which they are licensed or authorized to do business, in addition to regulation by federal agencies. Future regulatory action by state or federal authorities could have a material adverse effect on the profitability or marketability of our health benefits or managed care products or on our business, financial condition and results of operations. In addition, because of our participation in government-sponsored programs such as Medicare and Medicaid, a number of our subsidiaries are also subject to regulation by CMS and state Medicaid agencies, and to changes in government regulations or policy with respect to, among other things, reimbursement levels, eligibility requirements, benefit coverage requirements and additional governmental participation which could also adversely affect our business, financial condition and results of operations. In addition, changes in tax laws and regulations, or changes in the interpretation of tax laws and regulations by federal and/or state authorities may have a material adverse effect on our business, operations or financial condition.

State legislatures will continue to focus on health care delivery and financing issues. Such issues are sometimes addressed directly by voters in ballot initiatives, such as the upcoming ballot initiative in Colorado that would replace health insurers in the state with a single government payer. Most states are very focused on how to manage and reduce their budgets and are exploring ways to mitigate cost increases. As such, some states have acted to reduce or limit increases to premium payments. Others have enacted, or are contemplating enacting, significant reform of their health insurance markets to include provisions affecting both public programs and privately-financed health insurance arrangements. If enacted into law, these state proposals could have a material adverse impact on our business, cash flows, operations or financial condition.

The existence of multiple public insurance exchange options has led to increased uncertainties and made our planning for the public exchanges more difficult as we are required to comply with the varying rules of multiple exchanges. In addition, a number of states in which we offer Medicaid products, including Florida, Georgia, Kansas, Louisiana, South Carolina, Tennessee, Texas, Virginia and Wisconsin, have indicated their current decision to opt out of Medicaid expansion, at least for the present time. If states allow certain programs to expire or choose to opt out of Medicaid expansion, we could experience reduced Medicaid enrollment and reduced growth opportunities.

Additionally, from time to time, Congress has considered, and may consider in the future, various forms of managed care reform legislation which, if adopted, could fundamentally alter the treatment of coverage decisions under ERISA. There have been legislative attempts to limit ERISA's preemptive effect on state laws and litigants' ability to seek damages beyond the benefits offered under their plans. If adopted, such limitations could increase our liability exposure, could permit greater state regulation of our operations, and could expand the scope of damages, including punitive damages, litigants could be awarded. While we cannot predict if any of these initiatives will ultimately become effective or, if enacted, what their terms will be, their enactment could increase our costs, expose us to expanded liability or require us to revise the ways in which we conduct business.

Our inability to contain health care costs, implement increases in premium rates on a timely basis, maintain adequate reserves for policy benefits or maintain cost effective provider agreements may adversely affect our business and profitability.

Our profitability depends in large part on accurately predicting health care costs and on our ability to manage future health care costs through medical management, product design, negotiation of favorable provider contracts and underwriting criteria. Government-imposed limitations on Medicare and Medicaid reimbursement have also caused the private sector to bear a greater share of increasing health care costs. Changes in health care practices, demographic characteristics, inflation,

new technologies, the cost of prescription drugs, clusters of high cost cases, changes in the regulatory environment and numerous other factors affecting the cost of health care may adversely affect our ability to predict and manage health care costs, as well as our business, financial condition and results of operations.

Relatively small differences between predicted and actual health care costs as a percentage of premium revenues can result in significant changes in our results of operations, particularly with respect to our products sold through the public exchanges, as we and our competitors have limited experience with pricing such products or the utilization rates for medical or other covered services by members who purchase our products through such exchanges. The public exchanges may increase the risk that our products will be selected by individuals who have a higher risk profile or utilization rate than the pool of participants we anticipated when we established the pricing for these public exchange products. Health care benefit costs in excess of our cost projections reflected in our public exchange product pricing cannot be recovered in the current premium period through higher premiums. Although federal risk adjustment mechanisms, including risk adjustment payments, risk corridors and reinsurance, could help offset health care benefit costs in excess of our projections if our assumptions regarding cost trends, utilization, enrollment, adverse selection, acuity and other assumptions utilized in setting our premium rates are significantly different than actual results, our income statement and financial position could be adversely affected.

In addition to the challenge of managing health care costs, we face pressure to contain premium rates. Our customers may renegotiate their contracts to seek to contain their costs or may move to a competitor to obtain more favorable premiums. Further, federal and state regulatory agencies may restrict our ability to implement changes in premium rates. For example, the ACA includes an annual rate review requirement to prohibit unreasonable rate increases, and our plans may be excluded from participating in the public exchanges if they are deemed to have a history of "unreasonable" rate increases. Fiscal concerns regarding the continued viability of programs such as Medicare and Medicaid may cause decreasing reimbursement rates, delays in premium payments or a lack of sufficient increase in reimbursement rates for government-sponsored programs in which we participate. A limitation on our ability to increase or maintain our premium or reimbursement levels or a significant loss of membership resulting from our need to increase or maintain premium or reimbursement levels could adversely affect our business, cash flows, financial condition and results of operations.

The reserves that we establish for health insurance policy benefits and other contractual rights and benefits are based upon assumptions concerning a number of factors, including trends in health care costs, expenses, general economic conditions and other factors. To the extent the actual claims experience is less favorable than estimated based on our underlying assumptions, our incurred losses would increase and future earnings could be adversely affected.

Our profitability is dependent in part upon our ability to contract on favorable terms with hospitals, physicians and other health care providers. The failure to maintain or to secure cost-effective health care provider contracts on competitive terms may result in a loss of membership or higher medical costs, which could adversely affect our business. In addition, ACO practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other care providers choose may change the way that these providers interact with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which may impact our relationship with these providers or affect the way that we price our products and estimate our costs and may require us to incur costs to change our operations, and our results of operations, financial position and cash flow could be adversely affected. Further, our inability to contract with providers, or if providers attempt to use their market position to negotiate more favorable contracts or place us at a competitive disadvantage, or the inability of providers to provide adequate care, could adversely affect our business. In addition, we do not have contracts with all providers that render services to our members and, as a result, do not have a pre-established agreement about the amount of compensation those out-of-network providers will accept for the services they render, which can result in significant litigation or arbitration proceedings.

A significant reduction in the enrollment in our health benefits programs could have an adverse effect on our business and profitability.

A significant reduction in the number of enrollees in our health benefits programs could adversely affect our business, financial condition and results of operations. Factors that could contribute to a reduction in enrollment include: reductions in workforce by existing customers; general economic downturn that results in business failures and high unemployment rates; employers no longer offering certain health care coverage as an employee benefit or electing to offer this coverage on a

voluntary, employee-funded basis; participation on public exchanges and related underwriting changes; state and federal regulatory changes; failure to obtain new customers or retain existing customers; premium increases and benefit changes; our exit from a specific market; negative publicity and news coverage; and failure to attain or maintain nationally recognized accreditations.

There are various risks associated with participating in Medicaid and Medicare programs, including dependence upon government funding and the timing of payments, compliance with government contracts and increased regulatory oversight.

We contract with various state and federal agencies, including CMS, to provide managed health care services, including Medicare Advantage plans, Medicare Supplement plans, Medicare approved prescription drug plans, Medicaid, TANF, SPD, LTSS, CHIP and ACA-related Medicaid expansion programs. We also provide various administrative services for several other entities offering medical and/or prescription drug plans to their Medicare eligible members through our affiliated companies and we offer employer group waiver plans which provide medical and/or prescription drug coverage to retirees. We are also participating in Medicare and Medicaid dual eligible programs in several states. These programs in our Government Business segment have been the subject of recent regulatory reform initiatives, including Health Care Reform, which are still in the process of being implemented. It is difficult to predict the future impact of Health Care Reform on our Government Business segment due to Health Care Reform's complexity, gradual implementation, and possible amendment. Changes in Health Care Reform to date have required us to make investments in new products, services and technologies, which investments may not be realized if certain provisions are delayed or substantially modified. Health Care Reform, other regulatory reform initiatives or additional changes in existing laws or regulations, or their interpretations, could have a material adverse effect on our business, cash flow, financial condition and results of operations.

Revenues from the Medicare and Medicaid programs are dependent, in whole or in part, upon annual funding from the federal government and/or applicable state governments. The base premium rate paid by each state or federal agency differs depending upon a combination of various factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix, member eligibility category and risk scores. Future levels of Medicare and Medicaid rates may be affected by continued government efforts to contain costs and may be further affected by state and federal budgetary constraints. If the federal government or any state in which we operate were to decrease rates paid to us, pay us less than the amount necessary to keep pace with our cost trends or seek an adjustment to previously negotiated rates, it could have a material adverse effect on our business, financial condition and results of operations. Further, certain of our contracts with the states are subject to cancellation in the event of the unavailability of state funds. In addition, the various states' new Medicare and Medicaid dual eligible programs are still subject to uncertainty surrounding payment rates and other requirements, which could affect where we seek to participate in these new programs. An unexpected reduction, inadequate government funding or significantly delayed payments for these programs may adversely affect our revenues, cash flow and financial results.

A portion of our premium revenue comes from CMS through our Medicare Advantage and Medicare Part D contracts. As a consequence, our Medicare Advantage and Medicare Part D plans are dependent on federal government funding levels. The premium rates paid to Medicare plans are established based on benchmarks which are now tied to a percentage of Medicare fee for service, although the rates differ depending on a combination of factors, including upper payment limits established by CMS, a member's health profile and status, age, gender, county or region, benefit mix, member eligibility categories and risk scores. Beginning in 2014, Medicare Advantage and Medicare Part D plans became subject to MLR rules. Continuing government efforts to contain health care related expenditures, including prescription drug cost, and other federal budgetary constraints that result in changes in the Medicare program, including changes with respect to funding, could lead to reductions in the amount of reimbursement, or other changes that could have a material adverse effect on our business, cash flow, financial condition and results of operations. Risks associated with the Medicare Advantage and Medicare Part D plans include potential uncollectability of receivables resulting from processing and/or verifying enrollment, inadequacy of underwriting assumptions, inability to receive and process correct information (including inability due to systems issues by the federal government, the applicable state government or us), uncollectability of premiums from members, increased medical or pharmaceutical costs, overpayments identified as a result of ongoing auditing and monitoring activities, and the limited enrollment periods in this business. While we believe we have adequately reviewed our assumptions and estimates regarding these complex and wide-ranging programs under Medicare Parts C and D, including those related to collectability of receivables and establishment of liabilities, the actual results may be materially different than our assumptions and estimates and could have a material adverse effect on our business, financial condition and results of operations. There is also

the possibility that Medicare Advantage Special Needs plans will not be re-authorized by Congress. Without Congressional action, these plans will expire on December 31, 2016. If the Special Needs plans are not re-authorized, there could be a loss of revenue and it would become more difficult to coordinate Medicare benefits with other coverage. The ACA also established recovery audit programs for Medicare Parts C and D. The Medicare Part D Recovery Audit Contractor, or RAC, has been auditing Medicare Part D claims since 2012, and a Medicare Part C RAC is expected to be named in 2016, which could increase the volume of audits and subsequent recoupments by the federal government.

The ACA authorized state Medicaid programs to implement RAC programs similar to Medicare RAC programs and a number of states have done so. State RAC programs could increase the amount of audits and any subsequent recoupment by the federal and state governments, which could adversely affect our financial condition and results of our operations.

Our contracts with the various state governmental agencies and CMS contain certain provisions regarding data submission, provider network maintenance, quality measures, claims payment, continuity of care, call center performance and other requirements specific to state and federal program regulations. If we fail to comply with these requirements, we may be subject to fines, penalties, liquidated damages and retrospective adjustments in payments made to our health plans, that could impact our profitability. Additionally, we could be required to file a corrective plan of action with additional penalties for noncompliance, including a negative impact on future membership enrollment levels. Further, certain of our CMS and state Medicaid contracts are subject to a competitive procurement process, and if our existing contracts are not renewed or if we are not awarded new contracts as a result of this competitive procurement process, this could have a material adverse effect on our business, cash flows, financial condition and results of operations.

In addition to the contractual requirements affecting our participation in Medicaid and Medicare programs, we are also subject to various state and federal health care laws and regulations, including those directed at preventing fraud and abuse in government funded programs. Failure to comply with these laws and regulations could result in investigations or litigation, with the imposition of fines, restrictions or exclusions from program participation or the imposition of corporate integrity agreements or other agreements with a federal or state governmental agency that could adversely impact our business, cash flows, financial condition and results of operations.

CMS has been conducting audits of our Medicare Advantage health plans to validate the diagnostic data and patient claims that are submitted to CMS and the Medicare Part D RAC has been conducting audits of our Medicare Part D plans. These audits may result in retrospective adjustments in payments made to our health plans. In addition, if we fail to report and correct errors discovered through our own auditing procedures or during a CMS or RAC audit, or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil penalties or other sanctions which could have a material adverse effect on our ability to participate in these programs, and on our financial condition, cash flows and results of operations.

In addition, there are an increasing number of investigations regarding compliance with various provisions of the ACA. These investigations are being conducted by both CMS and state regulators. As a result, we could be subject to multiple investigations of the same issue. These investigations, and any possible enforcement actions, could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

We may not complete the acquisition of Cigna within the time frame we anticipate or at all, which could have a negative effect on our business or our results of operations.

On July 23, 2015, we entered into an Agreement and Plan of Merger, or Merger Agreement, under which we will acquire all of the outstanding shares of Cigna. The acquisition is subject to a number of closing conditions, such as antitrust and other regulatory approvals, which may not be received or may take longer than expected. The acquisition is also subject to other risks and uncertainties, such as the possibility that Cigna could receive an unsolicited proposal from a third party or that either we or Cigna could exercise our respective termination rights. If the acquisition is not consummated within the expected time frame, or at all, it could have a negative effect on our ability to execute on our growth strategy or on our financial performance.

Failure to complete the acquisition could negatively impact our share price and future business, as well as our financial results.

If the acquisition is not completed, our ongoing business may be adversely affected and, without realizing any of the benefits of having completed the acquisition, we could be subject to a number of risks, including the following: we may be required to pay Cigna a termination fee of \$1.85 billion or an expense fee of up to \$600 million if the Merger Agreement is terminated under certain circumstances (as more fully described in the Merger Agreement); and we could be subject to litigation related to any failure to complete the acquisition or related to any enforcement proceeding commenced against us to perform our obligations under the Merger Agreement. If the acquisition is not completed, these risks may materialize and may adversely affect our business, cash flows and financial condition.

We may experience difficulties in integrating Cigna's business and realizing the expected benefits of the proposed acquisition.

The success of the Cigna acquisition, if completed, will depend, in part, on our ability to realize the anticipated business opportunities and growth prospects from combining our businesses with those of Cigna. We may never realize these business opportunities and growth prospects. Integrating operations will be complex and will require significant efforts and expenditures on the part of both us and Cigna. Our management might have its attention diverted while trying to integrate operations and corporate and administrative infrastructures. We might experience increased competition that limits our ability to expand our business, and we might fail to capitalize on expected business opportunities, including retaining current customers.

The integration process could result in a disruption of each company's ongoing businesses, tax costs or inefficiencies, or inconsistencies in standards, controls, information technology systems, procedures and policies, any of which could adversely affect our ability to maintain relationships with clients, employees or other third parties or our ability to achieve the anticipated benefits of the Cigna acquisition and could harm our financial performance.

If we are unable to successfully or timely integrate the operations of Cigna's business into our business, we may be unable to realize the revenue growth, synergies and other anticipated benefits resulting from the proposed acquisition and our business and results of operations could be adversely affected. Even if we complete the Cigna acquisition, the acquired business may underperform relative to our expectations.

The health benefits industry is subject to negative publicity, which could adversely affect our business and profitability.

The health benefits industry is subject to negative publicity, which can arise from, among other things, the ongoing debate over Health Care Reform. Negative publicity may result in increased regulation and legislative review of industry practices, which may further increase our costs of doing business and adversely affect our profitability by: adversely affecting our ability to market our products and services; requiring us to change our products and services; or increasing the regulatory burdens under which we operate.

In addition, as long as we use the Blue Cross and Blue Shield names and marks in marketing our health benefits products and services, any negative publicity concerning the BCBSA or other BCBSA licensees may adversely affect us and the sale of our health benefits products and services. Any such negative publicity could adversely affect our business, cash flows, financial condition and results of operations.

We face competition in many of our markets and customers and brokers have flexibility in moving between competitors.

As a health benefits company, we operate in a highly competitive environment and in an industry that is currently subject to significant changes from legislative reform, business consolidations, new strategic alliances, aggressive marketing practices by other health benefits organizations and market pressures brought about by an informed and organized customer base, particularly among large employers. For example, we began to compete for sales on public exchanges in 2014, which has required, and will continue to require, us to develop or acquire the tools (including social media tools) necessary to interact with the exchanges and with consumers using the exchanges, increase our focus on individual customers and improve

our consumer-focused sales and marketing, customer interfaces and product offerings. These factors have produced and will likely continue to produce significant pressures on our profitability.

We also will have to respond to pricing and other actions taken by existing competitors and potentially disruptive new entrants. Due to the price transparency provided by public exchanges, in the market for individual health insurance we face competitive pressures from new and existing competitors. These risks may be enhanced if employers shift to defined contribution health care benefits plans and make greater utilization of private insurance exchanges or encourage their employees to purchase health insurance on the public exchanges. We can provide no assurance that we will be able to compete successfully on these public exchanges or that we will be able to benefit from any opportunities presented by such exchanges. If we are not competitive on these public exchanges or are unsuccessful in reducing our cost structure, our future growth and profitability may be adversely impacted.

We are currently dependent on the non-exclusive services of independent agents and brokers in the marketing of our health care products, particularly with respect to individuals, seniors and small employer group customers. We face intense competition for the services and allegiance of these independent agents and brokers, who may also market the products of our competitors. Our relationship with our brokers and independent agents could be adversely impacted by changes in our business practices to address Health Care Reform legislation, including potential reductions in commissions and consulting fees paid to agents and brokers. We cannot ensure that we will be able to compete successfully against current and future competitors or that competitive pressures faced by us will not materially and adversely affect our business, cash flows, financial condition and results of operations.

We face intense competition to attract and retain employees. Further, managing key executive succession and retention is critical to our success.

We are dependent on retaining existing employees, attracting additional qualified employees to meet current and future needs and achieving productivity gains from our investment in technology. We face intense competition for qualified employees, and there can be no assurance that we will be able to attract and retain such employees or that such competition among potential employers will not result in increasing salaries. An inability to retain existing employees or attract additional employees could have a material adverse effect on our business, cash flows, financial condition and results of operations.

We would be adversely affected if we fail to adequately plan for succession of our Chairman, President and Chief Executive Officer and other senior management and retention of key executives. While we have succession plans in place for members of our senior management, and continue to review and update those plans, and we have employment arrangements with certain key executives, these plans and arrangements do not guarantee that the services of our senior executives will continue to be available to us or that we will be able to attract and retain suitable successors.

A change in our health care product mix may impact our profitability.

Our health care products that involve greater potential risk generally tend to be more profitable than administrative services products and those health care products where the employer groups assume the underwriting risks. Individuals and small employer groups are more likely to purchase our higher-risk health care products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures. Typically, government-sponsored programs also involve our higher-risk health care products. It is not yet clear whether our products sold on the public exchanges will be more or less profitable products. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our financial condition and results of operations.

As a holding company, we are dependent on dividends from our subsidiaries. These dividends are necessary to pay our outstanding indebtedness. Our regulated subsidiaries are subject to state regulations, including restrictions on the payment of dividends, maintenance of minimum levels of capital and restrictions on investment portfolios.

We are a holding company whose assets include all of the outstanding shares of common stock (or other ownership interest) of our subsidiaries including our intermediate holding companies and regulated insurance and HMO subsidiaries. Our subsidiaries are separate legal entities. As a holding company, we depend on dividends from our subsidiaries. Furthermore, our subsidiaries are not obligated to make funds available to us, and creditors of our subsidiaries will have a superior claim to certain of our subsidiaries' assets. Among other restrictions, state insurance and HMO laws may restrict the

ability of our regulated subsidiaries to pay dividends. In some states, we have made special undertakings that may limit the ability of our regulated subsidiaries to pay dividends. In addition, our subsidiaries' ability to make any payments to us will also depend on their earnings, the terms of their indebtedness, business and tax considerations and other legal restrictions. Our ability to repurchase shares or pay dividends in the future to our shareholders and meet our obligations, including paying operating expenses and debt service on our outstanding and future indebtedness, will depend upon the receipt of dividends from our subsidiaries. An inability of our subsidiaries to pay dividends in the future in an amount sufficient for us to meet our financial obligations may materially adversely affect our business, cash flows, financial condition and results of operations.

Most of our regulated subsidiaries are subject to RBC standards, imposed by their states of domicile. These laws are based on the RBC Model Act adopted by the NAIC and require our regulated subsidiaries to report their results of risk-based capital calculations to the departments of insurance and the NAIC. Failure to maintain the minimum RBC standards could subject our regulated subsidiaries to corrective action, including state supervision or liquidation. As discussed in more detail below, we are a party to license agreements with the BCBSA which contain certain requirements and restrictions regarding our operations, including minimum capital and liquidity requirements, which could restrict the ability of our regulated subsidiaries to pay dividends.

Our regulated subsidiaries are subject to state laws and regulations that require diversification of their investment portfolios and limit the amount of investments in certain riskier investment categories, such as below-investment-grade fixed maturity securities, mortgage loans, real estate and equity investments, which could generate higher returns on our investments. Failure to comply with these laws and regulations might cause investments exceeding regulatory limitations to be treated as non-admitted assets for purposes of measuring statutory surplus and risk-based capital, and, in some instances, require the sale of those investments.

We have substantial indebtedness outstanding and may incur additional indebtedness in the future in connection with the Cigna acquisition or otherwise. Such indebtedness could also adversely affect our ability to pursue desirable business opportunities.

Our debt service obligations require us to use a portion of our cash flow to pay interest and principal on debt instead of for other corporate purposes, including funding future expansion. If our cash flow and capital resources are insufficient to service our debt obligations, we may be forced to seek extraordinary dividends from our subsidiaries, sell assets, seek additional equity or debt capital or restructure our debt. However, these measures might be unsuccessful or inadequate in permitting us to meet scheduled debt service obligations.

Upon completion of the Cigna acquisition, we expect to have incurred acquisition-related indebtedness of approximately \$26.5 billion and to have assumed approximately \$5.1 billion of Cigna's outstanding debt. Our substantially increased indebtedness and debt-to-equity ratio on a recent historical basis will have the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and may increase our borrowing costs. In addition, the amount of cash required to service our increased indebtedness levels and thus the demands on our cash resources may be greater than the percentages of cash flows required to service our indebtedness or the indebtedness of Cigna individually prior to the acquisition. The increased levels of indebtedness could also reduce funds available for our investments in product development as well as capital expenditures, share repurchases, shareholder dividends, other desirable business opportunities and other activities and may create competitive disadvantages for us relative to other companies with lower debt levels.

In addition to the expected acquisition-related debt financing described above, we may also incur future debt obligations that might subject us to restrictive covenants that could affect our financial and operational flexibility. Our breach or failure to comply with any of these covenants could result in a default under our credit agreement or other indebtedness. If we default under our credit agreement, the lenders could cease to make further extensions of credit or cause all of our outstanding debt obligations under our credit agreement to become immediately due and payable, together with accrued and unpaid interest. If the indebtedness under our notes or our credit agreement or our other indebtedness is accelerated, we may be unable to repay or finance the amounts due.

A downgrade in our credit ratings could have an adverse effect on our business, financial condition and results of operations.

Claims-paying ability and financial strength ratings by nationally recognized statistical rating organizations are an important factor in establishing the competitive position of insurance companies and health benefits companies. We believe our strong credit ratings are an important factor in marketing our products to customers, since credit ratings information is broadly disseminated and generally used throughout the industry. In addition, if our credit ratings are downgraded or placed under review, our business, financial condition and results of operations could be adversely impacted by limitations on future borrowings and a potential increase in our borrowing costs. Our ratings reflect each rating agency's opinion of our financial strength, operating performance and ability to meet our obligations to policyholders and creditors, and are not evaluations directed toward the protection of investors in our common stock.

Each of the ratings organizations reviews our ratings periodically, and there can be no assurance that our current ratings will be maintained in the future. Following the announcement of the Cigna acquisition, each of Standard & Poor's, A.M. Best, Fitch and Moody's placed certain of our debt, financial strength and other credit ratings under review for a possible downgrade.

We face risks related to litigation.

We are, or may in the future, be a party to a variety of legal actions that may affect any business, such as employment and employment discrimination-related suits and administrative charges before government agencies, employee benefit claims, breach of contract actions, tort claims and intellectual property-related litigation. In addition, because of the nature of our business, we are subject to a variety of legal actions relating to our business operations, including the design, administration and offering of our products and services. These could include claims relating to the denial of health care benefits; the rescission of health insurance policies; development or application of medical policy; medical malpractice actions; product liability claims; allegations of anti-competitive and unfair business activities; provider disputes over compensation; provider tiering programs; narrow networks; termination of provider contracts; the recovery of overpayments from providers; self-funded business; disputes over co-payment calculations; reimbursement of out-of-network claims; the failure to disclose certain business or corporate governance practices; the failure to comply with various state or federal laws, including but not limited to, ERISA and the Mental Health Parity Act; and customer audits and contract performance, including government contracts. These actions or proceedings could have a material adverse effect on our business, cash flows, financial condition and results of operations.

In addition, we are also involved in, or may in the future be party to, pending or threatened litigation of the character incidental to the business transacted, arising out of our operations or our 2001 demutualization, including, but not limited to, breaches of security and violations of privacy requirements (including as a result of the cyber attack reported by us in February 2015, as more fully described under Note 13, "Commitments and Contingencies - *Cyber Attack Incident*," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K), shareholder actions, compliance with federal and state laws and regulations (including *qui tam* or "whistleblower" actions), or sales and acquisitions of businesses or assets. From time to time, we are involved as a party in various governmental investigations, audits, reviews and administrative proceedings, including challenges to the award of government contracts by disappointed bidders. These investigations, audits and reviews include routine and special investigations by various state insurance departments, state attorneys general and the U.S. Attorney General. Following an investigation, we may be subject to civil or criminal fines, penalties and other sanctions if we are determined to be in violation of applicable laws or regulations. Liabilities that may result from these actions could have a material adverse effect on our cash flows, results of operations or financial position.

Recent court decisions and legislative activity may increase our exposure for any of these types of claims. In some cases, substantial non-economic (including injunctive relief), treble or punitive damages may be sought. Although we maintain insurance coverage for some of these potential liabilities, some liabilities and damages may not be covered by insurance, insurers may dispute coverage or the amount of insurance may not be enough to cover the damages awarded. In addition, insurance coverage for all or certain forms of liability may become unavailable or prohibitively expensive in the future. Any adverse judgment against us resulting in such damage awards could have an adverse effect on our cash flows, results of operations and financial condition.

Further, litigation brought against the federal and some state governments over Health Care Reform could have a material adverse effect on our business, cash flows, financial condition and results of operations as changes to Health Care Reform resulting from this litigation create uncertainty over the applicability and enforceability of portions of the law and the various regulations, which impacts our strategy and could negatively impact our future growth opportunities.

Our future obligations for state guaranty association assessments could increase in the event that Health Care Reform and its implementation result in increased insolvencies of health insurance plans.

Under insolvency or guaranty association laws in most states, insurance companies can be assessed for amounts paid by guaranty funds for policyholder losses incurred when a health insurance plan becomes insolvent. Most state insolvency or guaranty association laws provide for assessments based upon the amount of premiums received on insurance underwritten within such state. Although health insurance company insolvencies have been infrequent, with the implementation of Health Care Reform, a number of smaller health insurance companies and Consumer Operated and Oriented Plan, or Co-op, programs have established premiums that appear to be insufficient to cover the cost of care for their members, which may result in increased insolvencies of health insurance companies and Co-ops covered by these state insolvency or guaranty association laws. In that event, we may experience increased guaranty association assessments, the amount and timing of which cannot be predicted with certainty. In light of significant uncertainty surrounding whether, and to what extent, there may be an increase in insurer or Co-op insolvencies, we are not currently able to estimate our potential financial obligations, losses, or the availability of potential offsets associated with potential increases in guaranty association assessments; however, any significant increase in guaranty association assessments could have a material adverse effect on our business, cash flows, financial condition and results of operations.

There are various risks associated with providing health care services.

The direct provision of health care services by our CareMore subsidiary involves risks of additional litigation arising from medical malpractice actions based on our treatment decisions or brought against us or our physician associates for alleged malpractice or professional liability claims arising out of the delivery of health care and related services. In addition, liability may arise from maintaining health care premises that serve the public. If we fail to maintain adequate insurance coverage for these liabilities, or if such insurance is not available, the resulting costs could adversely affect our cash flows, financial condition or results of operations.

Additionally, many states in which we operate our CareMore subsidiary limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals. Business corporations generally may not exercise control over the medical decisions of physicians ("corporate practice of medicine") and we are not licensed to practice medicine. Rules and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary from state to state. Further, certain federal and state laws, including those covering our Medicare and Medicaid plans, prohibit the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of patient care opportunities, including, but not limited to, Medicare patients ("anti-kickback rules"), and also generally prohibit physicians from making referrals to any entity providing certain designated health services if the referring physician or related person has an ownership or financial interest in the entity ("self-referral rules"). Any enforcement actions by governmental officials alleging non-compliance with these rules and regulations could adversely affect our business, cash flows, financial condition or results of operations.

We are a party to license agreements with the BCBSA that entitle us to the exclusive and in certain areas non-exclusive use of the Blue Cross and Blue Shield names and marks in our geographic territories. The termination of these license agreements or changes in the terms and conditions of these license agreements could adversely affect our business, financial condition and results of operations. Upon completion of the Cigna acquisition, we may not initially be in compliance with the BCBSA's national "best efforts" requirement.

We use the Blue Cross and Blue Shield names and marks as identifiers for our products and services under licenses from the BCBSA. Our license agreements with the BCBSA contain certain requirements and restrictions regarding our operations and our use of the Blue Cross and Blue Shield names and marks, including: minimum capital and liquidity requirements imposed by the BCBSA; enrollment and customer service performance requirements; participation in programs that provide portability of membership between plans; disclosures to the BCBSA relating to enrollment and financial conditions; disclosures as to the structure of the Blue Cross and Blue Shield system in contracts with third parties and in public

statements; plan governance requirements; cyber security requirements; a requirement that at least 80% (or, in the case of Blue Cross of California, substantially all) of a licensee's annual combined local net revenue, as defined by the BCBSA, attributable to health care plans and related services within its service areas must be sold, marketed, administered or underwritten under the Blue Cross and Blue Shield names and marks; a requirement that neither a plan nor any of its licensed affiliates may permit an entity other than a plan or a licensed affiliate to obtain control of the plan or the licensed affiliate or to acquire a substantial portion of its assets related to licensable services; a requirement that we divide our Board of Directors into three classes serving staggered three-year terms; a requirement that we guarantee certain contractual and financial obligations of our licensed affiliates; and a requirement that we indemnify the BCBSA against any claims asserted against it resulting from the contractual and financial obligations of any subsidiary that serves as a fiscal intermediary providing administrative services for Medicare Parts A and B. Failure to comply with the foregoing requirements could result in a termination of the license agreements.

In addition, our license agreements with the BCBSA include a requirement that at least 66 2/3% of our annual combined national net revenue, as defined by the BCBSA, attributable to health care plans and related services must be sold, marketed, administered or underwritten under the Blue Cross and Blue Shield names and marks, referred to as the "National Best Efforts Requirement." Due to the size of Cigna's business, we may not be in compliance with the National Best Efforts Requirement immediately after completion of the acquisition.

We will be required to submit an action plan for coming into compliance with the National Best Efforts Requirement within 120 days of the completion of the Cigna acquisition if we are out of compliance following closing of the acquisition. Under current BCBSA standards, we would be required to cure any non-compliance with the National Best Efforts Requirement within 24 months from the date when the relevant BCBSA committee makes a determination on our action plan. We believe there are multiple options at our disposal to regain compliance within the allotted timeframe, if necessary. Although we strongly believe there would be numerous ways in which we could re-establish compliance with the National Best Efforts Requirement within the required 24 month period, there can be no guarantee such efforts will be successful, and failure to comply with the requirement could ultimately result in a termination of our license agreements under certain circumstances.

The standards under the license agreements may be modified in certain instances by the BCBSA. For example, from time to time there have been proposals considered by the BCBSA to modify the terms of the license agreements to restrict various potential business activities of licensees. These proposals have included, among other things, a limitation on the ability of a licensee to make its provider networks available to insurance carriers or other entities not holding a Blue Cross or Blue Shield license. To the extent that such amendments to the license agreements are adopted in the future, they could have a material adverse effect on our future expansion plans or results of operations, or our ability to come back into compliance with the National Best Efforts Requirement if the Cigna acquisition is consummated. Further, BCBS licensees have certain requirements to perform administrative services for members of other BCBS licensees. If we or another BCBS licensee is not in compliance with all legal requirements or are unable to perform administrative services as required, this could have an adverse effect on our members and our ability to maintain our licenses, which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Upon the occurrence of an event causing termination of the license agreements, we would no longer have the right to use the Blue Cross and Blue Shield names and marks or to sell Blue Cross and Blue Shield health insurance products and services in one or more of our service areas. Furthermore, the BCBSA would be free to issue a license to use the Blue Cross and Blue Shield names and marks in these service areas to another entity. Our existing Blue Cross and Blue Shield members would be provided with instructions for obtaining alternative products and services licensed by the BCBSA. Events that could cause the termination of a license agreement with the BCBSA include failure to comply with minimum capital requirements imposed by the BCBSA, failure to comply with governance requirements such as maintaining a classified board structure, a change of control or violation of the BCBSA ownership limitations on our capital stock, impending financial insolvency and the appointment of a trustee or receiver or the commencement of any action against a licensee seeking its dissolution. We believe that the Blue Cross and Blue Shield names and marks are valuable identifiers of our products and services in the marketplace.

Upon termination of a license agreement, the BCBSA would have the right to impose a "Re-establishment Fee" upon us, which would be used in part to fund the establishment of a replacement Blue Cross and/or Blue Shield licensee in the vacated service area. The fee is set at \$98.33 per licensed enrollee. As of December 31, 2015, we reported 29.4 million Blue Cross

and/or Blue Shield enrollees. If the Re-establishment Fee was applied to our total Blue Cross and/or Blue Shield enrollees, we would be assessed approximately \$2.9 billion by the BCBSA. As a result, termination of the license agreements would have a material adverse effect on our business, financial condition and results of operations.

Regional concentrations of our business may subject us to economic downturns in those regions.

Most of our revenues are generated in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Maryland, Missouri, Nevada, New Hampshire, New York, Ohio, Tennessee, Texas, Virginia and Wisconsin. Due to this concentration of business in these states, we are exposed to potential losses resulting from the risk of state specific or regional economic downturns impacting these states. If such negative economic conditions do not improve, we may experience a reduction in existing and new business, which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Large-scale medical emergencies may have a material adverse effect on our business, cash flows, financial condition and results of operations.

Large-scale medical emergencies can take many forms and can cause widespread illness and death. For example, federal and state law enforcement officials have issued warnings about potential terrorist activity involving biological and other weapons. In addition, natural disasters such as hurricanes and the potential for a widespread pandemic of influenza coupled with the lack of availability of appropriate preventative medicines can have a significant impact on the health of the population of widespread areas. If the United States were to experience widespread bioterrorism or other attacks, large-scale natural disasters in our concentrated coverage areas or a large-scale pandemic or epidemic, our covered medical expenses could rise and we could experience a material adverse effect on our business, cash flows, financial condition and results of operations or, in the event of extreme circumstances, our viability could be threatened.

We have built a significant portion of our current business through mergers and acquisitions, joint ventures and strategic alliances and we expect to pursue such opportunities in the future.

The following are some of the risks associated with mergers, acquisitions, joint ventures and strategic alliances, referred to collectively as business combinations, that could have a material adverse effect on our business, financial condition and results of operations:

- some of the acquired businesses may not achieve anticipated revenues, earnings or cash flow, business opportunities, synergies, growth prospects and other anticipated benefits;
- the goodwill or other intangible assets established as a result of our business combinations may be incorrectly valued or become non-recoverable;
- we may assume liabilities that were not disclosed to us or which were under-estimated;
- we may experience difficulties in integrating acquired businesses, be unable to integrate acquired businesses successfully or as quickly as expected, and be unable to realize anticipated economic, operational and other benefits in a timely manner, which could result in substantial costs and delays or other operational, technical or financial problems;
- business combinations could disrupt our ongoing business, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies and procedures;
- we may finance future business combinations by issuing common stock for some or all of the purchase price, which could dilute the ownership interests of our shareholders;
- we may also incur additional debt related to future business combinations;
- we would be competing with other firms, some of which may have greater financial and other resources, to acquire attractive companies; and
- future business combinations may make it difficult to comply with the requirements of the BCBSA and lead to an increased risk that our BCBSA license agreements may be terminated.

The value of our intangible assets may become impaired.

Due largely to our past mergers, acquisitions and divestitures, goodwill and other intangible assets represent a substantial portion of our assets. If we make additional acquisitions, it is likely that we will record additional intangible assets on our consolidated balance sheets.

In accordance with applicable accounting standards, we periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may no longer be recoverable, in which case a charge to income may be necessary. This impairment testing requires us to make assumptions and judgments regarding the estimated fair value of our reporting units, including goodwill and other intangible assets (with indefinite lives). In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately. Estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used. If estimated fair values are less than the carrying values of goodwill and other intangible assets with indefinite lives in future impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially affect our results of operations and shareholders' equity in the period in which the impairment occurs. A material decrease in shareholders' equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

In addition, the estimated value of our reporting units may be impacted as a result of business decisions we make associated with the implementation of the various Health Care Reform regulations. Such decisions, which could unfavorably affect our ability to support the carrying value of certain goodwill and other intangible assets, could result in impairment charges in future periods.

Adverse securities and credit market conditions may significantly affect our ability to meet liquidity needs.

The securities and credit markets have been experiencing higher than normal volatility. In some cases, the markets have exerted downward pressure on availability of liquidity and credit capacity for certain issuers. We need liquidity to pay our operating expenses, make payments on our indebtedness and pay capital expenditures. The principal sources of our cash receipts are premiums, administrative fees, investment income, other revenue, proceeds from the sale or maturity of our investment securities, proceeds from borrowings and proceeds from the issuance of common stock under our employee stock plans.

Our access to additional financing will depend on a variety of factors such as market conditions, the general availability of credit, the volume of trading activities, the availability of credit to our industry, our credit ratings and credit capacity, as well as the possibility that customers or lenders could develop a negative perception of our long- or short-term financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If one or a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value may result in a loss charged to income.

The market values of our investments vary from time to time depending on economic and market conditions. For various reasons, we may sell certain of our investments at prices that are less than the carrying value of the investments. In addition, in periods of declining interest rates, bond calls and mortgage loan prepayments generally increase, resulting in the reinvestment of these funds at the then lower market rates. In periods of rising interest rates, the market values of our fixed maturity securities will generally decrease, which could result in material unrealized or realized losses on investments in future periods. In addition, defaults by issuers, primarily from investments in corporate and municipal bonds, who fail to pay or perform their obligations, could reduce net investment income, which would adversely affect our profitability. We cannot assure you that our investment portfolios will produce positive returns in future periods.

In accordance with FASB guidance for debt and equity investments, we classify fixed maturity and equity securities in our investment portfolio as "available-for-sale" or "trading" and report those securities at fair value. Current and long-term

available-for-sale investment securities represented a significant percentage of our total consolidated assets at December 31, 2015. Also, in accordance with applicable FASB accounting guidance, we review our investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis analyzing both quantitative and qualitative factors. Such factors considered include the length of time and the extent to which market value has been less than cost, financial condition and near term prospects of the issuer, recommendations of investment advisors and forecasts of economic, market or industry trends.

Changes in the economic environment, including periods of increased volatility of the securities markets, can increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. We believe we have adequately reviewed our investment securities for impairment and we believe that we have appropriately estimated the fair values of our investment securities. However, over time, the economic and market environment may provide additional insight, which could change our judgment regarding the fair value of certain securities and/or impairment. Given the sometimes rapidly changing market conditions and the significant judgments involved, there is continuing risk that further declines in fair value may occur and material other-than-temporary impairments may be charged to income in future periods, resulting in realized losses.

We may not be able to realize the value of our deferred tax assets.

In accordance with applicable accounting standards, we separately recognize deferred tax assets and deferred tax liabilities. Such deferred tax assets and deferred tax liabilities represent the tax effect of temporary differences between financial reporting and tax reporting measured at tax rates enacted at the time the deferred tax asset or liability is recorded.

At each financial reporting date, we evaluate our deferred tax assets to determine the likely realization of the benefit of the temporary differences. Our evaluation includes a review of the types of temporary differences that created the deferred tax asset; the amount of taxes paid on both capital gains and ordinary income in prior periods and available for a carry-back claim; the forecasted future taxable income, and therefore, the likely future deduction of the deferred tax item; and any other significant issues that might impact the realization of the deferred tax asset. If it is "more likely than not" that all or a portion of the deferred tax asset may not be realized, we establish a valuation allowance. Significant judgment is required in determining an appropriate valuation allowance.

Any future increase in the valuation allowance would result in additional income tax expense and a decrease in shareholders' equity, which could materially affect our financial position and results of operations in the period in which the increase occurs. A material decrease in shareholders' equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

An unauthorized disclosure of sensitive or confidential member or employee information, including by cyber attack or other security breach, could cause a loss of data, give rise to remediation or other expenses, expose us to liability under federal and state laws, and subject us to litigation and investigations, which could have an adverse effect on our business, cash flows, financial condition and results of operations.

As part of our normal operations, we collect, process and retain certain sensitive and confidential information. We are subject to various federal, state and international laws and rules regarding the use and disclosure of certain sensitive or confidential information, including HIPAA, the HITECH Act, the Gramm-Leach-Bliley Act, and numerous state laws governing personal information. Despite the security measures we have in place to help ensure data security and compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to cyber attacks, security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events.

In February 2015, we reported the discovery that certain of our information technology systems had been the target of an external cyber attack, as more fully described under Note 13, "Commitments and Contingencies - *Cyber Attack Incident*," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K. We are addressing the impact of this cyber attack and supporting federal law enforcement efforts to identify the responsible parties. The attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many individuals and employees. We have incurred expenses to investigate and remediate this matter and expect to continue to incur expenses of this nature in the foreseeable future. Actions have been filed in various federal and state courts

and other claims have been or may be asserted against us, allegedly arising out of the cyber attack. Further, we may be subject to additional litigation and governmental investigations which could divert the attention of management from the operation of our business, result in reputational damage and have a material adverse impact on our business, cash flows, financial condition and results of operations. While we have contingency plans and insurance coverage for potential liabilities of this nature, these may not be sufficient to cover all claims and liabilities.

In addition, we cannot ensure that we will be able to identify, prevent or contain the effects of additional cyber attacks or other cybersecurity risks in the future that bypass our security measures or disrupt our information technology systems or business. As a result, cybersecurity and the continued development and enhancement of our controls, processes and practices designed to protect our systems, computers, software, data and networks from attack, damage and unauthorized access, remain a priority for us. Noncompliance with any privacy or security laws and regulations, or any security breach, cyber attack or cybersecurity breach, and any incident involving the misappropriation, loss or other unauthorized disclosure or use of, or access to, sensitive or confidential member information, whether by us or by one of our vendors, could require us to expend significant resources to continue to modify or enhance our protective measures and to remediate any damage. In addition, this could result in interruptions to our operations and damage our reputation, and could also result in regulatory enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

The failure to effectively maintain and upgrade our information systems could adversely affect our business.

Our business depends significantly on effective information systems, and we have many different information systems for our various businesses. As a result of our merger and acquisition activities, we have acquired additional systems. Our information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and develop new systems in order to keep pace with continuing changes in information processing technology, emerging cybersecurity risks and threats, evolving industry and regulatory standards including public exchanges and other aspects of Health Care Reform, compliance with legal requirements, private insurance exchanges and changing customer preferences. In addition, we may from time to time obtain significant portions of our systems-related or other services or facilities from independent third parties, which may make our operations vulnerable if such third parties fail to perform adequately.

Failure to adequately implement and maintain effective and efficient information systems with sufficiently advanced technological capabilities, or our failure to efficiently and effectively consolidate our information systems to eliminate redundant or obsolete applications, could result in competitive and cost disadvantages to us compared to our competitors and could have a material adverse effect on our business, financial condition and results of operations. If the information we rely upon to run our business were found to be inaccurate or unreliable or if we fail to adequately maintain our information systems and data integrity effectively, we could have a decrease in membership, have problems in determining medical cost estimates and establishing appropriate pricing and reserves, have disputes with customers and providers, have regulatory problems, sanctions or penalties imposed, have increases in operating expenses or suffer other adverse consequences. In addition, federal regulations required us to begin using ICD-10 on October 1, 2015, which has required and will continue to require significant information technology investment. If we fail to adequately implement ICD-10 or encounter difficulties in providers' implementation of ICD-10, we may incur losses with respect to the resources invested and have other material adverse effects on our business and results of operations. Also, as we convert or migrate members to our more efficient and effective systems, the risk of disruption in our customer service is increased during the migration or conversion process and such disruption could have a material adverse effect on our business, cash flow, financial condition and results of operations.

We are dependent on the success of our relationships with third parties for various services and functions, including pharmacy benefit management services.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Certain of these third parties provide us with significant portions of our business infrastructure and operating requirements, and we could become overly dependent on key vendors, which could cause us to lose core competencies. A termination of our agreements with, or disruption in the performance of, one or more of these service providers could result in service disruptions or unavailability, reduced service quality and effectiveness, increased or duplicative costs, an inability to meet our obligations to our customers or require us to seek alternative service providers on less favorable contract terms, any of which could adversely affect our business, reputation, cash flows, financial condition and operating results.

In particular, we are a party to an agreement with Express Scripts whereby Express Scripts is the exclusive provider of certain PBM services to our plans, excluding our CareMore and Simply Healthcare subsidiaries and certain self-insured members, which have exclusive agreements with different PBM service providers. The Express Scripts PBM services include, but are not limited to, pharmacy network management, mail order and specialty drug fulfillment, claims processing, rebate management and specialty pharmaceutical management services. Accordingly, the agreement contains certain financial and operational requirements obligating both Express Scripts and us. The failure of either party to meet the respective requirements could potentially serve as a basis for early termination of the contract. If this relationship was terminated, we may not be able to meet the full demands of our customers, which could have a material adverse effect on our business, reputation and results of operations, particularly if Express Scripts failed to provide post-termination services. In addition, our failure to meet certain minimum script volume requirements results in financial penalties that could have a material adverse effect on our results of operations.

Indiana law, other applicable laws, our articles of incorporation and bylaws, and provisions of our BCBSA license agreements may prevent or discourage takeovers and business combinations that our shareholders might consider in their best interest.

Indiana law and our articles of incorporation and bylaws may delay, defer, prevent or render more difficult a takeover attempt that our shareholders might consider in their best interests. For instance, they may prevent our shareholders from receiving the benefit from any premium to the market price of our common stock offered by a bidder in a takeover context. Even in the absence of a takeover attempt, the existence of these provisions may adversely affect the prevailing market price of our common stock if they are viewed as discouraging takeover attempts in the future.

We are regulated as an insurance holding company and subject to the insurance holding company acts of the states in which our insurance company subsidiaries are domiciled, as well as similar provisions included in the health statutes and regulations of certain states where these subsidiaries are regulated as managed care companies or HMOs. The insurance holding company acts and regulations and these similar health provisions restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes and regulations, without such approval (or an exemption), no person may acquire any voting security of a domestic insurance company or HMO, or an insurance holding company which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would “control” the insurance holding company, insurance company or HMO. “Control” is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person. Further, the Indiana business corporation law contains business combination provisions that, in general, prohibit for five years any business combination with a beneficial owner of 10% or more of our common stock unless the holder’s acquisition of the stock was approved in advance by our Board of Directors.

Our articles of incorporation restrict the beneficial ownership of our capital stock in excess of specific ownership limits. The ownership limits restrict beneficial ownership of our voting capital stock to less than 10% for institutional investors and less than 5% for non-institutional investors, both as defined in our articles of incorporation. Additionally, no person may beneficially own shares of our common stock representing a 20% or more ownership interest in us. These restrictions are intended to ensure our compliance with the terms of our licenses with the BCBSA. Our articles of incorporation prohibit ownership of our capital stock beyond these ownership limits without prior approval of a majority of our continuing directors (as defined in our articles of incorporation). In addition, as discussed above in the risk factor describing our license agreements with the BCBSA, such license agreements are subject to termination upon a change of control and re-establishment fees would be imposed upon termination of the license agreements.

Certain other provisions included in our articles of incorporation and bylaws may also have anti-takeover effects and may delay, defer or prevent a takeover attempt that our shareholders might consider in their best interests. In particular, our articles of incorporation and bylaws: divide our Board of Directors into three classes serving staggered three-year terms (which is required by our license agreement with the BCBSA); permit our Board of Directors to determine the terms of and issue one or more series of preferred stock without further action by shareholders; restrict the maximum number of directors; limit the ability of shareholders to remove directors; impose restrictions on shareholders’ ability to fill vacancies on our Board of Directors; prohibit shareholders from calling special meetings of shareholders; impose advance notice requirements for shareholder proposals and nominations of directors to be considered at meetings of shareholders; and prohibit shareholders from amending our bylaws.

We also face other risks that could adversely affect our business, financial condition or results of operations, which include:

- any requirement to restate financial results in the event of inappropriate application of accounting principles;
- a significant failure of our internal control over financial reporting;
- failure of our prevention and control systems related to employee compliance with internal policies, including data security;
- provider fraud that is not prevented or detected and impacts our medical costs or those of self-insured customers;
- failure to protect our proprietary information; and
- failure of our corporate governance policies or procedures.

ITEM 1B. UNRESOLVED SEC STAFF COMMENTS.

None.

ITEM 2. PROPERTIES.

Our principal executive offices are located at 120 Monument Circle, Indianapolis, Indiana. In addition to this location, we have significant operating facilities located in each of the fourteen states where we operate as licensees of the BCBSA, in each of the additional ten states where Amerigroup conducts business and in Arizona where CareMore maintains a branch office. A majority of these locations are leased properties. Our facilities support our various business segments. We believe that our properties are adequate and suitable for our business as presently conducted as well as for the foreseeable future.

ITEM 3. LEGAL PROCEEDINGS.

For information regarding our legal proceedings, see the “*Litigation*,” “*Cyber Attack Incident*” and “*Other Contingencies*” sections of Note 13, “Commitments and Contingencies” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

ITEM 4. MINE SAFETY DISCLOSURES.

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES.

Market Prices

Our common stock, par value \$0.01 per share, is listed on the NYSE under the symbol "ANTM." On February 4, 2016, the closing price on the NYSE was \$126.64. As of February 4, 2016, there were 71,430 shareholders of record of our common stock. The following table presents high and low sales prices for our common stock on the NYSE for the periods indicated.

	High		Low	
2015				
First Quarter	\$	160.64	\$	122.86
Second Quarter		173.59		148.29
Third Quarter		165.93		134.62
Fourth Quarter		149.87		126.25
2014				
First Quarter	\$	102.56	\$	81.84
Second Quarter		110.03		90.75
Third Quarter		124.58		106.52
Fourth Quarter		129.96		108.92

Dividends

The quarterly cash dividend declared by our Board of Directors was \$0.6250, \$0.4375, and \$0.3750 per share in 2015, 2014 and 2013, respectively. On February 18, 2016, our Board of Directors declared a quarterly cash dividend to shareholders of \$0.6500 per share.

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors. Further, our ability to pay dividends to our shareholders, if authorized by our Board of Directors, is significantly dependent upon the receipt of dividends from our subsidiaries, including Anthem Insurance Companies, Inc., Anthem Southeast, Inc., Anthem Holding Corp., WellPoint Holding Corp., WellPoint Acquisition, LLC, WellPoint Insurance Services, Inc., ATH Holding Company, LLC and SellCore, Inc. The payment of dividends by our insurance subsidiaries without prior approval of the insurance department of each subsidiary's domiciliary jurisdiction is limited by formula. Dividends in excess of these amounts are subject to prior approval by the respective insurance departments.

Under the terms of the Merger Agreement with Cigna, during the period before completion of the merger, we will not declare, set aside, make or pay any dividend with respect to our capital stock, other than (1) regular quarterly cash dividends not exceeding, with respect to any quarter, \$0.6250 per share, (as such amount may be increased in the ordinary course of business), with declaration, record and payment dates consistent with past practice and in accordance with our dividend policy as of the date of the Merger Agreement and (2) dividends payable by a directly or indirectly wholly owned subsidiary to Anthem or to another directly or indirectly wholly owned subsidiary of Anthem. The cash dividend declared by our Board of Directors on February 18, 2016 was in accordance with the terms of the Merger Agreement.

Securities Authorized for Issuance under Equity Compensation Plans

The information required by this Item concerning securities authorized for issuance under our equity compensation plans is set forth in or incorporated by reference into Part III, Item 12 "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters" in this Annual Report on Form 10-K.

Issuer Purchases of Equity Securities

The following table presents information related to our repurchases of common stock for the periods indicated:

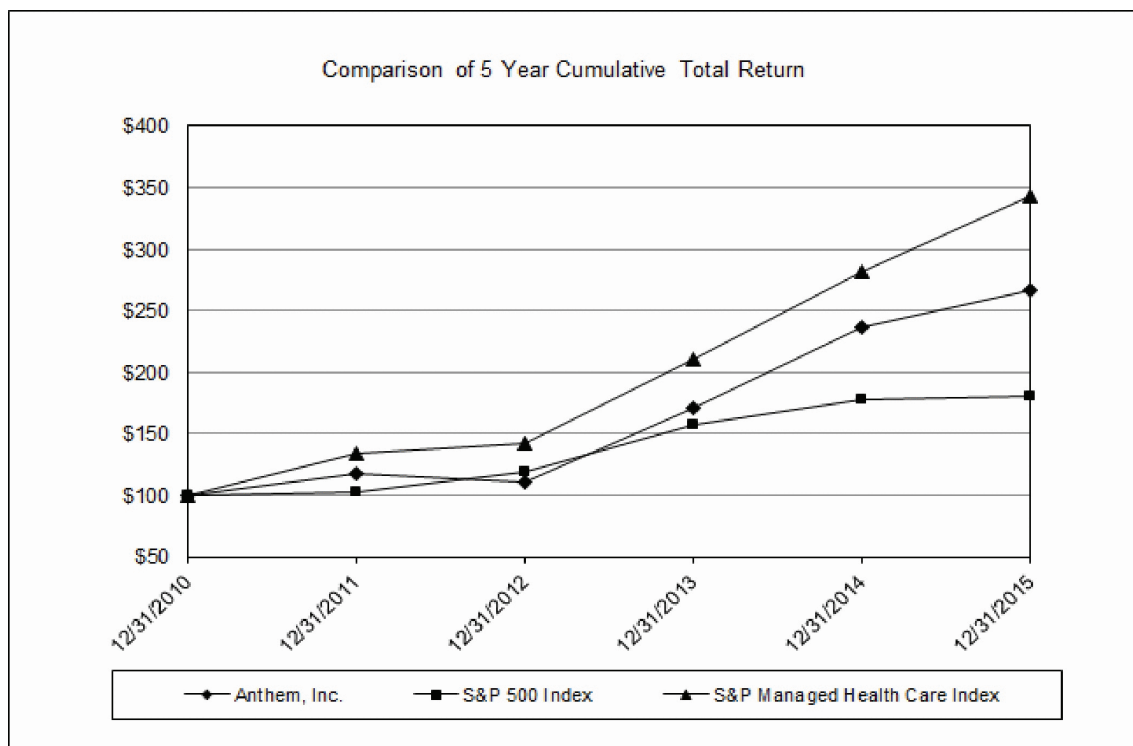
Period	Total Number of Shares Purchased ¹	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Programs ²	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Programs
<i>(In millions, except share and per share data)</i>				
October 1, 2015 to October 31, 2015	7,561	\$ 139.03	—	\$ 4,175.9
November 1, 2015 to November 30, 2015	893	138.66	—	4,175.9
December 1, 2015 to December 31, 2015	9,096	135.08	—	4,175.9
	<u>17,550</u>		<u>—</u>	

- ¹ Total number of shares purchased represents shares delivered to or withheld by us in connection with employee payroll tax withholding upon exercise or vesting of stock awards. Stock grants to employees and directors and stock issued for stock option plans and stock purchase plans in the consolidated statements of shareholders' equity are shown net of these shares purchased.
- ² Represents the number of shares repurchased through the common stock repurchase program authorized by our Board of Directors, which the Board evaluates periodically. During the year ended December 31, 2015, we repurchased 10,417,248 shares at a cost of \$1,515.8 under the program, including the cost of options to purchase shares. The Board of Directors has authorized our common stock repurchase program since 2003. The Board's most recent authorized increase to the program was \$5,000.0 on October 2, 2014. No duration has been placed on our common stock repurchase program and we reserve the right to discontinue the program at any time.

Performance Graph

The following Performance Graph and related information compares the cumulative total return to shareholders of our common stock for the period from December 31, 2010 through December 31, 2015, with the cumulative total return over such period of (i) the Standard & Poor's 500 Stock Index (the "S&P 500 Index") and (ii) the Standard & Poor's Managed Health Care Index (the "S&P Managed Health Care Index"). The graph assumes an investment of \$100 on December 31, 2010 in each of our common stock, the S&P 500 Index and the S&P Managed Health Care Index (and the reinvestment of all dividends).

The comparisons shown in the graph below are based on historical data and we caution that the stock price performance shown in the graph below is not indicative of, and is not intended to forecast, the potential future performance of our common stock. Information used in the graph was obtained from S&P Capital IQ, a source believed to be reliable, but we are not responsible for any errors or omissions in such information. The following graph and related information shall not be deemed "soliciting materials" or to be "filed" with the SEC, nor shall such information be incorporated by reference into any future filing under the Exchange Act, except to the extent that we specifically incorporate it by reference into such filing.



	December 31,					
	2010	2011	2012	2013	2014	2015
Anthem, Inc.	\$ 100	\$ 118	\$ 111	\$ 171	\$ 236	\$ 267
S&P 500 Index	100	102	118	157	178	181
S&P Managed Health Care Index	100	134	142	211	281	343

Based upon an initial investment of \$100 on December 31, 2010 with dividends reinvested.

The table below provides selected consolidated financial data of Anthem. The information has been derived from our consolidated financial statements for each of the years in the five year period ended December 31, 2015. You should read this selected consolidated financial data in conjunction with the audited consolidated financial statements and notes as of and for the year ended December 31, 2015 included in Part II, Item 8 “Financial Statements and Supplementary Data”, and Part II, Item 7 “Management’s Discussion and Analysis of Financial Condition and Results of Operations” included in this Annual Report on Form 10-K.

	As of and for the Years Ended December 31				
	2015 ¹	2014 ²	2013 ²	2012 ^{1, 2}	2011 ¹
<i>(in millions, except where indicated and except per share data)</i>					
Income Statement Data					
Total operating revenue ³	\$ 78,404.8	\$ 73,021.7	\$ 70,191.4	\$ 60,514.0	\$ 59,865.2
Total revenues	79,156.5	73,874.1	71,023.5	61,497.2	60,710.7
Income from continuing operations	2,560.0	2,560.1	2,634.3	2,651.0	2,646.7
Net income	2,560.0	2,569.7	2,489.7	2,655.5	2,646.7
Per Share Data					
Basic net income per share - continuing operations	\$ 9.73	\$ 9.28	\$ 8.83	\$ 8.25	\$ 7.35
Diluted net income per share - continuing operations	9.38	8.96	8.67	8.17	7.25
Dividends per share	2.50	1.75	1.50	1.15	1.00
Other Data (unaudited)					
Benefit expense ratio ⁴	83.3%	83.1%	85.1%	85.3%	85.1%
Selling, general and administrative expense ratio ⁵	16.0%	16.1%	14.2%	14.3%	14.1%
Income from continuing operations before income taxes as a percentage of total revenues	5.9%	5.9%	5.4%	6.3%	6.5%
Net income as a percentage of total revenues	3.2%	3.5%	3.5%	4.3%	4.4%
Medical membership <i>(in thousands)</i>	38,599	37,499	35,653	36,130	34,251
Balance Sheet Data					
Cash and investments	\$ 23,124.7	\$ 23,777.7	\$ 22,395.9	\$ 22,464.6	\$ 20,696.5
Total assets ^{6, 7}	61,717.8	61,676.3	59,095.3	58,610.7	51,693.6
Long-term debt, less current portion ⁶	15,324.5	14,019.6	13,477.4	14,069.3	8,420.9
Total liabilities ^{6, 7}	38,673.7	37,425.0	34,330.1	34,808.0	28,405.4
Total shareholders’ equity	23,044.1	24,251.3	24,765.2	23,802.7	23,288.2

- 1 The net assets of and results of operations for Simply Healthcare Holdings, Inc., AMERIGROUP Corporation and CareMore Health Group, Inc. are included from their respective acquisition dates of February 17, 2015, December 24, 2012 and August 22, 2011.
- 2 The operating results of 1-800 CONTACTS, Inc. are reported as discontinued operations at December 31, 2014, 2013 and 2012 as a result of the divestiture completed on January 31, 2014. Included in net income for the year ended December 31, 2014 is income from discontinued operations, net of tax, of \$9.6. Included in net income for the year ended December 31, 2013 is a loss from discontinued operations, net of tax, of \$144.6. Included in net income for the year ended December 31, 2012 is income from discontinued operations, net of tax, of \$4.5.
- 3 Operating revenue is obtained by adding premiums, administrative fees and other revenue.
- 4 The benefit expense ratio represents benefit expenses as a percentage of premium revenue.
- 5 The selling, general and administrative expense ratio represents selling, general and administrative expenses as a percentage of total operating revenue.
- 6 Amounts as of December 31, 2014, 2013, 2012 and 2011 have been retroactively restated to reflect the reclassification of unamortized debt issuance costs from an asset to a contra-liability as a result of the adoption of Accounting Standards Update No. 2015-03, *Interest—Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs*, during the year ended December 31, 2015.
- 7 Amounts as of December 31, 2014, 2013, 2012 and 2011 have been retroactively restated to reflect the reclassification of current deferred tax assets from an asset to a contra-liability as a result of the adoption of Accounting Standards Update No. 2015-07, *Balance Sheet Classification of Deferred Taxes*, during the year ended December 31, 2015.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS.

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

References in this Annual Report on Form 10-K to the terms "we," "our," "us," "Anthem" or the "Company" refer to Anthem, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries.

This Management's Discussion and Analysis, or MD&A, should be read in conjunction with our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Overview

We manage our operations through three reportable segments: Commercial and Specialty Business, Government Business and Other. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, merger and acquisition activity and changing laws and regulations. Therefore, these reportable segments may change in the future.

Our Commercial and Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial and Specialty Business segment offer fully-insured health products; provide a broad array of managed care services to self-funded customers including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services; and provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal health care guidance.

Our Government Business segment includes Medicare and Medicaid businesses, National Government Services, or NGS, and services provided to the federal government in connection with the Federal Employee Program, or FEP. Medicare business includes services such as Medicare Advantage, Medicare Part D, and Medicare Supplement. Medicaid business includes our managed care alternatives through publicly funded health care programs, including Medicaid; Temporary Assistance for Needy Family, or TANF, programs; programs for seniors and people with disabilities, or SPD; programs for long-term services and support, or LTSS; Children's Health Insurance Programs, or CHIP, and Medicaid expansion programs. NGS acts as a Medicare contractor for the federal government in several regions across the nation.

Our Other segment includes other businesses that do not meet the quantitative thresholds for an operating segment as defined by Financial Accounting Standards Board, or FASB, guidance, as well as corporate expenses not allocated to the other reportable segments.

Our operating revenue consists of premiums, administrative fees and other revenue. Premium revenue comes from fully-insured contracts where we indemnify our policyholders against costs for covered health and life benefits. Administrative fees come from contracts where our customers are self-insured, or where the fee is based on either processing of transactions or a percent of network discount savings realized. Additionally, we earn administrative fee revenues from our Medicare processing business and from other health-related businesses including disease management programs. Other revenue includes miscellaneous income other than premium revenue and administrative fees.

Our benefit expense primarily includes costs of care for health services consumed by our fully-insured members, such as outpatient care, inpatient hospital care, professional services (primarily physician care) and pharmacy benefit costs. All four components are affected both by unit costs and utilization rates. Unit costs include the cost of outpatient medical procedures per visit, inpatient hospital care per admission, physician fees per office visit and prescription drug prices. Utilization rates represent the volume of consumption of health services and typically vary with the age and health status of our members and their social and lifestyle choices, along with clinical protocols and medical practice patterns in each of our markets. A portion of benefit expense recognized in each reporting period consists of actuarial estimates of claims incurred but not yet paid by us. Any changes in these estimates are recorded in the period the need for such an adjustment arises. While we offer a diversified mix of managed care products and services through our managed care plans, our aggregate cost of care can fluctuate based on a change in the overall mix of these products and services. Our managed care plans include: preferred provider organizations, or PPOs; health maintenance organizations, or HMOs; point-of-service plans, or POS plans;

traditional indemnity plans and other hybrid plans, including consumer-driven health plans, or CDHPs; and hospital only and limited benefit products.

We classify certain claims-related costs as benefit expense to reflect costs incurred for our members' traditional medical care, as well as those expenses which improve our members' health and medical outcomes. These claims-related costs may be comprised of expenses incurred for: (i) medical management, including case and utilization management; (ii) health and wellness, including disease management services for such conditions as diabetes, high-risk pregnancies, congestive heart failure and asthma management and wellness initiatives like weight-loss programs and smoking cessation treatments; and (iii) clinical health policy. These types of claims-related costs are designed to ultimately lower our members' cost of care.

Our selling expense consists of external broker commission expenses, and generally varies with premium or membership volume. Our general and administrative expense consists of fixed and variable costs. Examples of fixed costs are depreciation, amortization and certain facilities expenses. Certain variable costs, such as premium taxes, vary directly with premium volume. Other variable costs, such as salaries and benefits, do not vary directly with changes in premium, but are more aligned with changes in membership. The acquisition or loss of a significant block of business would likely impact staffing levels, and thus associated compensation expense. Other variable costs include professional and consulting expenses and advertising. Other factors can impact our administrative cost structure, including systems efficiencies, inflation and changes in productivity.

Our results of operations depend in large part on our ability to accurately predict and effectively manage health care costs through effective contracting with providers of care to our members and our medical management and health and wellness programs. Several economic factors related to health care costs, such as regulatory mandates of coverage as well as direct-to-consumer advertising by providers and pharmaceutical companies, have a direct impact on the volume of care consumed by our members. The potential effect of escalating health care costs, any changes in our ability to negotiate competitive rates with our providers and any regulatory or market driven restrictions on our ability to obtain adequate premium rates to offset overall inflation in health care costs, including increases in unit costs and utilization resulting from the aging of the population and other demographics, as well as advances in medical technology, may impose further risks to our ability to profitably underwrite our business, and may have a material impact on our results of operations.

On July 24, 2015, we and Cigna Corporation, or Cigna, announced that we entered into an Agreement and Plan of Merger, or Merger Agreement, dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and our direct wholly-owned subsidiary, pursuant to which we will acquire all outstanding shares of Cigna, or the Acquisition. The Acquisition will further our goal of creating a premier health benefits company with critical diversification and scale to lead the transformation of health care delivery for consumers. Cigna is a global health services organization that delivers affordable and personalized products and services to customers through employer-based, government-sponsored and individual coverage arrangements. All of Cigna's products and services are provided exclusively by or through its operating subsidiaries, including Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Life Insurance Company of North America and Cigna Life Insurance Company of New York. Such products and services include an integrated suite of health services, such as medical, dental, behavioral health, pharmacy, vision, supplemental benefits, and other related products including group life, accident and disability insurance. Cigna maintains sales capability in 30 countries and jurisdictions.

Under the terms of the Merger Agreement, Cigna's shareholders will receive \$103.40 in cash and 0.5152 shares of our common stock for each Cigna common share outstanding. The value of the transaction is estimated to be approximately \$53,000.0 based on the closing price of our common stock on the New York Stock Exchange on July 23, 2015. The final purchase price will be determined based on our closing stock price on the date of closing of the Acquisition. The combined company will reflect a pro forma equity ownership comprised of approximately 67% Anthem shareholders and approximately 33% Cigna shareholders. We expect to finance the cash portion of the Acquisition through available cash on hand and the issuance of new debt. We entered into a bridge facility commitment letter and a joinder agreement with a group of lenders which will provide up to \$22,500.0 under a 364-day senior unsecured bridge term loan credit facility to finance the Acquisition in the event that we have not received proceeds from any combination of (i) senior unsecured term loans, (ii) common or preferred equity or equity-linked securities and/or (iii) senior unsecured notes in a public offering or private placement in an aggregate principal amount of at least \$22,500.0 prior to the consummation of the Acquisition. In addition, in August 2015, we entered into a term loan facility which will provide up to \$4,000.0 to finance a portion of the Acquisition. The commitment of the lenders to provide the bridge facility and the term loan facility is subject to several conditions,

including the completion of the Acquisition. We expect that our pro forma debt-to-capital ratio will approximate 49% at the closing of the Acquisition and we are committed to deleveraging to the low 40% range approximately twenty-four months following the closing. We also expect to maintain our common stock dividend and we will maintain flexibility with our share repurchase program.

For additional information, see "Risk Factors" included in Part I, Item 1A; and Note 3, "Business Acquisitions and Divestiture - *Pending Acquisition of Cigna Corporation*" included in Part II, Item 8 of this Annual Report on Form 10-K.

On February 17, 2015, we completed our acquisition of Simply Healthcare, a leading managed care company for people enrolled in Medicaid and Medicare programs in Florida. This acquisition aligns with our strategy for continued growth in our Government Business segment. As a result, we serve more than six hundred thousand members in Florida through our affiliated Amerigroup and Simply Healthcare Medicaid and Medicare plans. For additional information see Note 3, "Business Acquisitions and Divestiture - *Acquisition of Simply Healthcare*" included in Part II, Item 8 of this Annual Report on Form 10-K.

On January 31, 2014, we sold our 1-800 CONTACTS, Inc. business and our glasses.com related assets, or collectively, 1-800 CONTACTS. The operating results for 1-800 CONTACTS for the one month ended January 31, 2014 are reported as discontinued operations. These results were previously reported in the Commercial and Specialty Business segment. Unless otherwise specified, all financial and membership information, other than cash flows, disclosed in this MD&A is from continuing operations. In accordance with Financial Accounting Standards Board, or FASB, guidance, we have elected to not separately disclose net cash provided by or used in operating, investing, and financing activities and the net effect of those cash flows on cash and cash equivalents for discontinued operations during the periods presented. For additional information regarding these transactions, see Note 3, "Business Acquisitions and Divestiture - *Divestiture of 1-800 CONTACTS*," included in Part II, Item 8 of this Annual Report on Form 10-K.

Our future results of operations will also be impacted by certain external forces and resulting changes in our business model and strategy. In 2010, the Patient Protection and Affordable Care Act, or ACA, as well as the Health Care and Education Reconciliation Act of 2010, or collectively, Health Care Reform, became law, causing significant changes to the U.S. health care system. Since then, significant regulations have been enacted by the U.S. Department of Health and Human Services, or HHS, the Department of Labor and the Department of the Treasury. The legislation and regulations are far-reaching and are intended to expand access to health insurance coverage over time by mandating that most individuals obtain health insurance coverage, increasing the eligibility thresholds for most state Medicaid programs and providing certain other individuals and small businesses with tax credits to subsidize a portion of the cost of health insurance coverage. As a result of the complexity of the law, its impact on health care in the United States and the continuing modification and interpretation of Health Care Reform rules, we continue to analyze and refine our estimates of the ultimate impact of Health Care Reform on our business, cash flows, financial condition and results of operations. Health Care Reform presents us with new growth opportunities, but also introduces new risks, regulatory challenges and uncertainties, and required changes in the way products are designed, underwritten, priced, distributed and administered. For additional discussion, see Part I, Item 1 "Business - Regulation," and Part I, Item 1A "Risk Factors" in this Annual Report on Form 10-K.

Pricing in our Commercial and Specialty Business segment, including our Individual and Small Group lines of business, remains competitive and we strive to price our health care benefit products consistent with anticipated underlying medical trends. We believe our pricing strategy, based on predictive modeling, proprietary research and data-driven processes, as well as our overall investments for Health Care Reform, have positioned us to benefit from the potential growth opportunities available in fully-insured commercial products as a result of Health Care Reform. In the Individual and Small Group markets, we offer on-exchange products through state or federally facilitated marketplaces, referred to as public exchanges, and off-exchange products. Federal premium subsidies are available only for certain members who purchase certain public exchange products. The public exchanges have increased the risk that our products will be selected by individuals who have a higher risk profile or utilization rate than the pool of participants we anticipated when we established the pricing for these public exchange products. We believe that our pricing strategy, brand name and network quality will provide a strong foundation for commercial risk membership growth opportunities in the future.

In our Individual markets we offer bronze, silver and gold products, both on and off the public exchanges, in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. Additionally, we offer platinum products, both on and off the public exchanges, in California and New York.

In our Small Group markets, we offer bronze, silver and gold products, off the public exchanges, in California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, Ohio, Virginia and Wisconsin. We offer bronze, silver and gold products, on the public exchanges, in Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, New Hampshire, Ohio and Virginia. Additionally, we offer platinum products, off the public exchanges, in California, Connecticut, Georgia, Kentucky, Maine, Nevada and Virginia.

Private exchanges have gained visibility in the marketplace based on the promise of helping employers reduce costs, increase consumer engagement and manage the complexities created by the ACA and other market forces. While private exchanges have been a distribution channel in the Medicare and Individual markets for some time, the heightened level of activity and investment among the consulting and broker communities and other health insurance carriers has generated an increasing level of interest among employers in the Commercial market. To date, adoption levels have been lower than analyst predictions. While the ultimate volume, pace of growth and winning business models remain highly uncertain, we believe private exchanges will provide opportunities for growth.

Health Care Reform also imposes new regulations on the health insurance sector, including, but not limited to, guaranteed coverage and expanded benefit requirements; prohibitions on some annual and all lifetime limits on amounts paid on behalf of or to our members; increased restrictions on rescinding coverage; establishment of minimum medical loss ratio, or MLR, and customer rebate requirements; establishment of a mandatory annual Health Insurance Provider Fee, or HIP Fee; creation of a federal rate review process; a requirement to cover preventive services on a first dollar basis; the establishment of public exchanges and essential benefit packages and greater limitations on how we price certain of our products. In addition, the legislation reduces the reimbursement levels for our health plans participating in the Medicare Advantage program over time and limits the amount of executive compensation that is deductible for income tax purposes.

As a result of Health Care Reform, HHS issued MLR regulations that require us to meet minimum MLR thresholds for Large Group, Small Group and Individual lines of business. Plans that do not meet the minimum thresholds will have to pay a MLR rebate. For purposes of determining MLR rebates, HHS has defined the types of costs that should be included in the MLR rebate calculation. However, certain components of the MLR calculation as defined by HHS cannot be classified consistently under U.S. generally accepted accounting principles, or GAAP. While considered benefit expense or a reduction of premium revenue by HHS, certain of these costs are classified as other types of expense, such as income tax expense or general and administrative expense, in our GAAP basis financial statements. Accordingly, the benefit expense ratio determined using our consolidated GAAP operating results is not comparable to the MLR calculated under HHS regulations.

Health Care Reform also imposed a separate minimum MLR threshold of 85% for Medicare Advantage and Medicare Part D plans beginning in 2014. Medicare Advantage or Medicare Part D plans that do not meet this threshold will have to pay a MLR rebate. If a plan's MLR is below 85% for three consecutive years beginning with 2014, enrollment will be restricted. A Medicare Advantage or Medicare Part D plan contract will be terminated if the plan's MLR is below 85% for five consecutive years.

Beginning in 2014, Health Care Reform imposed an annual HIP Fee on health insurers that write certain types of health insurance on U.S. risks. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to an adjusted amount of health insurance for all U.S. health risk for those certain lines of business written during the preceding calendar year. The HIP Fee is non-deductible for federal income tax purposes. The total amount collected from allocations to health insurers in 2015 and 2014 was \$11,300.0 and \$8,000.0, respectively. We record our estimated liability for the HIP Fee in full at the beginning of the year with a corresponding deferred asset that is amortized on a straight-line basis to general and administrative expense. The final calculation and payment of the annual HIP Fee occurs in the third quarter each year and our portion of the HIP Fee for 2015 and 2014 was \$1,207.5 and \$893.3, respectively. The annual HIP Fee to be allocated to all health insurers remains at \$11,300.0 for 2016, has been suspended for 2017, and will resume and be increased to \$14,300.0 for 2018. For 2019 and beyond, the annual HIP Fee will equal the amount for the preceding year increased by the rate of premium growth for the preceding year less the rate of growth in the consumer price index for the preceding calendar year.

These and other provisions of Health Care Reform are likely to have significant effects on our future operations, which, in turn, could impact the value of our business model and results of operations, including potential impairments of our goodwill and other intangible assets. We will continue to evaluate the impact of Health Care Reform as key aspects go into

effect and additional guidance is made available. For additional discussion regarding Health Care Reform, see Part I, Item 1 “Business—Regulation” and Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K.

Finally, federal and state regulatory agencies may further restrict our ability to obtain new product approvals, implement changes in premium rates or impose additional restrictions, under new or existing laws that could adversely affect our business, cash flows, financial condition and results of operations.

We are also subject to regulations that may result in assessments under state insurance guaranty association laws. The National Organization of Life & Health Insurance Guaranty Associations, or NOLHGA, is a voluntary organization consisting of the state life and health insurance guaranty associations located throughout the U.S. Such associations, working together with NOLHGA, provide a safety net for their state’s policyholders, ensuring that they continue to receive coverage, subject to state maximum limits, even if their insurer is declared insolvent. We are aware that the Pennsylvania Insurance Commissioner, or Insurance Commissioner, has placed Penn Treaty Network America Insurance Company and its subsidiary American Network Insurance Company, or collectively Penn Treaty, in rehabilitation, an intermediate action before insolvency. The state court denied the Insurance Commissioner’s petition for the liquidation of Penn Treaty and ordered the Insurance Commissioner to file an updated plan of rehabilitation. The state court commenced a hearing in connection with the updated plan in July 2015, which has been adjourned. The state court has begun scheduling settlement conferences to resolve outstanding issues with the plan. In the event rehabilitation of Penn Treaty is unsuccessful and Penn Treaty is declared insolvent and placed in liquidation, we and other insurers may be required to pay a portion of their policyholder claims through state guaranty association assessments in future periods. Given the uncertainty around whether Penn Treaty will ultimately be declared insolvent and, if so, the amount of the insolvency, the amount and timing of any associated future guaranty fund assessments, and the availability and amount of any potential premium tax and other offsets, we currently cannot estimate our net exposure, if any, to this potential insolvency. We will continue to monitor the situation and may record a liability and expense in future reporting periods, which could be material to our cash flows and results of operations.

In addition to the external forces discussed in the preceding paragraphs, our results of operations are impacted by levels and mix of membership. In recent years, we have experienced membership growth due to the quality and pricing of our health benefits products and services, improved economic conditions, decreases in unemployment, acquisitions, entry into new markets and expansions in existing markets. In addition, we believe the self-insured portion of our group membership base will continue to increase as a percentage of total group membership. However, these membership trends could be negatively impacted by various factors that could have a material adverse effect on our future results of operations such as general economic downturns that result in business failures, failure to obtain new customers or retain existing customers, premium increases, benefit changes or our exit from a specific market. Further, our mix of membership may include more individuals with a higher acuity level obtaining coverage through our products available on the public exchanges, which may not be appropriately adjusted for in our premium rates.

In February 2015, we reported that we were the target of a sophisticated external cyber attack. The attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many individuals and employees. We have continued to implement security enhancements since this incident and are supporting federal law enforcement efforts to identify the responsible parties. For additional information about the cyber attack, see Note 13, “Commitments and Contingencies - *Cyber Attack Incident*,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Also see Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K, for a discussion of the factors identified above and other risk factors that could cause actual results to differ materially from those contained in forward-looking statements made in this Annual Report on Form 10-K and presented elsewhere by management from time to time.

Executive Summary

We are one of the largest health benefits companies in terms of medical membership in the United States, serving 38.6 medical members through our affiliated health plans as of December 31, 2015. We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as BCBS in 10 New York City metropolitan and surrounding counties, and as Blue Cross or BCBS in selected upstate

counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield, or Empire Blue Cross (in our New York service areas). We also conduct business through an arrangement with another BCBS licensee in South Carolina. We conduct business through our AMERIGROUP Corporation, or Amerigroup, subsidiary, in Florida, Georgia, Kansas, Louisiana, Maryland, Nevada, New Jersey, New Mexico, New York, Tennessee, Texas, Washington and effective January 1, 2016, in Iowa. In addition, we conduct business through our recently acquired Simply Healthcare Holdings, Inc., or Simply Healthcare, subsidiary in Florida. We also serve customers throughout the country as HealthLink, UniCare (including a non-risk arrangement with Massachusetts), and in certain Arizona, California, Nevada and Virginia markets through our CareMore Health Group, Inc., or CareMore, subsidiary. We are licensed to conduct insurance operations in all 50 states through our subsidiaries.

In preparation for the recent and ongoing changes to the U.S. health care system and to focus on our core growth opportunities across our Commercial and Specialty Business and Government Business segments, we entered into a definitive agreement in December 2013 to sell our 1-800 CONTACTS, Inc., or 1-800 CONTACTS, business to the private equity firm Thomas H. Lee Partners, L.P. Concurrently, we entered into an asset purchase agreement with Luxottica Group to sell our glasses.com related assets. The divestitures were completed on January 31, 2014. The operating results for 1-800 CONTACTS are reported as discontinued operations within the consolidated statements of income included in Part II, Item 8 of this Annual Report on Form 10-K. These results were previously reported in the Commercial and Specialty Business segment. Unless otherwise specified, all financial information disclosed in this MD&A is from continuing operations, other than net income, diluted earnings per share and cash flows. In accordance with FASB guidance, we have elected to not separately disclose net cash provided by or used in operating, investing, and financing activities and the net effect of those cash flows on cash and cash equivalents for discontinued operations during the periods presented. For additional information regarding these transactions, see Note 3, "Business Acquisitions and Divestiture," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Operating revenue for the year ended December 31, 2015 was \$78,404.8, an increase of \$5,383.1, or 7.4%, from the year ended December 31, 2014. The increase in operating revenue was primarily a result of higher premium revenue in our Government Business segment, and, to a lesser extent, increased administrative fees in both our Commercial and Specialty Business and Government Business segments. These increases were partially offset by lower premium revenue in our Commercial and Specialty Business segment.

Net income for the year ended December 31, 2015 was \$2,560.0, a decrease of \$9.7, or 0.4%, from the year ended December 31, 2014. The decrease in net income was primarily due to lower operating results in our Commercial and Specialty Business segment, higher income taxes, a decrease in net earnings from investment activities and increased interest expense. The decrease in net income was partially offset by an increase in the operating results of our Government Business segment and lower realized losses on the extinguishment of debt.

Our fully-diluted earnings per share, or EPS, for the year ended December 31, 2015 was \$9.38, an increase of \$0.39, or 4.3%, from the year ended December 31, 2014. Our diluted shares for the year ended December 31, 2015 were 272.9, a decrease of 13.0, or 4.5% compared to the year ended December 31, 2014. The increase in EPS resulted from the lower number of shares outstanding in 2015 due to share buyback activity under our share repurchase program, partially offset by the decrease in net income.

Operating cash flow for the year ended December 31, 2015 was \$4,116.0, or 1.6 times net income. Operating cash flow for the year ended December 31, 2014 was \$3,369.3, or 1.3 times net income. The increase in operating cash flow from 2014 of \$746.7 was primarily attributable to an increase in premium receipts as a result of rate increases across our businesses designed to cover overall cost trends and the HIP Fee, and growth in membership. The increase in cash provided by operating activities was further attributable to the receipt of the reinsurance recoveries payment related to the 2014 Health Care Reform reinsurance premium stabilization program and payments made in 2014 that did not recur in 2015 for the adjudication of claims relating to the New York State contract conversion from our fully-insured Local Group business to a self-funded ASO contract. The increase in cash provided by operating activities was partially offset by an increase in claims payments, primarily as a result of membership growth, an increase in income tax payments and an increase in the annual HIP Fee payment.

Our results of operations discussed throughout this MD&A are determined in accordance with GAAP. We also calculate operating gain, which is a non-GAAP measure, to further aid investors in understanding and analyzing our core operating results and comparing them among periods. Operating gain is calculated as total operating revenue less benefit expense, and selling, general and administrative expense. We use this measure as a basis for evaluating segment performance, allocating resources, setting incentive compensation targets and forecasting future operating periods. This information is not intended to be considered in isolation or as a substitute for income before income tax expense, net income or EPS prepared in accordance with GAAP, and may not be comparable to similarly titled measures reported by other companies. For additional details on operating gain, see our "Reportable Segments Results of Operations" discussion included in this MD&A. For a reconciliation of reportable segment operating gain to income from continuing operations before income tax expense, see Note 19, "Segment Information," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We intend to expand through a combination of organic growth, strategic acquisitions, including the pending acquisition of Cigna, and efficient use of capital in both existing and new markets. Our growth strategy is designed to enable us to take advantage of additional economies of scale as well as providing us access to new and evolving technologies and products. In addition, we believe geographic and product diversity reduces our exposure to local or regional regulatory, economic and competitive pressures and provides us with increased opportunities for growth. While we have achieved strong growth as a result of strategic mergers and acquisitions, we have also achieved organic growth in our existing markets over time by delivering excellent service, offering competitively priced products, providing access to high quality provider networks and effectively capitalizing on the brand strength of the Blue Cross and Blue Shield names and marks.

Significant Transactions

While Health Care Reform has caused significant changes to the U.S. health care system in recent years, the more significant transactions that have occurred over the last three years that have impacted or will impact our capital structure or that have or will influence how we conduct our business operations include:

- Pending acquisition of Cigna expected to close in the second half of 2016;
- Acquisition of Simply Healthcare (2015);
- Board of Directors declaration of dividends on common stock (February 2016 and prior) and an increase in the quarterly dividend to \$0.6500 per share (February 2016); authorization for repurchases of our common stock (2015 and prior); and debt repurchases and new debt issuance (2015 and prior); and
- Divestiture of 1-800 CONTACTS (2014).

For additional information regarding these transactions, see Note 3, "Business Acquisitions and Divestiture," Note 12, "Debt" and Note 14, "Capital Stock," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Membership

Our medical membership includes seven different customer types: Local Group, Individual, National Accounts, BlueCard®, Medicare, Medicaid and FEP. BCBS-branded business generally refers to members in our service areas licensed by the BCBSA. Non-BCBS-branded business refers to Amerigroup, CareMore and Simply Healthcare members as well as HealthLink and UniCare members predominantly outside of our BCBSA service areas.

- Local Group consists of those employer customers with less than 5% of eligible employees located outside of the headquarter state, as well as customers with more than 5% of eligible employees located outside of the headquarter state with up to 5,000 eligible employees. In addition, Local Group includes UniCare members and Employer Group Medicare Advantage members, or retired members of Local Group accounts who have selected a Medicare Advantage product. Local Group accounts are generally sold through brokers or consultants working with industry specialists from our in-house sales force and are offered both on and off the public exchanges. Local Group insurance premiums may be based on claims incurred by the group or sold on a self-insured basis. The customer's buying decision is typically based upon the size and breadth of our networks, customer service, the quality of our medical management services, the administrative cost included in our quoted price, our financial stability, reputation

and our ability to effectively service large complex accounts. Local Group accounted for 39.5%, 40.4% and 41.3% of our medical members at December 31, 2015, 2014 and 2013, respectively.

- Individual consists of individual customers under age 65 and their covered dependents. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the Internet. Individual business is sold on a fully-insured basis. We offer on-exchange products through public exchanges and off-exchange products. Federal premium subsidies are available only for certain public exchange Individual products. Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network, and the efficiency of administration. Customer turnover is generally higher with Individual as compared to Local Group. Individual business accounted for 4.3%, 4.8% and 4.9% of our medical members at December 31, 2015, 2014 and 2013, respectively.
- National Accounts generally consist of multi-state employer groups primarily headquartered in an Anthem service area with at least 5% of the eligible employees located outside of the headquarter state and with more than 5,000 eligible employees. Some exceptions are allowed based on broker and consultant relationships. Service area is defined as the geographic area in which we are licensed to sell BCBS products. National Accounts are generally sold through independent brokers or consultants retained by the customer working with our in-house sales force. We believe we have an advantage when competing for very large National Accounts due to the size and breadth of our networks and our ability to access the national provider networks of BCBS companies at their competitive local market rates. In addition, Employer Group Medicare Advantage members related to National Accounts groups are reported as part of National Accounts membership. The Employer Group Medicare Advantage members represent less than 1.0% of National Accounts membership. National Accounts represented 19.1%, 19.1% and 19.0% of our medical members at December 31, 2015, 2014 and 2013, respectively.
- BlueCard® host customers represent enrollees of Blue Cross and/or Blue Shield plans not owned by Anthem who receive health care services in our BCBSA licensed markets. BlueCard® membership consists of estimated host members using the national BlueCard® program. Host members are generally members who reside in or travel to a state in which an Anthem subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer-sponsored health plan issued by a non-Anthem controlled BCBSA licensee (i.e., the “home plan”). We perform certain administrative functions for BlueCard® members, for which we receive administrative fees from the BlueCard® members’ home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan. Host members are computed using, among other things, the average number of BlueCard® claims received per month. BlueCard® host membership accounted for 14.0%, 14.1% and 14.2% of our medical members at December 31, 2015, 2014 and 2013, respectively.
- Medicare customers are Medicare-eligible individual members age 65 and over who have enrolled in Medicare Advantage, a managed care alternative for the Medicare program, who have purchased Medicare Supplement benefit coverage, some disabled members under age 65, or members of all ages with End Stage Renal Disease. We also include in the Medicare category members enrolled in our dual eligible Medicare-Medicaid Plans, or MMPs, in the states where we participate. Medicare Supplement policies are sold to Medicare recipients as supplements to the benefits they receive from the Medicare program. Rates are filed with and in some cases approved by state insurance departments. Most of the premium for Medicare Advantage is paid directly by the federal government on behalf of the participant who may also be charged a small premium. Medicare Supplement and Medicare Advantage products are marketed in the same manner, primarily through independent agents and brokers. Medicare business accounted for 3.7%, 3.7% and 4.0% of our medical members at December 31, 2015, 2014 and 2013, respectively.
- Medicaid membership represents eligible members who receive health care benefits through publicly funded health care programs, including Medicaid, TANF, SPD, LTSS, CHIP and Medicaid expansion programs. Total Medicaid program business accounted for 15.3%, 13.8% and 12.3% of our medical members at December 31, 2015, 2014 and 2013, respectively.
- FEP members consist of United States government employees and their dependents within our geographic markets through our participation in the national contract between the BCBSA and the U.S. Office of Personnel Management. FEP business accounted for 4.1%, 4.1% and 4.3% of our medical members at December 31, 2015, 2014 and 2013, respectively.

In addition to reporting our medical membership by customer type, we report by funding arrangement according to the level of risk that we assume in the product contract. Our two principal funding arrangement categories are fully-insured and self-funded. Fully-insured products are products in which we indemnify our policyholders against costs for health benefits. Self-funded products are offered to customers, generally larger employers, who elect to retain most or all of the financial risk associated with their employees' health care costs. Some self-funded customers choose to purchase stop loss coverage to limit their retained risk.

The following table presents our medical membership by customer type, funding arrangement and reportable segment as of December 31, 2015, 2014 and 2013. Also included below is other membership by product. The medical membership and other membership presented are unaudited and in certain instances include estimates of the number of members represented by each contract at the end of the period.

(In thousands)	December 31			2015 vs. 2014		2014 vs. 2013	
	2015	2014	2013	Change	% Change	Change	% Change
Medical Membership							
Customer Type							
Local Group	15,241	15,137	14,725	104	0.7 %	412	2.8 %
Individual	1,675	1,793	1,755	(118)	(6.6)%	38	2.2 %
National:							
National Accounts	7,355	7,155	6,777	200	2.8 %	378	5.6 %
BlueCard®	5,407	5,279	5,050	128	2.4 %	229	4.5 %
Total National	12,762	12,434	11,827	328	2.6 %	607	5.1 %
Medicare	1,439	1,404	1,441	35	2.5 %	(37)	(2.6)%
Medicaid	5,914	5,193	4,378	721	13.9 %	815	18.6 %
FEP	1,568	1,538	1,527	30	2.0 %	11	0.7 %
Total Medical Membership by Customer Type	38,599	37,499	35,653	1,100	2.9 %	1,846	5.2 %
Funding Arrangement							
Self-Funded	23,666	22,800	20,294	866	3.8 %	2,506	12.3 %
Fully-Insured	14,933	14,699	15,359	234	1.6 %	(660)	(4.3)%
Total Medical Membership by Funding Arrangement	38,599	37,499	35,653	1,100	2.9 %	1,846	5.2 %
Reportable Segment							
Commercial and Specialty Business	29,678	29,364	28,307	314	1.1 %	1,057	3.7 %
Government Business	8,921	8,135	7,346	786	9.7 %	789	10.7 %
Total Medical Membership by Reportable Segment	38,599	37,499	35,653	1,100	2.9 %	1,846	5.2 %
Other Membership							
Life and Disability Members	4,849	4,762	4,819	87	1.8 %	(57)	(1.2)%
Dental Members	5,206	4,995	4,895	211	4.2 %	100	2.0 %
Dental Administration Members	5,282	4,918	4,886	364	7.4 %	32	0.7 %
Vision Members	5,641	5,096	4,743	545	10.7 %	353	7.4 %
Medicare Advantage Part D Members	622	690	628	(68)	(9.9)%	62	9.9 %
Medicare Part D Standalone Members	371	467	474	(96)	(20.6)%	(7)	(1.5)%

December 31, 2015 Compared to December 31, 2014

Medical Membership (in thousands)

During the year ended December 31, 2015, total medical membership increased 1,100, or 2.9%, primarily due to increases in our Medicaid, National Accounts, BlueCard® and Local Group membership, partially offset by decreases in our Individual membership.

Self-funded medical membership increased 866, or 3.8%, primarily due to increases in our Local Group self-funded accounts as a result of new sales and conversions of fully-insured contracts to self-funded administrative services only, or ASO, contracts, and growth in our National Accounts and BlueCard® membership.

Fully-insured membership increased 234, or 1.6%, primarily due to growth in our Medicaid and Medicare businesses including membership acquired with the acquisition of Simply Healthcare, and increased sales in our Individual business ACA-compliant on- and off-exchange product offerings. These increases were partially offset by Local Group fully-insured membership declines, largely driven by conversions of fully-insured contracts to self-funded ASO contracts and our decision to exit the Georgia employer group Medicare product offering. The increase was further offset by attrition in our Individual business non-ACA-compliant product offerings.

Local Group membership increased 104, or 0.7%, primarily due to increases in our self-funded accounts. The increase in membership was partially offset by attrition in our Small Group line of business resulting from product mix changes as members moved into Health Care Reform product offerings and competitive pressures. The increase was further offset by fully-insured membership declines resulting from our decision to exit the Georgia employer group Medicare product offering.

Individual membership decreased 118, or 6.6%, primarily due to attrition in non-ACA-compliant product offerings, partially offset by increased sales in ACA-compliant on- and off-exchange product offerings.

National Accounts membership increased 200, or 2.8%, primarily due to new sales and in-group change.

BlueCard® membership increased 128, or 2.4%, primarily due to favorable membership activity at other BCBSA plans whose members reside in or travel to our licensed areas.

Medicare membership increased 35, or 2.5%, primarily due to membership acquired through the acquisition of Simply Healthcare and growth in our MMPs primarily due to commencement of operations in new dual eligible markets.

Medicaid membership increased 721, or 13.9%, primarily due to commencement of operations in new markets including membership acquired through the acquisition of Simply Healthcare, and growth through Health Care Reform expansions.

FEP membership increased 30, or 2.0%, primarily due to higher sales during open enrollment.

Other Membership (in thousands)

Our Other products are often ancillary to our health business and can therefore be impacted by corresponding changes in our medical membership.

Life and disability membership increased 87, or 1.8%, primarily due to growth and higher sales in our Local Group business.

Dental membership increased 211, or 4.2%, primarily due to new sales and growth in our Local Group and Individual businesses, partially offset by attrition in our off-exchange Local Group and Individual business product offerings.

Dental administration membership increased 364, or 7.4%, primarily due to the acquisition of a large managed dental contract pursuant to which we provide dental administrative services.

Vision membership increased 545, or 10.7%, primarily due to increased sales and penetration in our Medicare business, and growth in our Local Group, National Accounts and Individual businesses. These increases were partially offset by attrition in our off-exchange Local Group and Individual business product offerings.

Medicare Advantage Part D membership decreased 68, or 9.9%, primarily due to membership declines resulting from our decision to exit the Georgia employer group Medicare product offering, partially offset by commencement of operations in new dual eligible markets and membership acquired through the acquisition of Simply Healthcare.

Medicare Part D standalone membership decreased 96, or 20.6%, primarily due to our product repositioning strategies and select strategic actions in certain markets.

December 31, 2014 Compared to December 31, 2013

Medical Membership (in thousands)

During the year ended December 31, 2014, total medical membership increased 1,846, or 5.2%, primarily due to increases in our Medicaid, Local Group, National Accounts and BlueCard® membership.

Self-funded medical membership increased 2,506, or 12.3%, primarily due to increases in our Local Group self-funded accounts including the New York State contract conversion from a fully-insured contract to a self-funded ASO contract and the acquisition of a large state ASO contract, which both occurred in the first quarter of 2014. The increase was further attributable to growth in our National Accounts and BlueCard® membership.

Fully-insured membership decreased 660, or 4.3%, primarily due to the New York State contract conversion and Local Group membership losses as a result of affordability challenges affecting healthcare consumers. The decrease was partially offset by growth in our Medicaid business.

Local Group membership increased 412, or 2.8%, primarily due to the acquisition of a large ASO state contract. This increase was partially offset by fully-insured membership declines resulting from affordability challenges affecting healthcare consumers.

Individual membership increased 38, or 2.2%, primarily due to public exchange sales in the majority of our markets, partially offset by off-exchange lapses.

National Accounts membership increased 378, or 5.6%, primarily due to new sales and in-group change partially offset by lapses.

BlueCard® membership increased 229, or 4.5%, primarily due to favorable membership activity at other BCBSA plans whose members reside in or travel to our licensed areas.

Medicare membership decreased 37, or 2.6%, primarily due to our product repositioning strategy toward HMO product offerings and select service area reductions.

Medicaid membership increased 815, or 18.6%, primarily due to market expansions and commencement of operations in new markets.

FEP membership increased 11, or 0.7%, primarily due to favorable open enrollment.

Other Membership (in thousands)

Our Other products are often ancillary to our health business and can therefore be impacted by corresponding changes in our medical membership.

Life and disability membership decreased 57, or 1.2%, primarily due to higher lapses and in-group change in our Local Group and Individual businesses.

Dental membership increased 100, or 2.0%, primarily due to new sales and growth in our Local Group and National Accounts businesses.

Dental administration membership increased 32, or 0.7%, primarily due to membership expansion under current contracts.

Vision membership increased 353, or 7.4%, primarily due to strong sales and in-group change in our Local Group and National Accounts businesses.

Medicare Advantage Part D membership increased 62, or 9.9%, primarily due to the addition of a new state contract, partially offset by decreases in various markets due to our product repositioning strategy toward HMO product offerings and select service area reductions.

Medicare Part D standalone membership decreased 7, or 1.5%, primarily due to competitive pressure in certain markets.

Cost of Care

The following discussion summarizes our aggregate underlying cost of care trends for the year ended December 31, 2015 for our Local Group fully-insured business only.

Our cost of care trends are calculated by comparing the year-over-year change in average per member per month claim costs. While our cost of care trend varies by geographic location, based on underlying medical cost trends, we estimate that our aggregate cost of care trend was in the lower half of the 6.5% to 7.5% range for the full year of 2015. We anticipate that medical cost trends will be in the range of 7.0% to 7.5% in 2016.

Medical utilization, including pharmacy utilization, has been lower than in previous years. Consistent with prior years, provider rate increases were a primary driver of medical cost trends. We continually negotiate with hospitals and physicians to manage these cost trends. We commonly negotiate multi-year contracts with hospitals and physicians, minimizing annual fluctuations in medical cost trend. We remain committed to optimizing our reimbursement rates and strategies to help address the cost pressures faced by employers and consumers. Unit cost increases were also a driver of pharmacy cost. High cost Hepatitis C drug therapies also have put upward pressure on pharmacy trend.

In response to cost trends, we continue to pursue contracting and plan design changes, promote and implement performance-based contracts that reward clinical outcomes and quality, and expand our disease management and advanced care management programs. We are taking a leadership role in the area of payment reform as evidenced by our Enhanced Personal Health Care program. By establishing the primary care doctor as central to the coordination of a patient's health care needs, the initiative builds on the success of current patient-centered medical home programs in helping to improve patient care while lowering costs.

A number of clinical management initiatives are in place to help mitigate inpatient trend. Focused review efforts continue in key areas, including targeting outlier facilities for length of stay and readmission, and high risk maternity and neonatal intensive care unit cases, among others. Additionally, we continue to refine our programs related to readmission management, focused behavioral health readmission reduction and post-discharge follow-up care.

Outpatient costs are a collection of different types of expenses, such as outpatient facilities, labs, x-rays, emergency room, occupational and physical therapy and many others. One example of the programs we have developed to mitigate outpatient costs is our Cancer Care Quality Program. This program, developed in collaboration with our subsidiary, AIM Specialty Health, identifies certain cancer treatment pathways selected based upon current medical evidence, peer-reviewed published literature, consensus guidelines and our clinical policies to support oncologists in identifying cancer treatment therapies that are highly effective and provide greater value.

Our consolidated summarized results of operations for the years ended December 31, 2015, 2014 and 2013 are discussed in the following section.

	Years Ended December 31			Change			
				2015 vs. 2014		2014 vs. 2013	
	2015	2014	2013	\$	%	\$	%
Total operating revenue	\$ 78,404.8	\$ 73,021.7	\$ 70,191.4	\$ 5,383.1	7.4 %	\$ 2,830.3	4.0 %
Net investment income	677.6	724.4	659.1	(46.8)	(6.5)%	65.3	9.9 %
Net realized gains on investments	157.5	177.0	271.9	(19.5)	(11.0)%	(94.9)	(34.9)%
Other-than-temporary impairment losses on investments	(83.4)	(49.0)	(98.9)	(34.4)	(70.2)%	49.9	50.5 %
Total revenues	79,156.5	73,874.1	71,023.5	5,282.4	7.2 %	2,850.6	4.0 %
Benefit expense	61,116.9	56,854.9	56,237.1	4,262.0	7.5 %	617.8	1.1 %
Selling, general and administrative expense	12,534.8	11,748.4	9,952.9	786.4	6.7 %	1,795.5	18.0 %
Other expense ¹	873.8	902.7	993.3	(28.9)	(3.2)%	(90.6)	(9.1)%
Total expenses	74,525.5	69,506.0	67,183.3	5,019.5	7.2 %	2,322.7	3.5 %
Income from continuing operations before income tax expense	4,631.0	4,368.1	3,840.2	262.9	6.0 %	527.9	13.7 %
Income tax expense	2,071.0	1,808.0	1,205.9	263.0	14.5 %	602.1	49.9 %
Income from continuing operations	2,560.0	2,560.1	2,634.3	(0.1)	— %	(74.2)	(2.8)%
Income (loss) from discontinued operations, net of tax²	—	9.6	(144.6)	(9.6)	NM³	154.2	NM³
Net income	\$ 2,560.0	\$ 2,569.7	\$ 2,489.7	\$ (9.7)	(0.4)%	\$ 80.0	3.2 %
Average diluted shares outstanding	272.9	285.9	303.8	(13.0)	(4.5)%	(17.9)	(5.9)%
Diluted net income (loss) per share:							
Diluted - continuing operations	\$ 9.38	\$ 8.96	\$ 8.67	\$ 0.42	4.7 %	\$ 0.29	3.3 %
Diluted - discontinued operations ²	—	0.03	(0.47)	(0.03)	NM ³	0.50	NM ³
Diluted net income per share	\$ 9.38	\$ 8.99	\$ 8.20	\$ 0.39	4.3 %	\$ 0.79	9.6 %
Benefit expense ratio ⁴	83.3%	83.1%	85.1%		20bp ⁵		(200)bp ⁵
Selling, general and administrative expense ratio ⁶	16.0%	16.1%	14.2%		(10)bp ⁵		(190)bp ⁵
Income from continuing operations before income taxes as a percentage of total revenue	5.9%	5.9%	5.4%		0bp ⁵		50bp ⁵
Net income as a percentage of total revenue	3.2%	3.5%	3.5%		(30)bp ⁵		0bp ⁵

Certain of the following definitions are also applicable to all other results of operations tables in this discussion:

- 1 Includes interest expense, amortization of other intangible assets and gain/loss on extinguishment of debt.
- 2 The operating results of 1-800 CONTACTS are reported as discontinued operations as a result of the divestiture completed on January 31, 2014.
- 3 Calculation not meaningful.
- 4 Benefit expense ratio represents benefit expense as a percentage of premium revenue. Premiums for the years ended December 31, 2015, 2014 and 2013 were \$73,385.1, \$68,389.8 and \$66,119.1, respectively. Premiums are included in total operating revenue presented above.
- 5 bp = basis point; one hundred basis points = 1%.
- 6 Selling, general and administrative expense ratio represents selling, general and administrative expense as a percentage of total operating revenue.

Year Ended December 31, 2015 Compared to the Year Ended December 31, 2014

Total operating revenue increased \$5,383.1, or 7.4%, to \$78,404.8 in 2015, resulting primarily from higher premiums, and, to a lesser extent, increased administrative fees. Higher premiums were mainly due to membership increases across our Government Business segment, including membership obtained through the acquisition of Simply Healthcare, and rate increases across our businesses designed to cover overall cost trends and the increase in the HIP Fee. The increase in premiums was further attributable to membership increases in our ACA-compliant on- and off-exchange Individual business product offerings and refinement of estimates associated with Medicare risk score revenue in the prior year. The increase in premiums was offset, in part, by the fully-insured membership declines in our Local Group business, attrition in non-ACA-compliant Individual business product offerings and revised estimates made to accruals for the Health Care Reform risk adjustment premium stabilization program, including revised estimates of prior year accruals. The increase in administrative fees primarily resulted from rate increases and membership growth for self-funded members in our Local Group and National Accounts businesses.

Net investment income decreased \$46.8, or 6.5%, to \$677.6 in 2015, primarily due to lower income from alternative investments, partially offset by higher investment yields on fixed maturity securities.

Net realized gains on investments decreased \$19.5, or 11.0%, to \$157.5 in 2015, primarily due to an increase in net realized losses on sales of fixed maturity securities, partially offset by an increase in net realized gains on sales of equity securities and settlements of derivative financial instruments.

Other-than-temporary impairment losses on investments increased \$34.4, or 70.2%, to \$83.4 in 2015, primarily due to an increase in impairment losses on equity and fixed maturity securities.

Benefit expense increased \$4,262.0, or 7.5%, to \$61,116.9 in 2015, primarily due to an increase in overall cost trends across our businesses, membership growth across our Government Business segment, including membership obtained through the acquisition of Simply Healthcare, and membership growth in our ACA-compliant on- and off-exchange Individual business product offerings. These increases were partially offset by the fully-insured membership declines in our Local Group business and non-ACA-compliant Individual business product offerings, as described above.

Our benefit expense ratio increased 20 basis points to 83.3% in 2015, largely driven by changes in the mix of the product portfolio, higher than expected medical costs in our Individual business, and adjustments made to current and prior year accruals related to the Health Care Reform risk adjustment premium stabilization program. These increases were partially offset by improvement in our Local Group business and certain Medicare lines of business predominantly due to improved medical cost performance. The increase in the ratio was further offset by refinement of estimates associated with Medicare risk score revenue in the prior year.

Selling, general and administrative expense increased \$786.4, or 6.7%, to \$12,534.8 in 2015. Our selling, general and administrative expense ratio decreased 10 basis points to 16.0% in 2015. The increase in the expense was primarily due to increased associate costs to support our growth in membership. The increase in expense was further due to net increases in Health Care Reform fees, primarily due to an increase in the HIP Fee of \$314.2, and increased premium taxes as a result of the growth in premiums. These increases were partially offset by a decrease in assessments related to the Health Care Reform reinsurance premium stabilization program of \$163.4. The decrease in the ratio was primarily due to the impact of Medicaid membership growth in our Government Business segment, which has a lower selling, general and administrative expense ratio than our consolidated average.

Other expense decreased \$28.9, or 3.2%, to \$873.8 in 2015, primarily due to changes in gains and losses on the extinguishment of debt. For the year ended December 31, 2015, we recognized net gains on extinguishment of debt of \$9.3 compared to net losses on extinguishment of debt of \$81.1 for the year ended December 31, 2014. The decrease in other expense was partially offset by higher interest expense in 2015 driven by higher outstanding debt balances and the amortization of fees incurred for the obtainment of the bridge facility commitment letter and joinder agreement to partially fund the pending acquisition of Cigna. The decrease in other expense was further offset by an increase in amortization of intangible assets. For additional information related to our borrowings, see "Liquidity and Capital Resources," below.

Income tax expense increased \$263.0, or 14.5%, to \$2,071.0 in 2015. The effective tax rates in 2015 and 2014 were 44.7% and 41.4%, respectively. The increase in income tax expense was primarily due to the increase of the non-tax

deductible HIP Fee, increased income before income taxes and increased state tax expense as a result of an adverse California franchise tax ruling. The increase in the effective tax rate for 2015 was primarily due to the increase in the non-tax deductible HIP fee and the state tax impact of the adverse California franchise tax ruling.

Our net income as a percentage of total revenue decreased 30 basis points to 3.2% in 2015 as compared to 2014 as a result of all factors discussed above.

Year Ended December 31, 2014 Compared to the Year Ended December 31, 2013

Total operating revenue increased \$2,830.3, or 4.0% to \$73,021.7 in 2014, resulting primarily from higher premiums and, to a lesser extent, increased administrative fees. Higher premiums were mainly due to rate increases across our businesses designed to cover overall cost trends and new fees associated with Health Care Reform, including HIP Fees reimbursed by Medicaid state plans. The increase in premiums was further attributable to membership increases in our Medicaid and Individual businesses. The increase in premiums was offset, in part, by fully-insured membership declines in our Local Group business as a result of the New York State contract conversion and affordability challenges affecting healthcare consumers. The increase was further offset by higher experience rated refunds in our Medicaid business, and lower premiums in our Medicare Advantage business primarily due to membership declines and a refinement of estimates associated with Medicare risk score revenue for prior years. The increase in administrative fees primarily resulted from membership growth in our Local Group business, including the New York State contract conversion and the acquisition of a large state ASO contract, which both occurred in the first quarter of 2014. The increase in administrative fees was further attributable to growth in our National Accounts business.

Net investment income increased \$65.3, or 9.9%, to \$724.4 in 2014, primarily due to higher income from alternative investments and higher investment yields.

Net realized gains on investments decreased \$94.9, or 34.9%, to \$177.0 in 2014, primarily due to a decrease in net realized gains on sales of equity securities, partially offset by an increase in net realized gains on sales of fixed maturity securities.

Other-than-temporary impairment losses on investments decreased \$49.9, or 50.5%, to \$49.0 in 2014, primarily due to a decrease in impairment losses on certain joint venture investments and fixed maturity securities.

Benefit expense increased \$617.8, or 1.1%, to \$56,854.9 in 2014, primarily due to benefit cost trends across our businesses and membership growth in our Medicaid and Individual businesses. The increase in benefit expense was further a result of higher pharmacy costs primarily attributable to new high cost Hepatitis C drug therapies. These increases were partially offset by the fully-insured membership declines in our Local Group and Medicare Advantage businesses, as described above. In addition, the increase in benefit expense was offset, in part, by our estimate of reinsurance recoveries relating to the Health Care Reform reinsurance premium stabilization program of \$753.4 for 2014.

Our benefit expense ratio decreased 200 basis points to 83.1% in 2014, primarily due to rate increases across our businesses designed to cover overall cost trends and new fees associated with Health Care Reform, including additional premiums collected to help cover the non-tax deductible impact of the HIP Fee. The decrease was further attributable to better than expected medical cost trends in our Medicaid business. These improvements were partially offset by higher pharmacy costs primarily attributable to new high cost Hepatitis C drug therapies.

Selling, general and administrative expense increased \$1,795.5, or 18.0%, to \$11,748.4 in 2014. Our selling, general and administrative expense ratio increased 190 basis points to 16.1% in 2014. The increases in the expense and ratio were both primarily due to new fees related to Health Care Reform that were effective January 1, 2014, including \$893.3 for the HIP Fee and \$447.7 of assessments related to the Health Care Reform reinsurance premium stabilization program.

Other expense decreased \$90.6, or 9.1%, to \$902.7 in 2014, primarily due to lower losses recognized on debt extinguishment associated with the early redemption and repurchase of outstanding senior unsecured notes. During the years ended December 31, 2014 and 2013, we recognized losses on extinguishment of debt of \$81.1 and \$145.3, respectively. The decrease in other expense was further attributable to reduced amortization of certain other intangible assets acquired in prior years. For additional information related to our borrowings, see "Liquidity and Capital Resources," below.

Income tax expense increased \$602.1, or 49.9%, to \$1,808.0 in 2014. The effective tax rates in 2014 and 2013 were 41.4% and 31.4%, respectively. The increase in income tax expense was primarily due to the non-tax deductible HIP Fee effective for 2014 and increased income before income taxes. The 2013 expense and effective tax rate were lower because they include benefits resulting from a favorable tax election made subsequent to the Amerigroup acquisition and from inclusion of Amerigroup in our state apportionment factors calculation, which produces a lower state tax expense. The increase in the effective tax rate for 2014 was primarily due to the non-tax deductible HIP fee.

Our net income as a percentage of total revenue was 3.5% in 2014 and 2013 as a result of all factors discussed above.

Reportable Segments Results of Operations

We use operating gain to evaluate the performance of our reportable segments, which are Commercial and Specialty Business; Government Business; and Other. Operating gain, which is a non-GAAP measure, is calculated as total operating revenue less benefit expense and selling, general and administrative expense. It does not include net investment income, net realized gains/losses on investments, other-than-temporary impairment losses recognized in income, interest expense, amortization of other intangible assets, loss on extinguishment of debt or income taxes, as these items are managed in a corporate shared service environment and are not the responsibility of operating segment management.

The discussion of segment results for the years ended December 31, 2015, 2014 and 2013 presented below are based on operating gain, as described above, and operating margin, which is calculated as operating gain divided by operating revenue. Our definitions of operating gain and operating margin may not be comparable to similarly titled measures reported by other companies. For additional information, including a reconciliation of non-GAAP financial measures, see Note 19, "Segment Information," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Our Commercial and Specialty Business, Government Business, and Other segments' summarized results of operations for the years ended December 31, 2015, 2014 and 2013 are as follows:

	Years Ended December 31			Change			
				2015 vs. 2014		2014 vs. 2013	
	2015	2014	2013	\$	%	\$	%
Commercial and Specialty Business							
Operating revenue	\$ 37,570.8	\$ 39,199.6	\$ 39,404.2	\$ (1,628.8)	(4.2)%	\$ (204.6)	(0.5)%
Operating gain	\$ 2,854.0	\$ 3,260.9	\$ 3,176.4	\$ (406.9)	(12.5)%	\$ 84.5	2.7 %
Operating margin	7.6%	8.3%	8.1%		(70)bp		20bp
Government Business							
Operating revenue	\$ 40,813.0	\$ 33,796.4	\$ 30,752.6	\$ 7,016.6	20.8 %	\$ 3,043.8	9.9 %
Operating gain	\$ 1,978.5	\$ 1,191.9	\$ 844.0	\$ 786.6	66.0 %	\$ 347.9	41.2 %
Operating margin	4.8%	3.5%	2.7%		130bp		80bp
Other							
Operating revenue ¹	\$ 21.0	\$ 25.7	\$ 34.6	\$ (4.7)	(18.3)%	\$ (8.9)	(25.7)%
Operating loss ²	\$ (79.4)	\$ (34.4)	\$ (19.0)	\$ (45.0)	130.8 %	\$ (15.4)	81.1 %

¹ Fluctuations not material.

² Fluctuations are primarily a result of changes in unallocated corporate expenses. The increase in 2015 was primarily due to transaction costs associated with our pending acquisition of Cigna.

Year Ended December 31, 2015 Compared to the Year Ended December 31, 2014

Commercial and Specialty Business

Operating revenue decreased \$1,628.8, or 4.2%, to \$37,570.8 in 2015, due in part to fully-insured membership declines in our Large Group business largely driven by the discontinuation of our Georgia employer group Medicare product offering. The decrease in operating revenue was further attributable to attrition in our Small Group line of business resulting from both product mix changes as members moved into Health Care Reform product offerings and competitive pressures. Additionally, operating revenue decreased as a result of attrition in non-ACA-compliant Individual business product offerings and revised estimates made to accruals for the Health Care Reform risk adjustment premium stabilization program, including revised estimates of prior year accruals. These decreases were partially offset by premium rate increases in our Individual and Local Group lines of business designed to cover overall cost trends and the increase in the HIP Fee. The decrease in operating revenue was further offset by membership growth in our ACA-compliant on- and off-exchange Individual business product offerings and increased administrative fees. The increase in administrative fees was primarily attributable to membership growth and rate increases for self-funded members in our Large Group and National Accounts businesses.

Operating gain decreased \$406.9, or 12.5%, to \$2,854.0 in 2015, primarily due to higher than expected medical costs in our Individual business, membership declines in our fully-insured Local Group and Individual lines of business and revised estimates made to current and prior year accruals related to the Health Care Reform risk adjustment premium stabilization program. These decreases were partially offset by an increase in operating gain in our Local Group business primarily due to improved medical cost performance. The increase in operating gain was further offset by increases in self-funded membership in our Local Group and National Accounts businesses.

The operating margin in 2015 was 7.6%, a 70 basis point decrease from 2014, primarily due to the factors discussed in the preceding two paragraphs.

Government Business

Operating revenue increased \$7,016.6, or 20.8%, to \$40,813.0 in 2015. The increase in operating revenue was primarily due to increased premiums in our Medicaid business as a result of membership growth through commencement of operations in new markets including membership obtained through the acquisition of Simply Healthcare, membership growth through Health Care Reform expansions and membership growth in existing markets. The increase in Medicaid premiums was further due to rate increases designed to cover overall cost trends and the increase in the HIP Fee. The increase in operating revenue was further attributable to premium increases in our Medicare business as a result of rate increases designed to cover overall cost trends, the acquisition of Simply Healthcare and refinement of estimates associated with Medicare risk score revenue in the prior year. Finally, increased premiums in our FEP business primarily due to increased benefit utilization contributed to the increase in operating revenue.

Operating gain increased \$786.6, or 66.0%, to \$1,978.5 in 2015, primarily due to membership growth and improved medical cost performance in certain markets in our Medicaid and Medicare business, and refinement of estimates associated with Medicare risk score revenue in the prior year that did not recur in the current year. The increase in operating gain was further attributable to higher reimbursements for the non-tax deductible portion of the HIP Fee. These increases were partially offset by higher administrative costs to support our growth in membership.

The operating margin in 2015 was 4.8%, a 130 basis point increase over 2014, primarily due to the factors discussed in the preceding two paragraphs.

Year Ended December 31, 2014 Compared to the Year Ended December 31, 2013

Commercial and Specialty Business

Operating revenue decreased \$204.6, or 0.5%, to \$39,199.6 in 2014, primarily due to fully-insured membership declines in our Local Group business resulting from the impact of the New York State contract conversion and affordability challenges affecting healthcare consumers. These decreases were partially offset by premium rate increases in our Local Group and Individual businesses designed to cover overall cost trends and new fees associated with Health Care Reform, and membership growth in our Individual business. The decrease in operating revenue was further offset by increased

administrative fees primarily resulting from membership growth in our Local Group business, including the acquisition of a large state ASO contract in the first quarter of 2014. The increase in administrative fees was further attributable to growth in our National Accounts business.

Operating gain increased \$84.5, or 2.7%, to \$3,260.9 in 2014, primarily as a result of improved performance in our Individual business reflecting our public exchange strategy implemented during the year, along with membership growth in self-funded products. The increase in operating gain was further attributable to additional premiums collected to help cover the non-tax deductible impact of the HIP Fee. These increases were partially offset by insured membership declines in our Local Group business, continued costs incurred associated with Health Care Reform market changes and higher pharmacy costs primarily attributable to new high cost Hepatitis C drug therapies.

The operating margin in 2014 was 8.3%, a 20 basis point increase over 2013, primarily due to the factors discussed in the preceding two paragraphs.

Government Business

Operating revenue increased \$3,043.8, or 9.9%, to \$33,796.4 in 2014, primarily due to increased premiums in our Medicaid and FEP businesses as a result of premium rate increases designed to cover overall cost trends and new fees associated with Health Care Reform. The increase in operating revenue was further attributable to membership growth in our Medicaid business and additional premiums collected to help cover the non-tax deductible impact of the HIP Fee. These increases were partially offset by higher experience rated refunds in our Medicaid business, lower premiums in our Medicare businesses, primarily due to membership declines in our Medicare Advantage business, and a refinement of estimates associated with Medicare risk score revenue for prior years.

Operating gain increased \$347.9, or 41.2%, to \$1,191.9 in 2014, primarily due to better than expected medical cost trends and membership growth in our Medicaid business. These increases were partially offset by higher pharmacy costs primarily attributable to new high cost Hepatitis C drug therapies, and a refinement of estimates associated with Medicare risk score revenue for prior years.

The operating margin in 2014 was 3.5%, an 80 basis point increase over 2013, primarily due to the factors discussed in the preceding two paragraphs.

Critical Accounting Policies and Estimates

We prepare our consolidated financial statements in conformity with GAAP. Application of GAAP requires management to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes and within this MD&A. We consider our most important accounting policies that require significant estimates and management judgment to be those policies with respect to liabilities for medical claims payable, income taxes, goodwill and other intangible assets, investments and retirement benefits, which are discussed below. Our other significant accounting policies are summarized in Note 2, "Basis of Presentation and Significant Accounting Policies," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We continually evaluate the accounting policies and estimates used to prepare the consolidated financial statements. In general, our estimates are based on historical experience, evaluation of current trends, information from third party professionals and various other assumptions that we believe to be reasonable under the known facts and circumstances.

Medical Claims Payable

The most subjective accounting estimate in our consolidated financial statements is our liability for medical claims payable. At December 31, 2015, this liability was \$7,569.8 and represented 19.6% of our total consolidated liabilities. We record this liability and the corresponding benefit expense for incurred but not paid claims, including the estimated costs of processing such claims. Incurred but not paid claims include (1) an estimate for claims that are incurred but not reported, as well as claims reported to us but not yet processed through our systems, which approximated 96.7%, or \$7,317.0, of our total medical claims liability as of December 31, 2015; and (2) claims reported to us and processed through our systems but not yet paid, which approximated 3.3%, or \$252.8, of the total medical claims payable as of December 31, 2015. The level of

claims payable processed through our systems but not yet paid may fluctuate from one period end to the next, from approximately 1% to 5% of our total medical claims liability, due to timing of when claim payments are made.

Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be appropriate under moderately adverse circumstances. We determine the amount of the liability for incurred but not paid claims by following a detailed actuarial process that entails using both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this process, historical paid claims data is formatted into "claim triangles," which compare claim incurred dates to the dates of claim payments. This information is analyzed to create "completion factors" that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims.

For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather they are projected by estimating the claims expense for those months based on recent claims expense levels and health care trend levels, or "trend factors."

Because the reserve methodology is based upon historical information, it must be adjusted for known or suspected operational and environmental changes. These adjustments are made by our actuaries based on their knowledge and their estimate of emerging impacts to benefit costs and payment speed. Circumstances to be considered in developing our best estimate of reserves include changes in utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations. A comparison of prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In our comparison of prior year, the methods and assumptions are not changed as reserves are recalculated; rather the availability of additional paid claims information drives our changes in the re-estimate of the unpaid claim liability. To the extent appropriate, changes in such development are recorded as a change to current period benefit expense.

We regularly review and set assumptions regarding cost trends and utilization when initially establishing claim liabilities. We continually monitor and adjust the claims liability and benefit expense based on subsequent paid claims activity. If it is determined that our assumptions regarding cost trends and utilization are significantly different than actual results, our income statement and financial position could be impacted in future periods. Adjustments of prior year estimates may result in additional benefit expense or a reduction of benefit expense in the period an adjustment is made. Further, due to the considerable variability of health care costs, adjustments to claim liabilities occur each period and are sometimes significant as compared to the net income recorded in that period. Prior period development is recognized immediately upon the actuary's judgment that a portion of the prior period liability is no longer needed or that an additional liability should have been accrued. That determination is made when sufficient information is available to ascertain that the re-estimate of the liability is reasonable.

While there are many factors that are used as a part of the estimation of our medical claims payable liability, the two key assumptions having the most significant impact on our incurred but not paid claims liability as of December 31, 2015 were the completion and trend factors. As discussed above, these two key assumptions can be influenced by other operational variables including system changes, provider submission patterns and business combinations.

There is variation in the reasonable choice of completion factors by duration for durations of three months through twelve months where the completion factors have the most significant impact. As previously discussed, completion factors tend to be less reliable for the most recent months and therefore are not specifically utilized for months one and two. In our analysis for the claim liabilities at December 31, 2015, the variability in months three to five was estimated to be between 40 and 90 basis points, while months six through twelve have much lower variability ranging from 0 to 30 basis points.

The difference in completion factor assumptions, assuming moderately adverse experience, results in variability of 2%, or approximately \$168.0, in the December 31, 2015 incurred but not paid claims liability, depending on the completion

factors chosen. It is important to note that the completion factor methodology inherently assumes that historical completion rates will be reflective of the current period. However, it is possible that the actual completion rates for the current period will develop differently from historical patterns and therefore could fall outside the possible variations described herein.

The other major assumption used in the establishment of the December 31, 2015 incurred but not paid claim liability was the trend factors. In our analysis for the period ended December 31, 2015, there was a 330 basis point differential in the high and low trend factors assuming moderately adverse experience. This range of trend factors would imply variability of 4%, or approximately \$337.0, in the incurred but not paid claims liability, depending upon the trend factors used. Because historical trend factors are often not representative of current claim trends, the trend experience for the most recent six to nine months, plus knowledge of recent events likely affecting current trends, have been taken into consideration in establishing the incurred but not paid claims liability at December 31, 2015.

See Note 11, "Medical Claims Payable," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K, for a reconciliation of the beginning and ending balance for medical claims payable for the years ended December 31, 2015, 2014 and 2013. Components of the total incurred claims for each year include amounts accrued for current year estimated claims expense as well as adjustments to prior year estimated accruals. In Note 11, "Medical Claims Payable," the line labeled "Net incurred medical claims: Prior years redundancies" accounts for those adjustments made to prior year estimates. The impact of any reduction of "Net incurred medical claims: Prior years redundancies" may be offset as we establish the estimate of "Net incurred medical claims: Current year." Our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for our claims. When we recognize a release of the redundancy, we disclose the amount that is not in the ordinary course of business, if material.

The ratio of current year medical claims paid as a percent of current year net medical claims incurred was 89.1% for 2015, 89.4% for 2014 and 89.3% for 2013. The decrease in this ratio for 2015 reflects slower claims processing that occurred over the most recent year.

We calculate the percentage of prior years' redundancies in the current year as a percent of prior years' net incurred claims payable less prior years' redundancies in the current year in order to demonstrate the development of the prior years' reserves. This metric was 15.1% for the year ended December 31, 2015, 9.7% for the year ended December 31, 2014 and 10.8% for the year ended December 31, 2013. The year ended December 31, 2015 metric reflects a slightly higher level of conservatism compared to the targeted prior year reserve for adverse deviation and a resultant higher level of prior years' redundancies than the years ended December 31, 2014 and 2013.

We calculate the percentage of prior years' redundancies in the current period as a percent of prior years' net incurred medical claims to indicate the percentage of redundancy included in the preceding year calculation of current year net incurred medical claims. We believe this calculation supports the reasonableness of our prior year estimate of incurred medical claims and the consistency in our methodology. For the year ended December 31, 2015, this metric was 1.4%, which was calculated using the redundancy of \$800.2. This metric was 1.0% for 2014 and 1.3% for 2013.

The following table shows the variance between total net incurred medical claims as reported in Note 11, "Medical Claims Payable," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K, for each of 2014 and 2013 and the incurred claims for such years had it been determined retrospectively (computed as the difference between "net incurred medical claims – current year" for the year shown and "net incurred medical claims – prior years redundancies" for the immediately following year):

	Years Ended December 31	
	2014	2013
Total net incurred medical claims, as reported	\$ 55,763.9	\$ 55,295.2
Retrospective basis, as described above	55,505.6	55,352.4
Variance	\$ 258.3	\$ (57.2)
Variance to total net incurred medical claims, as reported	0.5%	(0.1)%

Given that our business is primarily short tailed (which means that medical claims are generally paid within twelve months of the member receiving service from the provider), the variance to total net incurred medical claims, as reported

above, is used to assess the reasonableness of our estimate of ultimate incurred medical claims for a given calendar year with the benefit of one year of experience. We expect that substantially all of the development of the 2015 estimate of medical claims payable will be known during 2016.

The 2014 variance to total net incurred medical claims, as reported of 0.5% was greater in absolute value than the 2013 percentage of (0.1)%. The higher 2014 variance was driven by a higher level of prior year redundancies in 2015 associated with 2014 claim payments. Prior year redundancies in 2013 associated with 2012 claim payments were lower by comparison, thus creating a lower 2013 variance.

Income Taxes

We account for income taxes in accordance with FASB guidance, which requires, among other things, the separate recognition of deferred tax assets and deferred tax liabilities. Such deferred tax assets and deferred tax liabilities represent the tax effect of temporary differences between financial reporting and tax reporting measured at tax rates enacted at the time the deferred tax asset or liability is recorded. A valuation allowance must be established for deferred tax assets if it is "more likely than not" that all or a portion may be unrealized. Our judgment is required in determining an appropriate valuation allowance.

At each financial reporting date, we assess the adequacy of the valuation allowance by evaluating each of our deferred tax assets based on the following:

- the types of temporary differences that created the deferred tax asset;
- the amount of taxes paid in prior periods and available for a carry-back claim;
- the forecasted future taxable income, and therefore, likely future deduction of the deferred tax item; and
- any significant other issues impacting the likely realization of the benefit of the temporary differences.

We, like other companies, frequently face challenges from tax authorities regarding the amount of taxes due. These challenges include questions regarding the timing and amount of deductions that we have taken on our tax returns. In evaluating any additional tax liability associated with various positions taken in our tax return filings, we record additional liabilities for potential adverse tax outcomes. Based on our evaluation of our tax positions, we believe we have appropriately accrued for uncertain tax benefits, as required by the guidance. To the extent we prevail in matters we have accrued for, our future effective tax rate would be reduced and net income would increase. If we are required to pay more than accrued, our future effective tax rate would increase and net income would decrease. Our effective tax rate and net income in any given future period could be materially impacted.

In the ordinary course of business, we are regularly audited by federal and other tax authorities, and from time to time, these audits result in proposed assessments. We believe our tax positions comply with applicable tax law and we intend to defend our positions vigorously through the federal, state and local appeals processes. We believe we have adequately provided for any reasonable foreseeable outcome related to these matters. Accordingly, although their ultimate resolution may require additional tax payments, we do not anticipate any material impact on our results of operations from these matters.

For additional information, see Note 7, "Income Taxes," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Goodwill and Other Intangible Assets

Our consolidated goodwill at December 31, 2015 was \$17,562.2 and other intangible assets were \$8,158.0. The sum of goodwill and other intangible assets represented 41.7% of our total consolidated assets and 111.6% of our consolidated shareholders' equity at December 31, 2015.

We follow FASB guidance for business combinations and goodwill and other intangible assets, which specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Under the guidance, goodwill and other intangible assets (with indefinite lives) are not amortized but are tested for impairment at least annually. Furthermore, goodwill and other intangible assets are allocated to reporting units for purposes of the annual impairment test. Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units,

which include goodwill and other intangible assets. In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately.

We complete our annual impairment tests of existing goodwill and other intangible assets with indefinite lives during the fourth quarter of each year. These tests involve the use of estimates related to the fair value of goodwill at the reporting unit level and other intangible assets with indefinite lives, and require a significant degree of management judgment and the use of subjective assumptions. Certain interim impairment tests are also performed when potential impairment indicators exist or changes in our business or other triggering events occur.

Fair value is estimated using the income and market approaches for goodwill at the reporting unit level and the income approach for our indefinite lived intangible assets. Use of the income and market approaches for our goodwill impairment test reflects our view that both valuation methodologies provide a reasonable estimate of fair value. The income approach is developed using assumptions about future revenue, expenses and net income derived from our internal planning process. These estimated future cash flows are then discounted. Our assumed discount rate is based on our industry's weighted-average cost of capital. Market valuations are based on observed multiples of certain measures including membership, revenue and EBITDA (earnings before interest, taxes, depreciation and amortization) and include market comparisons to publicly traded companies in our industry.

We did not incur any impairment losses as a result of our 2015 annual impairment tests as the estimated fair values of our reporting units were substantially in excess of the carrying values as of December 31, 2015. Additionally, we do not believe that the estimated fair values of our reporting units are at risk of becoming impaired in the next twelve months. However, as a result of certain provisions of Health Care Reform, along with current economic conditions, we have experienced lower operating margins in certain lines of business. Those margins could become further compressed if results from implementation of Health Care Reform are significantly different than anticipated. As a result, the estimated fair values of certain of our reporting units with goodwill could fall below their carrying values in future periods and if that were to occur, we would be required to record impairment losses at that time.

While we believe we have appropriately allocated the purchase price of our acquisitions, this allocation requires many assumptions to be made regarding the fair value of assets and liabilities acquired. In addition, estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used. If estimated fair values are less than the carrying values of goodwill and other intangibles with indefinite lives in future annual impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

For additional information, see Note 3, "Business Acquisitions and Divestiture" and Note 9, "Goodwill and Other Intangible Assets," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Investments

Current and long-term available-for-sale investment securities were \$18,951.0 at December 31, 2015 and represented 30.7% of our total consolidated assets at December 31, 2015. We classify fixed maturity and equity securities in our investment portfolio as "available-for-sale" or "trading" and report those securities at fair value. Certain fixed maturity securities are available to support current operations and, accordingly, we classify such investments as current assets without regard to their contractual maturity. Investments used to satisfy contractual, regulatory or other requirements are classified as long-term, without regard to contractual maturity.

We review investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both qualitative and quantitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the length of time and the extent to which a security's market value has been less than its cost, the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors), financial condition and near term prospects of the issuer, including the credit ratings and changes in the credit ratings of the issuer, recommendations of investment advisors, and forecasts of economic, market or industry trends. In addition, for equity securities, we determine whether we have the intent and ability to hold the security for a period of time to allow for a

recovery of its fair value above its carrying amount. If any declines of equity securities are determined to be other-than-temporary, we charge the losses to income when that determination is made.

Certain FASB other-than-temporary impairment, or OTTI, guidance applies to fixed maturity securities and provides guidance on the recognition, presentation of, and disclosures for OTTIs. If a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, the decline in value is deemed to be other-than-temporary and is presented within the Other-than-temporary impairment losses recognized in income line item on our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, the credit component of the OTTI is presented within the Other-than-temporary impairment losses recognized in income line item on our consolidated statements of income and the non-credit component of the OTTI is recognized in other comprehensive income. Furthermore, unrealized losses entirely caused by non-credit related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive income.

The credit component of an OTTI is determined primarily by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting our best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of acquisition. For mortgage-backed and asset-backed securities, cash flow estimates are based on assumptions regarding the underlying collateral including prepayment speeds, vintage, type of underlying asset, geographic concentrations, default rates, recoveries and changes in value. For all other debt securities, cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings, and estimates regarding timing and amount of recoveries associated with a default.

We have a committee of accounting and investment associates and management that is responsible for managing the impairment review process. The current economic environment and volatility of securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets.

We believe we have adequately reviewed our investment securities for impairment and that our investment securities are carried at fair value. However, over time, the economic and market environment may provide additional insight regarding the fair value of certain securities, which could change our judgment regarding impairment. This could result in other-than-temporary impairment losses on investments being charged against future income. Given the current market conditions and the significant judgments involved, there is continuing risk that further declines in fair value may occur and additional, material other-than-temporary impairment losses on investments may be recorded in future periods.

In addition to available-for-sale investment securities, we held additional long-term investments of \$2,041.1, or 3.3% of total consolidated assets, at December 31, 2015. These long-term investments consisted primarily of certain other equity investments, cash surrender value of corporate-owned life insurance policies and real estate. Due to their less liquid nature, these investments are classified as long-term.

Through our investing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in equity market valuations. We manage the market risks through our investment policy, which establishes credit quality limits and limits on investments in individual issuers. Ineffective management of these risks could have an impact on our future earnings and financial position. Our investment portfolio includes fixed maturity securities with a fair value of \$17,478.2 at December 31, 2015. The weighted-average credit rating of these securities was "A" as of December 31, 2015. Included in this balance are investments in fixed maturity securities of states, municipalities and political subdivisions, mortgage-backed securities, and corporate securities of \$1,483.5, \$3.2 and \$0.3, respectively, that are guaranteed by third parties. With the exception of twenty-seven securities with a fair value of \$11.5, these securities are all investment-grade and carry a weighted-average credit rating of "AA" as of December 31, 2015. The securities are guaranteed by a number of different guarantors and we do not have any significant exposure to any single guarantor (neither indirect through the guarantees, nor direct through investment in the guarantor). Further, due to the high underlying credit rating of the issuers, the weighted-average credit rating of these securities without a guarantee was "AA" as of December 31, 2015 for the securities for which such information is available.

At December 31, 2015, we owned \$777.2 of energy sector fixed maturity securities out of a total available-for-sale investment portfolio of \$18,951.0. These energy sector securities had accumulated net unrealized losses of \$172.0 and have the potential for material future credit loss impairments if oil and natural gas prices stay at current levels or are further suppressed.

Fair values of available-for-sale fixed maturity and equity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level I or Level II inputs for the determination of fair value in accordance with FASB guidance for fair value measurements and disclosures. We have controls in place to review the pricing services' qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable.

We obtain only one quoted price for each security from the pricing services, which are derived through recently reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. As we are responsible for the determination of fair value, we perform monthly analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. Our analysis includes a review of month-to-month price fluctuations. If unusual fluctuations are noted in this review, we may obtain additional information from other pricing services to validate the quoted price. There were no adjustments to quoted market prices obtained from the pricing services during the years ended December 31, 2015 and 2014.

In certain circumstances, it may not be possible to derive pricing model inputs from observable market activity, and therefore, such inputs are estimated internally. Such securities are designated Level III in accordance with FASB guidance. Securities designated Level III at December 31, 2015 totaled \$315.8 and represented approximately 1.5% of our total assets measured at fair value on a recurring basis. Our Level III securities primarily consisted of certain corporate securities, equity securities and structured securities for which observable inputs were not always available and the fair values of these securities were estimated using internal estimates for inputs including, but not limited to, prepayment speeds, credit spreads, default rates and benchmark yields.

For additional information, see Part II, Item 7A "Quantitative and Qualitative Disclosures about Market Risk", and Part II, Item 8, Note 2, "Basis of Presentation and Significant Accounting Policies," Note 4, "Investments," and Note 6, "Fair Value," to our audited consolidated financial statements included in this Annual Report on Form 10-K.

Retirement Benefits

Pension Benefits

We sponsor defined benefit pension plans for some of our employees. These plans are accounted for in accordance with FASB guidance for retirement benefits, which requires that amounts recognized in financial statements be determined on an actuarial basis. As permitted by the guidance, we calculate the value of plan assets as described below. Further, the difference between our expected rate of return and the actual performance of plan assets, as well as certain changes in pension liabilities, are amortized over future periods.

An important factor in determining our pension expense is the assumption for expected long-term return on plan assets. As of our December 31, 2015 measurement date, we selected a weighted-average long-term rate of return on plan assets of 7.84%. We use a total portfolio return analysis in the development of our assumption. Factors such as past market performance, the long-term relationship between fixed maturity and equity securities, interest rates, inflation and asset allocations are considered in the assumption. The assumption includes an estimate of the additional return expected from active management of the investment portfolio. Peer data and an average of historical returns are also reviewed for appropriateness of the selected assumption. We believe our assumption of future returns is reasonable. However, if we lower our expected long-term return on plan assets, future contributions to the pension plan and pension expense would likely increase.

This assumed long-term rate of return on assets is applied to a calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over three years, producing the expected return on plan assets that is included in the determination of pension expense. We apply a corridor approach to amortize unrecognized actuarial gains or losses. Under this approach, only accumulated net actuarial gains or losses in excess of 10% of the greater of the projected benefit obligation or the fair value of plan assets are amortized over the average remaining service or lifetime of the workforce as a component of pension expense. The net deferral of past asset gains or losses affects the calculated value of plan assets and, ultimately, future pension expense.

The discount rate reflects the current rate at which the pension liabilities could be effectively settled at the end of the year based on our most recent measurement date. At the December 31, 2015 measurement date, the selected weighted-average discount rate was 3.92%, compared to 3.66% at the December 31, 2014 measurement date. We developed this rate using a yield curve approach. Using yields available on high-quality fixed maturity securities with various maturity dates, the yield curve approach provides a "customized" rate, which is meant to match the expected cash flows of our specific benefit plans. The net effect of changes in the discount rate, as well as the net effect of other changes in actuarial assumptions and experience, have been deferred and amortized as a component of pension expense in accordance with FASB guidance.

In managing the plan assets, our objective is to be a responsible fiduciary while minimizing financial risk. Plan assets include a diversified mix of investment grade fixed maturity securities, equity securities and alternative investments across a range of sectors and levels of capitalization to maximize the long-term return for a prudent level of risk. In addition to producing a reasonable return, the investment strategy seeks to minimize the volatility in our expense and cash flow.

Other Postretirement Benefits

We provide most associates with certain medical, vision and dental benefits upon retirement. We use various actuarial assumptions, including a discount rate and the expected trend in health care costs, to estimate the costs and benefit obligations for our retiree benefits.

At our December 31, 2015 measurement date, the selected discount rate for all plans was 4.01%, compared to a discount rate of 3.74% at the December 31, 2014 measurement date. We developed this rate using a yield curve approach as described above.

The assumed health care cost trend rates used to measure the expected cost of pre-Medicare (those who are not currently eligible for Medicare benefits) other benefits at our December 31, 2015 measurement date was 8.00% for 2016 with a gradual decline to 4.50% by the year 2028. The assumed health care cost trend rates used to measure the expected cost of post-Medicare (those who are currently eligible for Medicare benefits) other benefits at our December 31, 2015 measurement date was 5.75% for 2016 with a gradual decline to 4.50% by the year 2021. These estimated trend rates are subject to change in the future. The health care cost trend rate assumption has a significant effect on the amounts reported. For example, an increase in the assumed health care cost trend rate of one percentage point would increase the postretirement benefit obligation as of December 31, 2015 by \$45.0 and would increase service and interest costs by \$2.2. Conversely, a decrease in the assumed health care cost trend rate of one percentage point would decrease the postretirement benefit obligation by \$38.3 as of December 31, 2015 and would decrease service and interest costs by \$1.8.

For additional information regarding our retirement benefits, see Note 10, "Retirement Benefits," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

New Accounting Pronouncements

For information regarding new accounting pronouncements that were issued or became effective during the year ended December 31, 2015 that had, or are expected to have a material impact on our financial position, results of operations or financial statement disclosures, see the "*Recently Adopted Accounting Guidance*" and "*Recent Accounting Guidance Not Yet Adopted*" sections of Note 2, "Basis of Presentation and Significant Accounting Policies" to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Introduction

Our cash receipts result primarily from premiums, administrative fees, investment income, other revenue, proceeds from the sale or maturity of our investment securities, proceeds from borrowings, and proceeds from the issuance of common stock under our employee stock plans. Cash disbursements result mainly from claims payments, administrative expenses, taxes, purchases of investment securities, interest expense, payments on borrowings, acquisitions, capital expenditures, repurchases of our debt securities and common stock and the payment of cash dividends. Cash outflows fluctuate with the amount and timing of settlement of these transactions. Any future decline in our profitability would likely have an unfavorable impact on our liquidity.

We manage our cash, investments and capital structure so we are able to meet the short and long-term obligations of our business while maintaining financial flexibility and liquidity. We forecast, analyze and monitor our cash flows to enable investment and financing within the overall constraints of our financial strategy.

A substantial portion of the assets held by our regulated subsidiaries are in the form of cash and cash equivalents and investments. After considering expected cash flows from operating activities, we generally invest cash that exceeds our near term obligations in longer term marketable fixed maturity securities to improve our overall investment income returns. Our investment strategy is to make investments consistent with insurance statutes and other regulatory requirements, while preserving our asset base. Our investments are generally available-for-sale to meet liquidity and other needs. Our subsidiaries pay out excess capital annually in the form of dividends to their respective parent companies for general corporate use, as permitted by applicable regulations.

The availability of financing in the form of debt or equity is influenced by many factors including our profitability, operating cash flows, debt levels, debt ratings, contractual restrictions, regulatory requirements and market conditions. The securities and credit markets have been experiencing higher than normal volatility. During recent years, the federal government and various governmental agencies have taken a number of steps to restore liquidity in the financial markets and to help relieve the credit crisis and strengthen the regulation of the financial services market. In addition, governments around the world have developed their own plans to provide liquidity and security in the credit markets and to ensure adequate capital in certain financial institutions.

We have a \$2,500.0 commercial paper program. Should commercial paper issuance be unavailable, we have the ability to use a combination of cash on hand and/or our \$3,500.0 senior revolving credit facility to redeem any outstanding commercial paper upon maturity. Additionally, we believe the lenders participating in our credit facility would be willing and able to provide financing in accordance with their legal obligations. In addition to the \$3,500.0 senior revolving credit facility, we estimate that we will receive approximately \$2,100.0 of dividends from our subsidiaries during 2016, which also provides further operating and financial flexibility.

The table below outlines the cash flows provided by or used in operating, investing and financing activities for the years ended December 31, 2015, 2014 and 2013:

	Years Ended December 31		
	2015	2014	2013
Cash flows provided by (used in):			
Operating activities	\$ 4,116.0	\$ 3,369.3	\$ 3,052.3
Investing activities	(1,151.5)	(974.9)	(2,234.4)
Financing activities	(2,997.4)	(1,822.5)	(1,717.8)
Effect of foreign exchange rates on cash and cash equivalents	(5.3)	(7.1)	2.2
(Decrease) increase in cash and cash equivalents	\$ (38.2)	\$ 564.8	\$ (897.7)

Liquidity—Year Ended December 31, 2015 Compared to Year Ended December 31, 2014

During the year ended December 31, 2015, net cash flow provided by operating activities was \$4,116.0, compared to \$3,369.3 for the year ended December 31, 2014, an increase of \$746.7. The increase was primarily attributable to an increase in premium receipts as a result of rate increases across our businesses designed to cover overall cost trends and the HIP Fee, and growth in membership. The increase in cash provided by operating activities was further attributable to the receipt of the reinsurance recoveries payment related to the 2014 Health Care Reform reinsurance premium stabilization program and payments made in 2014 that did not recur in 2015 for the adjudication of claims relating to the New York State contract conversion from our fully-insured Local Group business to a self-funded ASO contract. The increase in cash provided by operating activities was partially offset by an increase in claims payments, primarily as a result of membership growth, an increase in income tax payments and an increase in the annual HIP Fee payment.

Net cash flow used in investing activities was \$1,151.5 during the year ended December 31, 2015, compared to \$974.9 for the year ended December 31, 2014. The increase in cash flow used in investing activities of \$176.6 primarily resulted from changes in cash flows relating to the purchase and sale of subsidiaries. Cash utilized for the purchase of subsidiaries during the year ended December 31, 2015 primarily related to the purchase of Simply Healthcare. During the year ended December 31, 2014, cash was provided by the sale of our 1-800 CONTACTS business and glasses.com related assets. The increase in cash flow used in investing activities was partially offset by changes in securities lending collateral and a decrease in net purchases of investments.

Net cash flow used in financing activities was \$2,997.4 during the year ended December 31, 2015, compared to \$1,822.5 for the year ended December 31, 2014. The increase in cash flow used in financing activities of \$1,174.9 primarily resulted from changes in long-term borrowings as a result of net repayments of long-term borrowings during 2015 compared to net proceeds from long-term borrowings during 2014. The increase in cash flow used in financing activities was further attributable to changes in securities lending payable, changes in bank overdrafts, an increase in cash dividends paid to shareholders and a decrease in proceeds from the issuance of common stock under our employee stock plans. The increase in cash flow used in financing activities was partially offset by a decrease in common stock repurchases, an increase in net proceeds from commercial paper borrowings, an increase in net proceeds from short-term borrowings and an increase in excess tax benefits from share-based compensation.

Liquidity—Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

During the year ended December 31, 2014, net cash flow provided by operating activities was \$3,369.3, compared to \$3,052.3 for the year ended December 31, 2013, an increase of \$317.0. This increase was primarily attributable to an increase in premium receipts as a result of rate increases across our businesses designed to cover overall cost trends and new fees associated with Health Care Reform and an increase in administrative fee receipts primarily as a result of growth in membership. The increase in cash provided by operating activities was offset, in part, by payments for new fees associated with Health Care Reform, including the HIP Fee and assessments related to the Health Care Reform reinsurance premium stabilization program. The increase was further offset by an increase in claims payments primarily as a result of membership growth, an increase in personnel service costs and an increase in income taxes paid.

Net cash flow used in investing activities was \$974.9 during the year ended December 31, 2014, compared to \$2,234.4 for the year ended December 31, 2013. The decrease in cash flow used in investing activities of \$1,259.5 primarily resulted from cash provided by the sale of our 1-800 CONTACTS business and glasses.com related assets on January 31, 2014 and a decrease in net purchases of investments, partially offset by changes in securities lending collateral.

Net cash flow used in financing activities was \$1,822.5 during the year ended December 31, 2014, compared to \$1,717.8 for the year ended December 31, 2013. The increase in cash flow used in financing activities of \$104.7 primarily resulted from an increase in common stock repurchases, a decrease in proceeds from the issuance of common stock under our employee stock plans and an increase in net repayments of commercial paper borrowings. These increases in net cash used in financing activities were partially offset by changes in short- and long-term borrowings as a result of net proceeds received from long-term borrowings during 2014 compared to net repayments of short- and long-term borrowings during 2013. In addition, the increase in net cash flow used in financing activities was partially offset by changes in bank overdrafts and changes in securities lending payable.

Financial Condition

We maintained a strong financial condition and liquidity position, with consolidated cash, cash equivalents and investments, including long-term investments, of \$23,124.7 at December 31, 2015. Since December 31, 2014, total cash, cash equivalents and investments, including long-term investments, decreased by \$653.0 primarily due to common stock repurchases, net repayments of short- and long-term borrowings, cash dividends paid to shareholders, the acquisition of Simply Healthcare, purchases of property and equipment, decreases in bank overdrafts and decreases in securities lending payables. These decreases were partially offset by cash generated from operations, net proceeds received from commercial paper borrowings, decreases in securities lending collateral, proceeds from issuance of common stock under employee stock plans and excess tax benefits from share-based compensation.

Many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their respective parent companies. Certain accounting practices prescribed by insurance regulatory authorities, or statutory accounting practices, differ from GAAP. Changes that occur in statutory accounting practices, if any, could impact our subsidiaries' future dividend capacity. In addition, we have agreed to certain undertakings to regulatory authorities, including the requirement to maintain certain capital levels in certain of our subsidiaries.

At December 31, 2015, we held \$1,368.3 of cash, cash equivalents and investments at the parent company, which are available for general corporate use, including investment in our businesses, acquisitions, potential future common stock repurchases and dividends to shareholders, repurchases of debt securities and debt and interest payments.

Debt

During the year ended December 31, 2015, we repurchased \$920.0 of the aggregate principal balance of our outstanding senior convertible debentures due 2042, or the Debentures. In addition, \$66.6 aggregate principal balance was surrendered for conversion by certain holders in accordance with the terms and provisions of the indenture governing the Debentures. We elected to settle the excess of the principal amount of the repurchases and conversions with cash for total payments of \$2,055.7. We recognized a gain on the extinguishment of debt related to the Debentures of \$12.7, based on the fair values of the debt on the repurchase and conversion settlement dates.

On September 10, 2015, we repaid, upon maturity, the \$625.0 outstanding principal balance of our 1.25% senior unsecured notes due 2015. Additionally, during the year ended December 31, 2015, we repurchased \$13.0 of outstanding principal balance of certain other senior unsecured notes, plus applicable premium, accrued and unpaid interest, for cash totaling \$16.2. We recognized a loss on extinguishment of debt of \$3.4 on the repurchase of these notes.

On May 12, 2015, we issued 25.0 Equity Units, pursuant to an underwriting agreement dated May 6, 2015, in an aggregate principal amount of \$1,250.0. Each Equity Unit has a stated amount of \$50 (whole dollars) and consists of a purchase contract obligating the holder to purchase a certain number of shares of our common stock on May 1, 2018, subject to earlier termination or settlement, for a price in cash of \$50 (whole dollars); and a 5% undivided beneficial ownership interest in \$1,000 (whole dollars) principal amount of our 1.900% remarketable subordinated notes, or RSNs, due 2028. We received \$1,228.8 in cash proceeds from the issuance of the Equity Units, net of underwriting discounts and commissions and offering expenses payable by us, and recorded \$1,250.0 in long-term debt.

On September 15, 2014, we redeemed the \$500.0 outstanding principal balance of our 5.000% senior unsecured notes due 2014, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling \$512.3. We recognized a loss on extinguishment of debt of \$2.3 on the redemption of these notes.

On September 11, 2014, we redeemed the \$1,097.9 outstanding principal balance of our 5.250% senior unsecured notes due 2016, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling \$1,178.2. We recognized a loss on extinguishment of debt of \$67.6 on the redemption of these notes.

Additionally, during the year ended December 31, 2014, we repurchased \$52.0 of outstanding principal amount of certain other senior unsecured notes, plus applicable premium for early redemption plus accrued and unpaid interest, for cash totaling \$61.0. We recognized a loss on extinguishment of debt of \$11.2 for the year ended December 31, 2014 on the repurchase of these notes.

On August 12, 2014, we issued \$850.0 of 2.250% notes due 2019, \$800.0 of 3.500% notes due 2024, \$800.0 of 4.650% notes due 2044, and \$250.0 of 4.850% notes due 2054 under our shelf registration statement. We used the proceeds from this offering in part to fund the purchase price of the 5.000% and 5.250% senior unsecured notes discussed above, and the remaining net proceeds were used for general corporate purposes. Interest on the notes is payable semi-annually in arrears on February 15 and August 15 of each year and commenced on February 15, 2015. The notes have a call feature that allows us to redeem the notes at any time at our option and a put feature that allows a note holder to redeem the notes upon the occurrence of both a change in control event and a downgrade of the notes below an investment grade rating.

On September 5, 2013, we redeemed the \$400.0 outstanding principal balance of our 6.000% senior unsecured notes due 2014, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling \$411.0. We recognized a loss on extinguishment of debt of \$10.0 on the redemption of these notes.

On July 30, 2013, we initiated a cash tender offer and consent solicitation to purchase up to \$300.0 aggregate principal amount of our outstanding 5.875% notes due 2017 and 7.000% notes due 2019 (the "First Tranche Offer") and to purchase up to \$300.0 aggregate principal amount of our outstanding 5.950% notes due 2034, 5.850% notes due 2036, 6.375% notes due 2037 and 5.800% notes due 2040 (the "Second Tranche Offer"), collectively, the "Tender Offers". The Tender Offers were each subject to increase up to an additional \$100.0 at our election. On August 12, 2013, we increased the Second Tranche Offer to \$400.0 and on August 13, 2013 we repurchased \$300.0 of the First Tranche Offer notes and \$400.0 of the Second Tranche Offer notes for cash totaling \$837.7. Holders who tendered their notes prior to the early tender date received the principal amounts, applicable premium for early redemption and accrued and unpaid interest to the early tender offer settlement date. We recognized a loss on extinguishment of debt of \$135.3 on the repurchase of these notes.

On July 30, 2013, we issued \$650.0 of 2.300% notes due 2018 and \$600.0 of 5.100% notes due 2044 under our shelf registration statement. We used the proceeds from this offering in part to fund the purchase price of the 6.000% senior unsecured notes and the Tender Offers discussed above, and the balance for general corporate purposes. Interest on the notes is payable semi-annually in arrears on January 15 and July 15 of each year and commenced on January 15, 2014. The notes have a call feature that allows us to repurchase the notes at any time at our option and a put feature that allows a note holder to require us to repurchase the notes upon the occurrence of both a change in control event and a downgrade of the notes below an investment grade rating.

On January 25, 2013, we redeemed the outstanding principal balance of \$475.0 of 7.500% senior unsecured notes due 2019, plus applicable premium, accrued and unpaid interest, for cash totaling \$555.6. The weighted-average redemption price of the notes was approximately 117% of the principal amount outstanding.

For additional information related to our borrowing activities, see Note 12, "Debt" to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We calculate our consolidated debt-to-capital ratio, a non-GAAP measure, which we believe assists investors and rating agencies in measuring our overall leverage and additional borrowing capacity. In addition, our bank covenants include a maximum debt-to-capital ratio that we cannot and did not exceed. Our debt-to-capital ratio is calculated as the sum of debt divided by the sum of debt plus shareholders' equity. Our debt-to-capital ratio may not be comparable to similarly titled measures reported by other companies. Our consolidated debt-to-capital ratio was 40.8% and 38.3% as of December 31, 2015 and 2014, respectively. We expect that our pro forma debt-to-capital ratio will approximate 49% at the closing of the acquisition of Cigna and we are committed to deleveraging to the low 40% range approximately twenty-four months following the closing.

Our senior debt is rated "A" by Standard & Poor's, "BBB" by Fitch, Inc., "Baa2" by Moody's Investor Service, Inc. and "bbb+" by AM Best Company, Inc. We intend to maintain our senior debt investment grade ratings. A significant downgrade in our debt ratings could adversely affect our borrowing capacity and costs.

Future Sources and Uses of Liquidity

During the year ended December 31, 2015, we entered into a bridge facility commitment letter and a joinder agreement, and a term loan facility, to finance a portion of the pending acquisition of Cigna. The commitment of the lenders to provide the bridge facility and the term loan facility is subject to several conditions, including the completion of the Acquisition. For additional information, see the "Overview" section included in this "Management's Discussion and Analysis of Financial

Condition and Results of Operations"; and Note 3, "Business Acquisitions and Divestiture - *Pending Acquisition of Cigna Corporation*" included in Part II, Item 8 of this Annual Report on Form 10-K.

We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. In April 2015, we filed a post-effective amendment to our shelf registration statement to register warrants, depositary shares, rights, stock purchase contracts and stock purchase units as additional securities that can be offered under the shelf registration statement. Specific information regarding terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansion.

On August 25, 2015, we terminated our \$2,000.0 senior revolving credit facility, initially scheduled to mature on September 29, 2016, and entered into a new \$3,500.0 senior revolving credit facility, or the Facility, with a group of lenders. The interest rate on the Facility is based on either the LIBOR rate or a base rate plus a predetermined rate based on our public debt rating at the date of utilization. Our ability to borrow under the Facility is subject to compliance with certain covenants. The Facility matures on August 25, 2020 and is available for general corporate purposes. There were no amounts outstanding under the senior revolving credit facilities at December 31, 2015 or 2014.

We have an authorized commercial paper program of up to \$2,500.0, the proceeds of which may be used for general corporate purposes. At December 31, 2015, we had \$682.2 outstanding under our commercial paper program. We did not have any borrowings outstanding under our commercial paper program at December 31, 2014. Commercial paper borrowings have been classified as long-term debt at December 31, 2015 as our general practice and intent is to replace short-term commercial paper outstanding at expiration with additional short-term commercial paper for an uninterrupted period extending for more than one year and we have the ability to redeem our commercial paper with borrowings under the senior revolving credit facility described above.

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati and the Federal Home Loan Bank of Atlanta, collectively, the FHLBs, and as a member we have the ability to obtain short-term cash advances subject to certain minimum collateral requirements. At December 31, 2015 and 2014, \$540.0 and \$400.0, respectively, were outstanding under our short-term FHLBs borrowings.

As discussed in "Financial Condition" above, many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid. Based upon these requirements, we are currently estimating approximately \$2,100.0 of dividends to be paid to the parent company during 2016. During 2015, we received \$2,672.3 of dividends from our subsidiaries.

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors.

A summary of the cash dividend activity for the year ended December 31, 2015 is as follows:

Declaration Date	Record Date	Payment Date	Cash Dividend per Share	Total
January 27, 2015	March 10, 2015	March 25, 2015	\$ 0.6250	\$ 166.6
April 28, 2015	June 10, 2015	June 25, 2015	0.6250	163.9
July 28, 2015	September 10, 2015	September 25, 2015	0.6250	163.0
October 27, 2015	December 4, 2015	December 21, 2015	0.6250	163.1

On February 18, 2016, our Board of Directors declared a quarterly cash dividend of \$0.6500 per share on the outstanding shares of our common stock. This quarterly dividend is payable on March 25, 2016 to the shareholders of record as of March 10, 2016.

A summary of common stock repurchases for the year ended December 31, 2015 is as follows:

	Year Ended December 31, 2015
Shares repurchased	10.4
Average price per share	\$ 145.50
Aggregate cost	\$ 1,515.8
Authorization remaining at the end of each period	\$ 4,175.9

On October 2, 2014, the Board of Directors authorized a \$5,000.0 increase to the common stock repurchase program. Repurchases may be made from time to time at prevailing market prices, subject to certain restrictions on volume, pricing and timing. The repurchases are effected from time to time in the open market, through negotiated transactions, including accelerated share repurchase agreements, and through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. We expect to utilize the unused authorization remaining at December 31, 2015 over a multi-year period, subject to market and industry conditions. Our stock repurchase program is discretionary as we are under no obligation to repurchase shares. We repurchase shares under the program when we believe it is a prudent use of capital.

Contractual Obligations and Commitments

Our estimated contractual obligations and commitments as of December 31, 2015 are as follows:

	Total	Payments Due by Period			
		Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
On-Balance Sheet:					
Debt ¹	\$ 24,742.8	\$ 1,276.2	\$ 3,316.6	\$ 2,973.9	\$ 17,176.1
Other long-term liabilities ²	1,317.8	62.4	518.0	464.9	272.5
Off-Balance Sheet:					
Purchase obligations ³	2,819.3	1,820.5	750.9	247.9	—
Operating lease commitments	848.7	141.5	267.2	194.2	245.8
Investment commitments ⁴	685.3	272.8	224.7	148.9	38.9
Total contractual obligations and commitments	\$ 30,413.9	\$ 3,573.4	\$ 5,077.4	\$ 4,029.8	\$ 17,733.3

1 Includes estimated interest expense.

2 Primarily consists of reserves for future policy benefits, projected other postretirement benefits, deferred compensation, supplemental executive retirement plan liabilities and certain other miscellaneous long-term obligations. Estimated future payments for funded pension benefits have been excluded from this table as we had no funding requirements under ERISA at December 31, 2015 as a result of the value of the assets in the plans.

3 Includes estimated payments for future services under contractual arrangements from third-party service contracts.

4 Includes unfunded capital commitments for alternative investments.

The above table does not contain \$224.3 of gross liabilities for uncertain tax positions and interest for which we cannot reasonably estimate the timing of the resolutions with the respective taxing authorities. For further information, see Note 7, "Income Taxes," to the audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

In addition to the contractual obligations and commitments discussed above, we have a variety of other contractual agreements related to acquiring materials and services used in our operations. However, we do not believe these other agreements contain material noncancelable commitments.

We believe that funds from future operating cash flows, cash and investments and funds available under our senior revolving credit facility, bridge facility, term loan facility and/or from public or private financing sources, will be sufficient for future operations and commitments, and for capital acquisitions and other strategic transactions.

We do not have any off-balance sheet derivative instruments, guarantee transactions, agreements or other contractual arrangements or any indemnification agreements that will require funding in future periods. We have not transferred assets to an unconsolidated entity that serve as credit, liquidity or market risk support to such entity. We do not hold any variable interest in an unconsolidated entity where such entity provides us with financing, liquidity, market risk or credit risk support.

Risk-Based Capital

Our regulated subsidiaries' states of domicile have statutory risk-based capital, or RBC, requirements for health and other insurance companies and health maintenance organizations largely based on the National Association of Insurance Commissioners, or NAIC, RBC Model Act. These RBC requirements are intended to measure capital adequacy, taking into account the risk characteristics of an insurer's investments and products. The NAIC sets forth the formula for calculating the RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company's business. In general, under the RBC Model Act, an insurance company must submit a report of its RBC level to the state insurance department or insurance commissioner, as appropriate, at the end of each calendar year. Our regulated subsidiaries' respective RBC levels as of December 31, 2015, which was the most recent date for which reporting was required, were in excess of all mandatory RBC thresholds. In addition to exceeding the RBC requirements, we are in compliance with the liquidity and capital requirements for a licensee of the BCBSA and with the tangible net worth requirements applicable to certain of our California subsidiaries.

For additional information, see Note 21, "Statutory Information," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Forward-Looking Statements

This document contains certain forward-looking information about us that is intended to be covered by the safe harbor for "forward-looking statements" provided by the Private Securities Litigation Reform Act of 1995. Forward-looking statements are generally not historical facts. Words such as "expect," "feel," "believe," "will," "may," "should," "anticipate," "intend," "estimate," "project" "forecast," "plan," and similar expressions are intended to identify forward-looking statements. These statements include, but are not limited to: financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Such statements are subject to certain risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking statements. These risks and uncertainties include: those discussed and identified in our public filings with the U.S. Securities and Exchange Commission, or SEC; increased government participation in, or regulation or taxation of health benefits and managed care operations, including, but not limited to, the impact of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, or Health Care Reform; trends in health care costs and utilization rates; our ability to secure sufficient premium rates including regulatory approval for and implementation of such rates; our participation in federal and state health insurance exchanges under Health Care Reform, which have experienced and continue to experience challenges due to implementation of initial and phased-in provisions of Health Care Reform, and which entail uncertainties associated with the mix and volume of business, particularly in our Individual and Small Group markets, that could negatively impact the adequacy of our premium rates and which may not be sufficiently offset by the risk apportionment provisions of Health Care Reform; the ultimate outcome of our pending acquisition of Cigna Corporation ("Cigna") (the "Acquisition"), including our ability to achieve the synergies and value creation contemplated by the Acquisition within the expected time period, or at all, and the risk that unexpected costs will be incurred in connection therewith; the ultimate outcome and results of integrating our and Cigna's operations and disruption from the Acquisition making it more difficult to maintain businesses and operational relationships; the possibility that the Acquisition does not close, including, but not limited to, due to the failure to satisfy the closing conditions, including the receipt of required regulatory approvals; the risks and uncertainties detailed by Cigna with respect to its business as described in its reports and documents filed with the SEC; our ability to contract with providers on cost-effective and competitive terms; competitor pricing below market trends of increasing costs; reduced enrollment, as well as a negative change in our health care product mix; risks and uncertainties regarding Medicare and Medicaid programs, including those related to non-compliance with the complex regulations imposed thereon and funding risks with respect to revenue received from participation therein; a downgrade in our financial strength ratings; increases in costs and other

liabilities associated with increased litigation, government investigations, audits or reviews; medical malpractice or professional liability claims or other risks related to health care services provided by our subsidiaries; our ability to repurchase shares of our common stock and pay dividends on our common stock due to the adequacy of our cash flow and earnings and other considerations; non-compliance by any party with the Express Scripts, Inc. pharmacy benefit management services agreement, which could result in financial penalties, our inability to meet customer demands, and sanctions imposed by governmental entities, including the Centers for Medicare and Medicaid Services; events that result in negative publicity for us or the health benefits industry; failure to effectively maintain and modernize our information systems; events that may negatively affect our licenses with the Blue Cross and Blue Shield Association; state guaranty fund assessments for insolvent insurers; possible impairment of the value of our intangible assets if future results do not adequately support goodwill and other intangible assets; intense competition to attract and retain employees; unauthorized disclosure of member or employee sensitive or confidential information, including the impact and outcome of investigations, inquiries, claims and litigation related to the cyber attack we reported in February 2015; changes in economic and market conditions, as well as regulations that may negatively affect our investment portfolios and liquidity; possible restrictions in the payment of dividends by our subsidiaries and increases in required minimum levels of capital and the potential negative effect from our substantial amount of outstanding indebtedness; general risks associated with mergers, acquisitions and strategic alliances; various laws and provisions in our governing documents that may prevent or discourage takeovers and business combinations; future public health epidemics and catastrophes; and general economic downturns. Readers are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. We do not undertake to update or revise any forward-looking statements, except as required by applicable securities laws. Investors are also advised to carefully review and consider the various risks and other disclosures discussed in our SEC reports.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK.

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

As a result of our investing and borrowing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in market valuations. Potential impacts discussed below are based upon sensitivity analyses performed on our financial position as of December 31, 2015. Actual results could vary from these estimates. Our primary objectives with our investment portfolio are to provide safety and preservation of capital, sufficient liquidity to meet cash flow requirements, the integration of investment strategy with the business operations and an attainment of a competitive after-tax total return.

Investments

Our investment portfolio is exposed to three primary sources of risk: credit quality risk, interest rate risk and market valuation risk.

The primary risks associated with our fixed maturity securities are credit quality risk and interest rate risk. Credit quality risk is defined as the risk of a credit event, such as a ratings downgrade or default, to an individual fixed maturity security and the potential loss attributable to that event. Credit quality risk is managed through our investment policy, which establishes credit quality limitations on the overall portfolio as well as diversification and percentage limits on securities of individual issuers. The result is a well-diversified portfolio of fixed maturity securities, with an average credit rating of approximately "A." Interest rate risk is defined as the potential for economic losses on fixed maturity securities due to a change in market interest rates. Our fixed maturity portfolio is invested primarily in U.S. government securities, corporate bonds, asset-backed bonds, mortgage-related securities and municipal bonds, all of which have exposure to changes in the level of market interest rates. Interest rate risk is managed by maintaining asset duration within a band based upon our liabilities, operating performance and liquidity needs. Additionally, we have the capability of holding any security to maturity, which would allow us to realize full par value.

Our available-for-sale investment portfolio includes corporate securities which account for 41.7% of the total portfolio at December 31, 2015 and are subject to credit/default risk. In a declining economic environment, corporate yields will usually increase prompted by concern over the ability of corporations to make interest payments, thus causing a decrease in the price of corporate securities, and the decline in value of the corporate fixed maturity portfolio. We manage this risk through fundamental credit analysis, diversification of issuers and industries and an average credit rating of our corporate fixed maturity portfolio of approximately "BBB."

Our equity portfolio is comprised of large capitalization and small capitalization domestic equities, foreign equities and index mutual funds. Our equity portfolio is subject to the volatility inherent in the stock market, driven by concerns over economic conditions, earnings and sales growth, inflation, and consumer confidence. These systemic risks cannot be managed through diversification alone. However, more routine risks, such as stock/industry specific risks, are managed by investing in a diversified equity portfolio.

As of December 31, 2015, 92.2% of our available-for-sale investments were fixed maturity securities. Market risk is addressed by actively managing the duration, allocation and diversification of our investment portfolio. We have evaluated the impact on the fixed maturity portfolio's fair value considering an immediate 100 basis point change in interest rates. A 100 basis point increase in interest rates would result in an approximate \$776.2 decrease in fair value, whereas a 100 basis point decrease in interest rates would result in an approximate \$732.9 increase in fair value. While we classify our fixed maturity securities as "available-for-sale" for accounting purposes, we believe our cash flows and duration of our portfolio should allow us to hold securities to maturity, thereby avoiding the recognition of losses should interest rates rise significantly.

As of December 31, 2015, 7.8% of our available-for-sale investments were equity securities. An immediate 10% decrease in each equity investment's value, arising from market movement, would result in a fair value decrease of \$147.3. Alternatively, an immediate 10% increase in each equity investment's value, attributable to the same factor, would result in a fair value increase of \$147.3.

For additional information regarding our investments, see Part II, Item 8, Note 4, "Investments", to our audited consolidated financial statements and "Critical Accounting Policies and Estimates - Investments" within Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

Long-Term Debt

Our total long-term debt at December 31, 2015 consists of senior unsecured notes, remarketable subordinated notes, convertible debentures, commercial paper and subordinated surplus notes by one of our insurance subsidiaries. At December 31, 2015, the carrying value and estimated fair value of our long-term debt was \$15,324.5 and \$16,185.5, respectively. This debt is subject to interest rate risk as these instruments have fixed interest rates and the fair value is affected by changes in market interest rates. Should interest rates increase or decrease in the future, the estimated fair value of our fixed rate debt would decrease or increase accordingly.

For additional information regarding our long-term debt, see Note 6, "Fair Value" and Note 12, "Debt" to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Derivatives

We have exposure to economic losses due to interest rate risk arising from changes in the level or volatility of interest rates. We attempt to mitigate our exposure to interest rate risk through the use of derivative financial instruments. These strategies include the use of interest rate swaps and forward contracts, which are used to lock-in interest rates or to hedge (on an economic basis) interest rate risks associated with variable rate debt. We have used these types of instruments as designated hedges against specific liabilities.

Changes in interest rates will affect the estimated fair value of these derivatives. As of December 31, 2015, we recorded a net liability of \$69.0, the estimated fair value of the swaps at that date. We have evaluated the impact on the interest rate swaps' fair value considering an immediate 100 basis point change in interest rates. A 100 basis point increase in interest rates would result in an approximate \$655.2 decrease in fair value, whereas a 100 basis point decrease in interest rates would result in an approximate \$655.2 increase in fair value.

We also utilize put and call options on the S&P 500 index to hedge, on an economic basis, the exposure of our equity security portfolio to fluctuations in the equity markets. While the impact of fluctuations in the equity markets on these derivatives are largely offset by changes in the fair values of our equity security portfolio, the change in fair value of the derivatives is recognized immediately in our income statement, whereas the change in fair value of our equity securities is recognized in accumulated other comprehensive income. Accordingly, a decrease in the S&P 500 index of 10% would result in an approximate increase of \$24.3 in the fair value of these derivatives. An increase in the S&P 500 index of 10% would result in an approximate decrease of \$23.7 in the fair value of these derivatives.

For additional information regarding our derivatives, see Note 5, "Derivative Financial Instruments" to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K. Also for accounting related to securities in our equity portfolio, see "Critical Accounting Policies and Estimates – Investments" within Part II, Item 7 "Management Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

ANTHEM, INC.
CONSOLIDATED FINANCIAL STATEMENTS
Years ended December 31, 2015, 2014 and 2013

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**Report of Independent Registered
Public Accounting Firm**

The Board of Directors and Shareholders of Anthem, Inc.

We have audited the accompanying consolidated balance sheets of Anthem, Inc. (the “Company”) as of December 31, 2015 and 2014, and the related consolidated statements of income, comprehensive income, shareholders’ equity, and cash flows for each of the three years in the period ended December 31, 2015. Our audits also included the financial statement schedule listed in the Index at Item 15(a). These financial statements and schedule are the responsibility of the Company’s management. Our responsibility is to express an opinion on these financial statements and schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Anthem, Inc. at December 31, 2015 and 2014, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2015, in conformity with U.S. generally accepted accounting principles. Also, in our opinion, the related financial statement schedule, when considered in relation to the basic financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Anthem, Inc.’s internal control over financial reporting as of December 31, 2015, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 19, 2016 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Indianapolis, Indiana
February 19, 2016

Anthem, Inc.
Consolidated Balance Sheets

	December 31, 2015	December 31, 2014
<i>(In millions, except share data)</i>		
Assets		
Current assets:		
Cash and cash equivalents	\$ 2,113.5	\$ 2,151.7
Investments available-for-sale, at fair value:		
Fixed maturity securities (amortized cost of \$16,950.0 and \$17,120.4)	16,920.0	17,467.4
Equity securities (cost of \$1,055.8 and \$1,303.7)	1,441.8	1,906.6
Other invested assets, current	19.1	20.2
Accrued investment income	170.8	161.4
Premium and self-funded receivables	4,602.8	4,825.5
Other receivables	2,421.4	2,117.0
Income taxes receivable	316.6	308.9
Securities lending collateral	1,300.4	1,515.2
Other current assets	1,555.7	1,473.9
Total current assets	30,862.1	31,947.8
Long-term investments available-for-sale, at fair value:		
Fixed maturity securities (amortized cost of \$550.4 and \$500.7)	558.2	504.4
Equity securities (cost of \$27.3 and \$27.0)	31.0	31.5
Other invested assets, long-term	2,041.1	1,695.9
Property and equipment, net	2,019.8	1,944.3
Goodwill	17,562.2	17,082.0
Other intangible assets	8,158.0	7,958.1
Other noncurrent assets	485.4	512.3
Total assets	\$ 61,717.8	\$ 61,676.3
Liabilities and shareholders' equity		
Liabilities		
Current liabilities:		
Policy liabilities:		
Medical claims payable	\$ 7,569.8	\$ 6,861.2
Reserves for future policy benefits	71.9	68.1
Other policyholder liabilities	2,256.5	2,626.5
Total policy liabilities	9,898.2	9,555.8
Unearned income	1,145.5	1,078.1
Accounts payable and accrued expenses	3,318.8	3,651.8
Security trades pending payable	73.1	66.2
Securities lending payable	1,300.9	1,515.3
Short-term borrowings	540.0	400.0
Current portion of long-term debt	—	624.3
Other current liabilities	2,816.1	1,861.2
Total current liabilities	19,092.6	18,752.7
Long-term debt, less current portion	15,324.5	14,019.6
Reserves for future policy benefits, noncurrent	631.7	671.3
Deferred tax liabilities, net	2,630.6	2,945.6
Other noncurrent liabilities	994.3	1,035.8
Total liabilities	38,673.7	37,425.0
Commitments and contingencies—Note 13		
Shareholders' equity		
Preferred stock, without par value, shares authorized - 100,000,000; shares issued and outstanding - none	—	—
Common stock, par value \$0.01, shares authorized - 900,000,000; shares issued and outstanding - 261,238,188 and 268,109,932	2.6	2.7
Additional paid-in capital	8,555.6	10,062.3
Retained earnings	14,778.5	14,014.4
Accumulated other comprehensive (loss) income	(292.6)	171.9
Total shareholders' equity	23,044.1	24,251.3

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Income

	Years Ended December 31		
	2015	2014	2013
<i>(In millions, except per share data)</i>			
Revenues			
Premiums	\$ 73,385.1	\$ 68,389.8	\$ 66,119.1
Administrative fees	4,976.6	4,590.6	4,031.9
Other revenue	43.1	41.3	40.4
Total operating revenue	78,404.8	73,021.7	70,191.4
Net investment income	677.6	724.4	659.1
Net realized gains on investments	157.5	177.0	271.9
Other-than-temporary impairment losses on investments:			
Total other-than-temporary impairment losses on investments	(99.9)	(56.2)	(100.6)
Portion of other-than-temporary impairment losses recognized in other comprehensive income	16.5	7.2	1.7
Other-than-temporary impairment losses recognized in income	(83.4)	(49.0)	(98.9)
Total revenues	79,156.5	73,874.1	71,023.5
Expenses			
Benefit expense	61,116.9	56,854.9	56,237.1
Selling, general and administrative expense:			
Selling expense	1,441.1	1,490.1	1,526.9
General and administrative expense	11,093.7	10,258.3	8,426.0
Total selling, general and administrative expense	12,534.8	11,748.4	9,952.9
Interest expense	653.0	600.7	602.7
Amortization of other intangible assets	230.1	220.9	245.3
(Gain) loss on extinguishment of debt	(9.3)	81.1	145.3
Total expenses	74,525.5	69,506.0	67,183.3
Income from continuing operations before income tax expense	4,631.0	4,368.1	3,840.2
Income tax expense	2,071.0	1,808.0	1,205.9
Income from continuing operations	2,560.0	2,560.1	2,634.3
Income (loss) from discontinued operations, net of tax	—	9.6	(144.6)
Net income	\$ 2,560.0	\$ 2,569.7	\$ 2,489.7
Basic net income (loss) per share:			
Basic - continuing operations	\$ 9.73	\$ 9.28	\$ 8.83
Basic - discontinued operations	—	0.03	(0.49)
Basic net income per share	\$ 9.73	\$ 9.31	\$ 8.34
Diluted net income (loss) per share:			
Diluted - continuing operations	\$ 9.38	\$ 8.96	\$ 8.67
Diluted - discontinued operations	—	0.03	(0.47)
Diluted net income per share	\$ 9.38	\$ 8.99	\$ 8.20
Dividends per share	\$ 2.50	\$ 1.75	\$ 1.50

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Comprehensive Income

	Years Ended December 31		
	2015	2014	2013
<i>(In millions)</i>			
Net income	\$ 2,560.0	\$ 2,569.7	\$ 2,489.7
Other comprehensive (loss) income, net of tax:			
Change in net unrealized gains/losses on investments	(384.3)	118.6	(294.7)
Change in non-credit component of other-than-temporary impairment losses on investments	(5.6)	(3.9)	1.7
Change in net unrealized gains/losses on cash flow hedges	(45.2)	(3.6)	3.0
Change in net periodic pension and postretirement costs	(26.0)	(118.1)	172.7
Foreign currency translation adjustments	(3.4)	(4.3)	1.4
Other comprehensive loss	<u>(464.5)</u>	<u>(11.3)</u>	<u>(115.9)</u>
Total comprehensive income	<u>\$ 2,095.5</u>	<u>\$ 2,558.4</u>	<u>\$ 2,373.8</u>

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Cash Flows

	Years Ended December 31		
	2015	2014	2013
<i>(In millions)</i>			
Operating activities			
Net income	\$ 2,560.0	\$ 2,569.7	\$ 2,489.7
Adjustments to reconcile net income to net cash provided by operating activities:			
Net realized gains on investments	(157.5)	(177.0)	(271.9)
Other-than-temporary impairment losses recognized in income	83.4	49.0	98.9
(Gain) loss on extinguishment of debt	(9.3)	81.1	145.3
(Gain) loss on disposal from discontinued operations	—	(3.2)	221.8
Loss (gain) on disposal of assets	16.0	(1.7)	3.9
Deferred income taxes	(65.9)	30.7	59.1
Amortization, net of accretion	802.1	744.5	800.9
Depreciation expense	105.8	106.5	107.9
Impairment of property and equipment	1.8	7.9	47.7
Share-based compensation	148.2	168.9	146.0
Excess tax benefits from share-based compensation	(95.8)	(46.4)	(30.1)
Changes in operating assets and liabilities:			
Receivables, net	(42.9)	(1,899.7)	(418.3)
Other invested assets	5.9	(21.7)	(15.1)
Other assets	33.8	405.5	(33.6)
Policy liabilities	193.0	1,240.6	(345.8)
Unearned income	33.9	255.1	(73.8)
Accounts payable and accrued expenses	(219.3)	(14.4)	303.6
Other liabilities	686.4	(7.9)	(154.6)
Income taxes	41.5	(34.0)	9.3
Other, net	(5.1)	(84.2)	(38.6)
Net cash provided by operating activities	4,116.0	3,369.3	3,052.3
Investing activities			
Purchases of fixed maturity securities	(9,792.0)	(9,613.4)	(13,704.5)
Proceeds from fixed maturity securities:			
Sales	8,909.2	8,066.0	10,977.9
Maturities, calls and redemptions	1,313.6	1,318.7	1,836.8
Purchases of equity securities	(1,561.4)	(912.0)	(820.3)
Proceeds from sales of equity securities	1,471.1	746.5	721.0
Purchases of other invested assets	(505.8)	(205.7)	(251.5)
Proceeds from sales of other invested assets	85.9	124.7	127.1
Settlement of non-hedging derivatives	(36.5)	(67.4)	(109.8)
Changes in securities lending collateral	214.4	(545.6)	(405.1)
Purchases of subsidiaries, net of cash acquired	(638.9)	—	—
Proceeds from sale of subsidiary, net of cash sold	—	740.0	—
Purchases of property and equipment	(638.2)	(714.6)	(646.5)
Proceeds from sales of property and equipment	35.3	88.0	39.2
Other, net	(8.2)	(0.1)	1.3
Net cash used in investing activities	(1,151.5)	(974.9)	(2,234.4)
Financing activities			
Net proceeds from (repayments of) commercial paper borrowings	682.2	(379.2)	(191.7)
Proceeds from long-term borrowings	1,226.5	2,700.0	1,250.0
Repayments of long-term borrowings	(2,697.2)	(1,730.1)	(1,801.9)
Proceeds from short-term borrowings	2,760.0	2,050.0	1,100.0
Repayments of short-term borrowings	(2,620.0)	(2,050.0)	(950.0)
Changes in securities lending payable	(214.4)	545.6	405.0
Changes in bank overdrafts	(243.8)	173.0	9.9
Premiums paid on equity call options	(16.7)	—	(25.8)
Proceeds from sale of put options	16.6	—	—
Repurchase and retirement of common stock	(1,515.8)	(2,998.8)	(1,620.1)

Simply Healthcare Plans, Inc.
D/B/A Clear Health Alliance

Attachment 2015 Anthem Inc.
Annual Report - Form 10 K

Cash dividends	(656.6)	(480.7)	(448.0)
Proceeds from issuance of common stock under employee stock plans	186.0	301.3	524.7
Excess tax benefits from share-based compensation	95.8	46.4	30.1
Net cash used in financing activities	(2,997.4)	(1,822.5)	(1,717.8)
Effect of foreign exchange rates on cash and cash equivalents	(5.3)	(7.1)	2.2
Change in cash and cash equivalents	(38.2)	564.8	(897.7)
Cash and cash equivalents at beginning of year	2,151.7	1,586.9	2,484.6
Cash and cash equivalents at end of year	2,113.5	2,151.7	1,586.9
Less cash and cash equivalents of discontinued operations at end of year	—	—	(4.8)
Cash and cash equivalents of continuing operations at end of year	\$ 2,113.5	\$ 2,151.7	\$ 1,582.1

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Shareholders' Equity

	Common Stock		Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Shareholders' Equity
	Number of Shares	Par Value				
(In millions)						
January 1, 2013	304.7	\$ 3.0	\$ 10,853.5	\$ 12,647.1	\$ 299.1	\$ 23,802.7
Net income	—	—	—	2,489.7	—	2,489.7
Other comprehensive loss	—	—	—	—	(115.9)	(115.9)
Premiums paid on equity options	—	—	(7.9)	—	—	(7.9)
Repurchase and retirement of common stock	(20.7)	(0.1)	(749.5)	(870.5)	—	(1,620.1)
Convertible debentures tax adjustment	—	—	(3.3)	—	—	(3.3)
Dividends and dividend equivalents	—	—	—	(452.4)	—	(452.4)
Issuance of common stock under employee stock plans, net of related tax benefits	9.3	—	672.4	—	—	672.4
December 31, 2013	293.3	2.9	10,765.2	13,813.9	183.2	24,765.2
Net income	—	—	—	2,569.7	—	2,569.7
Other comprehensive loss	—	—	—	—	(11.3)	(11.3)
Settlement of equity options	—	—	(31.4)	—	—	(31.4)
Repurchase and retirement of common stock	(30.4)	(0.2)	(1,115.5)	(1,883.1)	—	(2,998.8)
Dividends and dividend equivalents	—	—	—	(486.1)	—	(486.1)
Issuance of common stock under employee stock plans, net of related tax benefits	5.2	—	444.0	—	—	444.0
December 31, 2014	268.1	2.7	10,062.3	14,014.4	171.9	24,251.3
Net income	—	—	—	2,560.0	—	2,560.0
Other comprehensive loss	—	—	—	—	(464.5)	(464.5)
Premiums for and settlement of equity options	—	—	(14.0)	—	—	(14.0)
Repurchase and retirement of common stock	(10.4)	(0.1)	(382.2)	(1,133.5)	—	(1,515.8)
Dividends and dividend equivalents	—	—	—	(662.4)	—	(662.4)
Issuance of common stock under employee stock plans, net of related tax benefits	3.5	—	308.2	—	—	308.2
Convertible debenture repurchases and conversions	—	—	(1,287.8)	—	—	(1,287.8)
Equity Units contract payments and issuance costs	—	—	(130.9)	—	—	(130.9)
December 31, 2015	261.2	\$ 2.6	\$ 8,555.6	\$ 14,778.5	\$ (292.6)	\$ 23,044.1

See accompanying notes.

Anthem, Inc.

Notes to Consolidated Financial Statements

December 31, 2015

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

1. Organization

References to the terms “we”, “our”, “us”, “Anthem” or the “Company” used throughout these Notes to Consolidated Financial Statements refer to Anthem, Inc., an Indiana corporation, and unless the context otherwise requires, its direct and indirect subsidiaries.

We are one of the largest health benefits companies in terms of medical membership in the United States, serving 38.6 medical members through our affiliated health plans as of December 31, 2015. We offer a broad spectrum of network-based managed care plans to large and small employer, individual, Medicaid and Medicare markets. Our managed care plans include: preferred provider organizations, or PPOs; health maintenance organizations, or HMOs; point-of-service, or POS, plans; traditional indemnity plans and other hybrid plans, including consumer-driven health plans, or CDHPs; and hospital only and limited benefit products. In addition, we provide a broad array of managed care services to self-funded customers, including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services. We provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal health care. We also provide services to the federal government in connection with the Federal Employee Program, or FEP. We sold contact lenses, eyeglasses and other ocular products through our 1-800 CONTACTS, Inc., or 1-800 CONTACTS, business which was divested on January 31, 2014.

We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as BCBS in 10 New York City metropolitan and surrounding counties, and as Blue Cross or BCBS in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield, or Empire Blue Cross (in our New York service areas). We also conduct business through an arrangement with another BCBS licensee in South Carolina. We conduct business through our AMERIGROUP Corporation, or Amerigroup, subsidiary, in Florida, Georgia, Kansas, Louisiana, Maryland, Nevada, New Jersey, New Mexico, New York, Tennessee, Texas, Washington and effective January 1, 2016, in Iowa. In addition, we conduct business through our recently acquired Simply Healthcare Holdings, Inc., or Simply Healthcare, subsidiary in Florida. We also serve customers throughout the country as HealthLink, UniCare (including a non-risk arrangement with Massachusetts), and in certain Arizona, California, Nevada and Virginia markets through our CareMore Health Group, Inc., or CareMore, subsidiary. We are licensed to conduct insurance operations in all 50 states through our subsidiaries.

2. Basis of Presentation and Significant Accounting Policies

Basis of Presentation: The accompanying consolidated financial statements include the accounts of Anthem and its subsidiaries and have been prepared in conformity with U.S. generally accepted accounting principles, or GAAP. All significant intercompany accounts and transactions have been eliminated in consolidation.

Certain of our subsidiaries operate outside of the United States and have functional currencies other than the U.S. dollar, or USD. We translate the assets and liabilities of those subsidiaries to USD using the exchange rate in effect at the end of the period. We translate the revenues and expenses of those subsidiaries to USD using the average exchange rates in effect during the period. The net effect of these translation adjustments is included in “Foreign currency translation adjustments” in our consolidated statements of comprehensive income.

Reclassifications: Certain prior year amounts have been reclassified to conform to the current year presentation.

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

Use of Estimates: The preparation of consolidated financial statements in conformity with GAAP requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and Cash Equivalents: Cash and cash equivalents includes available cash and all highly liquid investments with maturities of three months or less when purchased. We control a number of bank accounts that are used exclusively to hold customer funds for the administration of customer benefits. At December 31, 2015 we held \$122.6 of customer cash with an offsetting liability in other current liabilities.

Investments: Certain Financial Accounting Standards Board, or FASB, other-than-temporary impairment, or OTTI, guidance applies to fixed maturity securities and provides guidance on the recognition, presentation of, and disclosures for OTTIs. If a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, the decline in value is deemed to be other-than-temporary and is presented within the Other-than-temporary impairment losses recognized in income line item on our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, the credit component of the OTTI is presented within the Other-than-temporary impairment losses recognized in income line item on our consolidated statements of income and the non-credit component of the OTTI is recognized in other comprehensive income. Furthermore, unrealized losses entirely caused by non-credit related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive income, or AOCI.

The credit component of an OTTI is determined primarily by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting our best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of acquisition. For mortgage-backed and asset-backed securities, cash flow estimates are based on assumptions regarding the underlying collateral including prepayment speeds, vintage, type of underlying asset, geographic concentrations, default rates, recoveries and changes in value. For all other debt securities, cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings, and estimates regarding timing and amount of recoveries associated with a default.

The unrealized gains or losses on our current and long-term equity securities classified as available-for-sale are included in accumulated other comprehensive income as a separate component of shareholders' equity, unless the decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such equity securities until their full cost can be recovered, in which case such equity securities are written down to fair value and the loss is charged to other-than-temporary impairment losses recognized in income.

We maintain various rabbi trusts to account for the assets and liabilities under certain deferred compensation plans. Under these plans, the participants can defer certain types of compensation and elect to receive a return on the deferred amounts based on the changes in fair value of various investment options, primarily a variety of mutual funds. We have corporate-owned life insurance policies on certain participants in the deferred compensation plans. The cash surrender value of the corporate-owned life insurance policies is reported in other invested assets, long-term, in the consolidated balance sheets. The remaining rabbi trust assets are generally invested according to the participant's investment election, and are classified as trading, which are reported in other invested assets, current, in the consolidated balance sheets.

We use the equity method of accounting for investments in companies in which our ownership interest enables us to influence the operating or financial decisions of the investee company. Our proportionate share of equity in net income of these unconsolidated affiliates is reported with net investment income.

For asset-backed securities included in fixed maturity securities, we recognize income using an effective yield based on anticipated prepayments and the estimated economic life of the securities. When estimates of prepayments change, the effective yield is recalculated to reflect actual payments to date and anticipated future payments. The net investment in the securities is adjusted to the amount that would have existed had the new effective yield been applied since the acquisition of the securities. Such adjustments are reported with net investment income.

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

Investment income is recorded when earned. All securities sold resulting in investment gains and losses are recorded on the trade date. Realized gains and losses are determined on the basis of the cost or amortized cost of the specific securities sold.

We participate in securities lending programs whereby marketable securities in our investment portfolio are transferred to independent brokers or dealers in exchange for cash and securities collateral. Under FASB guidance related to accounting for transfers and servicing of financial assets and extinguishments of liabilities, we recognize the collateral as an asset, which is reported as "Securities lending collateral" on our consolidated balance sheets and we record a corresponding liability for the obligation to return the collateral to the borrower, which is reported as "Securities lending payable." The securities on loan are reported in the applicable investment category on our consolidated balance sheets. Unrealized gains or losses on securities lending collateral are included in accumulated other comprehensive income as a separate component of shareholders' equity. The market value of loaned securities and that of the collateral pledged can fluctuate in non-synchronized fashions. To the extent the loaned securities' value appreciates faster or depreciates slower than the value of the collateral pledged, we are exposed to the risk of the shortfall. As a primary mitigating mechanism, the loaned securities and collateral pledged are marked to market on a daily basis and the shortfall, if any, is collected accordingly. Secondly, the collateral level is set at 102% of the value of the loaned securities, which provides a cushion before any shortfall arises. The investment of the cash collateral is subject to market risk, which is managed by limiting the investments to higher quality and shorter duration instruments.

Premium and Self-Funded Receivables: Premium and self-funded receivables include the uncollected amounts from fully-insured and self-funded groups, individuals and government programs, and are reported net of an allowance for doubtful accounts of \$318.3 and \$213.6 at December 31, 2015 and 2014, respectively. The allowance for doubtful accounts is based on historical collection trends and our judgment regarding the ability to collect specific accounts.

Other Receivables: Other receivables include pharmacy rebates, provider advances, claims recoveries, reinsurance, proceeds due from brokers on investment trades, other government receivables and other miscellaneous amounts due to us. These receivables are reported net of an allowance for doubtful accounts of \$301.2 and \$142.2 at December 31, 2015 and 2014, respectively, which is based on historical collection trends and our judgment regarding the ability to collect specific amounts.

Income Taxes: We file a consolidated income tax return. Deferred income tax assets and liabilities are recognized for temporary differences between the financial statement and tax return bases of assets and liabilities based on enacted tax rates and laws. The deferred tax benefits of the deferred tax assets are recognized to the extent realization of such benefits is more likely than not. Deferred income tax expense or benefit generally represents the net change in deferred income tax assets and liabilities during the year, excluding the impact from amounts initially recorded for business combinations, if any, and amounts recorded to accumulated other comprehensive income. Current income tax expense represents the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported.

We account for income tax contingencies in accordance with FASB guidance that contains a model to address uncertainty in tax positions and clarifies the accounting for income taxes by prescribing a minimum recognition threshold, which all income tax positions must achieve before being recognized in the financial statements.

Property and Equipment: Property and equipment is recorded at cost, net of accumulated depreciation. Depreciation is computed principally by the straight-line method over estimated useful lives ranging from fifteen to thirty-nine years for buildings and improvements, three to five years for data processing equipment and computer software, and the lesser of the remaining life of the building lease or seven years for furniture and other equipment. Leasehold improvements are depreciated over the term of the related lease. Certain costs related to the development or purchase of internal-use software are capitalized and amortized.

Goodwill and Other Intangible Assets: FASB guidance requires business combinations to be accounted for using the acquisition method of accounting and it also specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Goodwill represents the excess of cost of acquisition over the fair value of net assets acquired. Other intangible assets represent the values assigned to subscriber bases, provider and hospital networks, Blue Cross and Blue Shield and other trademarks, licenses, non-compete and other agreements. Goodwill and other intangible assets are allocated to reportable segments based on the relative fair value of the components of the businesses acquired.

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Notes to Consolidated Financial Statements (continued)

Goodwill and other intangible assets with indefinite lives are not amortized but are tested for impairment at least annually. We complete our annual impairment tests of existing goodwill and other intangible assets with indefinite lives during the fourth quarter of each year. Certain interim impairment tests are also performed when potential impairment indicators exist or changes in our business or other triggering events occur. Goodwill and other intangible assets are allocated to reporting units for purposes of the annual goodwill impairment test. In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately.

FASB guidance allows for qualitative assessments of whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount for purposes of a goodwill impairment analysis and whether it is more likely than not that an indefinite-lived intangible asset is impaired for purposes of an indefinite-lived intangible asset impairment analysis. Quantitative analysis must be performed if qualitative analyses are not conclusive. Entities also have the option to bypass the assessment of qualitative factors and proceed directly to performing quantitative analyses. We begin our annual tests with quantitative analyses. Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units, including goodwill and other intangible assets with indefinite lives. Estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used.

Fair value for purposes of the goodwill impairment test is calculated using a blend of a projected income and market valuation approach. The projected income approach is developed using assumptions about future revenue, expenses and net income derived from our internal planning process. Our assumed discount rate is based on our industry's weighted-average cost of capital and reflects volatility associated with the cost of equity capital. Market valuations are based on observed multiples of certain measures including membership, revenue, EBITDA (earnings before interest, taxes, depreciation and amortization) and net income as well as market capitalization analyses of Anthem and other comparable companies. A goodwill impairment loss is recognized to the extent that the carrying amount exceeds the asset's fair value. This determination is made at the reporting unit level and consists of two steps. First, the fair value of a reporting unit is determined and compared to its carrying amount. Second, if the carrying amount of a reporting unit exceeds its fair value, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation on a business acquisition, at the impairment test date.

The fair value of indefinite-lived intangible assets is estimated and compared to the carrying value. We estimate the fair value of indefinite-lived intangible assets using a projected income approach. We recognize an impairment loss when the estimated fair value of indefinite-lived intangible assets is less than the carrying value. If significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

Derivative Financial Instruments: We primarily invest in the following types of derivative financial instruments: interest rate swaps, forward contracts, put and call options, credit default swaps, embedded derivatives, warrants and swaptions. Derivatives embedded within non-derivative instruments, such as options embedded in convertible fixed maturity securities, are bifurcated from the host instrument when the embedded derivative is not clearly and closely related to the host instrument. Our use of derivatives is limited by statutes and regulations promulgated by the various regulatory bodies to which we are subject, and by our own derivative policy. Our derivative use is generally limited to hedging purposes, on an economic basis, and we generally do not use derivative instruments for speculative purposes.

We have exposure to economic losses due to interest rate risk arising from changes in the level or volatility of interest rates. We attempt to mitigate our exposure to interest rate risk through active portfolio management, including rebalancing our existing portfolios of assets and liabilities, as well as changing the characteristics of investments to be purchased or sold in the future. In addition, derivative financial instruments are used to modify the interest rate exposure of certain liabilities or forecasted transactions. These strategies include the use of interest rate swaps and forward contracts, which are used to lock-in interest rates or to hedge, on an economic basis, interest rate risks associated with variable rate debt. We have used these types of instruments as designated hedges against specific liabilities.

All investments in derivatives are recorded as assets or liabilities at fair value. If certain correlation, hedge effectiveness and risk reduction criteria are met, a derivative may be specifically designated as a hedge of exposure to changes in fair value or cash flow. The accounting for changes in the fair value of a derivative depends on the intended use of the derivative and

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Notes to Consolidated Financial Statements (continued)

the nature of any hedge designation thereon. Amounts excluded from the assessment of hedge effectiveness, if any, as well as the ineffective portion of the gain or loss, are reported in results of operations immediately. If the derivative is not designated as a hedge, the gain or loss resulting from the change in the fair value of the derivative is recognized in results of operations in the period of change. Cash flows associated with the settlement of non-designated derivatives are shown on a net basis in investing activity in our consolidated statements of cash flow.

From time to time, we may also purchase derivatives to hedge, on an economic basis, our exposure to foreign currency exchange fluctuations associated with the operations of certain of our subsidiaries. We generally use futures or forward contracts for these transactions. We generally do not designate these contracts as hedges and, accordingly, the changes in fair value of these derivatives are recognized in income immediately.

Credit exposure associated with non-performance by the counterparties to derivative instruments is generally limited to the uncollateralized fair value of the asset related to instruments recognized in the consolidated balance sheets. We attempt to mitigate the risk of non-performance by selecting counterparties with high credit ratings and monitoring their creditworthiness and by diversifying derivatives among multiple counterparties. At December 31, 2015, we believe there were no material concentrations of credit risk with any individual counterparty.

We generally enter into master netting agreements, which reduce credit risk by permitting net settlement of transactions with the same counterparty. Certain of our derivative agreements also contain credit support provisions that require us or the counterparty to post collateral if there are declines in the derivative fair value or our credit rating. The derivative assets and derivative liabilities are reported at their fair values net of collateral and netting by the counterparty. At December 31, 2015 we had posted collateral of \$182.7 and received collateral of \$32.2 related to our derivative financial instruments.

Retirement Benefits: We recognize the funded status of pension and other postretirement benefit plans on the consolidated balance sheets based on fiscal-year-end measurements of plan assets and benefit obligations. Prepaid pension benefits represent prepaid costs related to defined benefit pension plans and are reported with other noncurrent assets. Postretirement benefits represent outstanding obligations for retiree medical, life, vision and dental benefits. Liabilities for pension and other postretirement benefits are reported with current and noncurrent liabilities based on the amount by which the actuarial present value of benefits payable in the next twelve months included in the benefit obligation exceeds the fair value of plan assets.

We determine the expected return on plan assets using the calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over three years. We apply a corridor approach to amortize unrecognized actuarial gains or losses. Under this approach, only accumulated net actuarial gains or losses in excess of 10% of the greater of the projected benefit obligation or the fair value of plan assets are amortized over the average remaining service or lifetime of the workforce as a component of net periodic benefit cost.

Medical Claims Payable: Liabilities for medical claims payable include estimated provisions for incurred but not paid claims on an undiscounted basis, as well as estimated provisions for expenses related to the processing of claims. Incurred but not paid claims include (1) an estimate for claims that are incurred but not reported, as well as claims reported to us but not yet processed through our systems; and (2) claims reported to us and processed through our systems but not yet paid.

Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in aggregate by employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be appropriate under moderately adverse circumstances. We determine the amount of the liability for incurred but not paid claims by following a detailed actuarial process that entails using both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities.

We regularly review and set assumptions regarding cost trends and utilization when initially establishing claim liabilities. We continually monitor and adjust the claims liability and benefit expense based on subsequent paid claims activity. If our assumptions regarding cost trends and utilization are significantly different than actual results, our income statement and financial position could be impacted in future periods.

Premium deficiencies are recognized when it is probable that expected claims and administrative expenses will exceed future premiums on existing medical insurance contracts without consideration of investment income. Determination of

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Notes to Consolidated Financial Statements (continued)

premium deficiencies for longer duration life and disability contracts includes consideration of investment income. For purposes of premium deficiencies, contracts are deemed to be either short or long duration and are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts. Once established, premium deficiencies are released commensurate with actual claims experience over the remaining life of the contract. No premium deficiencies were established at December 31, 2015 or 2014.

Reserves for Future Policy Benefits: Reserves for future policy benefits include liabilities for life and long-term disability insurance policy benefits based upon interest, mortality and morbidity assumptions from published actuarial tables, modified based upon our experience. Future policy benefits also include liabilities for insurance policies for which some of the premiums received in earlier years are intended to pay anticipated benefits to be incurred in future years. Future policy benefits are continually monitored and reviewed, and when reserves are adjusted, differences are reflected in benefit expense.

The current portion of reserves for future policy benefits relates to the portion of such reserves that we expect to pay within one year. We believe that our liabilities for future policy benefits, along with future premiums received are adequate to satisfy our ultimate benefit liability; however, these estimates are inherently subject to a number of variable circumstances. Consequently, the actual results could differ materially from the amounts recorded in our consolidated financial statements.

Other Policyholder Liabilities: Other policyholder liabilities include rate stabilization reserves associated with retrospectively rated insurance contracts and certain case-specific reserves. Other policyholder liabilities also includes liabilities for premium refunds based upon the minimum medical loss ratio, or MLR, the relative health risk of members, or other contractual or regulatory requirements. Rate stabilization reserves represent accumulated premiums that exceed what customers owe us based on actual claim experience. The timing of payment of these retrospectively rated refunds is based on the contractual terms with the customers and can vary from period to period based on the specific contractual requirements.

We are required to meet certain minimum MLR thresholds prescribed by the Patient Protection and Affordable Care Act, or ACA, and related Health Care and Education Reconciliation Act of 2010, or collectively, Health Care Reform. If we do not meet or exceed the minimum MLR thresholds specified by Health Care Reform, we are required to pay rebates to certain customers. Minimum MLR rebates are calculated by applicable line of business (Large Group, Small Group, Individual and Medicare) and legal entity in accordance with regulations issued by the Department of Health and Human Services, or HHS. Such calculations are made using estimated calendar year medical loss expense and premiums, as defined by HHS.

We follow HHS guidelines for determining the types of expenses that may be included in our minimum MLR rebate calculations, which differ from benefit expense and premiums as reported in our consolidated financial statements prepared in conformity with GAAP. Certain amounts reported as expense in our GAAP basis consolidated financial statements may be reported as a reduction of premiums in accordance with HHS regulations. In addition, profit amounts included in our payments to third party administrative service providers are recorded as benefit expense in our consolidated GAAP financial statements while HHS does not allow for the inclusion of these expenses within the medical loss expense for purposes of calculating minimum MLR.

Revenue Recognition: Premiums for fully-insured contracts are recognized as revenue over the period insurance coverage is provided, and, if applicable, net of amounts recognized for the Health Care Reform minimum MLR rebates, risk adjustment, reinsurance and risk corridor or contractual premium stabilization programs. Premium payments from contracted government agencies are based on eligibility lists produced by the government agencies. Premiums related to the unexpired contractual coverage periods are reflected in the accompanying consolidated balance sheets as unearned income. Premiums include revenue from retrospectively rated contracts where revenue is based on the estimated ultimate loss experience of the contract. Premium revenue includes an adjustment for retrospectively rated refunds based on an estimate of incurred claims. Premium rates for certain lines of business are subject to approval by the Department of Insurance of each respective state. Additionally, delays in annual premium rate changes from contracted government agencies require that we defer the recognition of any increases to the period in which the premium rates become final. The value of the impact can be significant in the period in which it is recognized dependent on the magnitude of the premium rate increase, the membership to which it applies and the length of the delay between the effective date of the rate increase and the final contract date. Premium rate decreases are recognized in the period the change in premium rate becomes effective and the change in the rate is known, which may be prior to the period when the contract amendment affecting the rate is finalized.

Administrative fees include revenue from certain group contracts that provide for the group to be at risk for all, or with supplemental insurance arrangements, a portion of their claims experience. We charge these self-funded groups an

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Notes to Consolidated Financial Statements (continued)

administrative fee, which is based on the number of members in a group or the group's claim experience. In addition, administrative fees include amounts received for the administration of Medicare or certain other government programs. Under our self-funded arrangements, revenue is recognized as administrative services are performed. All benefit payments under these programs are excluded from benefit expense.

Share-Based Compensation: Our current compensation philosophy provides for share-based compensation, including stock options, restricted stock awards and an employee stock purchase plan. Stock options are granted for a fixed number of shares with an exercise price at least equal to the fair value of the shares at the date of the grant. Restricted stock awards are issued at the fair value of the stock on the grant date. The employee stock purchase plan allows for a purchase price per share which is 95% of the fair value of a share of common stock on the last trading day of the plan quarter. The employee stock purchase plan discount is not recognized as compensation expense based on GAAP guidance. All other share-based payments to employees are recognized as compensation expense in the income statement based on their fair values. Additionally, excess tax benefits, which result from actual tax benefits exceeding deferred tax benefits previously recognized based on grant date fair value, are recognized as additional paid-in-capital and are reclassified from operating cash flows to financing cash flows in the consolidated statements of cash flows. Our share-based employee compensation plans and assumptions are described in Note 14, "Capital Stock."

Advertising and Marketing Costs: We use print, broadcast and other advertising to promote our products and to develop our corporate image. We market our products through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships for Individual and Medicare customers, and for certain Local Group customers with a smaller employee base. Products for National Accounts and Local Group customers with a larger employee base are generally sold through independent brokers or consultants retained by the customer and working with industry specialists from our in-house sales force. In the Individual and Small Group markets we offer products through state or federally facilitated marketplaces, or public exchanges, and off-exchange products. The cost of advertising and marketing for product promotion is expensed as incurred while advertising and marketing costs associated with corporate image is expensed when first aired. Total advertising and marketing expense was \$313.5, \$337.0 and \$350.9 for the years ended December 31, 2015, 2014 and 2013, respectively.

Health Insurance Provider Fee: Beginning in 2014, Health Care Reform imposed an annual Health Insurance Provider Fee, or HIP Fee, on health insurers that write certain types of health insurance on U.S. risks. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to an adjusted amount of health insurance for all U.S. health risk for those certain lines of business written during the preceding calendar year. The HIP Fee is non-deductible for federal income tax purposes. The total amount collected from allocations to health insurers in 2015 and 2014 was \$11,300.0 and \$8,000.0, respectively. We record our estimated liability for the HIP Fee in full at the beginning of the year with a corresponding deferred asset that is amortized on a straight-line basis to general and administrative expense. The final calculation and payment of the annual HIP Fee occurs in the third quarter each year and our portion of the HIP Fee for 2015 and 2014 was \$1,207.5 and \$893.3, respectively. The annual HIP Fee to be allocated to all health insurers remains at \$11,300.0 for 2016, has been suspended for 2017 and will resume and be increased to \$14,300.0 for 2018. For 2019 and beyond, the annual HIP Fee will equal the amount for the preceding year increased by the rate of premium growth for the preceding year less the rate of growth in the consumer price index for the preceding calendar year.

Earnings per Share: Earnings per share amounts, on a basic and diluted basis, have been calculated based upon the weighted-average common shares outstanding for the period.

Basic earnings per share excludes dilution and is computed by dividing income available to common shareholders by the weighted-average number of common shares outstanding for the period. Diluted earnings per share includes the dilutive effect of stock options, restricted stock and convertible debentures, using the treasury stock method. The treasury stock method assumes exercise of stock options and vesting of restricted stock, with the assumed proceeds used to purchase common stock at the average market price for the period. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Recently Adopted Accounting Guidance: In November 2015, the FASB issued Accounting Standards Update No. 2015-17, *Balance Sheet Classification of Deferred Taxes*, or ASU 2015-17. This amendment requires that all deferred tax assets and liabilities, along with any related valuation allowance, be classified as noncurrent on the balance sheet. Prior to the

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Notes to Consolidated Financial Statements (continued)

issuance of ASU 2015-17, deferred taxes were required to be presented as a net current asset or liability and a net noncurrent asset or liability. We adopted the provisions of ASU 2015-17 upon issuance and prior period amounts have been reclassified to conform to the current period presentation. As of December 31, 2014, the previously reported balance of our net current deferred tax assets of \$280.4 was reclassified in the consolidated balance sheet and netted against the net long-term deferred tax liabilities. The adoption of ASU 2015-17 did not impact our consolidated financial position, results of operations or cash flows.

In September 2015, the FASB issued Accounting Standards Update No. 2015-16, *Business Combinations (Topic 805): Simplifying the Accounting for Measurement-Period Adjustments*, or ASU 2015-16. This amendment requires the acquirer in a business combination to recognize in the reporting period in which adjustment amounts are determined, any adjustments to provisional amounts that are identified during the measurement period, calculated as if the accounting had been completed at the acquisition date. Prior to the issuance of ASU 2015-16, an acquirer was required to restate prior period financial statements as of the acquisition date for adjustments to provisional amounts. The amendments in ASU 2015-16 are to be applied prospectively upon adoption. The adoption of the provisions of ASU 2015-16 upon issuance did not have a material impact on our consolidated financial position, results of operations or cash flows.

In April 2015, the FASB issued Accounting Standards Update No. 2015-03, *Interest - Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs*, or ASU 2015-03. ASU 2015-03 amends current presentation guidance by requiring that debt issuance costs related to a recognized debt liability be presented in the balance sheet as a direct deduction from the carrying amount of that debt liability, consistent with debt discounts. Prior to the issuance of ASU 2015-03, debt issuance costs were required to be presented as an asset in the balance sheet. We adopted the provisions of ASU 2015-03 upon issuance and prior period amounts have been reclassified to conform to the current period presentation. As of December 31, 2014, \$0.7 of debt issuance costs were reclassified in the consolidated balance sheet from other current assets to current portion of long-term debt and \$107.6 was reclassified from other noncurrent assets to long-term debt, less current portion. The adoption of ASU 2015-03 did not impact our consolidated financial position, results of operations or cash flows.

In June 2014, the FASB issued Accounting Standards Update No. 2014-11, *Transfers and Servicing (Topic 860): Repurchase-to-Maturity Transactions, Repurchase Financings, and Disclosures*, or ASU 2014-11. This amendment requires repurchase-to-maturity transactions to be accounted for as secured borrowings and eliminates previous guidance for repurchase financings. The amendment also expands the disclosure requirements related to certain transactions accounted for as secured borrowings and certain transfers accounted for as sales when the transferor also retains substantially all of the exposure to the economic return on the transferred financial assets throughout the term of the transaction. The amendments related to the accounting of, and disclosure requirements for, certain transactions accounted for as a sale became effective as of January 1, 2015 and did not have an impact on our consolidated financial position, results of operations, cash flows or disclosures. The new disclosure requirements for repurchase agreements, securities lending transactions and repurchase-to-maturity transactions accounted for as secured borrowings became effective as of April 1, 2015. See Note 4, "Investments - Securities Lending Programs," for additional disclosure information related to the adoption of ASU 2014-11.

Recent Accounting Guidance Not Yet Adopted: In January 2016, the FASB issued Accounting Standards Update No. 2016-01, *Financial Instruments - Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities*, or ASU 2016-01. The amendments in ASU 2016-01 change the accounting for non-consolidated equity investments that are not accounted for under the equity method of accounting by requiring changes in fair value to be recognized in income. Under current guidance, changes in fair value for investments of this nature are recognized in accumulated other comprehensive income as a component of shareholders' equity. Additionally, ASU 2016-01 simplifies the impairment assessment of equity investments without readily determinable fair values; requires entities to use the exit price when estimating the fair value of financial instruments; and modifies various presentation disclosure requirements for financial instruments. ASU 2016-01 is effective for interim and annual reporting periods beginning after December 15, 2017. We are currently evaluating the effects the adoption of ASU 2016-01 will have on our results of operations and related disclosures.

In August 2015, the FASB issued Accounting Standards Update No. 2015-14, *Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date*. This amendment defers the effective date of the previously issued Accounting Standards Update No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*, or ASU 2014-09, until the interim and annual reporting periods beginning after December 15, 2017. Earlier application is permitted for interim and annual reporting

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Notes to Consolidated Financial Statements (continued)

periods beginning after December 15, 2016. We intend to adopt the provisions of ASU 2014-09 for interim and annual reporting periods beginning after December 15, 2017. Upon the effective date, ASU 2014-09 will supersede almost all existing revenue recognition guidance under GAAP, with certain exceptions, including an exception for revenue accounted for in accordance with the provisions of Accounting Standards Codification Topic 944, *Financial Services - Insurance*, or Topic 944. ASU 2014-09 will require a company to recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. An entity has the option to apply the provisions of ASU 2014-09 either retrospectively to each prior reporting period presented or retrospectively with the cumulative effect of initially applying the new guidance recognized at the date of initial application. We are currently evaluating the effects the adoption of ASU 2014-09 will have on our results of operations, cash flows, consolidated financial position and related disclosures.

In May 2015, the FASB issued Accounting Standards Update No. 2015-09, *Financial Services—Insurance (Topic 944): Disclosures about Short-Duration Contracts*, or ASU 2015-09. This amendment requires new and expanded disclosures in interim and annual reporting periods related to the liability for unpaid claims and claim adjustment expenses for short-duration insurance contracts. ASU 2015-09 is effective for annual reporting periods beginning after December 15, 2015, and interim reporting periods within annual reporting periods beginning after December 15, 2016. The adoption of ASU 2015-09 will not impact our consolidated financial position, results of operations or cash flows.

In April 2015, the FASB issued Accounting Standards Update No. 2015-05, *Intangibles - Goodwill and Other - Internal-Use Software (Subtopic 350-40): Customer's Accounting for Fees Paid in a Cloud Computing Arrangement*, or ASU 2015-05. This amendment provides guidance to help entities determine whether a cloud computing arrangement contains a software license that should be accounted for as internal-use software or as a service contract. ASU 2015-05 is effective for interim and annual reporting periods beginning after December 15, 2015. Upon adoption, an entity has the option to apply the provisions of ASU 2015-05 either prospectively to all arrangements entered into or materially modified, or retrospectively. The adoption of ASU 2015-05 is not expected to have a material impact on our consolidated financial position, results of operations or cash flows.

In February 2015, the FASB issued Accounting Standards Update No. 2015-02, *Consolidation (Topic 810): Amendments to the Consolidation Analysis*, or ASU 2015-02. ASU 2015-02 amends current consolidation guidance by modifying the evaluation of whether limited partnerships and similar legal entities are variable interest entities or voting interest entities, eliminating the presumption that a general partner should consolidate a limited partnership, and affects the consolidation analysis of reporting entities that are involved with variable interest entities. ASU No. 2015-02 is effective for interim and annual reporting periods beginning after December 15, 2015. All legal entities are subject to reevaluation under the revised consolidation model. The adoption of ASU 2015-02 is not expected to have a material impact on our consolidated financial position, results of operations or cash flows.

There were no other new accounting pronouncements that were issued or became effective during the year ended December 31, 2015 that had, or are expected to have, a material impact on our financial position, results of operations, cash flows or financial statement disclosures.

3. Business Acquisitions and Divestiture

Pending Acquisition of Cigna Corporation

On July 24, 2015, we and Cigna Corporation, or Cigna, announced that we entered into an Agreement and Plan of Merger, or Merger Agreement, dated as of July 23, 2015, by and among Anthem, Cigna and Anthem Merger Sub Corp., a Delaware corporation and our direct wholly-owned subsidiary, pursuant to which we will acquire all outstanding shares of Cigna, or the Acquisition. The Acquisition will further our goal of creating a premier health benefits company with critical diversification and scale to lead the transformation of health care delivery for consumers. Cigna is a global health services organization that delivers affordable and personalized products and services to customers through employer-based, government-sponsored and individual coverage arrangements. All of Cigna's products and services are provided exclusively by or through its operating subsidiaries, including Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Life Insurance Company of North America and Cigna Life Insurance Company of New York. Such products and services include an integrated suite of health services, such as medical, dental, behavioral health, pharmacy,

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Notes to Consolidated Financial Statements (continued)

vision, supplemental benefits, and other related products including group life, accident and disability insurance. Cigna maintains sales capability in 30 countries and jurisdictions.

Under the terms of the Merger Agreement, Cigna's shareholders will receive \$103.40 in cash and 0.5152 shares of our common stock for each Cigna common share outstanding. The value of the transaction is estimated to be approximately \$53,000.0 based on the closing price of our common stock on the New York Stock Exchange on July 23, 2015. The final purchase price will be determined based on our closing stock price on the date of closing of the Acquisition. The combined company will reflect a pro forma equity ownership comprised of approximately 67% Anthem shareholders and approximately 33% Cigna shareholders. We expect to finance the cash portion of the Acquisition through available cash on hand and the issuance of new debt. We entered into a bridge facility commitment letter and a joinder agreement with a group of lenders which will provide up to \$22,500.0 under a 364-day senior unsecured bridge term loan credit facility to finance the Acquisition in the event that we have not received proceeds from any combination of (i) senior unsecured term loans, (ii) common or preferred equity or equity-linked securities and/or (iii) senior unsecured notes in a public offering or private placement in an aggregate principal amount of at least \$22,500.0 prior to the consummation of the Acquisition. In addition, in August 2015, we entered into a term loan facility which will provide up to \$4,000.0 to finance a portion of the Acquisition. The commitment of the lenders to provide the bridge facility and the term loan facility is subject to several conditions, including the completion of the Acquisition.

Acquisition of Simply Healthcare

On February 17, 2015, we completed our acquisition of Simply Healthcare, a leading managed care company for people enrolled in Medicaid and Medicare programs in Florida. This acquisition aligns with our strategy for continued growth in our Government Business segment.

In accordance with FASB accounting guidance for business combinations, the consideration transferred was allocated to the fair value of Simply Healthcare's assets acquired and liabilities assumed, including identifiable intangible assets. The excess of the consideration transferred over the fair value of net assets acquired resulted in non-tax-deductible goodwill of \$474.7 at December 31, 2015, all of which was allocated to our Government Business segment. Goodwill recognized from the acquisition of Simply Healthcare primarily relates to the future economic benefits arising from the assets acquired and is consistent with our stated intentions to strengthen our position and expand operations in the government sector to service Medicaid and Medicare enrollees. Subsequent to the acquisition date, we recognized a \$14.2 reduction to goodwill primarily related to adjustments to provisional amounts of intangible assets recorded on the acquisition date.

The fair value of the net assets acquired from Simply Healthcare includes \$430.0 of other intangible assets, which primarily consist of indefinite-lived state licenses and finite-lived customer relationships with amortization periods ranging from 2 to 4 years.

The results of operations of Simply Healthcare are included in our consolidated financial statements within our Government Business segment for the period following February 17, 2015. The pro-forma effects of this acquisition for prior periods were not material to our consolidated results of operations.

Divestiture of 1-800 CONTACTS

In December 2013, we entered into a definitive agreement to sell our 1-800 CONTACTS business to the private equity firm Thomas H. Lee Partners, L.P. Additionally, we entered into an asset purchase agreement with Luxottica Group to sell our glasses.com related assets, or collectively, 1-800 CONTACTS. The operating results for 1-800 CONTACTS are reported as discontinued operations in the accompanying consolidated statements of income. These results were previously reported in the Commercial and Specialty Business segment.

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The sales were completed on January 31, 2014 and did not result in any material difference to the loss on disposal from discontinued operations recorded during the year ended December 31, 2013. Prior to the sales, 2014 income from discontinued operations, net of tax, was \$9.6. Summarized financial information for the 1-800 CONTACTS discontinued operations for the year ended December 31, 2013 is as follows:

	2013
Revenues	\$ 434.7
Income from discontinued operations before tax	\$ 17.3
Income tax benefit	(2.6)
Income from discontinued operations	19.9
Loss on disposal from discontinued operations, net of tax	(164.5)
Loss from discontinued operations, net of tax	\$ (144.6)

In connection with the sale of 1-800 CONTACTS, we recognized a loss on disposal of \$221.8, net of an income tax benefit of \$57.3 for the year ended December 31, 2013. The loss on disposal was calculated as the difference between the fair value, as determined by the sales agreements less costs to sell, and the carrying value of the held for sale assets at December 31, 2013.

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Notes to Consolidated Financial Statements (continued)

4. Investments

A summary of current and long-term investments, available-for-sale, at December 31, 2015 and 2014 is as follows:

			Gross Unrealized Losses				Non-Credit Component of Other-Than- Temporary Impairments Recognized in AOCI
	Cost or Amortized Cost	Gross Unrealized Gains	Less than 12 Months	12 Months or Greater	Estimated Fair Value		
December 31, 2015							
Fixed maturity securities:							
United States Government securities	\$ 349.5	\$ 2.0	\$ (1.6)	\$ —	\$ 349.9	\$	—
Government sponsored securities	75.6	0.5	(0.1)	(0.1)	75.9		—
States, municipalities and political subdivisions, tax-exempt	5,976.7	284.1	(4.0)	(5.2)	6,251.6		—
Corporate securities	8,209.7	61.1	(267.2)	(110.5)	7,893.1		(15.4)
Residential mortgage-backed securities	1,724.5	41.2	(7.6)	(7.2)	1,750.9		—
Commercial mortgage-backed securities	407.6	1.4	(4.3)	(0.4)	404.3		—
Other debt securities	756.8	4.1	(5.8)	(2.6)	752.5		—
Total fixed maturity securities	17,500.4	394.4	(290.6)	(126.0)	17,478.2	\$	(15.4)
Equity securities	1,083.1	420.6	(30.9)	—	1,472.8		
Total investments, available-for-sale	\$ 18,583.5	\$ 815.0	\$ (321.5)	\$ (126.0)	\$ 18,951.0		
December 31, 2014							
Fixed maturity securities:							
United States Government securities	\$ 315.7	\$ 4.6	\$ (0.3)	\$ —	\$ 320.0	\$	—
Government sponsored securities	94.6	0.8	—	(0.4)	95.0		—
States, municipalities and political subdivisions, tax-exempt	5,451.4	287.0	(1.8)	(3.0)	5,733.6		—
Corporate securities	8,335.9	162.9	(123.1)	(43.2)	8,332.5		(6.8)
Options embedded in convertible securities	98.7	—	—	—	98.7		—
Residential mortgage-backed securities	2,099.7	68.9	(1.0)	(8.6)	2,159.0		—
Commercial mortgage-backed securities	504.8	6.1	(0.6)	(0.4)	509.9		—
Other debt securities	720.3	6.1	(1.7)	(1.6)	723.1		—
Total fixed maturity securities	17,621.1	536.4	(128.5)	(57.2)	17,971.8	\$	(6.8)
Equity securities	1,330.7	618.5	(11.1)	—	1,938.1		
Total investments, available-for-sale	\$ 18,951.8	\$ 1,154.9	\$ (139.6)	\$ (57.2)	\$ 19,909.9		

At December 31, 2015, we owned \$2,155.2 of mortgage-backed securities and \$698.6 of asset-backed securities out of a total available-for-sale investment portfolio of \$18,951.0. These securities included sub-prime and Alt-A securities with fair values of \$30.9 and \$58.2, respectively. These sub-prime and Alt-A securities had accumulated net unrealized gains of \$1.0 and \$3.3, respectively. The average credit rating of the sub-prime and Alt-A securities was “CCC” and “CC”, respectively.

At December 31, 2015, we owned \$777.2 of energy sector fixed maturity securities out of a total available-for-sale investment portfolio of \$18,951.0. These energy sector securities had accumulated net unrealized losses of \$172.0.

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

For available-for-sale securities in an unrealized loss position at December 31, 2015 and 2014, the following table summarizes the aggregate fair values and gross unrealized losses by length of time those securities have continuously been in an unrealized loss position.

	Less than 12 Months			12 Months or Greater		
	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss
<i>(Securities are whole amounts)</i>						
December 31, 2015						
Fixed maturity securities:						
United States Government securities	48	\$ 248.4	\$ (1.6)	2	\$ 0.9	\$ —
Government sponsored securities	13	18.3	(0.1)	6	8.2	(0.1)
States, municipalities and political subdivisions, tax-exempt	198	467.8	(4.0)	43	83.0	(5.2)
Corporate securities	2,492	4,912.3	(267.2)	372	447.0	(110.5)
Residential mortgage-backed securities	298	668.3	(7.6)	119	186.3	(7.2)
Commercial mortgage-backed securities	66	263.0	(4.3)	17	38.5	(0.4)
Other debt securities	153	488.2	(5.8)	28	77.0	(2.6)
Total fixed maturity securities	3,268	7,066.3	(290.6)	587	840.9	(126.0)
Equity securities	792	261.1	(30.9)	—	—	—
Total fixed maturity and equity securities	4,060	\$ 7,327.4	\$ (321.5)	587	\$ 840.9	\$ (126.0)
December 31, 2014						
Fixed maturity securities:						
United States Government securities	17	\$ 145.3	\$ (0.3)	2	\$ 0.9	\$ —
Government sponsored securities	2	0.3	—	16	29.3	(0.4)
States, municipalities and political subdivisions, tax-exempt	136	315.6	(1.8)	80	174.3	(3.0)
Corporate securities	1,802	3,213.3	(123.1)	314	514.6	(43.2)
Residential mortgage-backed securities	78	155.0	(1.0)	186	398.3	(8.6)
Commercial mortgage-backed securities	43	156.2	(0.6)	10	33.2	(0.4)
Other debt securities	79	270.6	(1.7)	21	65.0	(1.6)
Total fixed maturity securities	2,157	4,256.3	(128.5)	629	1,215.6	(57.2)
Equity securities	407	125.4	(11.1)	—	—	—
Total fixed maturity and equity securities	2,564	\$ 4,381.7	\$ (139.6)	629	\$ 1,215.6	\$ (57.2)

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

The amortized cost and fair value of available-for-sale fixed maturity securities at December 31, 2015, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because the issuers of the securities may have the right to prepay obligations.

	Amortized Cost	Estimated Fair Value
Due in one year or less	\$ 276.6	\$ 278.6
Due after one year through five years	4,872.9	4,792.3
Due after five years through ten years	5,392.0	5,390.1
Due after ten years	4,826.8	4,862.0
Mortgage-backed securities	2,132.1	2,155.2
Total available-for-sale fixed maturity securities	<u>\$ 17,500.4</u>	<u>\$ 17,478.2</u>

The major categories of net investment income (loss) for the years ended December 31 are as follows:

	2015	2014	2013
Fixed maturity securities	\$ 679.0	\$ 644.1	\$ 638.9
Equity securities	61.7	57.7	45.9
Cash equivalents	0.7	0.8	1.0
Other	(22.6)	66.3	19.8
Investment income	<u>718.8</u>	<u>768.9</u>	<u>705.6</u>
Investment expense	<u>(41.2)</u>	<u>(44.5)</u>	<u>(46.5)</u>
Net investment income	<u>\$ 677.6</u>	<u>\$ 724.4</u>	<u>\$ 659.1</u>

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

Net realized investment gains/losses and net change in unrealized appreciation/depreciation in investments for the years ended December 31 are as follows:

	2015	2014	2013
Net realized gains (losses) on investments:			
Fixed maturity securities:			
Gross realized gains from sales	\$ 135.9	\$ 198.2	\$ 225.9
Gross realized losses from sales	(182.1)	(50.6)	(125.7)
Net realized (losses) gains from sales of fixed maturity securities	(46.2)	147.6	100.2
Equity securities:			
Gross realized gains from sales	233.4	93.5	189.6
Gross realized losses from sales	(45.1)	(13.9)	(13.4)
Net realized gains from sales of equity securities	188.3	79.6	176.2
Other investments:			
Gross realized gains from sales	139.8	14.4	107.2
Gross realized losses from sales	(124.4)	(64.6)	(111.7)
Net realized gains (losses) from sales of other investments	15.4	(50.2)	(4.5)
Net realized gains on investments	157.5	177.0	271.9
Other-than-temporary impairment losses recognized in income:			
Fixed maturity securities	(31.2)	(22.3)	(42.5)
Equity securities	(35.6)	(13.5)	(13.9)
Other invested assets, long-term	(16.6)	(13.2)	(42.5)
Other-than-temporary impairment losses recognized in income	(83.4)	(49.0)	(98.9)
Change in net unrealized (losses) gains on investments:			
Fixed maturity securities	(372.9)	145.2	(679.8)
Equity securities	(217.7)	36.5	225.4
Other invested assets, long-term	(4.1)	—	—
Total change in net unrealized (losses) gains on investments	(594.7)	181.7	(454.4)
Deferred income tax benefit (expense)	210.4	(63.1)	159.7
Net change in net unrealized (losses) gains on investments	(384.3)	118.6	(294.7)
Net realized gains on investments, other-than-temporary impairment losses recognized in income and net change in net unrealized (losses) gains on investments	\$ (310.2)	\$ 246.6	\$ (121.7)

A primary objective in the management of our fixed maturity and equity portfolios is to maximize total return relative to underlying liabilities and respective liquidity needs. In achieving this goal, assets may be sold to take advantage of market conditions or other investment opportunities as well as tax considerations. Sales will generally produce realized gains and losses. In the ordinary course of business, we may sell securities at a loss for a number of reasons, including, but not limited to: (i) changes in the investment environment; (ii) expectations that the fair value could deteriorate further; (iii) desire to reduce exposure to an issuer or an industry; (iv) changes in credit quality; or (v) changes in expected cash flow.

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

Proceeds from fixed maturity securities, equity securities and other invested assets and the related gross realized gains and gross realized losses for the years ended December 31 are as follows:

	2015	2014	2013
Proceeds	\$ 11,779.8	\$ 10,255.9	\$ 13,662.8
Gross realized gains	509.1	306.1	522.7
Gross realized losses	(351.6)	(129.1)	(250.8)

A significant judgment in the valuation of investments is the determination of when an other-than-temporary decline in value has occurred. We follow a consistent and systematic process for recognizing impairments on securities that sustain other-than-temporary declines in value. We have established a committee responsible for the impairment review process. The decision to impair a security incorporates both quantitative criteria and qualitative information. The impairment review process considers a number of factors including, but not limited to: (i) the length of time and the extent to which the fair value has been less than book value, (ii) the financial condition and near term prospects of the issuer, (iii) our intent and ability to retain impaired investments for a period of time sufficient to allow for any anticipated recovery in fair value, (iv) our intent to sell or the likelihood that we will need to sell a fixed maturity security before recovery of its amortized cost basis, (v) whether the debtor is current on interest and principal payments, (vi) the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors) and (vii) general market conditions and industry or sector specific factors. For securities that are deemed to be other-than-temporarily impaired, the security is adjusted to fair value and the resulting losses are recognized in the consolidated statements of income. The new cost basis of the impaired securities is not increased for future recoveries in fair value.

Other-than-temporary impairments recorded in 2015, 2014 and 2013 were primarily the result of the continued credit deterioration on specific issuers in the bond markets and the fair values of certain equity securities remaining below cost for an extended period of time. There were no individually significant OTTI losses on investments by issuer during 2015, 2014 or 2013.

Investment securities are exposed to various risks, such as interest rate, market and credit. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is possible that changes in these risk factors in the near term could have an adverse material impact on our results of operations or shareholders' equity.

The changes in the amount of the credit component of OTTI losses on fixed maturity securities recognized in income, for which a portion of the OTTI losses was recognized in other comprehensive income, was not material for the years ended December 31, 2015, 2014 or 2013.

At December 31, 2015 and 2014, no investments exceeded 10% of shareholders' equity.

At December 31, 2015 and 2014, the carrying value of fixed maturity investments that did not produce income during the years then ended were \$0.2 and \$9.2, respectively.

As of December 31, 2015 we had committed approximately \$662.3 to future capital calls from various third-party investments in exchange for an ownership interest in the related entities.

At December 31, 2015 and 2014, securities with carrying values of approximately \$558.2 and \$504.4, respectively, were deposited by our insurance subsidiaries under requirements of regulatory authorities.

In the tables above, certain amounts for the years ended December 31, 2014 and 2013 have been reclassified to conform to the current year presentation. The reclassifications do not impact amounts presented in the financial statements.

Securities Lending Programs

The fair value of the collateral received at the time of the securities lending transactions amounted to \$1,300.9 and \$1,515.3 at December 31, 2015 and 2014, respectively. The value of the collateral represented 103% of the market value of the securities on loan at December 31, 2015 and 2014.

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

The remaining contractual maturity of our securities lending agreements at December 31, 2015 is as follows:

	Overnight and Continuous	Less than 30 days	30-90 days	Greater Than 90 days	Total
Securities lending transactions					
United States Government securities	\$ 102.3	\$ 9.7	\$ 1.0	\$ 32.1	\$ 145.1
Corporate securities	813.3	—	—	—	813.3
Equity securities	300.2	6.3	—	—	306.5
Other debt securities	36.0	—	—	—	36.0
Total	<u>\$ 1,251.8</u>	<u>\$ 16.0</u>	<u>\$ 1.0</u>	<u>\$ 32.1</u>	<u>\$ 1,300.9</u>

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

5. Derivative Financial Instruments

A summary of the aggregate contractual or notional amounts and estimated fair values related to derivative financial instruments at December 31, 2015 and 2014 is as follows:

	Contractual/ Notional Amount	Balance Sheet Location	Estimated Fair Value	
			Asset	(Liability)
December 31, 2015				
Hedging instruments				
Interest rate swaps - fixed to floating	\$ 1,385.0	Other assets/other liabilities	\$ 7.0	\$ (0.8)
Interest rate swaps - forward starting pay fixed	4,650.0	Other assets/other liabilities	15.7	(90.9)
Subtotal hedging	6,035.0	Subtotal hedging	22.7	(91.7)
Non-hedging instruments				
Interest rate swaps	271.7	Equity securities	1.2	(6.0)
Options	16,917.4	Other assets/other liabilities	305.7	(332.1)
Futures	—	Equity securities	0.1	(0.2)
Subtotal non-hedging	17,189.1	Subtotal non-hedging	307.0	(338.3)
Total derivatives	\$ 23,224.1	Total derivatives	329.7	(430.0)
		Amounts netted	(170.6)	170.6
		Net derivatives	\$ 159.1	\$ (259.4)
December 31, 2014				
Hedging instruments				
Interest rate swaps - fixed to floating	\$ 1,185.0	Other assets/other liabilities	\$ 2.6	\$ (7.8)
Non-hedging instruments				
Derivatives embedded in convertible fixed maturity securities	287.0	Fixed maturity securities	98.7	—
Interest rate swaps	97.9	Equity securities	—	(9.4)
Options	12,208.5	Other assets/other liabilities	428.0	(458.4)
Futures	—	Equity securities	0.5	(1.5)
Subtotal non-hedging	12,593.4	Subtotal non-hedging	527.2	(469.3)
Total derivatives	\$ 13,778.4	Total derivatives	529.8	(477.1)
		Amounts netted	(216.7)	216.7
		Net derivatives	\$ 313.1	\$ (260.4)

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

Fair Value Hedges

We have entered into various interest rate swap contracts to convert a portion of our interest rate exposure on our long-term debt from fixed rates to floating rates. The floating rates payable on all of our fair value hedges are benchmarked to LIBOR. A summary of our outstanding fair value hedges at December 31, 2015 and 2014 is as follows:

Type of Fair Value Hedges	Year Entered Into	Outstanding Notional Amount		Interest Rate Received	Expiration Date
		2015	2014		
Interest rate swap	2015	\$ 200.0	\$ —	4.350 %	August 15, 2020
Interest rate swap	2014	150.0	150.0	4.350	August 15, 2020
Interest rate swap	2013	10.0	10.0	4.350	August 15, 2020
Interest rate swap	2012	200.0	200.0	4.350	August 15, 2020
Interest rate swap	2012	625.0	625.0	1.875	January 15, 2018
Interest rate swap	2012	200.0	200.0	2.375	February 15, 2017
Total notional amount outstanding		<u>\$ 1,385.0</u>	<u>\$ 1,185.0</u>		

A summary of the effect of fair value hedges on our income statement for the years ended December 31, 2015, 2014 and 2013 is as follows:

Type of Fair Value Hedges	Income Statement Location of Hedge Gain	Hedge Gain Recognized	Hedged Item	Income Statement Location of Hedged Item Loss	Hedged Item Loss Recognized
Year ended December 31, 2015					
Interest rate swaps	Interest expense	<u>\$ 12.1</u>	Fixed rate debt	Interest expense	<u>\$ (12.1)</u>
Year ended December 31, 2014					
Interest rate swaps	Interest expense	<u>\$ 25.5</u>	Fixed rate debt	Interest expense	<u>\$ (25.5)</u>
Year ended December 31, 2013					
Interest rate swaps	Interest expense	<u>\$ 31.5</u>	Fixed rate debt	Interest expense	<u>\$ (31.5)</u>

Cash Flow Hedges

During the year ended December 31, 2015, we entered into a series of forward starting pay fixed interest rate swaps in the notional amount of \$4,650.0, with the objective of eliminating the variability of cash flows in the interest payments on anticipated future financings beginning in 2017. At December 31, 2015, \$4,650.0 was outstanding under these swaps. No cash flow hedges were outstanding at December 31, 2014.

The unrecognized loss for all outstanding and terminated cash flow hedges included in accumulated other comprehensive income, net of tax, was \$81.1 and \$35.9 at December 31, 2015 and 2014, respectively. As of December 31, 2015, the total amount of amortization over the next twelve months for all cash flow hedges will increase interest expense by approximately \$5.8.

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

A summary of the effect of cash flow hedges on our financial statements for the years ended December 31, 2015, 2014 and 2013 is as follows:

Type of Cash Flow Hedge	Effective Portion			Ineffective Portion	
	Pretax Hedge Loss Recognized in Other Comprehensive Income (Loss)	Income Statement Location of Loss Reclassification from Accumulated Other Comprehensive Income	Hedge Loss Reclassified from Accumulated Other Comprehensive Income	Income Statement Location of Loss Recognized	Hedge Loss Recognized
Year ended December 31, 2015					
Forward starting pay fixed swaps	\$ (75.2)	Interest expense	\$ (5.5)	None	\$ —
Year ended December 31, 2014					
Forward starting pay fixed swaps	\$ —	Interest expense	\$ (5.0)	None	\$ —
Year ended December 31, 2013					
Forward starting pay fixed swaps	\$ —	Interest expense	\$ (4.6)	None	\$ —

We test for cash flow hedge effectiveness at hedge inception and re-assess at the end of each reporting period. No amounts were excluded from the assessment of hedge effectiveness.

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

Non-Hedging Derivatives

A summary of the effect of non-hedging derivatives on our income statement for the years ended December 31, 2015, 2014 and 2013 is as follows:

Type of Non-hedging Derivatives	Income Statement Location of Gain (Loss) Recognized	Derivative Gain (Loss) Recognized
Year ended December 31, 2015		
Derivatives embedded in convertible fixed maturity securities	Net realized gains on investments	\$ (22.2)
Interest rate swaps	Net realized gains on investments	(1.9)
Options	Net realized gains on investments	34.7
Futures	Net realized gains on investments	(0.1)
Swaptions	Net realized gains on investments	(0.1)
Total		<u>\$ 10.4</u>
Year ended December 31, 2014		
Derivatives embedded in convertible fixed maturity securities	Net realized gains on investments	\$ 11.6
Interest rate swaps	Net realized gains on investments	(11.6)
Options	Net realized gains on investments	(54.6)
Futures	Net realized gains on investments	(10.0)
Swaptions	Net realized gains on investments	1.3
Total		<u>\$ (63.3)</u>
Year ended December 31, 2013		
Derivatives embedded in convertible fixed maturity securities	Net realized gains on investments	\$ 31.5
Interest rate swaps	Net realized gains on investments	2.2
Options	Net realized gains on investments	(111.7)
Futures	Net realized gains on investments	22.3
Swaptions	Net realized gains on investments	\$ 3.0
Total		<u>\$ (52.7)</u>

Anthem, Inc.

Notes to Consolidated Financial Statements (continued)

6. Fair Value

Assets and liabilities recorded at fair value in the consolidated balance sheets are categorized based upon the level of judgment associated with the inputs used to measure their fair value. Level inputs, as defined by FASB guidance for fair value measurements and disclosures, are as follows:

Level Input:	Input Definition:
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The following methods, assumptions and inputs were used to determine the fair value of each class of the following assets and liabilities recorded at fair value in the consolidated balance sheets:

Cash equivalents: Cash equivalents primarily consist of highly rated money market funds with maturities of three months or less, and are purchased daily at par value with specified yield rates. Due to the high ratings and short-term nature of the funds, we designate all cash equivalents as Level I.

Fixed maturity securities, available-for-sale: Fair values of available-for-sale fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level I or Level II inputs for the determination of fair value to facilitate fair value measurements and disclosures. United States Government securities represent Level I securities, while Level II securities primarily include corporate securities, securities from states, municipalities and political subdivisions, mortgage-backed securities and certain other asset back securities. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. We have controls in place to review the pricing services' qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. We also have certain fixed maturity securities, primarily corporate debt securities, that are designated Level III securities. For these securities, the valuation methodologies may incorporate broker quotes or discounted cash flow analyses using assumptions for inputs such as expected cash flows, benchmark yields, credit spreads, default rates and prepayment speeds that are not observable in the markets.

Equity securities, available-for-sale: Fair values of equity securities are generally designated as Level I and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level II. We also have certain equity securities, including private equity securities, for which the fair value is estimated based on each security's current condition and future cash flow projections. Such securities are designated Level III. The fair values of these private equity securities are generally based on either broker quotes or discounted cash flow projections using assumptions for inputs such as the weighted-average cost of capital, long-term revenue growth rates and earnings before interest, taxes, depreciation and amortization, or EBITDA, and/or revenue multiples that are not observable in the markets.

Other invested assets, current: Other invested assets, current include securities held in rabbi trusts that are classified as trading. These securities are designated Level I securities as fair values are based on quoted market prices.

Securities lending collateral: Fair values of securities lending collateral are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level I or Level II inputs for the determination of fair value, to facilitate fair value measurements and disclosures.

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

Derivatives: Fair values are based on the quoted market prices by the financial institution that is the counterparty to the derivative transaction. We independently verify prices provided by the counterparties using valuation models that incorporate market observable inputs for similar derivative transactions. Derivatives are designated as Level II securities.

In addition, the following methods and assumptions were used to determine the fair value of each class of pension benefit plan assets and other benefit plan assets not defined above (see Note 10, "Retirement Benefits," for fair values of benefit plan assets):

Mutual funds: Fair values are based on quoted market prices, which represent the net asset value, or NAV, of shares held.

Common and collective trusts: Fair values of common/collective trusts that replicate traded money market funds are based on cost, which approximates fair value. Fair values of common/collective trusts that invest in securities are valued at the NAV of the shares held, where the trust applies fair value measurements to the underlying investments to determine the NAV.

Partnership interests: Fair values are estimated based on the plan's proportionate share of the undistributed partners' capital as reported in audited financial statements of the partnership.

Contract with insurance company: Fair value of the contract in the insurance company general investment account is determined by the insurance company based on the fair value of the underlying investments of the account.

Investment in DOL 103-12 trust: Fair value is based on the plan's proportionate share of the fair value of investments held by the trust, qualified as a Department of Labor Regulation 2520.103-12 entity, or DOL 103-12 trust, as reported in the audited financial statements of the trust, where the trustee applies fair value measurements to the underlying investments of the trust.

Life insurance contracts: Fair value is based on the cash surrender value of the policies as reported by the insurer.

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

A summary of fair value measurements by level for assets and liabilities measured at fair value on a recurring basis at December 31, 2015 and 2014 is as follows:

	Level I	Level II	Level III	Total
December 31, 2015				
Assets:				
Cash equivalents	\$ 701.0	\$ —	\$ —	\$ 701.0
Investments available-for-sale:				
Fixed maturity securities:				
United States Government securities	349.9	—	—	349.9
Government sponsored securities	—	75.9	—	75.9
States, municipalities and political subdivisions, tax-exempt	—	6,251.6	—	6,251.6
Corporate securities	77.6	7,629.3	186.2	7,893.1
Residential mortgage-backed securities	—	1,750.9	—	1,750.9
Commercial mortgage-backed securities	—	402.4	1.9	404.3
Other debt securities	55.7	671.2	25.6	752.5
Total fixed maturity securities	483.2	16,781.3	213.7	17,478.2
Equity securities	1,253.8	116.9	102.1	1,472.8
Other invested assets, current	19.1	—	—	19.1
Securities lending collateral	708.1	592.3	—	1,300.4
Derivatives (reported with other assets)	—	159.1	—	159.1
Total assets	\$ 3,165.2	\$ 17,649.6	\$ 315.8	\$ 21,130.6
Liabilities:				
Derivatives (reported with other liabilities)	\$ —	\$ (259.4)	\$ —	\$ (259.4)
Total liabilities	\$ —	\$ (259.4)	\$ —	\$ (259.4)
December 31, 2014				
Assets:				
Cash equivalents	\$ 573.2	\$ —	\$ —	\$ 573.2
Investments available-for-sale:				
Fixed maturity securities:				
United States Government securities	320.0	—	—	320.0
Government sponsored securities	—	95.0	—	95.0
States, municipalities and political subdivisions, tax-exempt	—	5,733.6	—	5,733.6
Corporate securities	7.1	8,180.8	144.6	8,332.5
Options embedded in convertible securities	—	98.7	—	98.7
Residential mortgage-backed securities	—	2,159.0	—	2,159.0
Commercial mortgage-backed securities	—	506.6	3.3	509.9
Other debt securities	89.2	627.3	6.6	723.1
Total fixed maturity securities	416.3	17,401.0	154.5	17,971.8
Equity securities	1,696.9	192.9	48.3	1,938.1
Other invested assets, current	20.2	—	—	20.2
Securities lending collateral	808.3	706.9	—	1,515.2
Derivatives excluding embedded options (reported with other assets)	—	224.8	—	224.8
Total assets	\$ 3,514.9	\$ 18,525.6	\$ 202.8	\$ 22,243.3
Liabilities:				
Derivatives (reported with other liabilities)	\$ —	\$ (260.4)	\$ —	\$ (260.4)
Total liabilities	\$ —	\$ (260.4)	\$ —	\$ (260.4)

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

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level III inputs for the years ended December 31, 2015, 2014 and 2013 is as follows:

	Corporate Securities	Residential Mortgage- backed Securities	Commercial Mortgage- backed Securities	Other Debt Securities	Equity Securities	Total
Year ended December 31, 2015						
Beginning balance at January 1, 2015	\$ 144.6	\$ —	\$ 3.3	\$ 6.6	\$ 48.3	\$ 202.8
Total (losses) gains:						
Recognized in net income	1.4	—	—	0.2	(1.5)	0.1
Recognized in accumulated other comprehensive income	0.7	—	—	(0.2)	3.9	4.4
Purchases	132.6	—	1.1	28.3	52.1	214.1
Sales	(11.7)	—	(1.1)	(0.9)	(13.8)	(27.5)
Settlements	(51.6)	—	(1.4)	(0.2)	—	(53.2)
Transfers into Level III	4.8	—	—	—	13.1	17.9
Transfers out of Level III	(34.6)	—	—	(8.2)	—	(42.8)
Ending balance at December 31, 2015	<u>\$ 186.2</u>	<u>\$ —</u>	<u>\$ 1.9</u>	<u>\$ 25.6</u>	<u>\$ 102.1</u>	<u>\$ 315.8</u>
Change in unrealized losses included in net income related to assets still held for the year ended December 31, 2015	<u>\$ (0.6)</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ (1.4)</u>	<u>\$ (2.0)</u>
Year ended December 31, 2014						
Beginning balance at January 1, 2014	\$ 115.2	\$ —	\$ 6.5	\$ 14.8	\$ 41.4	\$ 177.9
Total (losses) gains:						
Recognized in net income	(4.4)	—	—	—	(0.7)	(5.1)
Recognized in accumulated other comprehensive income	8.5	—	—	0.4	2.8	11.7
Purchases	68.9	—	3.6	6.5	15.9	94.9
Sales	(48.0)	—	—	(3.6)	(10.6)	(62.2)
Settlements	(11.0)	—	(3.7)	(0.4)	—	(15.1)
Transfers into Level III	24.8	—	—	—	—	24.8
Transfers out of Level III	(9.4)	—	(3.1)	(11.1)	(0.5)	(24.1)
Ending balance at December 31, 2014	<u>\$ 144.6</u>	<u>\$ —</u>	<u>\$ 3.3</u>	<u>\$ 6.6</u>	<u>\$ 48.3</u>	<u>\$ 202.8</u>
Change in unrealized losses included in net income related to assets still held for the year ended December 31, 2014	<u>\$ (11.1)</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ (0.7)</u>	<u>\$ (11.8)</u>
Year Ended December 31, 2013						
Beginning balance at January 1, 2013	\$ 121.1	\$ 4.3	\$ —	\$ 3.9	\$ 26.2	\$ 155.5
Total (losses) gains:						
Recognized in net income	(30.3)	—	—	(0.1)	(4.8)	(35.2)
Recognized in accumulated other comprehensive income	(3.5)	—	—	0.6	9.5	6.6
Purchases	51.9	—	—	1.6	17.6	71.1
Sales	(4.8)	—	—	—	(7.1)	(11.9)
Settlements	(15.5)	(1.9)	(6.1)	(0.7)	—	(24.2)
Transfers into Level III	3.0	13.1	12.6	9.8	—	38.5
Transfers out of Level III	(6.7)	(15.5)	—	(0.3)	—	(22.5)
Ending balance at December 31, 2013	<u>\$ 115.2</u>	<u>\$ —</u>	<u>\$ 6.5</u>	<u>\$ 14.8</u>	<u>\$ 41.4</u>	<u>\$ 177.9</u>
Change in unrealized losses included in net income related to assets still held for the year ended December 31, 2013	<u>\$ (30.8)</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ (0.1)</u>	<u>\$ (6.5)</u>	<u>\$ (37.4)</u>

Transfers between levels, if any, are recorded as of the beginning of the reporting period. There were no material transfers between levels during the years ended December 31, 2015, 2014 or 2013.

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

Certain assets and liabilities are measured at fair value on a nonrecurring basis; that is, the instruments are not measured at fair value on an ongoing basis but are subject to fair value adjustments only in certain circumstances. As disclosed in Note 3, "Business Acquisitions and Divestiture", we completed our acquisition of Simply Healthcare on February 17, 2015. The values of net assets acquired in our acquisition of Simply Healthcare and resulting goodwill and other intangible assets were recorded at fair value primarily using Level III inputs. The majority of Simply Healthcare's assets acquired and liabilities assumed were recorded at their carrying values as of the respective date of acquisition, as their carrying values approximated their fair values due to their short-term nature. The fair values of goodwill and other intangible assets acquired in our acquisition of Simply Healthcare were internally estimated based on the income approach. The income approach estimates fair value based on the present value of the cash flows that the assets could be expected to generate in the future. We developed internal estimates for the expected cash flows and discount rate in the present value calculation. Other than the assets acquired and liabilities assumed in our acquisition of Simply Healthcare described above, there were no material assets or liabilities measured at fair value on a nonrecurring basis during the years ended December 31, 2015 or 2014.

Our valuation policy is determined by members of our treasury and accounting departments. Whenever possible, our policy is to obtain quoted market prices in active markets to estimate fair values for recognition and disclosure purposes. Where quoted market prices in active markets are not available, fair values are estimated using discounted cash flow analyses, broker quotes or other valuation techniques. These techniques are significantly affected by our assumptions, including discount rates and estimates of future cash flows. Potential taxes and other transaction costs are not considered in estimating fair values. Our valuation policy is generally to obtain only one quoted price for each security from third party pricing services, which are derived through recently reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information. When broker quotes are used, we generally obtain only one broker quote per security. As we are responsible for the determination of fair value, we perform monthly analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. This analysis is performed by our internal treasury personnel who are familiar with our investment portfolios, the pricing services engaged and the valuation techniques and inputs used. Our analysis includes a review of month-to-month price fluctuations. If unusual fluctuations are noted in this review, we may obtain additional information from other pricing services to validate the quoted price. There were no adjustments to quoted market prices obtained from the pricing services during the years ended December 31, 2015, 2014 or 2013.

In addition to the preceding disclosures on assets recorded at fair value in the consolidated balance sheets, FASB guidance also requires the disclosure of fair values for certain other financial instruments for which it is practicable to estimate fair value, whether or not such values are recognized in the consolidated balance sheets.

Non-financial instruments such as real estate, property and equipment, other current assets, deferred income taxes, intangible assets and certain financial instruments, such as policy liabilities, are excluded from the fair value disclosures. Therefore, the fair value amounts cannot be aggregated to determine our underlying economic value.

The carrying amounts reported in the consolidated balance sheets for cash, accrued investment income, premium and self-funded receivables, other receivables, income taxes receivable/payable, unearned income, accounts payable and accrued expenses, security trades pending payable, securities lending payable and certain other current liabilities approximate fair value because of the short term nature of these items. These assets and liabilities are not listed in the table below.

The following methods and assumptions were used to estimate the fair value of each class of financial instrument that is recorded at its carrying value on the consolidated balance sheets:

Other invested assets, long-term: Other invested assets, long-term include primarily our investments in limited partnerships, joint ventures and other non-controlled corporations, as well as the cash surrender value of corporate-owned life insurance policies. Investments in limited partnerships, joint ventures and other non-controlled corporations are carried at our share in the entities' undistributed earnings, which approximates fair value. The carrying value of corporate-owned life insurance policies represents the cash surrender value as reported by the respective insurer, which approximates fair value.

Short-term borrowings: The fair value of our short-term borrowings is based on quoted market prices for the same or similar debt, or, if no quoted market prices were available, on the current market interest rates estimated to be available to us for debt of similar terms and remaining maturities.

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

Long-term debt - commercial paper: The carrying amount for commercial paper approximates fair value as the underlying instruments have variable interest rates at market value.

Long-term debt - senior unsecured notes, remarketable subordinated notes and surplus notes: The fair values of our notes are based on quoted market prices in active markets for the same or similar debt, or, if no quoted market prices are available, on the current market observable rates estimated to be available to us for debt of similar terms and remaining maturities.

Long-term debt—convertible debentures: The fair value of our convertible debentures is based on the quoted market price in the active private market in which the convertible debentures trade.

A summary of the estimated fair values by level of each class of financial instrument that is recorded at its carrying value on our consolidated balance sheets at December 31, 2015 and 2014 are as follows:

	Carrying Value	Estimated Fair Value			
		Level I	Level II	Level III	Total
December 31, 2015					
Assets:					
Other invested assets, long-term	\$ 2,041.1	\$ —	\$ —	\$ 2,041.1	\$ 2,041.1
Liabilities:					
Debt:					
Short-term borrowings	540.0	—	540.0	—	540.0
Commercial paper	682.2	—	682.2	—	682.2
Notes	14,311.6	—	14,523.2	—	14,523.2
Convertible debentures	330.7	—	980.1	—	980.1
December 31, 2014					
Assets:					
Other invested assets, long-term	\$ 1,695.9	\$ —	\$ —	\$ 1,695.9	\$ 1,695.9
Liabilities:					
Debt:					
Short-term borrowings	400.0	—	400.0	—	400.0
Notes	13,777.8	—	14,794.8	—	14,794.8
Convertible debentures	974.4	—	2,581.9	—	2,581.9
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Notes to Consolidated Financial Statements (continued)

7. Income Taxes

The components of deferred income taxes at December 31 are as follows:

	2015	2014
Deferred tax assets relating to:		
Retirement benefits	\$ 364.8	\$ 357.7
Accrued expenses	344.6	329.9
Insurance reserves	247.1	209.7
Net operating loss carryforwards	18.1	14.8
Bad debt reserves	154.8	132.9
State income tax	43.4	40.6
Deferred compensation	40.1	46.6
Investment basis difference	62.2	88.2
Other	68.4	34.2
Total deferred tax assets	1,343.5	1,254.6
Valuation allowance	—	(2.6)
Total deferred tax assets, net of valuation allowance	1,343.5	1,252.0
Deferred tax liabilities relating to:		
Unrealized gains on securities	127.8	331.4
Intangible assets:		
Trademarks and state Medicaid licenses	2,547.6	2,444.3
Customer, provider and hospital relationships	269.2	308.6
Internally developed software and other amortization differences	436.6	403.6
Retirement benefits	252.7	241.1
Debt discount	61.9	184.0
State deferred tax	36.4	49.1
Depreciation and amortization	44.2	29.6
Other	197.7	205.9
Total deferred tax liabilities	3,974.1	4,197.6
Net deferred tax liability	\$ (2,630.6)	\$ (2,945.6)

In the table above, certain deferred tax liability amounts related to intangible assets for the year ended December 31, 2014 have been reclassified to provide consistency with the disclosure components of other intangible assets in Note 9, "Goodwill and Other Intangible Assets." This reclassification does not impact amounts presented in the financial statements.

The elimination of the valuation allowance during 2015 was attributable to a reduction in a statutory state income tax rate and continued utilization of state net operating losses. Changes in the valuation allowance during 2014 included a decrease of \$9.8 related to a reduction in statutory state income tax rate, a decrease of \$16.2 related to utilization of state net operating losses, and an increase of \$4.5 related to the sale of 1-800 CONTACTS, for a net decrease of \$21.5.

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

Significant components of the provision for income taxes for the years ended December 31 consist of the following:

	2015	2014	2013
Current tax expense (benefit):			
Federal	\$ 1,996.6	\$ 1,629.4	\$ 1,226.4
State and local	133.0	65.8	(42.6)
Total current tax expense	2,129.6	1,695.2	1,183.8
Deferred tax (benefit) expense	(58.6)	112.8	22.1
Total income tax expense	<u>\$ 2,071.0</u>	<u>\$ 1,808.0</u>	<u>\$ 1,205.9</u>

State and local current tax expense is reported gross of federal benefit, and includes amounts related to true up of prior years' tax, audit settlements, uncertain tax positions and state tax credits. Such items are included in multiple lines in the following rate reconciliation table on a net of federal tax basis.

A reconciliation of income tax expense recorded in the consolidated statements of income and amounts computed at the statutory federal income tax rate for the years ended December 31 is as follows:

	2015		2014		2013	
	Amount	Percent	Amount	Percent	Amount	Percent
Amount at statutory rate	\$ 1,620.9	35.0 %	\$ 1,528.8	35.0 %	\$ 1,344.1	35.0 %
State and local income taxes net of federal tax benefit	75.3	1.6	49.0	1.1	24.4	0.6
Tax exempt interest and dividends received deduction	(63.2)	(1.3)	(65.9)	(1.5)	(64.9)	(1.7)
HIP Fee	422.6	9.1	312.6	7.2	—	—
Other, net	15.4	0.3	(16.5)	(0.4)	(97.7)	(2.5)
Total income tax expense	<u>\$ 2,071.0</u>	<u>44.7 %</u>	<u>\$ 1,808.0</u>	<u>41.4 %</u>	<u>\$ 1,205.9</u>	<u>31.4 %</u>

During the year ended December 31, 2015, we recognized income tax expense of \$422.6, or \$1.55 per diluted share, as a result of the non-tax deductibility of the HIP Fee payments. We also recognized income tax expense of \$42.3, or \$0.16 per diluted share, as a result of an adverse California franchise tax ruling. This expense is allocated between the "State and local income taxes net of federal tax benefit" and the "Other, net" line items in the table above.

During the year ended December 31, 2014, we recognized income tax expense of \$312.6, or \$1.09 per diluted share, as a result of the non-tax deductibility of the HIP Fee payments.

During the year ended December 31, 2013, we recognized income tax benefits of \$65.0, or \$0.21 per diluted share, resulting from a favorable tax election made subsequent to the Amerigroup acquisition. This benefit is included in "Other, net" above.

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

The change in the carrying amount of gross unrecognized tax benefits from uncertain tax positions for the years ended December 31 is as follows:

	2015	2014
Balance at January 1	\$ 115.8	\$ 103.2
Additions for tax positions related to:		
Current year	39.8	10.9
Prior years	65.1	31.3
Reductions related to:		
Tax positions of prior years	(7.9)	(24.5)
Settlements with taxing authorities	(0.8)	(5.1)
Balance at December 31	<u>\$ 212.0</u>	<u>\$ 115.8</u>

The table above excludes interest, net of related tax benefits, which is treated as income tax expense (benefit) under our accounting policy. The interest is included in the amounts described in the following paragraph.

As of December 31, 2015, \$113.4 of unrecognized tax benefits would impact our effective tax rate in future periods, if recognized. Also included in the table above is \$2.4 that would be recognized as an adjustment to additional paid-in capital, which would not affect our effective tax rate. The December 31, 2015 balance also includes \$0.3 of tax positions for which ultimate deductibility is highly certain but for which there is uncertainty about the timing of such deductibility. Excluding the impact of interest and penalties, the disallowance of the shorter deductibility period would not affect our effective tax rate, but would accelerate the payment of cash to the taxing authority to an earlier period.

For the years ended December 31, 2015 and 2014, we recognized net interest benefits of \$1.8 and \$4.2, respectively. For the year ended December 31, 2013, we recognized net interest expense of \$2.6. We had accrued approximately \$12.3 and \$14.1 for the payment of interest at December 31, 2015 and 2014, respectively.

As of December 31, 2015, as further described below, certain tax years remain open to examination by the Internal Revenue Service, or IRS, and various state and local authorities. In addition, we continue to discuss certain industry issues with the IRS. As a result of these examinations and discussions, we have recorded amounts for uncertain tax positions. It is anticipated that the amount of unrecognized tax benefits will change in the next twelve months due to possible settlements of audits and changes in temporary items. However, the ultimate resolution of these items is dependent on the completion of negotiations with various taxing authorities. While it is difficult to determine when other tax settlements will actually occur, it is reasonably possible that one could occur in the next twelve months and our unrecognized tax benefits could change within a range of approximately \$3.3 to \$(159.0).

We are a member of the IRS Compliance Assurance Process, or CAP. The objective of CAP is to reduce taxpayer burden and uncertainty while assuring the IRS of the accuracy of tax returns prior to filing, thereby reducing or eliminating the need for post-filing examinations.

As of December 31, 2015, the IRS examination of our 2015 tax year continues to be in process. During 2015, the examinations of our 2014 and 2013 tax years were resolved with the IRS.

In certain states, we pay premium taxes in lieu of state income taxes. Premium taxes are reported with general and administrative expense.

At December 31, 2015, we had unused federal tax net operating loss carryforwards of approximately \$43.9 to offset future taxable income. The loss carryforwards expire in the years 2017 through 2034. During 2015, 2014 and 2013, federal income taxes paid totaled \$1,952.1, \$1,659.0 and \$1,172.0, respectively.

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

8. Property and Equipment

A summary of property and equipment at December 31 is as follows:

	2015	2014
Land and improvements	\$ 21.5	\$ 25.8
Building and improvements	216.6	279.9
Data processing equipment, furniture and other equipment	1,046.1	940.3
Computer software, purchased and internally developed	2,344.9	2,162.4
Leasehold improvements	429.3	356.4
Property and equipment, gross	4,058.4	3,764.8
Accumulated depreciation and amortization	(2,038.6)	(1,820.5)
Property and equipment, net	\$ 2,019.8	\$ 1,944.3

Depreciation expense for 2015, 2014 and 2013 was \$105.8, \$106.5 and \$105.3, respectively. Amortization expense on computer software and leasehold improvements for 2015, 2014 and 2013 was \$409.8, \$367.8 and \$351.8, respectively, which includes amortization expense on computer software, both purchased and internally developed, for 2015, 2014 and 2013 of \$366.7, \$329.2 and \$313.6, respectively. Capitalized costs related to the internal development of software of \$2,024.7 and \$1,844.2 at December 31, 2015 and 2014, respectively, are reported with computer software.

During the years ended December 31, 2015, 2014 and 2013, we recognized \$1.8, \$7.9 and \$47.7, respectively, of impairments related to computer software (primarily internally developed) due to project cancellation or asset replacement, some of which resulted from a change in strategic focus needed to effectively manage business operations in a post-Health Care Reform environment.

9. Goodwill and Other Intangible Assets

No goodwill is allocated to our Other segment. A summary of the change in the carrying amount of goodwill for our Commercial and Specialty Business segment and Government Business segment (see Note 19, "Segment Information") for 2015 and 2014 is as follows:

	Commercial and Specialty Business	Government Business	Total
Balance as of January 1, 2014	\$ 11,554.0	\$ 5,363.2	\$ 16,917.2
Measurement period adjustments	(1.6)	(0.2)	(1.8)
Other adjustments	266.5	(99.9)	166.6
Balance as of December 31, 2014	11,818.9	5,263.1	17,082.0
Measurement period adjustments	—	—	—
Acquisitions	—	480.2	480.2
Balance as of December 31, 2015	\$ 11,818.9	\$ 5,743.3	\$ 17,562.2
Accumulated impairment as of December 31, 2015	\$ (41.0)	\$ —	\$ (41.0)

The increase in the Company's goodwill is primarily due to the acquisition of Simply Healthcare in February 2015. For additional information regarding this acquisition, see Note 3, "Business Acquisitions and Divestiture". Measurement period adjustments incurred during 2014 included a reduction of \$1.8 related to the tax benefit on the exercise of stock options issued as part of various acquisitions. Other adjustments incurred during 2014 included transfers between business segments and reclassification to goodwill of the indefinite-lived provider network intangible asset, net of deferred taxes.

As required by FASB guidance, we completed annual impairment tests of existing goodwill and other intangible assets with indefinite lives during 2015, 2014 and 2013. We perform these annual impairment tests during the fourth quarter. FASB guidance also requires interim impairment testing to be performed when potential impairment indicators exist. These tests

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

involve the use of estimates related to the fair value of goodwill and intangible assets with indefinite lives and require a significant degree of management judgment and the use of subjective assumptions. The fair values were estimated using the income and market value valuation methods, incorporating Level III internal estimates for inputs, including, but not limited to, revenue projections, income projections, cash flows and discount rates. We did not incur any impairment losses in 2015, 2014 or 2013 as the estimated fair values of our reporting units were substantially in excess of their carrying values.

The components of other intangible assets as of December 31 are as follows:

	2015			2014		
	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
Intangible assets with finite lives:						
Customer relationships	\$ 3,394.4	\$ (2,670.0)	\$ 724.4	\$ 3,318.4	\$ (2,473.4)	\$ 845.0
Provider and hospital relationships	150.9	(58.6)	92.3	140.9	(51.4)	89.5
Other	90.7	(39.7)	51.0	61.6	(33.3)	28.3
Total	3,636.0	(2,768.3)	867.7	3,520.9	(2,558.1)	962.8
Intangible assets with indefinite lives:						
Blue Cross and Blue Shield and other trademarks	6,298.7	—	6,298.7	6,298.7	—	6,298.7
State Medicaid licenses	991.6	—	991.6	696.6	—	696.6
Total	7,290.3	—	7,290.3	6,995.3	—	6,995.3
Other intangible assets	\$ 10,926.3	\$ (2,768.3)	\$ 8,158.0	\$ 10,516.2	\$ (2,558.1)	\$ 7,958.1

As of December 31, 2015, the estimated amortization expense for each of the five succeeding years is as follows: 2016, \$191.5; 2017, \$156.1; 2018, \$125.1; 2019, \$98.1; and 2020, \$78.1.

10. Retirement Benefits

We sponsor various non-contributory employee defined benefit plans through certain subsidiaries.

The Anthem Cash Balance Plan A and the Anthem Cash Balance Plan B are cash balance pension plans covering certain eligible employees of the affiliated companies that participate in these plans. Effective January 1, 2006, benefits were curtailed, with the result that most participants stopped accruing benefits but continue to earn interest on benefits accrued prior to the curtailment. Certain participants subject to collective bargaining and certain other participants who met grandfathering rules continue to accrue benefits. Participants that do not receive credits and/or benefit accruals are included in the Anthem Cash Balance Plan A, while current employees who are still receiving credits and/or benefits participate in the Anthem Cash Balance Plan B. Several pension plans acquired through various corporate mergers and acquisitions have been merged into these plans in prior years.

The UGS Pension Plan is a defined benefit pension plan with a cash balance component. The UGS Pension Plan covers eligible employees of the affiliated companies that participate in the UGS Pension Plan. Effective January 1, 2004, benefits were curtailed, with the result that most participants stopped accruing benefits but continue to earn interest on benefits previously accrued. Certain employees subject to collective bargaining and certain other employees who met grandfathering rules continue to accrue benefits.

The Employees' Retirement Plan of Blue Cross of California, or the BCC Plan, is a defined benefit pension plan that covers eligible employees of Blue Cross of California who are covered by a collective bargaining agreement. Effective January 1, 2007, benefits were curtailed under the BCC Plan with the result that no Blue Cross of California employees hired or rehired after December 31, 2006 are eligible to participate in the BCC Plan.

All of the plans' assets consist primarily of common stocks, fixed maturity securities, investment funds and short-term investments. The funding policies for all plans are to contribute amounts at least sufficient to meet the minimum funding requirements set forth in the Employee Retirement Income Security Act of 1974, as amended, or ERISA, including

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

amendment by the Pension Protection Act of 2006, and in accordance with income tax regulations, plus such additional amounts as are necessary to provide assets sufficient to meet the benefits to be paid to plan participants.

We use a December 31 measurement date for determining benefit obligations and fair value of plan assets.

The following tables disclose consolidated “pension benefits,” which include the defined benefit pension plans described above, and consolidated “other benefits,” which include postretirement health and welfare benefits including medical, vision and dental benefits offered to certain employees. Calculations were computed using assumptions at the December 31 measurement dates.

The reconciliation of the benefit obligation is as follows:

	Pension Benefits		Other Benefits	
	2015	2014	2015	2014
Benefit obligation at beginning of year	\$ 1,914.4	\$ 1,764.7	\$ 646.6	\$ 607.5
Service cost	13.1	13.0	2.1	3.2
Interest cost	68.2	74.1	23.4	26.3
Plan amendment	0.8	—	—	—
Actuarial (gain) loss	(41.2)	185.4	(58.1)	45.3
Benefits paid	(122.0)	(122.8)	(35.3)	(35.7)
Benefit obligation at end of year	<u>\$ 1,833.3</u>	<u>\$ 1,914.4</u>	<u>\$ 578.7</u>	<u>\$ 646.6</u>

The changes in the fair value of plan assets are as follows:

	Pension Benefits		Other Benefits	
	2015	2014	2015	2014
Fair value of plan assets at beginning of year	\$ 1,985.0	\$ 1,944.0	\$ 347.9	\$ 349.8
Actual return on plan assets	(1.5)	160.2	(1.2)	17.7
Employer contributions	3.7	3.6	17.3	16.1
Benefits paid	(122.0)	(122.8)	(35.6)	(35.7)
Fair value of plan assets at end of year	<u>\$ 1,865.2</u>	<u>\$ 1,985.0</u>	<u>\$ 328.4</u>	<u>\$ 347.9</u>

The net amount included in the consolidated balance sheets is as follows:

	Pension Benefits		Other Benefits	
	2015	2014	2015	2014
Noncurrent assets	\$ 103.4	\$ 146.3	\$ —	\$ —
Current liabilities	(10.5)	(4.3)	—	—
Noncurrent liabilities	(61.0)	(71.4)	(250.3)	(298.7)
Net amount at December 31	<u>\$ 31.9</u>	<u>\$ 70.6</u>	<u>\$ (250.3)</u>	<u>\$ (298.7)</u>

The net amounts included in accumulated other comprehensive loss (income) that have not been recognized as components of net periodic benefit costs are as follows:

	Pension Benefits		Other Benefits	
	2015	2014	2015	2014
Net actuarial loss	\$ 635.0	\$ 563.7	\$ 162.7	\$ 211.2
Prior service credit	(0.1)	(2.2)	(73.5)	(88.0)
Net amount before tax at December 31	<u>\$ 634.9</u>	<u>\$ 561.5</u>	<u>\$ 89.2</u>	<u>\$ 123.2</u>

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

The estimated net actuarial loss and prior service credit for the defined benefit pension plans that will be reclassified from accumulated other comprehensive loss into net periodic benefit costs over the next year are \$16.9 and \$0.6, respectively. The estimated net actuarial loss and prior service credit for postretirement benefit plans that will be reclassified from accumulated other comprehensive loss into net periodic benefit costs over the next year are \$12.4 and \$13.8, respectively.

The accumulated benefit obligation for the defined benefit pension plans was \$1,829.6 and \$1,908.1 at December 31, 2015 and 2014, respectively.

As of December 31, 2015, certain pension plans had accumulated benefit obligations in excess of plan assets. For those same plans, the projected benefit obligation was also in excess of plan assets. Such plans had a combined projected benefit obligation, accumulated benefit obligation and fair value of plan assets of \$106.7, \$104.9 and \$35.1, respectively.

The weighted-average assumptions used in calculating the benefit obligations for all plans are as follows:

	Pension Benefits		Other Benefits	
	2015	2014	2015	2014
Discount rate	3.92%	3.66%	4.01%	3.74%
Rate of compensation increase	3.00%	3.00%	3.00%	3.00%
Expected rate of return on plan assets	7.84%	7.62%	7.00%	7.00%

The components of net periodic benefit cost (benefit credit) included in the consolidated statements of income are as follows:

	2015	2014	2013
Pension Benefits			
Service cost	\$ 13.1	\$ 13.0	\$ 14.2
Interest cost	68.2	74.1	67.8
Expected return on assets	(143.2)	(137.5)	(133.1)
Recognized actuarial loss	25.7	21.0	28.3
Amortization of prior service credit	(0.6)	(0.8)	(0.8)
Settlement loss	6.5	5.2	11.0
Net periodic benefit credit	<u>\$ (30.3)</u>	<u>\$ (25.0)</u>	<u>\$ (12.6)</u>
Other Benefits			
Service cost	\$ 2.1	\$ 3.2	\$ 6.7
Interest cost	23.4	26.3	22.4
Expected return on assets	(23.7)	(23.4)	(22.1)
Recognized actuarial loss	15.3	9.4	11.2
Amortization of prior service credit	(14.4)	(14.4)	(13.3)
Net periodic benefit cost	<u>\$ 2.7</u>	<u>\$ 1.1</u>	<u>\$ 4.9</u>

During the years ended December 31, 2015, 2014 and 2013 we incurred total settlement losses of \$6.5, \$5.2 and \$11.0, respectively, as lump-sum payments exceeded the service cost and interest cost components of net periodic benefit cost for certain of our plans.

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

The weighted-average assumptions used in calculating the net periodic benefit cost for all plans are as follows:

	2015	2014	2013
Pension Benefits			
Discount rate	3.66%	4.39%	3.60%
Rate of compensation increase	3.00%	3.00%	3.50%
Expected rate of return on plan assets	7.62%	7.66%	7.91%
Other Benefits			
Discount rate	3.74%	4.48%	3.71%
Rate of compensation increase	3.00%	3.00%	3.50%
Expected rate of return on plan assets	7.00%	7.00%	7.00%

The assumed health care cost trend rates used to measure the expected cost of pre-Medicare (those who are not currently eligible for Medicare benefits) other benefits at our December 31, 2015 measurement date was 8.00% for 2016 with a gradual decline to 4.50% by the year 2028. The assumed health care cost trend rates used to measure the expected cost of post-Medicare (those who are currently eligible for Medicare benefits) other benefits at our December 31, 2015 measurement date was 5.75% for 2016 with a gradual decline to 4.50% by the year 2021. These estimated trend rates are subject to change in the future. The health care cost trend rate assumption has a significant effect on the amounts reported. For example, an increase in the assumed health care cost trend rate of one percentage point would increase the postretirement benefit obligation as of December 31, 2015 by \$45.0 and would increase service and interest costs by \$2.2. Conversely, a decrease in the assumed health care cost trend rate of one percentage point would decrease the postretirement benefit obligation by \$38.3 as of December 31, 2015 and would decrease service and interest costs by \$1.8.

Plan assets include a diversified mix of investment grade fixed maturity securities, equity securities and alternative investments across a range of sectors and levels of capitalization to maximize the long-term return for a prudent level of risk. The weighted-average target allocation for pension benefit plan assets is 45% equity securities, 46% fixed maturity securities, and 9% to all other types of investments. Equity securities primarily include a mix of domestic securities, foreign securities and mutual funds invested in equities. Fixed maturity securities primarily include treasury securities, corporate bonds, and asset-backed investments issued by corporations and the U.S. government. Other types of investments include partnership interests, collective trusts that replicate money market funds and insurance contracts designed specifically for employee benefit plans. As of December 31, 2015, there were no significant concentrations of investments in the pension benefit assets or other benefit assets. No plan assets were invested in Anthem common stock.

Pension benefit assets and other benefit assets recorded at fair value are categorized based upon the level of judgment associated with the inputs used to measure their fair value.

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

The fair values of our pension benefit assets and other benefit assets by asset category and level inputs at December 31, 2015, excluding cash, investment income receivable and amounts due to/from brokers, resulting in a net asset of \$3.4, are as follows (see Note 6, "Fair Value," for additional information regarding the definition of level inputs):

	Level I	Level II	Level III	Total
December 31, 2015				
Pension Benefit Assets:				
Equity securities:				
U.S. securities	\$ 542.8	\$ 4.4	\$ —	\$ 547.2
Foreign securities	258.8	—	—	258.8
Mutual funds	34.7	—	—	34.7
Fixed maturity securities:				
Government securities	176.6	—	—	176.6
Corporate securities	—	364.0	—	364.0
Asset-backed securities	—	141.1	—	141.1
Other types of investments:				
Common and collective trusts	—	48.1	—	48.1
Partnership interests	—	—	117.1	117.1
Insurance company contracts	—	—	174.2	174.2
Total pension benefit assets	<u>\$ 1,012.9</u>	<u>\$ 557.6</u>	<u>\$ 291.3</u>	<u>\$ 1,861.8</u>
Other Benefit Assets:				
Equity securities:				
U.S. securities	\$ 16.8	\$ 0.3	\$ —	\$ 17.1
Foreign securities	7.4	—	—	7.4
Mutual funds	36.6	—	—	36.6
Fixed maturity securities:				
Government securities	3.8	—	—	3.8
Corporate securities	—	9.5	—	9.5
Asset-backed securities	—	7.7	—	7.7
Other types of investments:				
Common and collective trusts	—	1.5	—	1.5
Partnership interests	—	—	1.5	1.5
Life insurance contracts	—	—	229.9	229.9
Investment in DOL 103-12 trust	—	13.4	—	13.4
Total other benefit assets	<u>\$ 64.6</u>	<u>\$ 32.4</u>	<u>\$ 231.4</u>	<u>\$ 328.4</u>

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

The fair values of our pension benefit assets and other benefit assets by asset category and level inputs at December 31, 2014, excluding cash, investment income receivable and amounts due to/from brokers, resulting in a net liability of \$0.2, are as follows (see Note 6, "Fair Value," for additional information regarding the definition of level inputs):

	Level I	Level II	Level III	Total
December 31, 2014				
Pension Benefit Assets:				
Equity securities:				
U.S. securities	\$ 591.2	\$ 4.5	\$ —	\$ 595.7
Foreign securities	246.2	—	—	246.2
Mutual funds	36.8	—	—	36.8
Fixed maturity securities:				
Government securities	206.5	11.5	—	218.0
Corporate securities	—	373.6	—	373.6
Asset-backed securities	—	170.0	—	170.0
Other types of investments:				
Common and collective trusts	—	37.1	—	37.1
Partnership interests	—	—	120.7	120.7
Insurance company contracts	—	—	187.7	187.7
Treasury futures contracts	(0.9)	—	—	(0.9)
Total pension benefit assets	<u>\$ 1,079.8</u>	<u>\$ 596.7</u>	<u>\$ 308.4</u>	<u>\$ 1,984.9</u>
Other Benefit Assets:				
Equity securities:				
U.S. securities	\$ 22.0	\$ 0.3	\$ —	\$ 22.3
Foreign securities	9.5	—	—	9.5
Mutual funds	33.6	—	—	33.6
Fixed maturity securities:				
Government securities	6.2	—	—	6.2
Corporate securities	—	10.0	—	10.0
Asset-backed securities	—	10.5	—	10.5
Other types of investments:				
Common and collective trusts	—	1.4	—	1.4
Partnership interests	—	—	1.5	1.5
Life insurance contracts	—	—	238.4	238.4
Investment in DOL 103-12 trust	—	14.8	—	14.8
Total other benefit assets	<u>\$ 71.3</u>	<u>\$ 37.0</u>	<u>\$ 239.9</u>	<u>\$ 348.2</u>

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

A reconciliation of the beginning and ending balances of plan assets measured at fair value using Level III inputs for the years ended December 31, 2015, 2014 and 2013 is as follows:

	Partnership Interests	Insurance Company Contracts	Life Insurance Contracts	Total
Year ended December 31, 2015				
Beginning balance at January 1, 2015	\$ 122.2	\$ 187.7	\$ 238.4	\$ 548.3
Actual return on plan assets:				
Relating to assets still held at the reporting date	(5.9)	(5.7)	(6.8)	(18.4)
Purchases	10.9	7.0	—	17.9
Sales	(8.6)	(14.8)	(1.7)	(25.1)
Ending balance at December 31, 2015	<u>\$ 118.6</u>	<u>\$ 174.2</u>	<u>\$ 229.9</u>	<u>\$ 522.7</u>
Year ended December 31, 2014				
Beginning balance at January 1, 2014	\$ 160.3	\$ 197.4	\$ 230.0	\$ 587.7
Actual return on plan assets:				
Relating to assets still held at the reporting date	(5.4)	1.4	8.4	4.4
Purchases	8.4	11.6	—	20.0
Sales	(41.1)	(22.7)	—	(63.8)
Ending balance at December 31, 2014	<u>\$ 122.2</u>	<u>\$ 187.7</u>	<u>\$ 238.4</u>	<u>\$ 548.3</u>
Year ended December 31, 2013				
Beginning balance at January 1, 2013	\$ 177.7	\$ 202.5	\$ 203.7	\$ 583.9
Actual return on plan assets:				
Relating to assets still held at the reporting date	2.2	(5.6)	26.3	22.9
Purchases	15.6	9.5	—	25.1
Sales	(35.2)	(9.0)	—	(44.2)
Ending balance at December 31, 2013	<u>\$ 160.3</u>	<u>\$ 197.4</u>	<u>\$ 230.0</u>	<u>\$ 587.7</u>

There were no transfers between Levels I, II and III during the years ended December 31, 2015, 2014 and 2013.

Our current funding strategy is to fund an amount at least equal to the minimum required funding as determined under ERISA with consideration of maximum tax deductible amounts. We may elect to make discretionary contributions up to the maximum amount deductible for income tax purposes. For the years ended December 31, 2015, 2014 and 2013, no material contributions were necessary to meet ERISA required funding levels. However, during the years ended December 31, 2015, 2014 and 2013, we made tax deductible discretionary contributions to the pension benefit plans of \$3.7, \$3.6 and \$38.6, respectively. Employer contributions to other benefit plans represent discretionary contributions and do not include payments to retirees for current benefits.

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

Our estimated future payments for pension benefits and postretirement benefits, which reflect expected future service, as appropriate, are as follows:

	Pension Benefits	Other Benefits
2016	\$ 157.5	\$ 41.1
2017	151.9	41.8
2018	150.4	42.4
2019	147.8	42.8
2020	146.5	42.6
2021 – 2025	637.1	201.8

In addition to the defined benefit plans, we maintain the Anthem 401(k) Plan and CareMore 401(k) Pension Plan which are qualified defined contribution plans covering substantially all employees. Voluntary employee contributions are matched by us subject to certain limitations. Contributions made by us totaled \$125.4, \$111.1 and \$102.5 during 2015, 2014 and 2013, respectively.

11. Medical Claims Payable

A reconciliation of the beginning and ending balances for medical claims payable for the years ended December 31 is as follows:

	Years Ended December 31		
	2015	2014	2013
Gross medical claims payable, beginning of year	\$ 6,861.2	\$ 6,127.2	\$ 6,174.5
Ceded medical claims payable, beginning of year	(767.4)	(23.4)	(27.2)
Net medical claims payable, beginning of year	6,093.8	6,103.8	6,147.3
Business combinations and purchase adjustments	121.8	—	—
Net incurred medical claims:			
Current year	60,708.4	56,305.8	55,894.3
Prior years redundancies	(800.2)	(541.9)	(599.1)
Total net incurred medical claims	59,908.2	55,763.9	55,295.2
Net payments attributable to:			
Current year medical claims	54,067.7	50,353.9	49,887.2
Prior years medical claims	5,131.9	5,420.0	5,451.5
Total net payments	59,199.6	55,773.9	55,338.7
Net medical claims payable, end of year	6,924.2	6,093.8	6,103.8
Ceded medical claims payable, end of year	645.6	767.4	23.4
Gross medical claims payable, end of year	\$ 7,569.8	\$ 6,861.2	\$ 6,127.2

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any period end are continually reviewed and re-estimated as information regarding actual claims payments, or runout, becomes known. This information is compared to the originally established year end liability. Negative amounts reported for incurred medical claims related to prior years result from claims being settled for amounts less than originally estimated. The prior year redundancy of \$800.2 shown above for the year ended December 31, 2015 represents an estimate based on paid claim activity from January 1, 2015 to December 31, 2015. Medical claim liabilities are usually described as having a “short tail,” which means that they are generally paid within twelve months of the member receiving service from the provider. Accordingly, the majority of the \$800.2 redundancy relates to claims incurred in calendar year 2014.

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

The following table provides a summary of the two key assumptions having the most significant impact on our incurred but not paid liability estimates for the years ended December 31, 2015, 2014 and 2013, which are the completion and trend factors. These two key assumptions can be influenced by utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations.

	Favorable Developments by Changes in Key Assumptions		
	2015	2014	2013
Assumed trend factors	\$ (467.9)	\$ (399.5)	\$ (428.4)
Assumed completion factors	(332.3)	(142.4)	(170.7)
Total	\$ (800.2)	\$ (541.9)	\$ (599.1)

The favorable development recognized in 2015 and 2014 resulted primarily from trend factors in late 2014 and late 2013, respectively, developing more favorably than originally expected as well as a smaller but significant contribution from completion factor development. The favorable development recognized in 2013 was driven by trend factors in late 2012 developing more favorably than originally expected.

12. Debt

Short-term Borrowings

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati and the Federal Home Loan Bank of Atlanta, collectively, the FHLBs, and as a member we have the ability to obtain short-term cash advances subject to certain minimum collateral requirements. At December 31, 2015 and 2014, \$540.0 and \$400.0, respectively, were outstanding under our short-term FHLBs borrowings. These outstanding short-term FHLBs borrowings at December 31, 2015 and 2014 had fixed interest rates of 0.424% and 0.195%, respectively.

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

Long-term Debt

The carrying value of long-term debt at December 31 consists of the following:

	2015	2014
Senior unsecured notes:		
1.250%, due 2015	\$ —	\$ 624.3
2.375%, due 2017	399.9	398.9
5.875%, due 2017	527.6	526.7
1.875%, due 2018	621.9	616.4
2.300%, due 2018	645.9	644.3
2.250%, due 2019	843.9	842.1
7.000%, due 2019	438.9	438.5
4.350%, due 2020	702.9	695.3
3.700%, due 2021	696.2	695.6
3.125%, due 2022	842.7	841.6
3.300%, due 2023	992.2	991.2
3.500%, due 2024	790.9	789.8
5.950%, due 2034	444.5	444.4
5.850%, due 2036	768.0	767.7
6.375%, due 2037	639.6	639.3
5.800%, due 2040	193.8	206.4
4.625%, due 2042	885.8	885.4
4.650%, due 2043	985.5	985.0
4.650%, due 2044	790.5	790.1
5.100%, due 2044	593.3	593.1
4.850%, due 2054	246.6	246.5
Remarketable subordinated notes:		
1.900%, due 2028	1,236.1	—
Surplus notes:		
9.000%, due 2027	24.9	24.9
Senior convertible debentures:		
2.750%, due 2042	330.7	956.4
Variable rate debt:		
Commercial paper program	682.2	—
Total long-term debt	15,324.5	14,643.9
Current portion of long-term debt	—	(624.3)
Long-term debt, less current portion	\$ 15,324.5	\$ 14,019.6

All debt is a direct obligation of Anthem, Inc., except for the surplus notes and the FHLB borrowings.

We generally issue senior unsecured notes for long-term borrowing purposes. On September 10, 2015, we repaid, upon maturity, the \$625.0 outstanding principal balance of our 1.25% Notes due 2015. Additionally, during the year ended December 31, 2015, we repurchased \$13.0 of outstanding principal balance of certain senior unsecured notes, plus applicable premium, accrued and unpaid interest, for cash totaling \$16.2. We recognized a loss on extinguishment of debt of \$3.4 on the repurchase of these notes.

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

On May 12, 2015, we issued 25.0 Equity Units, pursuant to an underwriting agreement dated May 6, 2015, in an aggregate principal amount of \$1,250.0. Each Equity Unit has a stated amount of \$50 (whole dollars) and consists of a purchase contract obligating the holder to purchase a certain number of shares of our common stock on May 1, 2018, subject to earlier termination or settlement, for a price in cash of \$50 (whole dollars); and a 5% undivided beneficial ownership interest in \$1,000 (whole dollars) principal amount of our 1.900% remarketable subordinated notes, or RSNs, due 2028. We received \$1,228.8 in cash proceeds from the issuance of the Equity Units, net of underwriting discounts and commissions and offering expenses payable by us, and recorded \$1,250.0 in long-term debt. The proceeds are being used for general corporate purposes, including, but not limited to, the repurchase of a portion of our outstanding senior convertible debentures due 2042. On May 1, 2018, if the applicable market value of our common stock is equal to or greater than \$207.805 per share, the settlement rate will be 0.2406 shares of our common stock. If the applicable market value of our common stock is less than \$207.805 per share but greater than \$143.865 per share, the settlement rate will be a number of shares of our common stock equal to \$50 (whole dollars) divided by the applicable market value of our common stock. If the applicable market value of common stock is less than or equal to \$143.865 per share, the settlement rate will be 0.3475 shares of our common stock. Holders of the Equity Units may elect early settlement at a minimum settlement rate of 0.2406 shares of our common stock for each purchase contract being settled. The RSNs are pledged as collateral to secure the purchase of common stock under the related stock purchase contracts. Quarterly interest payments on the RSNs commenced on August 1, 2015. The RSNs are scheduled to be remarketed during the five business day period ending on April 26, 2018 and may be remarketed earlier, at our election, during the period from January 30, 2018 through April 12, 2018. Following the remarketing, the interest rate on the RSNs will be set to current market rates and interest will be payable semi-annually. At December 31, 2015, the stock purchase contract liability was \$102.3 and is included in other current liabilities and other noncurrent liabilities. Contract adjustment payments commenced on August 1, 2015 at a rate of 3.350% per annum on the stated amount per Equity Unit. Subject to certain specified terms and conditions, we have the right to defer payments on all or part of the contract adjustment payments but not beyond the contract settlement date and we have the right to defer payment of interest on the RSNs but not beyond the purchase contract settlement date or maturity date.

On September 15, 2014, we redeemed the \$500.0 outstanding principal balance of our 5.000% senior unsecured notes due 2014, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling \$512.3. We recognized a loss on extinguishment of debt of \$2.3 on the redemption of these notes.

On September 11, 2014, we redeemed the \$1,097.9 outstanding principal balance of our 5.250% senior unsecured notes due 2016, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling \$1,178.2. We recognized a loss on extinguishment of debt of \$67.6 on the redemption of these notes.

Additionally, during the year ended December 31, 2014, we repurchased \$52.0 of outstanding principal amount of certain other senior unsecured notes, plus applicable premium, accrued and unpaid interest, for cash totaling \$61.0. We recognized a loss on extinguishment of debt of \$11.2 on the repurchase of these notes.

On August 12, 2014, we issued \$850.0 of 2.250% notes due 2019, \$800.0 of 3.500% notes due 2024, \$800.0 of 4.650% notes due 2044, and \$250.0 of 4.850% notes due 2054 under our shelf registration statement. We used the proceeds from this offering in part to fund the purchase price of the 5.000% and 5.250% senior unsecured notes discussed above, and the remaining net proceeds were used for general corporate purposes. Interest on the notes is payable semi-annually in arrears on February 15 and August 15 of each year, commencing on February 15, 2015. The notes have a call feature that allows us to redeem the notes at any time at our option and a put feature that allows a note holder to redeem the notes upon the occurrence of both a change in control event and a downgrade of the notes below an investment grade rating.

Surplus notes are unsecured obligations of Anthem Insurance Companies, Inc., or Anthem Insurance, a wholly owned subsidiary, and are subordinate in right of payment to all of Anthem Insurance's existing and future indebtedness. Any payment of interest or principal on the surplus notes may be made only with the prior approval of the Indiana Department of Insurance, or IDOI, and only out of capital and surplus funds of Anthem Insurance that the IDOI determines to be available for the payment under Indiana insurance laws.

On August 25, 2015, we terminated our \$2,000.0 senior revolving credit facility, initially scheduled to mature on September 29, 2016, and entered into a new \$3,500.0 senior revolving credit facility, or the Facility, with a group of lenders. The interest rate on the Facility is based on either the LIBOR rate or a base rate plus a predetermined rate based on our public debt rating at the date of utilization. Our ability to borrow under the Facility is subject to compliance with certain covenants.

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

The Facility matures on August 25, 2020 and is available for general corporate purposes. There were no amounts outstanding under the senior revolving credit facilities at December 31, 2015 or 2014.

We have an authorized commercial paper program of up to \$2,500.0, the proceeds of which may be used for general corporate purposes. At December 31, 2015, we had \$682.2 outstanding under our commercial paper program with a weighted-average interest rate of 0.705%. We did not have any borrowings outstanding under our commercial paper program at December 31, 2014. Commercial paper borrowings have been classified as long-term debt at December 31, 2015 as our general practice and intent is to replace short-term commercial paper outstanding at expiration with additional short-term commercial paper for an uninterrupted period extending for more than one year and we have the ability to redeem our commercial paper with borrowings under the senior credit facility described above.

During the year ended December 31, 2015, we entered into a bridge facility commitment letter and a joinder agreement, and a term loan facility, to finance a portion of the pending acquisition of Cigna. We paid \$106.6 in fees in connection with the bridge facility which were capitalized in other current assets and are amortized as interest expense over the term of the facility. We recorded \$36.8 of amortization of the bridge loan facility fees during the year ended December 31, 2015. The commitment of the lenders to provide the bridge facility and term loan facility is subject to several conditions, including the completion of the Acquisition. For additional information, see the "Pending Acquisition of Cigna Corporation" section of Note 3, "Business Acquisitions and Divestiture."

Convertible Debentures

On October 9, 2012, we issued \$1,500.0 of senior convertible debentures, or the Debentures. The Debentures are governed by an indenture, or the Indenture, dated as of October 9, 2012 between us and The Bank of New York Mellon Trust Company, N.A., as trustee. The Debentures bear interest at a rate of 2.750% per year, payable semi-annually in arrears in cash on April 15 and October 15 of each year, and mature on October 15, 2042, unless earlier redeemed, repurchased or converted into shares of common stock at the applicable conversion rate. The Debentures also have a contingent interest feature that will require us to pay additional interest based on certain thresholds and for certain events, as defined in the Indenture, beginning on October 15, 2022.

Holders may convert their Debentures at their option prior to the close of business on the business day immediately preceding April 15, 2042, only under the following circumstances: (1) during any fiscal quarter if the last reported sale price of our common stock for at least 20 trading days during a period of 30 consecutive trading days ending on the last trading day of the preceding fiscal quarter is greater than or equal to 130% of the applicable conversion price on each applicable trading day; (2) during the five business day period after any 10 consecutive trading day period, or the measurement period, in which the trading price per \$1,000 (whole dollars) principal amount of Debentures for each trading day of that measurement period was less than 98% of the product of the last reported sale price of our common stock and the applicable conversion rate on each such day; (3) if we call any or all of the Debentures for redemption, at any time prior to the close of business on the third scheduled trading day prior to the redemption date; or (4) upon the occurrence of specified corporate events, as defined in the Indenture. On and after April 15, 2042 and until the close of business on the third scheduled trading day immediately preceding the Debentures' maturity date of October 15, 2042, holders may convert their Debentures into common stock at any time irrespective of the preceding circumstances. The Debentures are redeemable at our option at any time on or after October 20, 2022, upon the occurrence of certain events, as defined in the Indenture.

Upon conversion of the Debentures, we will deliver cash up to the aggregate principal amount of the Debentures converted. With respect to any conversion obligation in excess of the aggregate principal amount of the Debentures converted, we have the option to settle the excess with cash, shares of our common stock or a combination thereof based on a daily conversion value, determined in accordance with the Indenture. The initial conversion rate for the Debentures was 13.2319 shares of our common stock per Debenture, which represented a 25% conversion premium based on the closing price of \$60.46 per share of our common stock on October 2, 2012 (the date the Debentures' terms were finalized) and is equivalent to an initial conversion price of \$75.575 per share of our common stock.

During the year ended December 31, 2015, we repurchased \$920.0 of the aggregate principal balance of the Debentures. In addition, \$66.6 aggregate principal balance was surrendered for conversion by certain holders in accordance with the terms and provisions of the indenture. We elected to settle the excess of the principal amount of the repurchases and conversions

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

with cash for total payments of \$2,055.7. We recognized a gain on the extinguishment of debt related to the Debentures of \$12.7, based on the fair values of the debt on the repurchase and conversion settlement dates.

As of December 31, 2015, our common stock was last traded at a price of \$139.44 per share. If the remaining Debentures had been converted or matured at December 31, 2015, we would be obligated to pay the principal of the Debentures plus an amount in cash or shares equal to \$452.3. The Debentures and underlying shares of our common stock have not been and will not be registered under the Securities Act of 1933, as amended, or the Securities Act, or any state securities laws and may not be offered or sold in the United States absent registration or an applicable exemption from registration requirements. The Debentures were offered and sold to qualified institutional buyers pursuant to Rule 144A under the Securities Act, the restrictions for which expired in October 2013.

We have accounted for the Debentures in accordance with the cash conversion guidance in FASB guidance for debt with conversion and other options. As a result, the value of the embedded conversion option has been bifurcated from its debt host and recorded as a component of "additional paid-in capital" (net of deferred taxes and equity issuance costs) in our consolidated balance sheet.

The following table summarizes at December 31, 2015 the related balances, conversion rate and conversion price of the Debentures:

Outstanding principal amount	\$	513.4
Unamortized debt discount	\$	176.8
Net debt carrying amount	\$	330.7
Equity component carrying amount	\$	186.1
Conversion rate (shares of common stock per \$1,000 of principal amount)		13.4886
Effective conversion price (per \$1,000 of principal amount)	\$	74.1360

The remaining amortization period of the unamortized debt discount as of December 31, 2015 is approximately 27 years. The unamortized discount will be amortized into interest expense using the effective interest method based on an effective interest rate of 5.130%, which represents the market interest rate for a comparable debt instrument that does not have a conversion feature. During the year ended December 31, 2015, we recognized \$32.5 of interest expense related to the Debentures, of which \$26.6 represented interest expense recognized at the stated interest rate of 2.750% and \$5.9 represented interest expense resulting from amortization of the debt discount.

Total interest paid during 2015, 2014 and 2013 was \$604.0, \$575.9, and \$597.2, respectively.

We were in compliance with all applicable covenants under all of our outstanding debt agreements at December 31, 2015.

Future maturities of all long-term debt outstanding at December 31, 2015 are as follows: 2016, \$682.2; 2017, \$927.5; 2018, \$1,267.8; 2019, \$1,282.8; 2020, \$702.9 and thereafter, \$10,461.3.

13. Commitments and Contingencies

Litigation

In the ordinary course of business, we are defendants in, or parties to, a number of pending or threatened legal actions or proceedings. To the extent a plaintiff or plaintiffs in the following cases have specified in their complaint or in other court filings the amount of damages being sought, we have noted those alleged damages in the descriptions below. With respect to the cases described below, we contest liability and/or the amount of damages in each matter and believe we have meritorious defenses.

We are defending a certified class action filed as a result of the 2001 demutualization of Anthem Insurance. The lawsuit names Anthem Insurance as well as Anthem, Inc. and is captioned *Ronald Gold, et al. v. Anthem, Inc. et al.* Anthem Insurance's 2001 Plan of Conversion, or the Plan, provided for the conversion of Anthem Insurance from a mutual insurance company into a stock insurance company pursuant to Indiana law. Under the Plan, Anthem Insurance distributed the fair

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

value of the company at the time of conversion to its Eligible Statutory Members, or ESMs, in the form of cash or Anthem common stock in exchange for their membership interests in the mutual company. Plaintiffs in *Gold* allege that Anthem Insurance distributed value to the wrong ESMs. Cross motions for summary judgment were granted in part and denied in part in July 2006 with regard to the issue of sovereign immunity asserted by co-defendant, the state of Connecticut, or the State. The trial court also denied our motion for summary judgment as to plaintiffs' claims in January 2005. The State appealed the denial of its motion to the Connecticut Supreme Court. We filed a cross-appeal on the sovereign immunity issue. In May 2010, the Supreme Court reversed the judgment of the trial court denying the State's motion to dismiss the plaintiff's claims under sovereign immunity and dismissed our cross-appeal. The case was remanded to the trial court for further proceedings. Plaintiffs' motion for class certification was granted in December 2011. We and the plaintiffs filed renewed cross-motions for summary judgment in January 2013. In August 2013, the trial court denied plaintiffs' motion for summary judgment. The trial court deferred a final ruling on our motion for summary judgment. In March 2014, the trial court denied our motion for summary judgment finding that an issue of material fact existed. A trial on liability was held in October 2014. In June 2015, the court entered judgment for Anthem Insurance on all issues, finding that (1) Anthem Insurance correctly determined the State to be an ESM, not Plaintiffs; (2) Anthem Insurance acted in good faith in making this determination, while Plaintiffs failed to present sufficient evidence to override a presumption that Anthem Insurance's ESM determination was correct; and (3) Plaintiffs failed to prove the breach of any contractual obligation. In July 2015, Plaintiffs filed a notice of appeal from the judgment entered for Anthem Insurance. In December 2015, the Connecticut Supreme Court decided it would hear the appeal directly rather than the appeal going to the intermediate appellate court. A date for argument has not been set. We intend to vigorously seek the affirmation of the trial court's judgment; however, the suit's ultimate outcome cannot be presently determined.

We are currently a defendant in eleven putative class actions relating to out-of-network, or OON, reimbursement that were consolidated into a single multi-district lawsuit called *In re WellPoint, Inc. (n/k/a Anthem, Inc.) Out-of-Network "UCR" Rates Litigation* that is pending in the United States District Court for the Central District of California. The lawsuits were filed in 2009. The plaintiffs include current and former members on behalf of a putative class of members who received OON services for which the defendants paid less than billed charges, the American Medical Association, four state medical associations, OON physicians, OON non-physician providers, the American Podiatric Medical Association, California Chiropractic Association and the California Psychological Association on behalf of putative classes of OON physicians and all OON non-physician health care providers. The plaintiffs have filed several amended complaints alleging that the defendants violated the Racketeer Influenced and Corrupt Organizations Act, or RICO, the Sherman Antitrust Act, ERISA, federal regulations, and state law by using an OON reimbursement database called Ingenix and by using non-Ingenix OON reimbursement methodologies. We have filed motions to dismiss in response to each of those amended complaints. Our motions to dismiss have been granted in part and denied in part by the court. The most recent pleading filed by the plaintiffs is a Fourth Amended Complaint to which we filed a motion to dismiss most, but not all, of the claims. In July 2013 the court issued an order granting in part and denying in part our motion. The court held that the state and federal anti-trust claims along with the RICO claims should be dismissed in their entirety with prejudice. The court further found that the ERISA claims, to the extent they involved non-Ingenix methodologies, along with those that involved our alleged non-disclosures should be dismissed with prejudice. The court also dismissed most of the plaintiffs' state law claims with prejudice. The only claims that remain after the court's decision are an ERISA benefits claim relating to claims priced based on Ingenix, a breach of contract claim on behalf of one subscriber plaintiff, a breach of implied covenant claim on behalf of one subscriber plaintiff, and one subscriber plaintiff's claim under the California Unfair Competition Law. The plaintiffs filed a motion for reconsideration of the motion to dismiss order, which the court granted in part and denied in part. The court ruled that the plaintiffs adequately allege that one Georgia provider plaintiff is deemed to have exhausted administrative remedies regarding non-Ingenix methodologies based on the facts alleged regarding that plaintiff so those claims are back in the case. Fact discovery is complete. The plaintiffs filed a motion for class certification in November 2013 seeking six different classes. Following expert discovery and briefing, oral argument was held on the motion. In late 2014, the court denied the plaintiffs' motion for class certification in its entirety. The California subscriber plaintiffs filed a motion for leave to file a renewed motion for class certification with more narrowly defined proposed classes, which the court denied. All but two of the individually named subscribers and all of the providers and medical associations dismissed their claims with prejudice. Motions for summary judgment are due in early 2016. Earlier in the case, in 2009, we filed a motion in the United States District Court for the Southern District of Florida, or the Florida Court, to enjoin the claims brought by the physician plaintiffs and certain medical association plaintiffs based on prior litigation releases, which was granted in 2011. The Florida Court ordered those plaintiffs to dismiss their claims that are barred by the release. The plaintiffs then filed a petition for declaratory judgment asking the court to find that these claims are not barred by the releases from the prior litigation. We

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filed a motion to dismiss the declaratory judgment action, which was granted. The plaintiffs appealed the dismissal of the declaratory judgment to the United States Court of Appeals for the Eleventh Circuit, but the dismissal was upheld. The enjoined physicians and some of the medical associations did not dismiss their barred claims. The Florida Court found those enjoined plaintiffs in contempt and sanctioned them in July 2012. Those plaintiffs appealed the Florida Court's sanctions order to the United States Court of Appeals for the Eleventh Circuit. The Eleventh Circuit upheld the Florida court's enforcement of the injunction as it relates to the plaintiffs' RICO and antitrust claims, but vacated it as it relates to certain ERISA claims. The plaintiffs filed a petition for rehearing en banc as to the antitrust claims only, which was denied. The plaintiffs then filed a petition for writ of certiorari with the U.S. Supreme Court. The American Medical Association filed an amicus brief in support of the petition. The U.S. Supreme Court denied the petition in February 2015. We intend to vigorously defend these suits; however, their ultimate outcome cannot be presently determined.

We are a defendant in multiple lawsuits that were initially filed in 2012 against the BCBSA as well as Blue Cross and/or Blue Shield licensees across the country. The cases were consolidated into a single multi-district lawsuit called *In re Blue Cross Blue Shield Antitrust Litigation* that is pending in the United States District Court for the Northern District of Alabama. Generally, the suits allege that the BCBSA and the Blue plans have engaged in a conspiracy to horizontally allocate geographic markets through license agreements, best efforts rules (which limit the percentage of non-Blue revenue of each plan), restrictions on acquisitions and other arrangements in violation of the Sherman Antitrust Act and related state laws. The cases were brought by two putative nationwide classes of plaintiffs, health plan subscribers and providers. Subscriber and provider plaintiffs each filed consolidated amended complaints in July 2013. The consolidated amended subscriber complaint was also brought on behalf of putative state classes of health plan subscribers in Alabama, Arkansas, California, Florida, Hawaii, Illinois, Louisiana, Michigan, Mississippi, Missouri, New Hampshire, North Carolina, Pennsylvania, Rhode Island, South Carolina, Tennessee, and Texas. Defendants filed motions to dismiss in September 2013, which were argued in April 2014. In June 2014, the court denied the majority of the motions, ruling that plaintiffs had alleged sufficient facts at this stage of the litigation to avoid dismissal of their claims. Following the subsequent filing of amended complaints by each of the subscriber and provider plaintiffs, we filed our answer and asserted our affirmative defenses in December 2014. Discovery has commenced. We intend to vigorously defend these suits; however, their ultimate outcome cannot be presently determined.

Our California affiliate Blue Cross of California doing business as Anthem Blue Cross, or BCC, has been named as a defendant, along with an unaffiliated entity, in a California taxpayer action filed in Los Angeles County Superior Court, captioned as *Michael D. Myers v. State Board of Equalization, et al.*, Los Angeles Superior Court Case No. BS143436, Second Appellate District Court Case No. B255455. This action is brought under a California statute that permits an individual taxpayer to sue a governmental agency when the taxpayer believes the agency has failed to enforce governing law. Plaintiff contends that BCC, a licensed Health Care Service Plan, or HCSP, is an "insurer" for purposes of taxation despite acknowledging it is not an "insurer" under regulatory law. Under California law, "insurers" must pay a gross premiums tax, or GPT, calculated as 2.35% on gross premiums. As a licensed HCSP, BCC has paid the California Corporate Franchise Tax, or CFT, the tax paid by California businesses generally. Plaintiff contends that BCC must pay the GPT rather than the CFT. Plaintiff seeks a writ of mandate directing the taxing agencies to collect the GPT, and seeks an order requiring BCC to pay GPT back taxes, interest, and penalties, for a period dating to eight years prior to the July 2013 filing of the complaint. In February 2014, the Superior Court sustained BCC's demurrer to the complaint, without leave to amend, ruling that BCC is not an "insurer" for purposes of taxation. Plaintiff appealed. In September 2015, the Court of Appeal reversed the Superior Court's ruling, and remanded. The Court of Appeal held that a HCSP could be an insurer for purposes of taxation if it wrote predominantly "indemnity" products. In October 2015, BCC filed a petition for rehearing in the Court of Appeal which was denied. In November 2015, BCC filed a petition for review with the California Supreme Court which was denied in December 2015. This lawsuit is being coordinated with similar lawsuits filed against other entities. All are set for an initial status conference in April 2016. BCC intends to vigorously defend this suit; however, its ultimate outcome cannot be presently determined.

Where available information indicates that it is probable that a loss has been incurred as of the date of the consolidated financial statements and we can reasonably estimate the amount of that loss, we accrue the estimated loss by a charge to income. In many proceedings, however, it is difficult to determine whether any loss is probable or reasonably possible. In addition, even where loss is possible or an exposure to loss exists in excess of the liability already accrued with respect to a previously identified loss contingency, it is not always possible to reasonably estimate the amount of the possible loss or range of loss.

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Notes to Consolidated Financial Statements (continued)

With respect to many of the proceedings to which we are a party, we cannot provide an estimate of the possible losses, or the range of possible losses in excess of the amount, if any, accrued, for various reasons, including but not limited to some or all of the following: (i) there are novel or unsettled legal issues presented, (ii) the proceedings are in early stages, (iii) there is uncertainty as to the likelihood of a class being certified or decertified or the ultimate size and scope of the class, (iv) there is uncertainty as to the outcome of pending appeals or motions, (v) there are significant factual issues to be resolved, and/or (vi) in many cases, the plaintiffs have not specified damages in their complaint or in court filings. For those legal proceedings where a loss is probable, or reasonably possible, and for which it is possible to reasonably estimate the amount of the possible loss or range of losses, we currently believe that the range of possible losses, in excess of established reserves, for all of those proceedings is from \$0 to approximately \$250.0 at December 31, 2015. This estimated aggregate range of reasonably possible losses is based upon currently available information taking into account our best estimate of such losses for which such an estimate can be made.

Cyber Attack Incident

In February 2015, we reported that we were the target of a sophisticated external cyber attack. The attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many individuals and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses, phone numbers and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that we will not identify additional information that was accessed or obtained.

We have continued to implement security enhancements since this incident and are supporting federal law enforcement efforts to identify the responsible parties. Upon discovery of the cyber attack, we took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate our systems and identify solutions based on the evolving landscape. We are providing credit monitoring and identity protection services to those who have been affected by this cyber attack. We have incurred expenses subsequent to the cyber attack to investigate and remediate this matter and expect to continue to incur expenses of this nature in the foreseeable future. We will recognize these expenses in the periods in which they are incurred.

Actions have been filed in various federal and state courts and other claims have been or may be asserted against us on behalf of current or former members, current or former employees, other individuals, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber attack. State and federal agencies, including state insurance regulators, state attorneys general, the Health and Human Services Office of Civil Rights and the Federal Bureau of Investigation, are investigating events related to the cyber attack, including how it occurred, its consequences and our responses. Although we are cooperating in these investigations, we may be subject to fines or other obligations, which may have an adverse effect on how we operate our business and our results of operations. With respect to the civil actions, a motion to transfer was filed with the Judicial Panel on Multidistrict Litigation in February 2015 and was subsequently heard by the Panel in May 2015. In June 2015, the Panel entered its order transferring the consolidated matter to the U.S. District Court for the Northern District of California. The U.S. District Court entered its Case Management Order in September 2015. We have filed a Motion to Dismiss several of the counts that are before the U.S. District Court. There remain a few state court cases that are presently proceeding outside of the Multidistrict Litigation.

We have contingency plans and insurance coverage for certain expenses and potential liabilities of this nature. The coverage has been sufficient to cover the majority of claims and liabilities incurred to date. While a loss from these matters is reasonably possible, we cannot reasonably estimate a range of possible losses because our investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

Other Contingencies

From time to time, we and certain of our subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. We, like HMOs and health insurers generally, exclude certain health care and other services from coverage under our HMO, PPO and other plans. We are, in the ordinary course of business, subject to the claims of our enrollees arising out of decisions to restrict or deny reimbursement for uncovered

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services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on us. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable settlements of coverage claims.

In addition to the lawsuits described above, we are also involved in other pending and threatened litigation of the character incidental to our business, and are from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits, reviews and administrative proceedings include routine and special inquiries by state insurance departments, state attorneys general, the U.S. Attorney General and subcommittees of the U.S. Congress. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on our business operations. Any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on our consolidated financial position or results of operations.

The National Organization of Life & Health Insurance Guaranty Associations, or NOLHGA, is a voluntary organization consisting of the state life and health insurance guaranty associations located throughout the U.S. Such associations, working together with NOLHGA, provide a safety net for their state's policyholders, ensuring that they continue to receive coverage, subject to state maximum limits, even if their insurer is declared insolvent. We are aware that the Pennsylvania Insurance Commissioner, or Insurance Commissioner, has placed Penn Treaty Network America Insurance Company and its subsidiary American Network Insurance Company, or collectively Penn Treaty, in rehabilitation, an intermediate action before insolvency. The state court denied the Insurance Commissioner's petition for the liquidation of Penn Treaty and ordered the Insurance Commissioner to file an updated plan of rehabilitation. The state court commenced a hearing in connection with the updated plan in July 2015, which has been adjourned. The state court has begun scheduling settlement conferences to resolve outstanding issues with the plan. In the event rehabilitation of Penn Treaty is unsuccessful and Penn Treaty is declared insolvent and placed in liquidation, we and other insurers may be required to pay a portion of their policyholder claims through state guaranty association assessments in future periods. Given the uncertainty around whether Penn Treaty will ultimately be declared insolvent and, if so, the amount of the insolvency, the amount and timing of any associated future guaranty fund assessments, and the availability and amount of any potential premium tax and other offsets, we currently cannot estimate our net exposure, if any, to this potential insolvency. We will continue to monitor the situation and may record a liability and expense in future reporting periods, which could be material to our cash flows and results of operations.

Contractual Obligations and Commitments

We are a party to an agreement with Express Scripts, Inc., or Express Scripts, whereby Express Scripts is the exclusive provider of certain pharmacy benefit management, or PBM, services to our plans, excluding our CareMore and Simply Healthcare subsidiaries and certain self-insured members, which have exclusive agreements with different PBM service providers. The initial term of this agreement expires on December 31, 2019. Under this agreement, the Express Scripts PBM services include, but are not limited to, pharmacy network management, mail order and specialty drug fulfillment, claims processing, rebate management and specialty pharmaceutical management services. Accordingly, the agreement contains certain financial and operational requirements obligating both Express Scripts and us. Express Scripts' primary obligations relate to the performance of such services in a compliant manner and meeting certain pricing guarantees and performance standards. Our primary responsibilities relate to formulary management, product and benefit design, provision of data, payment for services, certain minimum volume requirements and oversight. The failure by either party to meet the respective requirements could potentially serve as a basis for financial penalties or early termination of the contract. We believe we have appropriately recognized all rights and obligations under this contract at December 31, 2015.

During November 2015, we entered into an amended and restated agreement with Accenture LLP to provide business process outsourcing services. This new agreement supersedes certain prior agreements, converts certain services to transaction based pricing and also includes provisions for additional services. Our remaining commitment under this agreement at December 31, 2015 was \$224.0 through December 31, 2019. We have the ability to terminate this agreement upon the occurrence of certain events, subject to early termination fees.

During December 2014, we entered into a new agreement with International Business Machines Corporation to provide information technology infrastructure services. This new agreement supersedes certain prior agreements and also includes provisions for additional services. Our remaining commitment under this agreement at December 31, 2015 was \$378.4

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through March 31, 2020. We have the ability to terminate this agreement upon the occurrence of certain events, subject to early termination fees.

On March 31, 2009, we entered into an agreement with Affiliated Computer Services, Inc. to provide certain print and mailroom services that were previously performed in-house. Our remaining commitment under this agreement at December 31, 2015 was \$15.7 through March 31, 2016. We have the ability to terminate this agreement upon the occurrence of certain events, subject to early termination fees.

Vulnerability from Concentrations

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash equivalents, investment securities, premium receivables and instruments held through hedging activities. All investment securities are managed by professional investment managers within policies authorized by our Board of Directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. Concentrations of credit risk with respect to premium receivables are limited due to the large number of employer groups that constitute our customer base in the states in which we conduct business. As of December 31, 2015, there were no significant concentrations of financial instruments in a single investee, industry or geographic location.

14. Capital Stock

Stock Incentive Plans

Our Board of Directors has adopted the Anthem Incentive Compensation Plan, or Incentive Compensation Plan, which has been approved by our shareholders. The term of the Incentive Compensation Plan is such that no awards may be granted on or after May 20, 2019. The Incentive Compensation Plan gives authority to the Compensation Committee of the Board of Directors to make incentive awards to our non-employee directors, employees and consultants, consisting of stock options, stock, restricted stock, restricted stock units, cash-based awards, stock appreciation rights, performance shares and performance units. The Incentive Compensation Plan, as amended and restated, limits the number of available shares for issuance to 60.1 shares, subject to adjustment as set forth in the Incentive Compensation Plan.

Stock options are granted for a fixed number of shares with an exercise price at least equal to the fair value of the shares at the grant date. Stock options vest over three years in equal semi-annual installments and generally have a term of ten years from the grant date.

Certain option grants contain provisions whereby the employee continues to vest in the award subsequent to termination due to retirement. Our attribution method for newly granted awards considers all vesting and other provisions, including retirement eligibility, in determining the requisite service period over which the fair value of the awards will be recognized.

Awards of restricted stock or restricted stock units are issued at the fair value of the stock on the grant date and may also include one or more performance measures that must be met for the award to vest. The restrictions lapse in three equal annual installments. Performance units issued in 2015 will vest in 2018, based on earnings targets over the three year period of 2015 to 2017.

For the years ended December 31, 2015, 2014 and 2013, we recognized share-based compensation expense of \$148.2, \$168.9 and \$146.0, respectively, as well as related tax benefits of \$53.7, \$60.7 and \$52.6, respectively.

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Notes to Consolidated Financial Statements (continued)

A summary of stock option activity for the year ended December 31, 2015 is as follows:

	Number of Shares	Weighted-Average Option Price per Share	Weighted-Average Remaining Contractual Life (Years)	Aggregate Intrinsic Value
Outstanding at January 1, 2015	7.3	\$ 70.30		
Granted	1.3	146.73		
Exercised	(2.4)	67.74		
Forfeited or expired	(0.2)	102.14		
Outstanding at December 31, 2015	6.0	87.23	4.21	\$ 322.7
Exercisable at December 31, 2015	3.9	71.96	2.76	\$ 263.3

The intrinsic value of options exercised during the years ended December 31, 2015, 2014 and 2013 amounted to \$188.1, \$156.7 and \$176.0, respectively. We recognized tax benefits of \$68.0, \$53.2 and \$56.8 in 2015, 2014 and 2013, respectively, from option exercises and disqualifying dispositions. During the years ended December 31, 2015, 2014 and 2013 we received cash of \$162.2, \$283.6 and \$524.7, respectively, from exercises of stock options.

The total fair value of restricted stock awards that vested during the years ended December 31, 2015, 2014 and 2013 was \$257.2, \$174.0 and \$46.7, respectively.

A summary of the status of nonvested restricted stock activity, including restricted stock units, for the year ended December 31, 2015 is as follows:

	Restricted Stock Shares and Units	Weighted-Average Grant Date Fair Value per Share
Nonvested at January 1, 2015	3.6	\$ 75.63
Granted	0.9	147.00
Vested	(1.7)	72.25
Forfeited	(0.1)	101.57
Nonvested at December 31, 2015	2.7	101.66

During the year ended December 31, 2015, we granted approximately 0.4 restricted stock units that are contingent upon us achieving earning targets over the three year period of 2015 to 2017. These grants have been included in the activity shown above, but will be subject to adjustment at the end of 2017, based on results in the three year period.

As of December 31, 2015, the total remaining unrecognized compensation expense related to nonvested stock options and restricted stock amounted to \$19.3 and \$98.7, respectively, which will be amortized over the weighted-average remaining requisite service periods of 10 months.

As of December 31, 2015, there were approximately 18.7 shares of common stock available for future grants under the Incentive Compensation Plan.

Fair Value

We use a binomial lattice valuation model to estimate the fair value of all stock options granted. Expected volatility assumptions used in the binomial lattice model are based on an analysis of implied volatilities of publicly traded options on our stock and historical volatility of our stock price. The risk-free interest rate is derived from the U.S. Treasury strip rates at the time of the grant. The expected term of the options was derived from the outputs of the binomial lattice model, which incorporates post-vesting forfeiture assumptions based on an analysis of historical data. The dividend yield was based on our estimate of future dividend yields. Similar groups of employees that have dissimilar exercise behavior are considered separately for valuation purposes. We utilize the "multiple-grant" approach for recognizing compensation expense associated with each separately vesting portion of the share-based award.

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Notes to Consolidated Financial Statements (continued)

The following weighted-average assumptions were used to estimate the fair values of options granted during the years ended December 31:

	2015	2014	2013
Risk-free interest rate	1.96%	2.16%	1.25%
Volatility factor	31.00%	35.00%	35.00%
Dividend yield (annual)	1.70%	2.00%	2.40%
Weighted-average expected life (years)	4.00	3.75	4.00

The following weighted-average fair values were determined for the years ending December 31:

	2015	2014	2013
Options granted during the year	\$ 33.97	\$ 22.41	\$ 14.64
Restricted stock and stock awards granted during the year	147.00	90.53	63.06

The binomial lattice option-pricing model requires the input of highly subjective assumptions including the expected stock price volatility. Because our stock option grants have characteristics significantly different from those of traded options, and because changes in the subjective input assumptions can materially affect the fair value estimate, in our opinion, existing models do not necessarily provide a reliable single measure of the fair value of our stock option grants.

Employee Stock Purchase Plan

We have registered 14.0 shares of common stock for the Employee Stock Purchase Plan, or the Stock Purchase Plan, which is intended to provide a means to encourage and assist employees in acquiring a stock ownership interest in Anthem. Pursuant to terms of the Stock Purchase Plan, an employee is permitted to purchase no more than \$25,000 (actual dollars) worth of stock in any calendar year, based on the fair value of the stock at the end of each plan quarter. Employees become participants by electing payroll deductions from 1% to 15% of gross compensation. Once purchased, the stock is accumulated in the employee's investment account. The Stock Purchase Plan allows participants to purchase shares of our common stock at a price per share of 95% of the fair value of a share of common stock on the last trading day of the plan quarter. The employee stock purchase plan discount is not recognized as compensation expense based on GAAP guidance. There were 0.1 shares issued during the year ended December 31, 2015. As of December 31, 2015, 5.8 shares were available for issuance under the Stock Purchase Plan.

Use of Capital and Stock Repurchase Program

We regularly review the appropriate use of capital, including acquisitions, common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors.

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Notes to Consolidated Financial Statements (continued)

A summary of the cash dividend activity for the years ended December 31, 2015 and 2014 is as follows:

Declaration Date	Record Date	Payment Date	Cash Dividend per Share	Total
Year ended December 31, 2015				
January 27, 2015	March 10, 2015	March 25, 2015	\$ 0.6250	\$ 166.6
April 28, 2015	June 10, 2015	June 25, 2015	0.6250	163.9
July 28, 2015	September 10, 2015	September 25, 2015	0.6250	163.0
October 27, 2015	December 4, 2015	December 21, 2015	0.6250	163.1
Year ended December 31, 2014				
January 28, 2014	March 10, 2014	March 25, 2014	\$ 0.4375	\$ 123.4
April 29, 2014	June 10, 2014	June 25, 2014	0.4375	120.5
July 29, 2014	September 10, 2014	September 25, 2014	0.4375	119.2
October 28, 2014	December 5, 2014	December 22, 2014	0.4375	117.6

On February 18, 2016, our Board of Directors declared a quarterly cash dividend to shareholders of \$0.6500 per share on the outstanding shares of our common stock. This quarterly dividend is payable on March 25, 2016 to the shareholders of record as of March 10, 2016.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. On October 2, 2014, the Board of Directors authorized a \$5,000.0 increase to the common stock repurchase program. Repurchases may be made from time to time at prevailing market prices, subject to certain restrictions on volume, pricing and timing. The repurchases are effected from time to time in the open market, through negotiated transactions, including accelerated share repurchase agreements, and through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. Our stock repurchase program is discretionary as we are under no obligation to repurchase shares. We repurchase shares under the program when we believe it is a prudent use of capital. The excess cost of the repurchased shares over par value is charged on a pro rata basis to additional paid-in capital and retained earnings.

A summary of common stock repurchases for the years ended December 31, 2015 and 2014 is as follows:

	Years Ended December 31	
	2015	2014
Shares repurchased	10.4	30.4
Average price per share	\$ 145.50	\$ 98.52
Aggregate cost	\$ 1,515.8	\$ 2,998.8
Authorization remaining at the end of each period	\$ 4,175.9	\$ 5,691.7

During the year ended December 31, 2015, we entered into a series of call and put options with certain counterparties to repurchase shares of our common stock. We exercised call options that enabled us to repurchase 2.1 shares of our common stock at an average strike price of \$135.03. In order to set the call option strike prices below our market price at inception on certain of these options, we sold 5.3 put options, the majority containing an average strike price equal to the call options. During the year ended December 31, 2015, 4.6 put options expired unexercised, while the remaining 0.7 put options were assigned to us, resulting in our repurchase of 0.7 shares of our common stock at an average share price of \$143.89. Based on GAAP guidance, the initial value of the call options was recognized as a reduction of shareholders' equity and the initial value of the put options was recognized as a liability.

Under the common stock repurchase program authorized by our Board of Directors, on February 4, 2014, we entered into an accelerated share repurchase agreement with a counterparty. The agreement provided for the repurchase of a number of our shares, equal to \$600.0, as determined by the dollar volume weighted-average share price during the term of the agreement. In March 2014, we repurchased 6.6 shares under the agreement.

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

During 2013, we purchased call options on 3.0 shares of our common stock. The call options allowed us to repurchase shares at a predetermined strike price up through the expiration dates. The purpose of the call options was to reduce share price volatility on potential future common stock repurchases. The aggregate premium paid was \$25.8, of which \$7.9 was recorded as a reduction of shareholders' equity and the remaining \$17.9 was recorded as a derivative asset based on FASB guidance. The aggregate premium is reported in financing activities in our consolidated statements of cash flow. The call options had strike prices ranging from \$77.50 to \$83.10 per share. The aggregate fair value of the call options reported as a derivative asset was \$27.5 at December 31, 2013. The call options were exercised on various dates throughout January and February 2014.

For additional information regarding the use of capital for debt security repurchases, see Note 12, "Debt."

Equity Units

On May 12, 2015, we issued 25.0 Equity Units, pursuant to an underwriting agreement dated May 6, 2015, in an aggregate principal amount of \$1,250.0. For additional information relating to the Equity Units, see Note 12, "Debt."

15. Accumulated Other Comprehensive Income

A reconciliation of the components of accumulated other comprehensive income at December 31 is as follows:

	2015	2014
Investments:		
Gross unrealized gains	\$ 815.0	\$ 1,154.9
Gross unrealized losses	(447.5)	(196.8)
Net pretax unrealized gains	367.5	958.1
Deferred tax liability	(124.2)	(330.5)
Net unrealized gains on investments	243.3	627.6
Non-credit components of OTTI on investments:		
Gross unrealized losses	(15.4)	(6.8)
Deferred tax asset	5.4	2.4
Net unrealized non-credit component of OTTI on investments	(10.0)	(4.4)
Cash flow hedges:		
Gross unrealized losses	(124.8)	(55.2)
Deferred tax asset	43.7	19.3
Net unrealized losses on cash flow hedges	(81.1)	(35.9)
Defined benefit pension plans:		
Deferred net actuarial loss	(635.0)	(563.7)
Deferred prior service credits	0.1	2.2
Deferred tax asset	250.4	223.2
Net unrecognized periodic benefit costs for defined benefit pension plans	(384.5)	(338.3)
Postretirement benefit plans:		
Deferred net actuarial loss	(162.7)	(211.2)
Deferred prior service credits	73.5	88.0
Deferred tax asset	35.1	48.9
Net unrecognized periodic benefit costs for postretirement benefit plans	(54.1)	(74.3)
Foreign currency translation adjustments:		
Gross unrealized losses	(9.5)	(4.3)
Deferred tax asset	3.3	1.5
Net unrealized losses on foreign currency translation adjustments	(6.2)	(2.8)
Accumulated other comprehensive (loss) income	\$ (292.6)	\$ 171.9

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

Other comprehensive income (loss) reclassification adjustments for the years ended December 31 are as follows:

	2015	2014	2013
Investments:			
Net holding (loss) gain on investment securities arising during the period, net of tax benefit (expense) of \$180.4, (\$107.9), and \$102.4, respectively	\$ (336.1)	\$ 201.8	\$ (182.2)
Reclassification adjustment for net realized gain on investment securities, net of tax expense of \$25.9, \$44.8 and \$60.6, respectively	(48.2)	(83.2)	(112.5)
Total reclassification adjustment on investments	(384.3)	118.6	(294.7)
Non-credit component of OTTI on investments:			
Non-credit component of OTTI on investments, net of tax benefit (expense) of \$3.0, \$2.1, and (\$0.9), respectively	(5.6)	(3.9)	1.7
Cash flow hedges:			
Holding (loss) gain, net of tax benefit (expense) of \$24.4, \$1.9, and (\$1.6), respectively	(45.2)	(3.6)	3.0
Other:			
Net change in unrecognized periodic benefit costs for defined benefit pension and postretirement benefit plans, net of tax benefit (expense) of \$13.4, \$75.2, and (\$106.8), respectively	(26.0)	(118.1)	172.7
Foreign currency translation adjustment, net of tax benefit (expense) of \$1.8, \$2.2, and (\$0.6), respectively	(3.4)	(4.3)	1.4
Net loss recognized in other comprehensive loss, net of tax benefit of \$248.9, \$18.3, and \$53.1, respectively	\$ (464.5)	\$ (11.3)	\$ (115.9)

16. Reinsurance

We reinsure certain risks with other companies and assume risk from other companies. We remain primarily liable to policyholders under ceded insurance contracts and are contingently liable for amounts recoverable from reinsurers in the event that such reinsurers do not meet their contractual obligations. We evaluate the financial condition of our reinsurers and monitor concentrations of credit risk arising from similar geographic regions, activities, or economic characteristics of the reinsurers to minimize our exposure to significant losses from reinsurer insolvencies. In conjunction with the Health Care Reform temporary reinsurance premium stabilization program, we recognize assessments upon our fully-insured non-grandfathered individual market plans that are eligible for reinsurance recoveries as ceded premiums and estimated reinsurance recoveries as a reduction to benefit expense. Assessments upon all other lines of business not eligible for reinsurance recoveries are recognized in general and administrative expense.

A summary of direct, assumed and ceded premiums written and earned for the years ended December 31 is as follows:

	2015		2014		2013	
	Written	Earned	Written	Earned	Written	Earned
Direct	\$ 72,925.5	\$ 73,259.2	\$ 68,628.6	\$ 68,304.3	\$ 65,939.1	\$ 66,038.9
Assumed	221.8	221.9	192.3	194.0	174.3	174.0
Ceded	(95.8)	(96.0)	(108.5)	(108.5)	(92.6)	(93.8)
Net premiums	\$ 73,051.5	\$ 73,385.1	\$ 68,712.4	\$ 68,389.8	\$ 66,020.8	\$ 66,119.1
Percentage—assumed to net premiums	0.3%	0.3%	0.3%	0.3%	0.3%	0.3%

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

A summary of net premiums written and earned by segment (see Note 19, "Segment Information") for the years ended December 31 is as follows:

	2015		2014		2013	
	Written	Earned	Written	Earned	Written	Earned
Reportable segments:						
Commercial and Specialty Business	\$ 33,016.9	\$ 33,078.0	\$ 35,084.7	\$ 35,045.2	\$ 35,733.9	\$ 35,772.0
Government Business	40,034.6	40,307.1	33,627.7	33,344.6	30,286.9	30,347.1
Other	—	—	—	—	—	—
Net premiums	<u>\$ 73,051.5</u>	<u>\$ 73,385.1</u>	<u>\$ 68,712.4</u>	<u>\$ 68,389.8</u>	<u>\$ 66,020.8</u>	<u>\$ 66,119.1</u>

The effect of reinsurance on benefit expense for the years ended December 31 is as follows:

	2015	2014	2013
Direct	\$ 61,674.0	\$ 57,496.6	\$ 56,185.2
Assumed	192.2	182.4	155.6
Ceded	(749.3)	(824.1)	(103.7)
Net benefit expense	<u>\$ 61,116.9</u>	<u>\$ 56,854.9</u>	<u>\$ 56,237.1</u>

The effect of reinsurance on certain assets and liabilities at December 31 is as follows:

	2015	2014
Policy liabilities, assumed	\$ 56.7	\$ 57.4
Unearned income, assumed	0.5	0.4
Premiums payable, ceded	9.3	7.7
Premiums receivable, assumed	23.2	5.4

17. Leases

We lease office space and certain computer and related equipment using noncancelable operating leases. At December 31, 2015, future lease payments for operating leases with initial or remaining noncancelable terms of one year or more consist of the following:

2016	\$ 141.5
2017	140.0
2018	127.2
2019	109.9
2020	84.3
Thereafter	245.8
Total minimum payments required	<u>\$ 848.7</u>

We have certain lease agreements that contain contingent payment provisions. Under these provisions, we pay contingent amounts in addition to base rent, primarily based upon annual changes in the consumer price index. The schedule above contains estimated amounts for potential future increases in lease payments based on the contingent payment provisions.

Lease expense for 2015, 2014 and 2013 was \$212.9, \$192.5 and \$185.9, respectively.

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

18. Earnings per Share

The denominator for basic and diluted earnings per share at December 31 is as follows:

	2015	2014	2013
Denominator for basic earnings per share—weighted-average shares	263.0	275.9	298.5
Effect of dilutive securities—employee stock options, non-vested restricted stock awards and convertible debentures	9.9	10.0	5.3
Denominator for diluted earnings per share	272.9	285.9	303.8

During the years ended December 31, 2015, 2014 and 2013, weighted-average shares related to certain stock options of 1.0, 0.5 and 4.2, respectively, were excluded from the denominator for diluted earnings per share because the stock options were anti-dilutive.

During the years ended December 31, 2015, 2014 and 2013, we issued approximately 0.4, 0.7 and 0.9 restricted stock units, respectively, of which vesting was contingent upon meeting certain earnings targets. Contingent restricted stock units are excluded from the denominator for diluted earnings per share and are included only if and when the contingency is met. The 2015 contingent restricted stock units are being measured over the three year period of 2015 through 2017, and remain contingent as of December 31, 2015. The 2014 and 2013 contingent restricted stock units were based on annual targets and were subsequently included in the denominator for diluted earnings per share for the years ended December 31, 2015 and 2014, respectively.

The Equity Units are potentially dilutive securities but were excluded from the denominator for diluted earnings per share for each of the years presented as the dilutive stock price threshold was not met.

19. Segment Information

On May 20, 2013, we announced certain organizational and executive leadership changes to align with how our Chief Executive Officer is managing our operations. Beginning with the three months ended June 30, 2013, our organizational structure is comprised of three reportable segments: Commercial and Specialty Business; Government Business; and Other.

Our Commercial and Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial and Specialty Business segment offer fully-insured health products; provide a broad array of managed care services to self-funded customers including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services; and provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal health care guidance.

Our Government Business segment includes Medicare and Medicaid businesses, National Government Services, or NGS, and services provided to the federal government in connection with FEP. Medicare business includes services such as Medicare Advantage, Medicare Part D, and Medicare Supplement. Medicaid business includes our managed care alternatives through publicly funded health care programs, including Medicaid, Temporary Assistance for Needy Family programs, programs for seniors and people with disabilities, programs for long-term services and support, Children's Health Insurance Programs and ACA-related Medicaid expansion programs. NGS acts as a Medicare contractor for the federal government in several regions across the nation.

Our Other segment includes other businesses that do not meet the quantitative thresholds for an operating segment as defined by FASB guidance, as well as corporate expenses not allocated to the other reportable segments.

We define operating revenues, a non-GAAP measure, to include premium income, administrative fees and other revenues. Operating revenues are derived from premiums and fees received primarily from the sale and administration of health benefit products. Operating gain, a non-GAAP measure, is calculated as total operating revenue less benefit expense and selling, general and administrative expense.

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

Through our participation in various federal government programs, we generated approximately 18.8%, 21.0% and 20.3% of our total consolidated revenues from agencies of the U.S. government for the years ended December 31, 2015, 2014, and 2013, respectively. These revenues are contained in the Government Business segment.

The accounting policies of the segments are consistent with those described in the summary of significant accounting policies in Note 2, "Basis of Presentation and Significant Accounting Policies," except that certain shared administrative expenses for each segment are recognized on a pro rata allocated basis, which in aggregate approximates the consolidated expense. Any difference between the allocated expenses and actual consolidated expense is included in other expenses not allocated to reportable segments. Intersegment sales and expenses are recorded at cost and eliminated in the consolidated financial statements. We evaluate performance of the reportable segments based on operating gain or loss as defined above. We evaluate net investment income, net realized gains on investments, OTTI losses recognized in income, interest expense, amortization expense, gain or loss on extinguishment of debt, income taxes, assets and liabilities on a consolidated basis as these items are managed in a corporate shared service environment and are not the responsibility of segment operating management.

Financial data by reportable segment for the years ended December 31 is as follows:

	Commercial and Specialty Business	Government Business	Other	Total
Year ended December 31, 2015				
Operating revenue	\$ 37,570.8	\$ 40,813.0	\$ 21.0	\$ 78,404.8
Operating gain (loss)	2,854.0	1,978.5	(79.4)	4,753.1
Depreciation and amortization of property and equipment	—	—	515.6	515.6
Year ended December 31, 2014				
Operating revenue	\$ 39,199.6	\$ 33,796.4	\$ 25.7	\$ 73,021.7
Operating gain (loss)	3,260.9	1,191.9	(34.4)	4,418.4
Depreciation and amortization of property and equipment	—	—	474.3	474.3
Year ended December 31, 2013				
Operating revenue	\$ 39,404.2	\$ 30,752.6	\$ 34.6	\$ 70,191.4
Operating gain (loss)	3,176.4	844.0	(19.0)	4,001.4
Depreciation and amortization of property and equipment	—	—	457.1	457.1

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

The major product revenues for each of the reportable segments for the years ended December 31 are as follows:

	2015	2014	2013
Commercial and Specialty Business			
Managed care products	\$ 31,676.9	\$ 33,755.6	\$ 34,516.9
Managed care services	4,344.8	3,997.8	3,474.0
Dental/Vision products and services	1,111.7	1,037.3	952.5
Other	437.4	408.9	460.8
Total Commercial and Specialty Business	37,570.8	39,199.6	39,404.2
Government Business			
Managed care products	40,307.0	33,344.6	30,347.1
Managed care services	506.0	451.8	405.5
Total Government Business	40,813.0	33,796.4	30,752.6
Other			
Other	21.0	25.7	34.6
Total product revenues	<u>\$ 78,404.8</u>	<u>\$ 73,021.7</u>	<u>\$ 70,191.4</u>

The classification between managed care products and managed care services in the above table primarily distinguishes between the level of risk assumed. Managed care products represent insurance products where we bear the insurance risk, whereas managed care services represent product offerings where we provide claims adjudication and other administrative services to the customer, but the customer principally bears the insurance risk.

Asset, liability and equity details by reportable segment have not been disclosed, as we do not internally report such information.

A reconciliation of reportable segment operating revenues to the amounts of total revenues included in the consolidated statements of income for the years ended December 31 is as follows:

	2015	2014	2013
Reportable segments operating revenues	\$ 78,404.8	\$ 73,021.7	\$ 70,191.4
Net investment income	677.6	724.4	659.1
Net realized gains on investments	157.5	177.0	271.9
Other-than-temporary impairment losses recognized in income	(83.4)	(49.0)	(98.9)
Total revenues	<u>\$ 79,156.5</u>	<u>\$ 73,874.1</u>	<u>\$ 71,023.5</u>

A reconciliation of reportable segment operating gain to income from continuing operations before income taxes included in the consolidated statements of income for the years ended December 31 is as follows:

	2015	2014	2013
Reportable segments operating gain	\$ 4,753.1	\$ 4,418.4	\$ 4,001.4
Net investment income	677.6	724.4	659.1
Net realized gains on investments	157.5	177.0	271.9
Other-than-temporary impairment losses recognized in income	(83.4)	(49.0)	(98.9)
Interest expense	(653.0)	(600.7)	(602.7)
Amortization of other intangible assets	(230.1)	(220.9)	(245.3)
Gain (loss) on extinguishment of debt	9.3	(81.1)	(145.3)
Income from continuing operations before income tax expense	<u>\$ 4,631.0</u>	<u>\$ 4,368.1</u>	<u>\$ 3,840.2</u>

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

20. Related Party Transactions

We have a 19.99% equity investment in National Accounts Service Company, LLC, or NASCO, which processes National Accounts claims and provides other administrative services for us and certain other Blue Cross Blue Shield plans. Administrative expenses incurred related to NASCO services totaled \$83.6, \$85.3 and \$77.6, for the years ended December 31, 2015, 2014 and 2013, respectively. Amounts due to NASCO were \$5.4 and \$4.5 at December 31, 2015 and 2014, respectively.

21. Statutory Information

The majority of our insurance and HMO subsidiaries report their accounts in conformity with accounting practices prescribed or permitted by state insurance regulatory authorities, or statutory, which vary in certain respects from GAAP. However, certain of our insurance and HMO subsidiaries, including BCC, Blue Cross of California Partnership Plan, Inc., Golden West Health Plan, Inc. and CareMore Health Plan are regulated by the California Department of Managed Health Care, or DMHC, and report their accounts in conformity with GAAP (these entities are collectively referred to as the "DMHC regulated entities"). Typical differences of GAAP reporting as compared to statutory reporting are the inclusion of unrealized gains or losses relating to fixed maturity securities in shareholders' equity, recognition of all assets including those that are non-admitted for statutory purposes and recognition of all deferred tax assets without regard to statutory limits. The National Association of Insurance Commissioners, or NAIC, developed a codified version of the statutory accounting principles, designed to foster more consistency among the states for accounting guidelines and reporting. Prescribed statutory accounting practices are set forth in a variety of publications of the NAIC as well as state laws, regulations and general administrative rules.

Our ability to pay dividends and credit obligations is significantly dependent on receipt of dividends from our subsidiaries. The payment of dividends to us by our insurance and HMO subsidiaries without prior approval of the insurance departments of each subsidiary's domiciliary jurisdiction is limited by formula. Dividends in excess of these amounts are subject to prior approval by the respective state insurance departments or the DMHC.

Our statutory basis insurance and HMO subsidiaries are subject to risk-based capital requirements. Risk-based capital is a method developed by the NAIC to determine the minimum amount of statutory capital appropriate for an insurance company or HMO to support its overall business operations in consideration of its size and risk profile. The formula for determining the amount of risk-based capital specifies various factors, weighted based on the perceived degree of risk, which are applied to certain financial balances and financial activity. Below minimum risk-based capital requirements are classified within certain levels, each of which requires specified corrective action. Additionally, the DMHC regulated entities are subject to capital and solvency requirements as prescribed by the DMHC. As of December 31, 2015 and 2014, all of our regulated subsidiaries exceeded the minimum risk-based capital requirements and/or capital and solvency requirements of their applicable governmental regulator. The statutory risk-based capital necessary to satisfy regulatory requirements of our statutory basis insurance and HMO subsidiaries was approximately \$3,900.0 and \$3,400.0 as of December 31, 2015 and 2014, respectively. The tangible net equity required for the DMHC regulated entities was approximately \$560.0 and \$520.0 as of December 31, 2015 and 2014, respectively.

Statutory-basis capital and surplus of our insurance and HMO subsidiaries and capital and surplus of our other regulated subsidiaries, excluding the DMHC regulated entities, was \$9,676.7 and \$9,727.2 at December 31, 2015 and 2014, respectively. Statutory-basis net income of our insurance and HMO subsidiaries and net income of our other regulated subsidiaries, excluding the DMHC regulated entities, was \$2,359.9, \$2,403.8 and \$2,635.8 for 2015, 2014 and 2013, respectively. GAAP equity of the DMHC regulated entities was \$1,838.1 and \$1,696.1 at December 31, 2015 and 2014, respectively. GAAP net income of the DMHC regulated entities was \$477.5, \$453.6 and \$487.7 for the years ended December 31, 2015, 2014 and 2013, respectively.

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

22. Selected Quarterly Financial Data (Unaudited)

Selected quarterly financial data is as follows:

	For the Quarter Ended			
	March 31	June 30	September 30	December 31
2015				
Total revenues	\$ 19,051.5	\$ 20,015.5	\$ 19,901.6	\$ 20,187.9
Income before income taxes	1,569.1	1,558.0	1,129.6	374.3
Net income	865.2	859.1	654.8	180.9
Basic net income per share	\$ 3.25	\$ 3.27	\$ 2.51	\$ 0.69
Diluted net income per share	3.09	3.13	2.43	0.68
2014				
Total revenues	\$ 17,859.4	\$ 18,473.4	\$ 18,557.0	\$ 18,984.3
Income from continuing operations before income taxes	1,130.1	1,263.7	1,087.2	887.1
Income from continuing operations	691.4	731.1	630.9	506.7
Income from discontinued operations	9.6	—	—	—
Net income	701.0	731.1	630.9	506.7
Basic net income per share - continuing operations	\$ 2.43	\$ 2.64	\$ 2.31	\$ 1.88
Basic net income per share - discontinued operations	0.03	—	—	—
Basic net income per share	2.46	2.64	2.31	1.88
Diluted net income per share - continuing operations	\$ 2.37	\$ 2.56	\$ 2.22	\$ 1.80
Diluted net income per share - discontinued operations	0.03	—	—	—
Diluted net income per share	2.40	2.56	2.22	1.80

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE.

There have been no changes in or disagreements with our independent registered public accounting firm on accounting or financial disclosures.

ITEM 9A. CONTROLS AND PROCEDURES.

Evaluation of Disclosure Controls and Procedures

We carried out an evaluation as of December 31, 2015, under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures as defined in Rule 13a-15(e) of the Exchange Act. Based upon that evaluation, the Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures are effective in timely alerting them to material information relating to us (including our consolidated subsidiaries) required to be disclosed in our reports under the Exchange Act. In addition, based on that evaluation, the Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective in ensuring that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is accumulated and communicated to our management, including the Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosures.

Management's Report on Internal Control Over Financial Reporting

Management, under the supervision and with the participation of the principal executive officer and principal financial officer, of Anthem, Inc., or the Company, is responsible for establishing and maintaining effective internal control over financial reporting, or Internal Control, as such term is defined in the Exchange Act. The Company's Internal Control is designed to provide reasonable assurance regarding the reliability of the Company's financial reporting and the preparation of financial statements for external reporting purposes in accordance with U.S. generally accepted accounting principles, or GAAP. The Company's Internal Control includes those policies and procedures that (i) pertain to the maintenance of records that in reasonable detail accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the financial statements.

Because of inherent limitations in any Internal Control, no matter how well designed, misstatements due to error or fraud may occur and not be detected. Accordingly, even effective Internal Control can provide only reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with GAAP.

Management, under the supervision and with the participation of the principal executive officer and principal financial officer, assessed the effectiveness of the Company's Internal Control as of December 31, 2015. Management's assessment was based on criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission.

The Company completed its acquisition of Simply Healthcare Holdings, Inc. on February 17, 2015. As permitted by the U.S. Securities and Exchange Commission, management's assessment as of December 31, 2015 did not include the Internal Control of the former Simply Healthcare Holdings, Inc., whose balance sheet is included in the Company's consolidated financial statements as of December 31, 2015. Such operations of Simply Healthcare Holdings, Inc. constituted \$249.6 million and \$87.2 million of the Company's total assets and net assets, respectively, as of December 31, 2015, and \$1,090.6 million and \$18.7 million of the Company's operating revenue and net income, respectively, for the year then ended.

Based on management's assessment, which excluded an assessment of Internal Control of the acquired operations of Simply Healthcare Holdings, Inc., management has concluded that the Company's Internal Control was effective as of December 31, 2015 to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external reporting purposes in accordance with GAAP.

Ernst & Young LLP, the Company's independent registered public accounting firm, has audited the consolidated financial statements of the Company for the year ended December 31, 2015, and has also issued an audit report dated February 19, 2016, on the effectiveness of the Company's internal control over financial reporting as of December 31, 2015, which is included in this Annual Report on Form 10-K.

/s/ JOSEPH R. SWEDISH
Chairman, President and Chief Executive Officer

/s/ WAYNE S. DEVEYDT
Executive Vice President and Chief Financial Officer

Changes in Internal Control over Financial Reporting

There have been no changes in our internal control over financial reporting that occurred during the three months ended December 31, 2015 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders of Anthem, Inc.

We have audited Anthem, Inc.'s internal control over financial reporting as of December 31, 2015, based on criteria established in Internal Control–Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). Anthem, Inc.'s management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

As indicated in the accompanying Management's Report on Internal Control Over Financial Reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of the former Simply Healthcare Holdings, Inc., which is included in the 2015 consolidated financial statements of Anthem, Inc. and constituted \$249.6 million and \$87.2 million of total and net assets, respectively, as of December 31, 2015 and \$1,090.6 million and \$18.7 million of operating revenues and net income, respectively, for the year then ended. Our audit of internal controls over financial reporting of Anthem, Inc. also did not include an evaluation of the internal controls over financial reporting of Simply Healthcare Holdings, Inc.

In our opinion, Anthem, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2015, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Anthem, Inc. as of December 31, 2015 and 2014, and the related consolidated statements of income, comprehensive income, shareholders' equity, and cash flows for each of the three years in the period ended December 31, 2015 of Anthem, Inc. and our report dated February 19, 2016 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Indianapolis, Indiana
February 19, 2016

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE.

The information required by this Item concerning our Executive Officers, Directors and nominees for Director, Audit Committee members and financial expert(s) and concerning disclosure of delinquent filers under Section 16(a) of the Exchange Act and our Standards of Business Conduct is incorporated herein by reference from our definitive Proxy Statement for our 2016 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 11. EXECUTIVE COMPENSATION.

The information required by this Item concerning remuneration of our Executive Officers and Directors, material transactions involving such Executive Officers and Directors and Compensation Committee interlocks, as well as the Compensation Committee Report, are incorporated herein by reference from our definitive Proxy Statement for our 2016 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS.

The information required by this Item concerning the stock ownership of management and five percent beneficial owners and securities authorized for issuance under equity compensation plans is incorporated herein by reference from our definitive Proxy Statement for our 2016 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE.

The information required by this Item concerning certain relationships and related person transactions and director independence is incorporated herein by reference from our definitive Proxy Statement for our 2016 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES.

The information required by this Item concerning principal accounting fees and services is incorporated herein by reference from our definitive Proxy Statement for our 2016 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES.

(a) 1. Financial Statements:

The following consolidated financial statements of the Company are set forth in Part II, Item 8

Report of Independent Registered Public Accounting Firm

Consolidated Balance Sheets as of December 31, 2015 and 2014

Consolidated Statements of Income for the years ended December 31, 2015, 2014, and 2013

Consolidated Statements of Comprehensive Income for the years ended December 31, 2015, 2014, and 2013

Consolidated Statements of Shareholders' Equity for the years ended December 31, 2015, 2014 and 2013

Consolidated Statements of Cash Flows for the years ended December 31, 2015, 2014 and 2013

Notes to Consolidated Financial Statements

2. Financial Statement Schedule:

The following financial statement schedule of the Company is included in Item 15(c):

Schedule II—Condensed Financial Information of Registrant (Parent Company Only).

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore, have been omitted.

3. Exhibits:

A list of exhibits required to be filed as part of this report is set forth in the Index to Exhibits, which immediately precedes such exhibits, and is incorporated herein by reference.

(b) Exhibits

The response to this portion of Item 15 is submitted as a separate section of this report.

(c) Financial Statement Schedule

Schedule II—Condensed Financial Information of Registrant (Parent Company Only).

Anthem, Inc. (Parent Company Only)
Balance Sheets

<i>(In millions, except share data)</i>	December 31, 2015	December 31, 2014
Assets		
Current assets:		
Cash and cash equivalents	\$ 492.3	\$ 739.8
Investments available-for-sale, at fair value:		
Fixed maturity securities (amortized cost of \$889.6 and \$1,798.8)	794.0	1,753.4
Equity securities (cost of \$53.0 and \$148.7)	82.0	206.7
Other invested assets, current	5.9	5.7
Other receivables	77.0	44.6
Income taxes receivable	236.5	227.9
Net due from subsidiaries	—	327.3
Securities lending collateral	130.6	224.8
Other current assets	394.0	232.5
Total current assets	2,212.3	3,762.7
Long-term investments available-for-sale, at fair value:		
Equity securities (cost of \$6.5 and \$6.6)	6.5	6.6
Other invested assets, long-term	630.1	654.5
Property and equipment, net	116.8	134.0
Deferred tax assets, net	146.6	—
Investments in subsidiaries	36,524.4	35,647.2
Other noncurrent assets	129.8	113.0
Total assets	\$ 39,766.5	\$ 40,318.0
Liabilities and shareholders' equity		
Liabilities		
Current liabilities:		
Accounts payable and accrued expenses	\$ 615.5	\$ 599.9
Security trades pending payable	13.4	14.0
Securities lending payable	130.6	224.8
Net due to subsidiaries	93.2	—
Current portion of long-term debt	—	624.3
Other current liabilities	278.1	280.1
Total current liabilities	1,130.8	1,743.1
Long-term debt, less current portion	15,299.6	13,994.7
Deferred tax liabilities, net	—	15.2
Other noncurrent liabilities	292.0	313.7
Total liabilities	16,722.4	16,066.7
Commitments and contingencies—Note 5		
Shareholders' equity		
Preferred stock, without par value, shares authorized - 100,000,000; shares issued and outstanding - none	—	—
Common stock, par value \$0.01, shares authorized - 900,000,000; shares issued and outstanding - 261,238,188 and 268,109,932	2.6	2.7
Additional paid-in capital	8,555.6	10,062.3
Retained earnings	14,778.5	14,014.4
Accumulated other comprehensive (loss) income	(292.6)	171.9
Total shareholders' equity	23,044.1	24,251.3
Total liabilities and shareholders' equity	\$ 39,766.5	\$ 40,318.0

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Income

(In millions)	Years ended December 31		
	2015	2014	2013
Revenues			
Net investment income	\$ 99.7	\$ 87.4	\$ 61.2
Net realized losses on investments	(3.8)	(27.1)	(83.2)
Other-than-temporary impairment losses on investments:			
Total other-than-temporary impairment losses on investments	(49.2)	(35.5)	(51.6)
Portion of other-than-temporary impairment losses recognized in other comprehensive income	10.0	7.0	0.2
Other-than-temporary impairment losses recognized in income	(39.2)	(28.5)	(51.4)
Other revenue	3.5	4.8	4.4
Total revenues (losses)	60.2	36.6	(69.0)
Expenses			
General and administrative expense	77.9	20.3	196.6
Interest expense	649.7	597.8	598.4
(Gain) loss on extinguishment of debt	(9.3)	81.1	145.3
Total expenses	718.3	699.2	940.3
Loss before income tax credits and equity in net income of subsidiaries	(658.1)	(662.6)	(1,009.3)
Income tax credits	(270.1)	(255.4)	(369.7)
Equity in net income of subsidiaries	2,948.0	2,976.9	3,129.3
Net income	\$ 2,560.0	\$ 2,569.7	\$ 2,489.7

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Comprehensive Income

<i>(in millions)</i>	Years ended December 31		
	2015	2014	2013
Net income	\$ 2,560.0	\$ 2,569.7	\$ 2,489.7
Other comprehensive (loss) income, net of tax:			
Change in net unrealized gains/losses on investments	(384.3)	118.6	(294.7)
Change in non-credit component of other-than-temporary impairment losses on investments	(5.6)	(3.9)	1.7
Change in net unrealized gains/losses on cash flow hedges	(45.2)	(3.6)	3.0
Change in net periodic pension and postretirement costs	(26.0)	(118.1)	172.7
Foreign currency translation adjustments	(3.4)	(4.3)	1.4
Other comprehensive loss	(464.5)	(11.3)	(115.9)
Total comprehensive income	<u>\$ 2,095.5</u>	<u>\$ 2,558.4</u>	<u>\$ 2,373.8</u>

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Cash Flows

(In millions)	Years ended December 31		
	2015	2014	2013
Operating activities			
Net income	\$ 2,560.0	\$ 2,569.7	\$ 2,489.7
Adjustments to reconcile net income to net cash provided by operating activities:			
(Undistributed) distributed earnings of subsidiaries	(287.8)	244.3	(78.5)
Net realized losses on investments	3.8	27.1	83.2
Other-than-temporary impairment losses recognized in income	39.2	28.5	51.4
(Gain) loss on extinguishment of debt	(9.3)	81.1	145.3
Loss on disposal of assets	0.2	3.9	3.6
Deferred income taxes	55.0	52.7	(4.5)
Amortization, net of accretion	40.8	17.5	25.2
Depreciation expense	68.1	67.4	45.7
Share-based compensation	148.2	168.9	146.0
Excess tax benefits from share-based compensation	(95.8)	(46.4)	(30.1)
Changes in operating assets and liabilities:			
Receivables, net	(17.9)	(16.6)	3.5
Other invested assets, current	(0.2)	(3.8)	(0.3)
Other assets	(106.9)	55.6	42.3
Amounts due from/to subsidiaries	420.5	566.1	(983.1)
Accounts payable and accrued expenses	7.5	(111.4)	111.8
Other liabilities	(231.4)	(113.8)	(18.6)
Income taxes	47.2	(36.0)	83.9
Other, net	(10.2)	—	—
Net cash provided by operating activities	2,631.0	3,554.8	2,116.5
Investing activities			
Purchases of investments	(2,130.7)	(1,819.3)	(1,964.3)
Proceeds from sales, maturities, calls and redemptions of investments	3,076.6	820.7	2,443.3
Settlement of non-hedging derivatives	(36.5)	(67.4)	(109.8)
Capitalization of subsidiaries	(939.7)	(321.8)	(121.2)
Changes in securities lending collateral	94.0	(178.8)	(17.0)
Purchases of property and equipment, net of sales	(51.1)	(57.0)	(87.4)
Other, net	1.5	(38.0)	(18.9)
Net cash provided by (used in) investing activities	14.1	(1,661.6)	124.7
Financing activities			
Net proceeds from (repayments of) commercial paper borrowings	682.2	(379.2)	(191.7)
Proceeds from long-term borrowings	1,226.5	2,700.0	1,250.0
Repayments of long-term borrowings	(2,697.2)	(1,730.1)	(1,245.0)
Changes in securities lending payable	(94.2)	178.6	17.1
Changes in bank overdrafts	(89.3)	55.5	71.8
Premiums paid on equity call options	(16.7)	—	(25.8)
Proceeds from sale of put options	16.6	—	—
Repurchase and retirement of common stock	(1,515.8)	(2,998.8)	(1,620.1)
Cash dividends	(686.5)	(501.6)	(465.9)
Proceeds from issuance of common stock under employee stock plans	186.0	301.3	524.7
Excess tax benefits from share-based compensation	95.8	46.4	30.1
Net cash used in financing activities	(2,892.6)	(2,327.9)	(1,654.8)
Change in cash and cash equivalents	(247.5)	(434.7)	586.4
Cash and cash equivalents at beginning of year	739.8	1,174.5	588.1
Cash and cash equivalents at end of year	\$ 492.3	\$ 739.8	\$ 1,174.5

See accompanying notes.

Anthem, Inc.
(Parent Company Only)
Notes to Condensed Financial Statements
December 31, 2015
(In Millions, Except Per Share Data)

1. Basis of Presentation and Significant Accounting Policies

In the parent company only financial statements of Anthem, Inc., or Anthem, Anthem's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. Anthem's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting.

Certain amounts presented in the parent company only financial statements are eliminated in the consolidated financial statements of Anthem.

Anthem's parent company only financial statements should be read in conjunction with Anthem's audited consolidated financial statements and the accompanying notes included in this Annual Report on Form 10-K.

2. Subsidiary Transactions

Dividends from Subsidiaries

Anthem received cash dividends from subsidiaries of \$2,672.3, \$3,234.5 and \$3,046.5 during 2015, 2014 and 2013, respectively.

Dividends to Subsidiaries

Certain subsidiaries of Anthem own shares of Anthem common stock. Anthem paid cash dividends to subsidiaries related to these shares of common stock in the amount of \$29.9, \$20.9 and \$17.9 during 2015, 2014 and 2013, respectively.

Investments in Subsidiaries

Capital contributions to subsidiaries were \$939.7, \$321.8 and \$121.2 during 2015, 2014 and 2013, respectively.

Amounts Due to and From Subsidiaries

At December 31, 2015 and 2014, Anthem reported \$93.2 due to subsidiaries and \$327.3 due from subsidiaries, respectively. The amounts due to or from subsidiaries primarily include amounts for allocated administrative expenses or cash held overnight at the parent level resulting from daily cash management activities. These items are routinely settled, and as such, are classified as current assets or liabilities.

3. Derivative Financial Instruments

The information regarding derivative financial instruments contained in Note 5, "Derivative Financial Instruments," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries is incorporated herein by reference.

4. Long-Term Debt

The information regarding long-term debt contained in Note 12, "Debt," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries is incorporated herein by reference.

5. Commitments and Contingencies

The information regarding commitments and contingencies contained in Note 13, "Commitments and Contingencies," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries is incorporated herein by reference.

6. Capital Stock

The information regarding capital stock contained in Note 14, "Capital Stock," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries is incorporated herein by reference.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

ANTHEM, INC.

By: /s/ JOSEPH R. SWEDISH
Joseph R. Swedish
Chairman, President and Chief Executive Officer

Dated: February 19, 2016

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

<u>Signature</u>	<u>Title</u>	<u>Date</u>
<u>/s/ JOSEPH R. SWEDISH</u> Joseph R. Swedish	Chairman, President and Chief Executive Officer	February 19, 2016
<u>/s/ WAYNE S. DEVEYDT</u> Wayne S. DeVeydt	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 19, 2016
<u>/s/ RONALD W. PENCZEK</u> Ronald W. Penczek	Senior Vice President and Chief Accounting Officer (Principal Accounting Officer)	February 19, 2016
<u>/s/ GEORGE A. SCHAEFER, JR.</u> George A. Schaefer, Jr.	Director	February 19, 2016
<u>/s/ R. KERRY CLARK</u> R. Kerry Clark	Director	February 19, 2016
<u>/s/ ROBERT L. DIXON, JR.</u> Robert L. Dixon, Jr.	Director	February 19, 2016
<u>/s/ LEWIS HAY III</u> Lewis Hay III	Director	February 19, 2016
<u>/s/ JULIE A. HILL</u> Julie A. Hill	Director	February 19, 2016
<u>/s/ RAMIRO G. PERU</u> Ramiro G. Peru	Director	February 19, 2016
<u>/s/ WILLIAM J. RYAN</u> William J. Ryan	Director	February 19, 2016
<u>/s/ ELIZABETH E. TALLETT</u> Elizabeth E. Tallett	Director	February 19, 2016

INDEX TO EXHIBITS

<u>Exhibit Number</u>	<u>Exhibit</u>
2.1	Stock and Interest Purchase Agreement dated April 9, 2009, by and between the Company and Express Scripts, Inc., incorporated by reference to Exhibit 2.1 of the Company's Current Report on Form 8-K filed on April 13, 2009, SEC File No. 001-16751.
2.2	Agreement and Plan of Merger, dated as of July 23, 2015 among Anthem, Inc., Anthem Merger Sub. Corp. and Cigna Corporation, incorporated by reference to Exhibit 2.1 to the Company's Current Report on Form 8-K filed on July 27, 2015.
3.1	Amended and Restated Articles of Incorporation of the Company, as amended effective December 2, 2014, incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on December 2, 2014.
3.2	By-Laws of the Company, as amended effective July 23, 2015, incorporated by reference to Exhibit 3.2 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2015.
4.1	Indenture, dated as of December 9, 2004, between the Company and The Bank of New York Trust Company, N.A., as trustee, including the Form of the Company's 5.950% Notes due 2034, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on December 15, 2004, SEC File No. 001-16751.
4.2	Indenture, dated as of January 10, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. (formerly known as The Bank of New York Trust Company, N.A.), as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on January 11, 2006, SEC File No. 001-16751.
(a)	Form of 5.85% Notes due 2036, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on January 11, 2006, SEC File No. 001-16751.
(b)	Form of 5.875% Notes due 2017, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on June 8, 2007, SEC File No. 001-16751.
(c)	Form of 6.375% Notes due 2037, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on June 8, 2007, SEC File No. 001-16751.
(d)	Form of 7.000% Notes due 2019, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on February 5, 2009, SEC File No. 001-16751.
(e)	Form of 4.350% Notes due 2020, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on August 12, 2010, SEC File No. 001-16751.
(f)	Form of 5.800% Notes due 2040, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 12, 2010, SEC File No. 001-16751.
(g)	Form of 2.375% Notes due 2017, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on August 15, 2011.
(h)	Form of 3.700% Notes due 2021, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 15, 2011.
(i)	Form of 3.125% Notes due 2022, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on May 7, 2012.
(j)	Form of 4.625% Notes due 2042, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on May 7, 2012.
(k)	Form of 1.875% Notes due 2018, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on September 10, 2012.
(l)	Form of 3.300% Notes due 2023, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on September 10, 2012.

Exhibit
Number

Exhibit

- (m) Form of 4.650% Notes due 2043, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on September 10, 2012.
- (n) Form of 2.300% Notes due 2018, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on July 31, 2013.
- (o) Form of 5.100% Notes due 2044, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on July 31, 2013.
- (p) Form of 2.250% Notes due 2019, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on August 12, 2014.
- (q) Form of 3.500% Notes due 2024, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 12, 2014.
- (r) Form of 4.650% Notes due 2044, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on August 12, 2014.
- (s) Form of 4.850% Notes due 2054, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on August 12, 2014.
- 4.3 Indenture dated as of October 9, 2012 between the Company and The Bank of New York Mellon Trust Company, N.A. as trustee, including the Form of the 2.750% Senior Convertible Debentures due 2042, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on October 9, 2012.
- 4.4 Subordinated Indenture, dated as of May 12, 2015, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on May 12, 2015.
 - (a) First Supplemental Indenture to the Subordinated Indenture, dated as of May 12, 2015, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee, including the Form of 1.90% Remarketable Subordinated Notes due 2028, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on May 12, 2015.
- 4.5 Purchase Contract and Pledge Agreement, dated as of May 12, 2015, between the Company and The Bank of New York Mellon Trust Company, N.A., as Purchase Contract Agent, Collateral Agent, Custodial Agent and Securities Intermediary, including the Form of Remarketing Agreement, Form of Corporate Units Certificate and Form of Treasury Units Certificate, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on May 12, 2015.
- 4.6 Upon the request of the Securities and Exchange Commission, the Company will furnish copies of any other instruments defining the rights of holders of long-term debt of the Company or its subsidiaries.
- 10.1 * Anthem 2001 Stock Incentive Plan, amended and restated as of January 1, 2003, incorporated by reference to Exhibit 10.1(iii) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2003, SEC File No. 001-16751.
 - (a) Form of Stock Incentive Plan General Stock Option Grant Agreement as of March 1, 2006, incorporated by reference to Exhibit 10.1(b) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2006, SEC File No. 001-16751.
- 10.2 * Anthem Incentive Compensation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed on December 2, 2014.
 - (a) Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement under the 2006 Incentive Compensation Plan, incorporated by reference to Exhibit 10.2(j) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2007, SEC File No. 001-16751.
 - (b) Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2009 under the 2006 Incentive Compensation Plan, incorporated by reference to Exhibit 10.2(m) to the Company's Annual Report on Form 10-K for the year ended December 31, 2008, SEC File No. 001-16751.

Exhibit
Number

Exhibit

- (c) Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement, incorporated by reference to Exhibit 10.2(o) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2010, SEC File No. 001-16751.
- (d) Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2013, incorporated by reference to Exhibit 10.2(s) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2013.
- (e) Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2013, incorporated by reference to Exhibit 10.2(t) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2013.
- (f) Form of Incentive Compensation Plan Performance Share Award Agreement for 2013, incorporated by reference to Exhibit 10.2(u) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2013.
- (g) Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2014, incorporated by reference to Exhibit 10.2(p) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014.
- (h) Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2014, incorporated by reference to Exhibit 10.2(q) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014.
- (i) Form of Incentive Compensation Plan Performance Share Award Agreement for 2014, incorporated by reference to Exhibit 10.2(r) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014.
- (j) Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2015, incorporated by reference to Exhibit 10.2(n) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015.
- (k) Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2015, incorporated by reference to Exhibit 10.2(o) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015.
- (l) Form of Incentive Compensation Plan Performance Stock Unit Award Agreement for 2015, incorporated by reference to Exhibit 10.2(p) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2015.
- 10.3 * Anthem, Inc. Comprehensive Nonqualified Deferred Compensation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.3 to the Company's Annual Report on Form 10-K for the year ended December 31, 2014.
- 10.4 * Anthem, Inc. Executive Agreement Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.4 to the Company's Annual Report on Form 10-K for the year ended December 31, 2014.
- 10.5 * Anthem, Inc. Executive Salary Continuation Plan, as amended and restated effective December 2, 2014.
- 10.6 * Anthem, Inc. Directed Executive Compensation Plan amended effective January 1, 2014, incorporated by reference to Exhibit 10.6 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2013.
- 10.7 * Anthem, Inc. Board of Directors Compensation Program, as amended effective December 9, 2015.
- 10.8 * Anthem Board of Directors' Deferred Compensation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.8 to the Company's Annual Report on Form 10-K for the year ended December 31, 2014.
- 10.9 * Amerigroup Corporation 2009 Equity Incentive Plan effective May 7, 2009, incorporated by reference to Exhibit 99.1 to the Company's Registration Statement on Form S-8 filed on December 26, 2012 (Registration No. 333-185675).

**Exhibit
Number**

Exhibit

- 10.10 * (a) Form of Employment Agreement between the Company and Wayne S. DeVeydt, incorporated by reference to Exhibit A to Exhibit 10.7 to the Company's Current Report on Form 8-K filed on November 2, 2006, SEC File No. 001-16751.
- (b) Form of Employment Agreement between the Company and each of the following: Brian T. Griffin, Peter D. Haytaian, Gloria McCarthy, Martin Silverstein, M.D., Jose D. Tomas and Thomas C. Zielinski, incorporated by reference to Exhibit A to Exhibit 10.41 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2007, SEC File No. 001-16751.
- (c) Form of Employment Agreement between the Company and Joseph R. Swedish, incorporated by reference to Exhibit A to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on February 12, 2013.
- (d) Form of Employment Agreement between the Company and Craig E. Sammit, incorporated by reference to Exhibit A to Exhibit 10.4 to the Company's Annual Report on Form 10-K for the year ended December 31, 2014.
- 10.11 * Offer Letter, by and between WellPoint, Inc. and Joseph R. Swedish, dated as of February 6, 2013, incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on February 12, 2013.
- 10.12 Blue Cross License Agreement by and between Blue Cross Blue Shield Association and the Company, including revisions, if any, adopted by the Member Plans through September 18, 2015.
- 10.13 Blue Shield License Agreement by and between Blue Cross Blue Shield Association and the Company, including revisions, if any, adopted by the Member Plans through September 18, 2015.
- 10.14 Undertakings to California Department of Managed Health Care, dated October 15, 2012, delivered by Blue Cross of California, incorporated by reference to Exhibit 10.19 to the Company's Annual Report on Form 10-K for the year ended December 31, 2012.
- 10.15 Commitment letter, dated as of July 23, 2015, by and among Anthem, Inc., Bank of America, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, Credit Suisse Securities (USA) LLC, Credit Suisse AG, UBS AG and UBS Securities LLC, incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on July 27, 2015.
- (a) Bridge Facility Joinder Agreement, dated as of August 25, 2015, among Anthem, Inc. and the other parties thereto, incorporated by reference to Exhibit 10.2 to the Company's Registration Statement on Form S-4 filed on September 30, 2015 (Registration No. 333-207218).
- 21 Subsidiaries of the Company.
- 23 Consent of Independent Registered Public Accounting Firm.
- 31.1 Certification of Chief Executive Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
- 31.2 Certification of Chief Financial Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
- 32.1 Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
- 32.2 Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
- 101 The following materials from Anthem, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2015, formatted in XBRL (Extensible Business Reporting Language): (i) the Consolidated Balance Sheets; (ii) the Consolidated Statements of Income; (iii) the Consolidated Statements of Comprehensive Income; (iv) the Consolidated Statements of Cash Flows; (v) the Consolidated Statements of Shareholders' Equity; (vi) the Notes to Consolidated Financial Statements and (vii) Financial Statement Schedule II.

* Indicates management contracts or compensatory plans or arrangements.

Anthem, Inc. Executive Salary Continuation Plan

Effective January 1, 2006
Amended and Restated Effective December 2, 2014

Article 1: Definitions

Capitalized terms used in the Plan have the following meanings:

- 1.1 **“Authorized Health Care Provider”** means a person who is licensed to practice medicine and such other persons as are included by operation of state law. In no circumstances will a family member of an executive be an Authorized Health Care Provider for purposes of that executive's claim for benefits under this Plan.
- 1.2 **“Employer”** means Anthem, Inc. (“Anthem”) and its subsidiaries and affiliates.
- 1.3 **“Leave of Absence Team” or “LOA Team”** means the division of HRSolutions to which the Employer has delegated operational responsibility for the Plan.
- 1.4 **“Participant”** means an individual with an Anthem, Inc. title of Vice President or above who has completed 90 days of active employment (at any level). In no event will an executive be eligible for benefits under this Plan if he or she is eligible to receive disability benefits under another plan, contract, or other employment arrangement offered by the Employer. A Participant's coverage under the Plan ends upon the date his or her employment with the Employer terminates for any reason unless the Participant is receiving benefits under the Plan at the time of the termination of employment.
- 1.5 **“Plan”** means this Anthem, Inc. Executive Salary Continuation Plan, as now in effect and as hereafter amended from time to time.
- 1.6 **“Disability”** means a medical or behavioral health condition which is not work related, which continues for more than seven consecutive days, and which results in a Participant's inability to perform the essential duties of his or her job. The Employer will establish such reasonable procedures as in its discretion it deems appropriate to determine whether a Disability exists under the terms of the Plan. These procedures may include review of medical records by the LOA Team or its designee.
- 1.7 **“Disability Absence”** means a leave of absence for which salary continuation is provided under the terms of this Plan.
- 1.8 **“New Period of Disability”** means (1) when an Participant returns to work from a Disability Absence for at least one full business day and later qualifies for benefits under this Plan due to an unrelated condition; or (2) when an Participant returns to work from a Disability Absence for 90 or more days and subsequently begins another Disability Absence, whether or not for the same or a related condition.
- 1.9 **“Recurrent Disability”** means (1) when an Participant returns to work after a Disability Absence without exhausting the 180-day maximum benefit under this Plan and again becomes disabled from the same or a related condition within 90 calendar days of the end of the prior Disability Absence; (2) when an Participant incurs additional absences within 90 calendar days of a prior return to work as a result of the same or a related condition; or (3) when a subsequent period of Disability begins

for an unrelated condition before the Participant completes one full day of work following the prior Disability Leave.

Article 2: Plan Benefits

2.1 Filing a Claim for Benefits

To begin the process for obtaining benefits under the Plan, a Participant must notify the Leave of Absence Team of his or her disability and request a claim form. This step is called the Initial Notice. A Participant may appoint an authorized representative to make the Initial Notice and/or to take any other actions on his or her behalf.

The Participant must return the completed claim form to the LOA Team within 21 calendar days of the Initial Notice. Failure to return the completed claim form within this time period will result in a denial of benefits unless the Participant submits credible evidence that the delay was reasonable due to circumstances beyond his or her control.

Benefits may be provided retroactively for a period of leave that occurred up to 30 calendar days prior to the Initial Notice to the LOA Team. Benefits are not available for portions of leaves that occurred more than 30 days prior to the Initial Notice.

2.2 The Claim Determination Process

The LOA Team reviews the completed claim form and determines whether it contains sufficient information to approve or deny benefits. The LOA Team requires a certification substantiating the necessity and anticipated duration of the leave from an Authorized Health Care Provider who is treating the Participant for the condition for which the benefits are requested. The LOA Team may require such additional medical records and/or a second or third medical opinion from an Authorized Health Care Provider of its choice as it deems appropriate to determine a claim. In reaching a decision, the LOA Team will consider the diagnosis and nature of health care being received.

To receive benefits under the Plan, a Participant must have a non-work related total disability that lasts at least eight full consecutive days, or a partial disability as explained in Section 2.3. For the purposes of this Plan, a total disability is a condition which renders the Participant unable to perform substantially all of the normal duties of his or her job. Unless an exception is warranted due to reasonable cause, to qualify for benefits the Participant must receive treatment for the disabling condition within seven days of the last day worked and receive continuing treatment thereafter for the condition. In all cases, for benefits to be received, the effect of the care must be of demonstrable medical value for the disabling condition to effectively attain and/or maintain maximum medical improvement. Maximum medical improvement is the level at which, based on reasonable medical probability, further material recovery from, or lasting improvement to, an injury or sickness can no longer be reasonably anticipated.

A complete claim form accompanied by a provider certification and any other necessary medical information will be approved or denied within 45 days of receipt. In the event an incomplete claim is submitted, meaning that additional information is needed, the LOA Team will notify the

Participant of the additional information or documentation necessary to make a decision. Notice to the Participant of the need for additional information will suspend the running of the 45-day decision period. The 45-day decision period will begin running again when the LOA Team receives the additional information. The LOA Team will provide up to two 30-day periods for submission of the necessary information. If sufficient information is not submitted within that time period for the LOA Team to make a decision on the claim, the claim is treated as denied.

When a claim for Disability benefits is approved, the Participant is notified of the duration of the approved benefit period. When a claim is denied, the Participant is notified of the reason for the denial, including a description of any additional material or information necessary for the claim to be approved, with an explanation of why such additional information or material is necessary.

Additionally, if an internal rule, guideline, protocol or other criterion was relied upon in making the denial decision, that criterion will either be included in the denial notice or the notice will state that such a criterion was relied upon and is available without charge to the Participant upon request.

2.3 Commencement and Duration of Benefits

The Plan provides Participants with benefits under the Plan beginning on the eighth consecutive day of an absence due to a Disability. If a Participant does not remain completely disabled during the seven day waiting period, he or she will not qualify for benefits under the Plan. During this waiting period, the Participant will be required to use any available PTO time or other supplemental disability time during the waiting period to the extent consistent with applicable law.

When a claim for Disability benefits is approved, the approval notice will define the period of approved benefits. The benefit period will be determined based on the certification received from the Authorized Health Care Provider, the nature and expected duration of the disability and other relevant factors.

If the Disability continues past the initial period of approved benefits, the Participant may file a claim for an extension of benefits, together with a certification from an Authorized Health Care Provider in support of the extension. Claims for extension are due within fourteen days of (1) the expiration of the previously approved benefit period, or (2) notice of approval of the prior benefit period, whichever occurs later. Claims for extension will be reviewed and determined in accordance with the process set forth in Section 2.2 above.

The maximum duration of benefits under the Plan is 180 calendar days, inclusive of the seven day waiting period. Partial days are counted as whole days for the purpose of computing the 180 day maximum. If the Participant continues to be disabled after 180 days and has elected coverage under Anthem's Long Term Disability Plan, he or she may begin to receive benefits under that plan upon exhaustion of Disability benefits and approval of the long term disability claim.

Recurrent Disabilities are treated as extensions of the first Disability Absence. Satisfaction of the waiting period for the first period of Disability applies to Recurrent Disabilities, so benefits may commence without a waiting period. A single 180-day maximum benefit period

applies to an initial Disability Absence and all Recurrent Disabilities. The LOA Team determines in its discretion whether a subsequent condition is the same as or related to the initial condition.

For a New Period of Disability, a new waiting period will be imposed before Disability benefits commence, and a new 180-day maximum benefit period will apply.

2.4 Benefit Levels

The benefit for total disability under the Plan consists of 100% of weekly base salary. Benefits will be reduced to the extent they are duplicated by benefits from other payors, including without limitation severance and state disability programs.

To receive benefits for a partial disability, a Participant must first have a period of total disability which meets the criteria set forth in Section 2.2, including a duration of at least eight consecutive days. This eight-day period cannot be satisfied with days of partial attendance.

Following the period of total disability, the Authorized Health Care Provider who is treating the disabling condition must provide proof satisfactory to the LOA Team that the Participant is unable to perform substantially all of the normal duties of his or her job for a portion of the period that comprises his or her normal weekly work schedule. The Authorized Health Care Provider must submit in writing to the LOA Team the number of hours which the Participant can work or a weekly reduced set schedule.

The partial disability period must begin within 30 calendar days of the date a covered total disability ends and while the Participant is eligible for benefits under the Plan.

Unless an exception is warranted due to reasonable cause, during the partial disability period the Participant must receive continuing treatment for the disabling condition. In all cases, for benefits to be received, the effect of the care must be of demonstrable medical value for the disabling condition to effectively attain and/or maintain maximum medical improvement. Maximum medical improvement is the level at which, based on reasonable medical probability, further material recovery from, or lasting improvement to, an injury or sickness can no longer be reasonably anticipated.

If the Employer can reasonably accommodate a Participant's restrictions due to a disability to permit the Participant to return to work, the Participant will not be eligible for benefits under the Plan and will be expected to return to work.

2.5 Exclusions

This Plan does not provide benefits for a disability caused by or resulting from any of the following:

- War, declared or undeclared, or any act of war;
- Active participation in a riot or insurrection;
- Participation in the commission of a felony;

- Any cause which does not require the regular care and attendance of an Authorized Health Care Provider;
- Any illness or injury for which Worker's Compensation benefits are payable, whether related to current or past employment;
- Cosmetic procedures, plastic surgery, reconstructive surgery, or any other treatment or care connected with or incidental to treatment that is primarily intended to improve the Participant's appearance. Benefits are provided for disabilities that result from treatment that is intended to restore bodily function, however, or to correct a deformity resulting from disease, accidental injury, birth defects, or prior therapeutic processes.

2.6 Termination of Benefits

Disability benefits will end when the first of the following occurs: (1) the disability ends; (2) the 180-day maximum benefit is exhausted as set forth above; (3) the Participant's coverage under the Plan ends as set forth in Article I, 1.4.

Article 3: Privacy Rights

The Employer or its designee will need to access personal information, including medical information, in order to administer benefits under the Plan. The use and disclosure of medical information is performed in accordance with applicable laws.

Article 4: General Provisions

4.1 Amendment or Termination of the Plan

Anthem has the right to amend or terminate the Plan at any time.

4.2 Non-Alienation and Assignment

No benefit under this Plan shall be subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution, or any other voluntary or involuntary alienation.

4.3 Successors and Assigns

This Plan shall be binding upon the successors and assigns of Anthem.

ANTHEM, INC.
BOARD OF DIRECTORS COMPENSATION PROGRAM
(AS AMENDED EFFECTIVE DECEMBER 9, 2015)

Directors who are employed by Anthem, Inc. or its subsidiaries do not receive compensation for serving as Directors. However, Directors who are not employees of Anthem, Inc. or its subsidiaries are entitled to receive the following compensation:

CASH COMPENSATION—Retainers

Annual Board Retainer:

- \$95,000 for all Directors paid quarterly in advance (in four equal installments of \$23,750) on January 1, April 1, July 1 and October 1.

Annual Committee Retainer:

- \$15,000 for Audit Committee members paid quarterly in advance (in four equal installments of \$3,750) on January 1, April 1, July 1 and October 1.
- \$10,000 for the members of each other Committee of the Board of Directors paid quarterly in advance (in four equal installments of \$2,500) on January 1, April 1, July 1 and October 1.

Annual Retainer for Non-Executive Chair of Board:

- \$225,000 for the Non-Executive Chair of the Board, if any, paid quarterly in advance (in four equal installments of \$56,250) on January 1, April 1, July 1 and October 1.

Annual Retainer for Lead Director:

- \$30,000 for the Lead Director of the Board, if any, paid quarterly in advance (in four equal installments of \$7,500) on January 1, April 1, July 1 and October 1.

Annual Retainer for Committee Chairs:

- \$25,000 for the Chair of the Audit Committee of the Board of Directors paid quarterly in advance (in four equal installments of \$6,250) on January 1, April 1, July 1 and October 1.
- \$15,000 for the Chair of each other Committee of the Board of Directors paid quarterly in advance (in four equal installments of \$3,750) on January 1, April 1, July 1 and October 1.

If a Director is elected to the Board, appointed to a Committee or becomes the Non-Executive Chair or Lead Director of the Board or a Committee Chair on a date other than the first day of a calendar quarter, the retainers described above will be pro-rated based on days served in the applicable position.

STOCK COMPENSATION

Annual Full Value Share Grant:

Each Director will receive on the date of the Anthem, Inc. annual meeting of shareholders, subject to the deferral described below, an annual grant of a number of shares equal in value to \$175,000 (the "Annual Full Value Share Grant"). The exact number of shares for each Annual Full Value Share Grant will be calculated using the following formula:

Exhibit 10.7

$[\$175,000] \div [\text{the closing price of the Anthem, Inc. common stock as reported on the New York Stock Exchange on the date of the annual meeting of shareholders}] = \text{Number of shares of the Annual Full Value Share Grant.}$

Partial Value Share Grants:

Any Director who joins the Board of Directors after the date of the Anthem, Inc. annual meeting of shareholders (the "Effective Date") shall receive a pro-rated share grant (the "Partial Value Share Grant") on the first business day of the month following the Effective Date (unless the Effective Date is on the first business day of a month, in which case, the grant shall be made on the Effective Date). The Partial Value Share Grant shall be subject to the deferral described below. The exact number of shares of the Partial Value Share Grant will be calculated using the following formula:

$[\$175,000 \times (\text{the number of days from the Effective Date to the first annual meeting of shareholders after the Effective Date} \div 365)] \div \text{the closing price of the Anthem, Inc. common stock as reported on the New York Stock Exchange on the first business day of the month following the Effective Date (unless the Effective Date is on the first business day of a month, in which case, the closing price on the Effective Date shall be used)} = \text{Number of shares of the Partial Value Share Grant.}$

Deferral of Share Grants:

Share grants will be deferred for a minimum period of five years from the (1) grant date for Annual Full Value Share Grants and (2) the date of the annual meeting of shareholders that immediately precedes the Effective Date for Partial Value Share Grants (each a "Deferral Period") in accordance with the terms of the Director Deferred Compensation Plan. Such grants shall not be distributed to the Directors until the earlier of the expiration of the Deferral Period or the date on which a Director ceases to be a member of the Board of Directors.

Director Ownership Guidelines:

Each Director shall have the obligation to own at least \$500,000 of Anthem, Inc. common stock (including deferred shares and phantom stock, but not options) commencing on the fifth anniversary of the date such Director became a member of the Board of Directors.

MISCELLANEOUS

Annual Physical Exam:

Anthem, Inc. will pay the cost of an annual physical examination for each Director.

Expenses:

Anthem, Inc. will reimburse each Director for all travel, lodging and other expenses incurred in connection with attendance at and/or participation in any and all Board of Directors and Committee meetings and related matters.

BLUE CROSS LICENSE AGREEMENT
(Includes revisions, if any, adopted by Member Plans through their September 18, 2015 meeting)

This agreement by and between Blue Cross and Blue Shield Association ("BCBSA") and the Blue Cross Plan, known as _____ (the "Plan").

Preamble

WHEREAS, the Plan and/or its predecessor(s) in interest (collectively the "Plan") had the right to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") for health care plans in its service area, which was essentially local in nature;

WHEREAS, the Plan was desirous of assuring nationwide protection of the Licensed Marks, maintaining uniform quality controls among Plans, facilitating the provision of cost effective health care services to the public and otherwise benefiting the public;

WHEREAS, to better attain such ends, the Plan and the predecessor of BCBSA in 1972 simultaneously executed the BCA License Agreement (s) and the Ownership Agreement; and

WHEREAS, BCBSA and the Plan desire to supercede said Agreement(s) and to revise certain provisions of the Ownership Agreement to reflect their current practices and to assure the continued integrity of the Licensed Marks and of the BLUE CROSS system;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

Agreement

1. BCBSA hereby grants to the Plan, upon the terms and conditions of this License Agreement ("Agreement" or "Primary License Agreement", the right to use BLUE CROSS in its trade and/or corporate name (the "Licensed Name"), and the right to use the Licensed Marks, in the sale, marketing and administration of health care plans and related services in the Service Area set forth and defined in paragraph 5 below. As used herein, health care plans and related services shall include acting as a nonprofit health care plan, a for-profit health care plan, or mutual health insurer operating on a not-for-profit or for-profit basis, under state law; financing access to health care services; when working with a bank that holds the relevant license to use the Licensed Name and Marks, offering: (i) tax-favored savings accounts for medical expenses and means for accessing such accounts, such as debit cards or checks, that are provided solely to support access to such tax-favored savings accounts, all pursuant to such license, or (ii) prepaid rewards cards that are provided for completion of a wellness program, all pursuant to such license; providing health care management and administration; administering, but not underwriting, non-health portions of Worker's Compensation insurance; delivering health care services, except hospital services (as defined in the Guidelines to Membership Standards Applicable to Regular Members); and performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by a group account to its members, including benefit plans not provided by the Plan, provided that the Plan has contracted to provide Health Coverage under the Licensed Marks to the account (as the terms "Health Coverage," "Eligibility" and "Enrollment" are defined in Exhibit 4, Paragraph 2.t.).

2. The Plan may use the Licensed Marks and Name in connection with the offering of: i) health care plans and related services in the Service Area through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit I hereto (the "Controlled Affiliate License Agreement"); and: ii) insurance coverages offered by life insurers under the applicable law in the Service Area, other than those which the Plan may offer in its own name, provided through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1A hereto (the "Controlled Affiliate License Agreement Applicable to Life Insurance Companies") or the Agreement attached as Exhibit 1A1 hereto (the "Controlled Affiliate Trademark License Agreement for Life and Disability Insurance Products") and further provided that the offering of such services does not and will not dilute or tarnish the unique value of the Licensed Marks and Name; and iii) administration and underwriting of Workers' Compensation Insurance Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit I hereto (the "Controlled Affiliate License."); and iv) regional Medicare Advantage PPO products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1B hereto (the "Controlled Affiliate License Agreement Applicable to Regional Medicare Advantage PPO Products"); and v) regional Medicare Part D Prescription Drug Plan products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1C hereto (the "Controlled Affiliate License Agreement Applicable to Regional Medicare Part D Prescription Drug Plan Products"). As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans and, if the entity meets the standards of Paragraph 2a.B but not Paragraph 2a.A, the entity, its owners, and persons

Amended as of September 19, 2014

with authority to select or appoint members or board members, other than a Plan or Plans, have received written approval of BCBSA. Absent written approval by BCBSA of an alternative method of control, bona fide control shall have the meaning set forth in Paragraphs 2a. and 2b.

2a. With respect to the Controlled Affiliate Licenses authorized in clauses i) through iii) of Paragraph 2, bona fide control shall mean that a Plan (the "Sponsoring Plan") authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to this Primary License Agreement with BCBSA must have:

- A. The legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; (b) to exercise control over the policy and operations of the Controlled Affiliate; (c) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or
- B. The legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; (c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan. Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:
 - 1. Change its legal and/or trade name;
 - 2. Change the geographic area in which it operates;
 - 3. Change any of the types of businesses in which it engages;
 - 4. Create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;
 - 5. Sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;
 - 6. Make any loans or advances except in the ordinary course of business;

Amended as of March 26, 2015

7. Enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners of the Controlled Affiliate or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);
8. Conduct any business other than under the Licensed Marks and Name;
9. Take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks or Names.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or

C. With respect to a Controlled Affiliate that is 100% controlled by Plans

including the Sponsoring Plan and which offers solely Medicaid products and services, the legal authority together with such other Plans (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B to Exhibit 1 attached hereto.

2b. With respect to the Controlled Affiliate License Agreements authorized in clauses iv) and v) of Paragraph 2, bona fide control shall mean that the Controlled Affiliate is organized and operated in such a manner that it meets the following requirements:

A. The Controlled Affiliate is owned or controlled by two or more Plans authorized to use the Licensed Marks pursuant to this License Agreement with BCBSA (for purposes of this subparagraph A. through subparagraph C., the "Controlling Plans"); and

Amended as of March 26, 2015

- B. Each Controlling Plan is authorized pursuant to this Agreement to use the Licensed Marks in a geographic area in the Region (as that term is defined in such Controlled Affiliate License Agreements) and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
- C. The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur; and (c) to exercise control over the policy and operations of the Controlled Affiliate. Notwithstanding anything to the contrary in (a) through (c) of this subparagraph E., the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:
1. Change its legal and/or trade names;
 2. Change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
 3. Change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
 4. Take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Amended as of June 19, 2014

3. With respect to a Controlled Affiliate that is not licensed to use the Licensed Marks and Name, the Plan may, in communications that contain the Licensed Marks or Name, indicate its corporate relationship to the Affiliate and permit such Affiliate to indicate its corporate relationship to the Plan, solely in the circumstances, style and manner specified by BCBSA from time-to-time in regulations of general application consistent with the avoidance of confusion or mistake or the dilution or tarnishment of the Licensed Marks and Name. No rights are hereby created in any Controlled Affiliate to use the Licensed Marks or Name in its own name or otherwise.

4. The Plan recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Plan further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide. The Plan agrees (a) to maintain in good standing its membership in BCBSA; (b) promptly to pay its dues to BCBSA, said dues to represent the royalties for this License Agreement; (c) materially to comply with all applicable laws; (d) to comply with the Membership Standards Applicable to Regular Members of BCBSA, a current copy of which is attached as Exhibit 2 hereto; and (e) reasonably to permit BCBSA, upon a written, good faith request and during reasonable business hours, to inspect the Plan's books and records necessary to ascertain compliance herewith. As to other Plans and third parties, BCBSA shall maintain the confidentiality of all documents and information furnished by the Plan pursuant hereto, or pursuant to the Membership Standards, and clearly designated by the Plan as containing proprietary information of the Plan.

5. The rights hereby granted are exclusive to the Plan within the geographical area(s) served by the Plan on June 30, 1972, and/or as to which the Plan has been granted a subsequent license, which is hereby defined as the "Service Area," except that BCBSA reserves the right to use the Licensed Marks in said Service Area, and except to the extent that said Service Area may overlap areas served by one or more other licensed Blue Cross Plans as of said date or subsequent license, as to which overlapping areas the rights hereby granted are nonexclusive as to such other Plan or Plans only.

Amended as of June 19, 2014

6. Except as expressly provided by BCBSA with respect to National Accounts, Government Programs and certain other necessary and collateral uses, the current rules and regulations governing which are attached as Exhibit 3 and Exhibit 4 hereto, and are contained in other documents referenced herein, or as expressly provided herein, the Plan may not use the Licensed Marks and Name outside the Service Area or in connection with other goods and services, nor may the Plan use the Licensed Marks or Name in a manner which is intended to transfer in the Service Area the goodwill associated therewith to another mark or name. Nothing herein shall be construed to prevent the Plan from engaging in lawful activity anywhere under other marks and names not confusingly similar to the Licensed Marks and Name, provided that engaging in such activity does and will not dilute or tarnish the unique value of the Licensed Marks and Name. In addition to any and all remedies available hereunder, BCBSA may impose monetary fines on the Plan for the Plan's use of the Licensed Marks and Names outside the Service Area, and provided that the procedure used in imposing a fine is consistent with procedures specifically prescribed by BCBSA from time to time in regulations of general application. In the case of regional Medicare Advantage PPO and regional Medicare Part D Prescription Drug Plan products offered by consenting and participating Plans in a region that includes the Service Areas, or portions thereof, of more than one Plan, such fine may be imposed jointly on the consenting and participating Plans for use of the Licensed Marks and Name in any geographic area of the region in which a Plan having exclusive rights to the Licensed Marks and Name does not consent to and participate in such offering, provided that the basis for imposition of such fine is consistent with rules specifically prescribed by BCBSA from time to time in regulations of general application.

7. The Plan agrees that it will display the Licensed Marks and Name only in such form, style and manner as shall be specifically prescribed by BCBSA from time-to-time in regulations of general application in order to prevent impairment of the distinctiveness of the Licensed Marks and Name and the goodwill pertaining thereto. The Plan shall cause to appear on all materials on or in connection with which the Licensed Marks or Name are used such legends, markings and notices as BCBSA may reasonably request in order to give appropriate notice of service mark or other proprietary rights therein or pertaining thereto.

8. BCBSA agrees that: (a) it will not grant any other license effective during the term of this License Agreement for the use of the Licensed Marks or Name which is inconsistent with the rights granted to the Plan hereunder; and (b) it will not itself use the Licensed Marks in derogation of the rights of the Plan or in a manner to deprive the Plan of the full benefits of this License Agreement, provided that BCBSA shall have the right to use the Licensed Marks in conjunction with any national offering under the Federal Employees Health Benefits Program in the manner set forth in Exhibit 4, Paragraph 4 (including subparagraphs) to this License Agreement. The Plan agrees that it will not attack the title of BCBSA in and to the Licensed Marks or Name or attack the validity of the Licensed Marks or of this License Agreement. The Plan further agrees that all use by it of the Licensed Marks and Name or any similar mark or name shall inure to the benefit of BCBSA, and the Plan shall cooperate with BCBSA in effectuating the assignment to BCBSA of any service mark or trademark registrations of the Licensed Marks or any similar mark or name held by the Plan or a Controlled Affiliate of the Plan, all or any portion of which registration consists of the Licensed Marks.

Amended as of November 16, 2006

9. (a). Should the Plan fail to comply with the provisions of paragraphs 2-4, 6, 7 and/or 12, and not cure such failure within thirty (30) days of receiving written notice thereof (or commence curing such failure within such thirty day period and continue diligent efforts to complete the curing of such failure if such curing cannot reasonably be completed within such thirty day period), BCBSA shall have the right to issue a notice that the Plan is in a state of noncompliance. Except as to the termination of a Plan's License Agreement or the merger of two or more Plans, disputes as to noncompliance, and all other disputes between or among BCBSA, the Plan, other Plans and/or Controlled Affiliates, shall be submitted promptly to mediation and mandatory dispute resolution pursuant to the rules and regulations of BCBSA, a current copy of which is attached as Exhibit 5 hereto, and shall be timely presented and resolved. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. If a state of noncompliance as aforesaid is undisputed by the Plan or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the License Agreement. Except, however, as provided in paragraphs 9(d)(iii), 15(a)(i)-(viii), and 15(a)(x) below, no Plan's license to use the Licensed Marks and Name may be finally terminated for any reason without the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

(b). Notwithstanding any other provision of this License Agreement, a Plan's license to use the Licensed Marks and Name may be forthwith terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to Member Plans for: (i) failure to comply with any minimum capital or liquidity requirement under the Membership Standard on Financial Responsibility; or (ii) impending financial insolvency; or (iii) the pendency of any action instituted against the Plan seeking its dissolution or liquidation or its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property of business, unless this License Agreement has been earlier terminated under paragraph 15(a); or (iv) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans and/or the Licensed Marks.

Amended as of November 16, 2006

(c). To the extent not otherwise provided therein, neither: (i) the Membership Standards Applicable to Regular Members of BCBSA; nor (ii) the rules and regulations governing Government Programs and certain other uses; nor (iii) the rules and regulations governing mediation and mandatory dispute resolution, may be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans. The rules and regulations governing National Accounts and other national programs required by the Membership Standards Applicable to Regular Members of BCBSA (Exhibit 2) are contained, in addition to those set forth in Exhibit 3, in the following documents, as amended from time to time: (1) the Inter-Plan Programs Policies and Provisions; (2) Inter-Plan Medicare Advantage Program Policies and Provisions. The voting requirements specified in rules and regulations governing such national programs may not be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans.

Amended as of November 21, 2014

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

(i) The Plan shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement and the Plan's membership in BCBSA.

(ii) The Plan shall not use the licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Plan in any securities market. The Plan shall use the licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(iii) Plan's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Plan knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Plan ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Plan knows, or there is an SEC filing indicating that, any Noninstitutional Investor has become the Beneficial Owner of securities representing 5% or more of the voting power of the Plan ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Plan knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner of 20% or more of the Plan's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 9(d)(iv) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Plan went public constituted the Board of Directors of the Plan (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Plan went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Plan consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Plan in a writing received by BCBSA prior to such automatic termination becoming effective, the provisions of this paragraph 9(d)(iii) may be waived, in whole or in part,

Amended as of September 17, 1997

upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 9(d)(iii)(a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Plan's license to use the Licensed Marks and Name is terminated pursuant to this Paragraph 9(d)(iii), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Plan demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(iv) The Plan shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities or (iii) such other securities as the Plan may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(v) For purposes of paragraph 9(d)(iii), the following definitions shall apply:

(a) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(b) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(i) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

Amended as of September 17, 1997

(ii) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(iii) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (b)(ii)(B) above) or disposing of any securities of the Plan.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Plan, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(c) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

(d) "Noninstitutional Investor" means any Person who is not an Institutional Investor.

(e) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

Amended as of September 17, 1997

10. This License Agreement shall remain in effect: (a) until terminated as provided herein; or (b) until this and all such other License Agreements are terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans; or (c) until termination of aforesaid Ownership Agreement; or (d) until terminated by the Plan upon eighteen (18) months written notice to BCBSA or upon a shorter notice period approved by BCBSA in writing at its sole discretion.

11. Except as otherwise provided in paragraph 15 below or by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans, or unless this and all such other License Agreements are simultaneously terminated by force of law, the termination of this License Agreement for any reason whatsoever shall cause the reversion to BCBSA of all rights in and to the Licensed Marks and Name, and the Plan agrees that it will promptly discontinue all use of the Licensed Marks and Name, will not use them thereafter, and will promptly, upon written notice from BCBSA, change its corporate name so as to eliminate the Licensed Name therefrom.

12. The license hereby granted to Plan to use the Licensed Marks and Name is and shall be personal to the Plan so licensed and shall not be assignable by any act of the Plan, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Plan mortgage or part with possession or control of this license or any right hereunder, and the Plan shall have no right to grant any sublicense to use the Licensed Marks and Name.

13. BCBSA shall maintain appropriate service mark registrations of the Licensed Marks and BCBSA shall take such lawful steps and proceedings as may be necessary or proper to prevent use of the Licensed Marks by any person who is not authorized to use the same. Any actions or proceedings undertaken by BCBSA under the provisions of this paragraph shall be at BCBSA's sole cost and expense. BCBSA shall have the sole right to determine whether or not any legal action shall be taken on account of unauthorized use of the Licensed Marks, such right not to be unreasonably exercised. The Plan shall report any unlawful usage of the Licensed Marks to BCBSA in writing and agrees, free of charge, to cooperate fully with BCBSA's program of enforcing and protecting the service mark rights, trade name rights and other rights in the Licensed Marks.

14. The Plan hereby agrees to save, defend, indemnify and hold BCBSA and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of the activities of the Plan or of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan. BCBSA hereby agrees to save, defend, indemnify and hold the Plan and any other Plan(s) harmless from and against all claims, damages, liabilities And costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of BCBSA.

Amended as of June 21, 2012

15. (a). This Agreement shall automatically terminate upon the occurrence of any of the following events: (i) a voluntary petition shall be filed by the Plan or by BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against the Plan or BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Plan or BCBSA respectively, or (iii) an order for relief is entered against the Plan or BCBSA in any case under the bankruptcy laws of the United States, or the Plan or BCBSA is adjudged bankrupt or insolvent (as that term is defined in the Uniform Commercial Code as enacted in the state of Illinois) by any court of competent jurisdiction, or (iv) the Plan or BCBSA makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of the Plan or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Plan or BCBSA respectively, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of the Plan's or BCBSA's property or business is appointed, or the Plan or BCBSA is ordered dissolved or liquidated, or (ix) the Plan shall fail to pay its dues and shall not cure such failure within thirty (30) days of receiving written notice thereof, or (x) if, due to regulatory action, the Plan together with any applicable Controlled Affiliate becomes unable to do business using the Names and Marks in any State or portion thereof included in its Service Area, provided that: (i) automatic termination shall not occur prior to the exhaustion by any such Plan of its rights to appeal or challenge such regulatory action; and (ii) in the event the Plan is licensed to do business using the Names and Marks in multiple States or portions of States, the termination of its License Agreement shall be solely limited to the State(s) or portions thereof in which the regulatory action applies. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Plan's or BCBSA's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 15(a)(vii) and (viii) of this Agreement.

Amended as of March 26, 2015

(b). BCBSA, or the Plans (as provided and in addition to the rights conferred in Paragraph 10(b) above), may terminate this Agreement immediately upon written notice upon the occurrence of either of the following events: (a) the Plan or BCBSA becomes insolvent (as that term is defined in the Uniform Commercial Code enacted in the state of Illinois), or (b) any final judgment against the Plan or BCBSA remains unsatisfied or unbonded of record for a period of sixty (60) days or longer.

(c). If this License Agreement is terminated as to BCBSA for any reason stated in subparagraphs 15(a) and (b) above, the ownership of the Licensed Marks shall revert to each of the Plans as provided in the Ownership Agreement.

(d). Upon termination of this License Agreement or any Controlled Affiliate License Agreement of a Larger Controlled Affiliate, as defined in Exhibit 1 to this License Agreement, the following conditions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 15 (a)(x)(ii) of this Agreement, the notices, national account listing, payment and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

- (i) The terminated entity shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the terminated entity or its Controlled Affiliates under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination or, if termination is pursuant to paragraph 10(d) of this Agreement, within 15 days after the written notice to BCBSA described in paragraph 10(d).
- (ii) The terminated entity shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the terminated entity is involved (in a Control, Participating or Servicing capacity), identifying the national account and the terminated entity's role therein. For those accounts where the terminated entity is the Control Plan, the Plan must also indicate the Participating and Servicing Plans in the national account syndicate.

Amended as of June 16, 2005

(iii) Unless the cause of termination is an event stated in paragraph

15(a) or (b) above respecting BCBSA, the Plan and its Licensed Controlled Affiliates shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. The Re-Establishment Fee shall be indexed to a base fee of \$80. The Re-Establishment Fee through December 31, 2005 shall be \$80. The Re-Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was \$278.60, \$285.00 and \$290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be \$83.27 (100% of the base fee plus \$1.84 for calendar year 2005 and \$1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (a) the end of the last fiscal year of the terminated entity which ended prior to termination or (b) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph (d)(iii) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Plan to fall below 100% of the Health Risk-Based Capital formula or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and

Amended as of June 16, 2005

three-fourths of the total then current weighted vote of all the Plans), measured as of the date of termination and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plan or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue;

provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Plan (and/or its Licensed Controlled Affiliates, as the case may be) for

payments made under this subparagraph only to the extent that such payments exceed the amounts due to BCBSA pursuant to subparagraph 15(d)(vi) and any costs associated with

reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the terminated entity.

(iv) The terminated entity shall comply with all financial settlement

procedures set forth in BCBSA's License Termination Contingency Plan, as amended from time to time and shall work diligently and in good faith with BCBSA, any Alternative Control Licensee or Replacement Licensee and any existing or potential new account for Blue-branded products and services to minimize the disruption of termination, and honor, to the fullest extent possible, the desire of accounts to continue to receive or obtain Blue-branded products and services through a new Licensee ("Transition"). Such diligence and good faith on the part of the terminated entity shall include, but not be limited to:

(a) working cooperatively with BCBSA to protect the Names and Marks from potential harm; (b) cooperating with BCBSA's use of the Names and Marks in the terminated entity's former service area during the termination and Transition; (c) transmitting, upon the request of an

Amended as of June 16, 2005

existing Blue account or of BCBSA with consent and on behalf of an existing Blue account, all member and account-data relating to the Federal Employee Program to BCBSA, and all member and account data relating to other programs to an Alternative Control Licensee or Replacement Licensee; (d) working with BCBSA and the Alternative Control or Replacement Licensee with respect to potential new Blue accounts headquartered in the terminated entity's former service area; (e) continuing to service Blue accounts during the Transition; (f) continuing to comply with National Programs, Federal Employee Program and NASCO policies and procedures and all voluntary BCBSA programs, policies and performance standards, such as Away From Home Care, including being responsible for payment of all penalties for non-compliance duly levied in conformity with the License Agreements, Membership Standards, or the Federal Employee Program agreements, that may arise during the Transition; (g) maintaining and providing access to its provider networks, as defined by Federal Employee Program agreements and National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and making those networks and discounts available to members and providers who participate in National Programs and the Federal Employee Program during the Transition; (h) maintaining its technical connections and processing capabilities during the Transition; and (i) working diligently to conclude all financial settlements and account reconciliations as negotiated in the termination transition agreement.

- (v) Notwithstanding any other provision in this Agreement, BCBSA shall have the right, with the approval of its Board of Directors, to assess additional fines against the terminated entity during the Transition in the event it fails to maintain and provide access to provider networks as defined by Federal Employee Program agreements, National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and/or pass on applicable discounts. Such fines shall be in addition to any other assessments, fees or liquidated damages payable herein, or under existing policies and programs and shall be imposed to make whole BCBSA and/or the Plans. Terminated entity shall pay any such fines to BCBSA no later than 30 days after they are approved by the Board of Directors.
- (vi) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third-party auditor to examine and audit the books and records of the terminated entity and its Licensed Controlled Affiliates to verify compliance with the terms and requirements this paragraph 15(d).

Amended as of November 16, 2006

- (vii) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.
- (viii) As to a breach of 15 (d) (i), (ii), (iii), (iv), (vi), or (vii) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 15 (d) (i), (ii), (iv), (vi), or (vii) by the Plan, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.
- (ix) In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Plan and its Licensed Controlled Affiliates shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.
- (e). BCBSA shall be entitled to enjoin the Plan or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this License Agreement unless the License Agreement has been terminated pursuant to paragraph 10 (d) of this Agreement upon the required six (6) month written notice.
- (f). BCBSA acknowledges that it is not the owner of assets of the Plan.

Amended as of June 16, 2005

16. This Agreement supersedes any and all other agreements between the parties with respect to the subject matter herein, and contains all of the covenants and agreements of the parties as to the licensing of the Licensed Marks and Name. This Agreement may be amended only by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

17. If any provision or any part of any provision of this Agreement is judicially declared unlawful, each and every other provision, or any part of any provision, shall continue in full force and effect notwithstanding such judicial declaration.

18. No waiver by BCBSA or the Plan of any breach or default in performance on the part of BCBSA or the Plan or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

19a. All notices provided for hereunder shall be in writing and shall be sent in duplicate by regular mail to BCBSA or the Plan at the address currently published for each by BCBSA and shall be marked respectively to the attention of the President and, if any, the General Counsel, of BCBSA or the Plan.

19b. Except as provided in paragraphs 9(b), 9(d)(iii), 15(a), and 15(b) above, this Agreement may be terminated for a breach only upon at least 30 days' written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Member Plans.

19c. For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2006

20. Nothing herein contained shall be construed to constitute the parties hereto as partners or joint venturers, or either as the agent of the other, and Plan shall have no right to bind or obligate BCBSA in any way, nor shall it represent that it has any right to do so. BCBSA shall have no liability to third parties with respect to any aspect of the business, activities, operations, products, or services of the Plan.

21. This Agreement shall be governed, construed and interpreted in accordance with the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By _____

Title _____

Date _____

PLAN:

By _____

Title _____

Date _____

**BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT**

(Includes revisions adopted by Member Plans through their September 18, 2015 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA")
and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan, known as
_____ ("Plan" or "Sponsoring Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non-health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the Sponsoring Plan's net subscription revenue.

This grant of rights is non-exclusive and is limited to the Service Area served by the Plan. Subject to paragraph 3A(3) of this Agreement, Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market, unless such Controlled Affiliate is a not-for-profit company which may use the Licensed Marks and Name, or an approved derivative therefor, to identify itself in debt securities markets. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

Amended as of March 26, 2015

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that the Sponsoring Plan has:

(1) The legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and

(c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

Amended as of September 19, 2014

- (iii) change any of the type(s) of businesses in which it engages;
- (iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;
- (v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;
- (vi) make any loans or advances except in the ordinary course of business;
- (vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);
- (viii) conduct any business other than under the Licensed Marks and Name;
- (ix) take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

- (2) the legal authority directly or indirectly through wholly-owned subsidiaries:
 - (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:

Amended as of March 26, 2015

- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and
- (c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

(3) With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid products and services, the legal authority together with such other Plans:

- (a) to select all members of the Controlled Affiliate's governing body; and
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and
- (c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate with the Sponsoring Plan and such other Plans each having an ownership interest. Such control and ownership by Plans must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License attached hereto as Exhibit B.

3. FOR-PROFIT, PUBLICLY TRADED LICENSEES

A. The Controlled Affiliate may operate as a for-profit publicly traded company on the following conditions:

- (1) The Controlled Affiliate shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement.
- (2) The Controlled Affiliate shall provide 90 days advance written notice to BCBSA prior to the initial filing with the SEC.

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(3) The Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Controlled Affiliate in any securities market. The Controlled Affiliate shall use the Licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(4) The Controlled Affiliate's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Controlled Affiliate ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Noninstitutional Investor, other than a Plan or Plans or Controlled Affiliate Licensee or Licensees has become the Beneficial Owner of securities representing 5% or more of the voting power of the Controlled Affiliate ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner, other than a Plan or Plans or Controlled Affiliate Licensee or Licensees, of 20% or more of the Controlled Affiliate's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 3A(4) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Controlled Affiliate went public constituted the Board of Directors of the Controlled Affiliate (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Controlled Affiliate went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Controlled Affiliate consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Sponsoring Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Controlled Affiliate in a writing received by BCBSA prior to such automatic termination becoming effective, the provisions of this paragraph 3A(4) may be waived, in whole or in part, upon the affirmative vote of a majority of the disinterested Plans and majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by

Amended as of March 26, 2015

the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 3A(4) (a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Controlled Affiliate's license, or any other license, to use the Licensed Marks and Name is terminated pursuant to Paragraph 3A(4), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Controlled Affiliate demonstrates that the Person referred to in clause (a), (b), or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(5) The Controlled Affiliate shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities or (iii) such other securities as the Controlled Affiliate may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(6) For purposes of paragraph 3A(4) above, the following definitions shall apply:

(i) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(ii) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(1) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

(2) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to

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beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(3) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (ii)2(B) above) or disposing of any securities of the Controlled Affiliate.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Controlled Affiliate, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(iii) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

(iv) "Noninstitutional Investor" means any Person who is not an Institutional Investor.

(v) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

4. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

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B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this Agreement, Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name.

5. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

6. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

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7. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to: (i) Controlled Affiliate's rendering of services under the Licensed Marks and Name; or (ii) the activities of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan or Controlled Affiliate.

8. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) the Plan ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement the Plan ceases to be authorized to use the Licensed Names and Marks in the geographic area served by the Controlled Affiliate provided, however, that if the Controlled Affiliate is serving more than one State or portions thereof, the termination of this Agreement shall be limited to the State(s) or portions thereof in which the Plan's license to use the Licensed Marks and Names is terminated. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless

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this Controlled Affiliate License Agreement has been earlier terminated under paragraph 8(E); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 8(B), 8(C) or 8(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 8(B), 8(C) or 8(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 8(B) and 8(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Controlled Affiliate shall no longer comply with item 2(E) above;
- (2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 10 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or
- (3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled

Amended as of March 26, 2015

Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 8(E)(3)(vii) and (viii) of this Agreement.

(4) The for-profit, publicly traded Controlled Affiliate is terminated pursuant to Paragraph 3A(4) of this Agreement. In which case, the licenses of any Controlled Affiliates directly or indirectly owned by the terminated for-profit, publicly traded Controlled Affiliate also shall immediately terminate as provided for in paragraph 3A(4) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

Amended as of March 26, 2015

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 8(B) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 8.G. shall not apply and the following provisions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 8(B)(ii) of this Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated.

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area.

Amended as of March 26, 2015

The Re-Establishment Fee shall be indexed to a base fee of \$80. The Re-Establishment Fee through December 31, 2005 shall be \$80. The Re-establishment Fee for calendar years after December 31,

2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative

percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was \$278.60, \$285.00 and \$290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be \$83.27 (100% of base fee plus \$1.84 for calendar year 2005 and \$1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Plan or its other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 8.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 8.M. and any costs associated with reestablishing the Service Area, including payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the Controlled Affiliate.

Amended as of March 26, 2015

(4) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third party auditor to examine and audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 8.H.

(5) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

(6) As to a breach of 8.H.(1), (2), (3), (4) or (5) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 8.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. This Agreement shall remain in effect until terminated by the Controlled Affiliate or the Plan upon not less than eighteen (18) months written notice to the Association or upon a shorter notice period approved by BCBSA in writing at its sole discretion, or until terminated as otherwise provided herein. The Plan's right to terminate without cause upon such notice is unfettered and may be exercised in the Plan's sole discretion.

J. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3. and M. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

K. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of the Plan's license agreement upon the required 18 months written notice.

L. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

M. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E) (2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 8(C) and 8(D) above shall require the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

Amended as of March 26, 2015

N. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

9. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

10. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit C.

11. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

12. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

13. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

Amended as of March 26, 2015

14. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

15. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question.

Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

Amended as of March 26, 2015

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16. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

17. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: __

Date: __

Plan:

By: __

Date: __

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: __

Date: __

Amended as of March 26, 2015

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS September 2015

PREAMBLE

For purposes of definition:

- A "smaller Controlled Affiliate:" (1) comprises less than fifteen percent (15%) of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers' compensation insurance and has total premium revenue less than 15 percent of the Sponsoring Plan's net subscription revenue.
- A "larger Controlled Affiliate" comprises fifteen percent (15%) or more of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate's status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate's health and workers' compensation administration business reaches or surpasses fifteen percent (15%) of the total member enrollment of the Sponsoring Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

Amended as of September 19, 2014

EXHIBIT A (continued)

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA "Health Risk-Based Capital (HRBC)" as defined by the NAIC and state-established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and
2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers' compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

*For purposes of this calculation, The numerator equals:

Applicant Controlled Affiliate's member enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Sponsoring Plan and all other licensed Controlled Affiliates' member enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

Amended as of September 19, 2002

EXHIBIT A (continued)

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

Each licensed controlled affiliate shall be subject to certain standards as determined below:

1. What percent of the licensed controlled affiliate is controlled by the Sponsoring Plan and other Plans?				
More than 50% by Sponsoring Plan		50% by Sponsoring Plan		100% Plan control but less than 50% Sponsoring Plan Control and it offers solely Medicaid
↓		↓		↓
Standard 1A, 4		Standard 1B, 4		products and services Standard 1C, 4
IN ADDITION,				
2. Is risk being assumed?				
Yes			No	
↙	↓	↘	↙	↓
Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates
↓				↓
Standards 7A-7E, 11				Standard 6H
	↓		↓	
	Standard 2 (Guidelines 1.1, 1.2) and Standard 11		Standard 2 (Guidelines 1.1, 1.3) and Standard 11	
		↓		
		Standard 6H		

IN ADDITION,				
3. Is medical care being directly provided?				
<p>YES</p> <p>↓</p> <p>Standard 3A</p>	<p>NO</p> <p>↓</p> <p>Standard 3B</p>			
IN ADDITION,				
4. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total member enrollment of Plan and its licensed Controlled Affiliates?				
Yes	No			
<p>↓</p> <p>Standards 6A-6J</p>	<table border="1"> <tr> <td> <p>Controlled Affiliate is not a former primary licensee and is not subject to Standard 1(C)</p> <p>↓</p> <p>Standards 5, 8, 9B, 10, 11</p> </td> <td> <p>Controlled Affiliate is a former primary licensee</p> <p>↓</p> <p>Standards 5, 8, 9A, 10, 11</p> </td> <td> <p>Controlled Affiliate is not a former primary licensee and is subject to Standard 1(C) and does not elect to participate in BCBSA National programs</p> <p>↓</p> <p>Standards 5, 8, 9B, 11</p> </td> </tr> </table>	<p>Controlled Affiliate is not a former primary licensee and is not subject to Standard 1(C)</p> <p>↓</p> <p>Standards 5, 8, 9B, 10, 11</p>	<p>Controlled Affiliate is a former primary licensee</p> <p>↓</p> <p>Standards 5, 8, 9A, 10, 11</p>	<p>Controlled Affiliate is not a former primary licensee and is subject to Standard 1(C) and does not elect to participate in BCBSA National programs</p> <p>↓</p> <p>Standards 5, 8, 9B, 11</p>
<p>Controlled Affiliate is not a former primary licensee and is not subject to Standard 1(C)</p> <p>↓</p> <p>Standards 5, 8, 9B, 10, 11</p>	<p>Controlled Affiliate is a former primary licensee</p> <p>↓</p> <p>Standards 5, 8, 9A, 10, 11</p>	<p>Controlled Affiliate is not a former primary licensee and is subject to Standard 1(C) and does not elect to participate in BCBSA National programs</p> <p>↓</p> <p>Standards 5, 8, 9B, 11</p>		

EXHIBIT A (continued)

Standard 1 - Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA, (the "Sponsoring Plan"), has the legal authority, directly or indirectly through wholly-owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate.

1B.) The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA, (the "Sponsoring Plan"), has the legal authority, directly or indirectly through wholly-owned subsidiaries:

- 1) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and
- 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and
- 3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan.

Amended as of September 19, 2014

EXHIBIT A (continued)

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by Sponsoring Plan before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate.

Amended September 19, 2014

1C.) The Standard for 100% Plan control but less than 50% Sponsoring Plan Control:

A Controlled Affiliate shall be organized and operated in such a manner that (i) it offers solely Medicaid products and services; and (ii) a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA (the “Sponsoring Plan,”) has the legal authority together with Other Plans:

- 1) to select all members of the Controlled Affiliate’s governing body; and
- 2) to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; and
- 3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License.

Amended September 19, 2014

EXHIBIT A (continued)

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk-assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk-assuming Controlled Affiliate ceases operations for any reason, Sponsoring Plan will provide for services to its customers. The requirements of the preceding two sentences shall apply to all lines of business unless a line of business is specially exempted from the requirement(s) by the BCBSA Board of Directors.

Standard 3 - State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Amended as of September 19, 2014

EXHIBIT A (continued)

Standard 5 - Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its Sponsoring licensed Plan shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Other Standards for Larger Controlled Affiliates Standards 6(A) - (I) that follow apply to larger Controlled

Affiliates. Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost-effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Amended as of September 19, 2014

EXHIBIT A (continued)

Such programs are applicable to licensees, and include:

1. BlueCard Program;
2. Inter-Plan Teleprocessing System (ITS);
3. National Account Programs;
4. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
5. Inter-Plan Medicare Advantage Program. Standard Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter-licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Local and National Best Efforts

Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this License Agreement, during each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross Mark.

Amended as of November 21, 2014

EXHIBIT A (continued)

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

- A) BCBSA Controlled Affiliate Licensure Information Request; and
- B) Biennial trade name and service mark usage material, including disclosure material; and
- C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and
- D) Semi-annual "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

Amended as of November 17, 2011

EXHIBIT A (continued)

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 - Other Standards for Risk-Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) - (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

- A. BCBSA Controlled Affiliate Licensure Information Request; and
- B. Biennial trade name and service mark usage materials, including disclosure materials; and
- C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk-Based Capital Worksheets for Property and Casualty Insurers; and
- D. Quarterly Estimated Risk-Based Capital for Property and Casualty Insurers, Insurance Department Examination Report; and

Amended as of November 17, 2011

EXHIBIT A (continued)

- E. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and
- F. Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended as of November 16, 2000

EXHIBIT A (continued)

Standard 8 - Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

A smaller controlled affiliate that formerly was a Primary Licensee shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of November 21, 2014

EXHIBIT A (continued)

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

C. Reporting requirements include:

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

Amended as of June 13, 2002

EXHIBIT A (continued)

Standard 9(B) - Participation in National Programs by Smaller Controlled Affiliates

A smaller controlled affiliate shall participate in national programs in accordance with BlueCard and other relevant Policies and Provisions shall effectively and efficiently participate in national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of June 20, 2013

EXHIBIT A (continued)

Standard 10 - Participation in Inter-Plan Medicare Advantage Program

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

- A. Inter-Plan Medicare Advantage Program.

Standard 11: Participation in Master Business Associate Agreement by Smaller Controlled Affiliate Licensees

Effective April 14, 2003, all smaller controlled affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of September 19, 2014

EXHIBIT B

**ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES
LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1C.**

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Cross Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association

("Licensor"), _____ ("Controlled Affiliate Licensee")

and _____ ("Sponsoring Plan")

dated the ____ day of _____, ____ ("Agreement"). The parties to

this Addendum are Licensor, Controlled Affiliate Licensee, Sponsoring Plan, and the undersigned other Plans ("Other Plans"). This Addendum is made and shall be deemed effective as of the date of the Agreement.

WHEREAS, the Sponsoring Plan asserts that it can serve the Medicaid market in its Service Area more efficiently and with less risk though a Medicaid enterprise jointly owned and controlled with other Plans than through a wholly owned and controlled Medicaid enterprise;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1C. permits the licensing of a Controlled Affiliate that is less than 50% owned and controlled by the Sponsoring Plan but which is 100% owned and controlled by Plans including the Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan and all such other owning and controlling Plans enter into this Addendum.;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. The Sponsoring Plan shall participate operationally in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that participation may take many forms, one of which should be providing a network of providers in the Service Area of the Controlled Affiliate for the Medicaid services being offered under the Agreement and being involved in network development and provider relations.
2. Each of the Other Plans agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and

Amended September 19 2014

Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it will not take any action, either individually or jointly with any of the Other Plans, that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with any of the Other Plans, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

3. Each of the Other Plans acknowledges that it has reviewed the Agreement and understands that Sponsoring Plan has the right to terminate the Agreement without cause upon notice as provided in Paragraph 7 of the Agreement, and that such right is unfettered and may be exercised by Sponsoring Plan in its sole discretion.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By:___

[Controlled Affiliate Licensee]

By:___

[Sponsoring Plan]

By:___

[Other Plan 1]

By:___

[Other Plan 2]

By:___

Amended September 19 2014

EXHIBIT C

ROYALTY FORMULA FOR SECTION 9 OF THE CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of \$5,000 per license for a Controlled Affiliate subject to Standard 7.

Amended as of September 19, 2014

EXHIBIT C (continued)

FOR NONRISK PRODUCTS:

For third-party administrative business, an amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For non-third party administrative business (e.g., case management, provider networks, etc.), an amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

- 1) An annual fee of \$5,000 per license for a Controlled Affiliate subject to Standard 6 D.
- 2) An annual fee of \$2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Amended as of September 19, 2014

CONTROLLED AFFILIATE LICENSE AGREEMENT APPLICABLE TO LIFE INSURANCE COMPANIES
(Includes revisions adopted by Member Plans through their September 18, 2015 meeting)

This agreement by and among Blue Cross and Blue Shield Association

("BCBSA") _____ ("Controlled Affiliate"), a
Controlled Affiliate of the Blue Cross Plan(s), known as
_____ ("Plan").

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, the Plan and the Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Controlled Affiliate the exclusive right to use the licensed Marks and Names in connection with and only in connection with those life insurance and related services authorized by applicable state law, other than health care plans and related services (as defined in the Plan's License Agreements with BCBSA) which services are not separately licensed to Controlled Affiliate by BCBSA, in the Service Area served by the Plan, except that BCBSA reserves the right to use the Licensed Marks and Name in said Service Area, and except to the extent that said Service Area may overlap the area or areas served by one or more other licensed Blue Cross Plans as of the date of this License as to which overlapping areas the rights hereby granted are non-exclusive as to such other Plan or Plans and their respective Licensed Controlled Affiliates only. Controlled Affiliate cannot use the Licensed Marks or Name outside the Service Area or in its legal or trade name; provided, however, that if and only for so long as Controlled Affiliate also holds a Blue Cross Controlled Affiliate License Agreement applicable to health care plans and related services, Controlled Affiliate may use the Licensed Marks and Name in its legal and trade name according to the terms of such license agreement.

Amended as of June 12, 2003

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in relation to the sale, marketing and rendering of authorized products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A as it may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having not less than 51% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Plan or Plans shall own at least 51% of any for-profit Controlled Affiliate. If the Controlled Affiliate is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items (a) and (c) above, proxies representing 51% of the votes at any meeting of the policyholders and shall demonstrate that there is no reason to believe this such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

3. SERVICE MARK USE

Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks, and shall comply with such rules (applicable to all Controlled Affiliates licensed to use the Marks) relative to service mark use, as are issued from time-to-time by BCBSA. If there is any public reference to the affiliation between the Plan and the Controlled Affiliate, all of the Controlled Affiliate's licensed services in the Service Area of the Plan shall be rendered under the Licensed Marks. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENTS

Controlled Affiliate shall promptly notify Plan and BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate hereby agrees to save, defend, indemnify and hold Plan and BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Controlled Affiliate's rendering of health care services under the Licensed Marks.

7. LICENSE TERM

The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods upon evidence satisfactory to the Plan and BCBSA that Controlled Affiliate meets the then applicable quality control standards, unless one of the parties hereto notifies the other party of the termination hereof at least sixty (60) days prior to expiration of any license period.

This Agreement may be terminated by the Plan or by BCBSA for cause at any time provided that Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Controlled Affiliate's failure to abide by the quality control provisions of Paragraph 2, above, shall be considered a proper ground for cancellation of this Agreement.

This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

A. Controlled Affiliate shall no longer comply with Standard No. 1 (Organization and Governance) of Exhibit A or, following an opportunity to cure, with the remaining quality control provisions of Exhibit A, as it may be amended from time-to-time; or

B. Plan ceases to be authorized to use the Licensed Marks; or

C. Appropriate dues for Controlled Affiliate pursuant to item 8 hereof, which are the royalties for this License Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks including any use in its trade name.

In the event of any disagreement between Plan and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of the Blue Cross and Blue Shield Association and provide instruction on how the customer can contact the Blue Cross and Blue Shield Association or a designated licensee to obtain further information on securing coverage. The written notification required by this paragraph shall be in writing and in a form approved by the Association. The Association shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. DUES

Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars (\$5,000) per license, plus
- .05% of gross revenue per year from branded group products, plus
- .5% of gross revenue per year from branded individual products plus
- .14% of gross revenue per year from branded individual annuity products.

The foregoing percentages shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® license are issued to the same entity. In the event that any License period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Plan will promptly and timely transmit to BCBSA all dues owed by Controlled Affiliate as determined by the above formula and if Plan shall fail to do so, Controlled Affiliate shall pay such dues directly.

Amended as of November 20, 1997

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

9A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

10. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

Amended as of June 16, 2005

11. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by a writing executed by all parties.

12. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way effect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

13. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: __

Date: __

Controlled Affiliate:

By: __

Date: __

Plan:

By: __

Date: __

EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES
Page 1 of 2

PREAMBLE

The standards for licensing Life Insurance Companies (Life and Health Insurance companies, as defined by state statute) are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote of all Plans. Each Licensed Plan is required to use a standard controlled affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Life Insurance Company maintains compliance with the license standards.

An organization meeting the following standards shall be eligible for a license to use the Licensed Marks within the service area of its sponsoring Licensed Plan to the extent and the manner authorized under the Controlled Affiliate License applicable to Life Insurance Companies and the principal license to the Plan.

Standard 1 - Organization and Governance

The LIC shall be organized and operated in such a manner that it is controlled by a licensed Plan or Plans which have, directly or indirectly: 1) not less than 51% of the voting control of the LIC; and 2) the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the LIC with which it does not concur; and 3) operational control of the LIC.

If the LIC is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items 1 and 2 above, proxies representing at least 51% of the votes at any policyholder meeting and shall demonstrate that there is no reason to believe such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

Standard 2 - State Licensure

The LIC must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life and health insurance company in each state in which the LIC does business.

EXHIBIT A

**CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES**

Page 2 of 2

Standard 3 - Records and Examination

The LIC and its sponsoring licensed Plan(s) shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the LIC as may be required in order to establish compliance with the license agreement. The LIC and its sponsoring licensed Plan(s) shall permit BCBSA to examine the affairs of the LIC and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the sponsoring Plan(s).

Standard 4 - Mediation

The LIC and its sponsoring Plan(s) shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed controlled affiliate, a licensed Plan or BCBSA.

Standard 5 - Financial Responsibility

The LIC shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with Affiliate License Performance Response Process Protocol

The LIC and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing LIC compliance problems identified thereunder.

**CONTROLLED AFFILIATE
TRADEMARK LICENSE AGREEMENT
FOR LIFE AND DISABILITY INSURANCE PRODUCTS**

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____, ("Life and Disability Controlled Affiliate") which is a company offering life and disability insurance products owned and controlled by _____, _____, _____ (individually, "Sponsoring Plan" and when referred to collectively, "Sponsoring Plans").

Whereas, BCBSA is the owner of the BLUE CROSS and BLUE SHIELD word and design service marks and any derivatives thereof ("Licensed Marks");

Whereas, each Sponsoring Plan is licensed separately by BCBSA to use one or more of the Licensed Marks in a particular Service Area;

Whereas, the Sponsoring Plans and the Life and Disability Controlled Affiliate desire that the latter be entitled to use the appropriate Licensed Marks in connection with life and disability insurance products in some or all of such Sponsoring Plans' Service Areas and in the Service Areas of other Regular Member Plans, as defined in the BCBSA By-laws, ("Blue Plans") consistent with the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

A. Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Life and Disability Controlled Affiliate the limited right to use the Licensed Marks in connection with and only in connection with the following life and disability insurance products authorized by state law: (1) Group: Term Life, Long Term Disability, Whole Life, Benefit Life, Universal Life; (2) Individual: Term Life, Whole Life, Dependent Life, Spouse Life; (3)

Other: Disability Income, Short Term Disability, Long Term Disability, Income Replacement; and (4) such other life and disability products approved by BCBSA in writing ("Licensed Products") in the Service Areas served by the Sponsoring Plans or in the Service Area or Areas of one or more other licensed Blue Plans, provided that such Blue Plans have consented to such use as authorized by this Agreement. Life and Disability Controlled Affiliate may not use the Licensed Marks in its legal or trade name.

B. Notwithstanding that the license granted to Life and Disability Controlled Affiliate is a license to use all of the Licensed Marks, Life and Disability Controlled Affiliate may only use those of the Licensed Marks in

the Service Area of a Sponsoring Plan or other consenting Blue Plan as described below that such Plan is authorized to use as a Blue Plan pursuant to its separate license agreements with BCBSA.

C. Life and Disability Controlled Affiliate may use the Licensed Marks in the Service Areas of Sponsoring Plans or in the Service Area of a Blue Plan that is not a signatory to this Agreement only after such Sponsoring Plan(s) or non-signatory Blue Plan consents to such use by executing a written consent in substantially the same form as the Consent Agreement attached as Exhibit B.

D. The following provisions apply with respect to Consent Agreements once such agreements have been fully and properly executed:

(1) All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in the Service Area of Sponsoring Plan or consenting Blue Plan (hereinafter, such consenting Sponsoring Plan or consenting Blue Plan collectively referred to "Consenting Plan(s)") must clearly identify the Consenting Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");

(2) To the extent the Consenting Plan has separate divisions or other Affiliates that use the Licensed Marks in distinct geographic areas within its Service Area, consent obtained under this Agreement may be limited to one or more of such specific geographic areas as specified by the Consenting Plan in its signed Consent Agreement. For purposes of this entire Agreement, all references to the Service Area of a Sponsoring Plan, Blue Plan or Consenting Plan may include the entire Service Area or a distinct geographic area within such Service Area as specified in this Section 1 D (2);

(3) Where BCBSA has licensed two or more Blue Plans to use the same Licensed Marks in the same Service Area, in addition to the requirements set forth in Section D (1) above, the sales, marketing and advertising materials referenced in such section above must be communicated to the Consenting Plan's existing and prospective accounts through or with the approval of such Consenting Plan, and the personnel of such Consenting Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the Consenting Plan;

(4) Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the Consenting Plan has been granted by BCBSA the license to use under its Blue Plan license

(5) agreements (for example, if a Consenting Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

(6) If a Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless BCBSA and the Consenting Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

2. QUALITY CONTROL

A. Life and Disability Controlled Affiliate agrees to use the Licensed Marks only in relation to the sale, marketing and administration of the Licensed Products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A and the Guidelines to Administer the Standards for Trademark License Agreement for Life and Disability Insurance Products attached thereto.

B. Life and Disability Controlled Affiliate agrees that BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Life and Disability Controlled Affiliate's rendering of service and use of the Licensed Marks.

C. Life and Disability Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by BCBSA) a report to BCBSA demonstrating Life and Disability Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Life and Disability Controlled Affiliate is defined as: An entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

3. SERVICE MARK USE

Life and Disability Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and shall ensure all uses of the Licensed Marks comply with the BCBSA Brand Regulations, as amended by BCBSA from time to time. Life and Disability Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Life and Disability Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

The license hereby granted to Life and Disability Controlled Affiliate to use the Licensed Marks is and shall be personal to Life and Disability Controlled Affiliate and shall not be assignable by any act of the Life and Disability Controlled Affiliate, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Life and Disability Controlled Affiliate mortgage or part with possession or control of this license or any right hereunder, and the Life and Disability Controlled Affiliate shall have no right to grant any sublicense to use the Licensed Marks.

5. INFRINGEMENTS

Life and Disability Controlled Affiliate shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Life and Disability Controlled Affiliate shall not be entitled to require BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Life and Disability Controlled Affiliate agrees to render to BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA. BCBSA shall have sole control of the defense and resolution of any claim of infringement brought or threatened by others.

6. LIABILITY INDEMNIFICATION

Life and Disability Controlled Affiliate hereby agrees to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Life and Disability Controlled Affiliate's conduct.

7. LICENSE TERM

A. The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods, unless either BCBSA or Life and Disability Controlled Affiliate notifies the other party in writing of the termination hereof at least sixty (60) days prior to expiration of any license period.

B. This Agreement may be terminated by BCBSA for cause at any time provided that Life and Disability Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Life and Disability Controlled Affiliate's failure to abide by the conditions regarding use of the Licensed Marks set forth in Section 1 of this Agreement or the quality control provisions of Section 2 (other than with respect to Section 2 D which is subject to immediate termination as stated in Section 7 C (1) below) shall be considered proper grounds for termination of this Agreement.

C. This Agreement and all of Life and Disability Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Life and Disability Controlled Affiliate shall no longer comply with Section 2 D (or Standard No. 1 (Organization and Governance) of Exhibit A); or
- (2) Any Sponsoring Plan ceases to be authorized to use the Licensed Marks; or
- (3) Appropriate fees for Life and Disability Controlled Affiliate pursuant to Section 8 of this Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Life and Disability Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks.

In the event of any disagreement between Life and Disability Controlled Affiliate and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Life and Disability Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. ROYALTIES

Life and Disability Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars (\$5,000) per license, plus
- .05% of gross revenue per year from group products sold under the Licensed Marks, plus
- .5% of gross revenue per year from individual products sold under the Licensed Marks

In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Life and Disability Controlled Affiliate will promptly and timely transmit to BCBSA all fees owed by Life and Disability Controlled Affiliate as determined by the above formula.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between any Sponsoring Plan and Life and Disability Controlled Affiliate or between among them and/or BCBSA.

10. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by: (a) a writing signed by all parties; or (b) a writing approved by the affirmative vote of three-fourths of the Blue Plans and three-fourths of the total then current weighted vote of all the Blue Plans as officially recorded by the BCBSA Corporate Secretary. Upon such adoption by the Blue Plans, this Agreement and all other Trademark License Agreements for Life and Disability Insurance Products then in effect shall simultaneously be amended.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Life and Disability Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: __

Date: __

Life and Disability Controlled Affiliate:

By: __

Date: __

Sponsoring Plan:

By: __

Date: __

Name: _____

Sponsoring Plan:

By: __

Date: __

Name: _____

[Add other Sponsoring Plans as necessary]

EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS Page 1 of 2

Standard 1 - Organization and Governance

Any Life and Disability Controlled Affiliate licensed under the Trademark License Agreement for Life and Disability Insurance Products ("licensee") shall be organized and operated in such a manner that it is an entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

Standard 2 - State Licensure

The licensee must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life company in each state in which the licensee does business.

Standard 3 - Records and Examination

The licensee shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the licensee as may be required in order to establish compliance with the Agreement. The licensee shall permit BCBSA to examine the affairs of the licensee and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the Sponsoring Plan(s).

Standard 4 - Mediation

The licensee, its Sponsoring Plan(s) and all consenting Blue Plans shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed Life and Disability Controlled Affiliate, a Sponsoring Plan and or consenting Blue Plan or BCBSA.

EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS Page 2 of 2

Standard 5 - Financial Responsibility

The licensee shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with BCBSA Governance

The licensee shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of and in addressing licensee compliance problems that may be identified in connection with the operation or administration of the Trademark License Agreement for Life and Disability Insurance Products.

EXHIBIT B

CONSENT AGREEMENT

This Consent Agreement is made and entered into by and among the undersigned Blue Plan, and _____ (“Life and Disability Controlled Affiliate”), and the Blue Cross and Blue Shield Association (“BCBSA”) and shall be deemed effective on _____ (“Effective Date”).

Whereas, BCBSA owns the Blue Cross and Blue Shield word and design service marks and any derivative mark thereof (the “Brands”);

Whereas, the undersigned Blue Plan is licensed to use one or more of the Brands within a specific geographic area (“Service Area”);

Whereas Life and Disability Controlled Affiliate is licensed by BCBSA to use one or more of the Brands to offer life and disability insurance products (“Products”) as defined and authorized in the Trademark License Agreement for Life and Disability Insurance Products (“Life and Disability License Agreement”);

Whereas neither the Blue Plan nor its affiliates offer the Products under any of the Brands in such Blue Plan’s Service Area or portion thereof where Blue Plan has consented to sale of the Products by Life and Disability Controlled Affiliate; and

Whereas BCBSA and the undersigned Blue Plan desire to consent to Life and Disability Controlled Affiliate’s use of the Brands in Blue Plan’s Service Area consistent with the terms of the Life and Disability License Agreement and this Consent Agreement.

Now, therefore, in consideration of the obligations and conditions stated in this Agreement, Blue Plan, Life and Disability Controlled Affiliate and BCBSA agree as follows:

1. Life and Disability Controlled Affiliate may market, sell, administer and underwrite the Products in Blue Plan’s Service Area under the Brands licensed to Blue Plan in such Service Area subject to the terms of this Consent Agreement, the Life and Disability License Agreement and Blue Plan’s license agreement(s) with BCBSA. Life and Disability Controlled Affiliate’s rights under the Brands to offer the Products under the Brands are limited to offering the Products only under the Brand(s) licensed to the consenting Blue Plan.
 2. Life and Disability Controlled Affiliate shall work with the undersigned Blue Plan to develop a written sales and marketing agreement that identifies the relationship between it and Blue Plan for the sales, marketing and customer service for the Products. The term of the sales and marketing agreement shall be the same as the term of this Consent Agreement.
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3. All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in a consenting Blue Plan's Service Area must clearly identify the consenting Blue Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");
 4. Life and Disability Controlled Affiliate may use the Brands to sell the Products in the following Service Area or portion thereof as designated by Blue Plan:

 5. If two or more Blue Plans to use the same Licensed Marks in the same Service Area, Life and Disability Controlled Affiliate shall work with the consenting Blue Plan in the following manner: (a) the sales, marketing and advertising materials must be communicated to the consenting Blue Plan's existing and prospective accounts through or with the approval of such Blue Plan, and (b) the personnel of such Blue Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the consenting Blue Plan;
 6. Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the consenting Blue Plan has been granted by BCBSA the license to use under its license agreement (for example, if a consenting Blue Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).
 7. If this Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless each BCBSA and the Blue Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.
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8. The term of this Consent Agreement shall be one year from the Effective Date. Unless either Blue Plan or Life and Disability Controlled Affiliate provides the other party with written notice of its desire not to renew this Consent Agreement at least 60 days prior to expiration of the term or any extended term or unless terminated as provided in Paragraph 9 below, this Consent Agreement shall automatically renew for subsequent one year periods.

9. This Consent Agreement may be terminated as follows:

- A. Upon mutual written consent of Life and Disability Controlled Affiliate and Blue Plan;
- B. By Blue Plan or Life and Disability Controlled Affiliate upon 60 days advance written notice to the non-terminating party and BCBSA; or
- C. By Blue Plan immediately if Life and Disability Controlled Affiliate does not comply with this Consent Agreement or the sales protocol agreement.

10. This Consent Agreement shall automatically terminate if Blue Plan's primary licensee agreement terminates for any reason or if the Life and Disability License Agreement terminates for any reason.

Agreed and Accepted by: [Blue Plan]:

By: ____

Title: ____

BLUE CROSS AND BLUE SHIELD ASSOCIATION:

By: ____

Title: ____

LIFE AND DISABILITY CONTROLLED AFFILIATE:

By: ____

Title: ____

BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS
(Adopted by Member Plans at their September 18, 2015 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Advantage PPO products in geographic regions designated by CMS (hereafter "regional MAPPO products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name") to offer regional MAPPO products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional MAPPO products and related services.

This grant of rights is non-exclusive and is limited to the following states:

_____ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

- A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.
- B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.
- C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.
- D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.
- E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:
- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
 - (2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
-

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

- (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
- (c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
 - (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
 - (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
 - (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.
-

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional MAPPO products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this

Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x) (ii) of the Blue Cross License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to \$25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and

any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last

known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: __

Date: __

Controlling Plan:

By: __

Date: __

Controlling Plan:

By: __

Date: __

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: __

Date: __

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS

September 2015

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Advantage PPO Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
 - (2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
 - (3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:
 - (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
 - (b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
 - (c) exercise control over the policy and operations of the Controlled Affiliate; and
-

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

- a. the structure of the Blue Cross and Blue Shield System; and
- b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross Marks.

Standard 7 - Participation in Certain National Programs

A Controlled Affiliate shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area.

National program requirements include:

- a. Inter-Plan Teleprocessing System (ITS); and
- b. Inter-Plan Medicare Advantage Program.

Standard 8 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of November 15, 2007

EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional MAPPO products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

**BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN
PRODUCTS
(Adopted by Member Plans at their September 18, 2015 meeting)**

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Part D Prescription Drug Plan products in geographic regions designated by CMS (hereafter "regional PDP products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name") to offer regional PDP products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional PDP products and related services.

This grant of rights is non-exclusive and is limited to the following states:

_____ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing Body having not less than 100% voting control thereof;

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;

(c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates

(except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);

(iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive

national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional PDP products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely

as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that

the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Controlled Affiliate shall no longer comply with item 2(E) above;
 - (2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or
 - (3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its
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dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Cross

License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to \$25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths

of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the

termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: __

Date: __

Controlling Plan:

By:

Date: __

Controlling Plan:

By: __

Date: __

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: __

Date: __

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS September 2015

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Part D Prescription Drug Plan Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
 - (2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
 - (3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:
 - (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
 - (b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
 - (c) exercise control over the policy and operations of the Controlled Affiliate; and
-

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

- a. the structure of the Blue Cross and Blue Shield System; and
- b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross Marks.

Standard 7 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional PDP products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

EXHIBIT 2

Membership Standards Page 1 of 5

Preamble

The Membership Standards apply to all organizations seeking to become or to continue as Regular Members of the Blue Cross and Blue Shield Association. Any organization seeking to become a Regular Member must be found to be in substantial compliance with all Membership Standards at the time membership is granted and the organization must be found to be in substantial compliance with all Membership Standards for a period of two (2) years preceding the date of its application. If Membership is sought by an entity which controls or is controlled by one or more Plans, such compliance shall be determined on the basis of compliance by such Plan or Plans.

The Regular Member Plans shall have authority to interpret these Standards.

A Regular Member Plan that operates as a "Shell Holding Company" is defined as an entity that assumes no underwriting risk and has less than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) and less than 5% of the consolidated enterprise net general and administrative expenses.

A Regular Member Plan that operates as a "Hybrid Holding Company" is defined as an entity that assumes no underwriting risk and has either more than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) or more than 5% of the consolidated enterprise net general and administrative expenses.

Standard 1: A Plan shall maintain a governing Board, which shall control the Plan and ensure that the Plan follows appropriate practices of corporate governance. A Plan's Board shall not be controlled by any special interest group, shall make an annual determination that a majority of its directors are independent, and shall act in the best interest of its Corporation and its customers. The Board shall be composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Amended as of March 15, 2007

EXHIBIT 2

Membership Standards Page 2 of 5

Standard 2: A Plan shall furnish to the Association on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between the Association and the Plans. Such reports and records are the following:

- A. BCBSA Membership Information Request;
- B. Biennial trade name and service mark usage material, including disclosure material under Standard 7;
- C. Changes in the governance of the Plan, including changes in a Plan's Charter, Articles of Incorporation, or Bylaws, changes in a Plan's Board composition, or changes in the identity of the Plan's Principal Officers;
- D. Quarterly Financial Report, Semi-annual "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC, Annual Budget, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), Plan, Subsidiary and Affiliate Report; and
 - Plans that are a Shell Holding Company as defined in the Preamble hereto are required to furnish only a calendar year-end "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC.

Amended as of November 17, 2011

EXHIBIT 2

Membership Standards Page 3 of 5

E. Quarterly Enrollment Report, Quarterly Member Touchpoint Measures Index (MTM) through 12/31/2011, and Semi-annual MTM Index starting 1/1/2012 and thereafter.

- For purposes of MTM reporting only, a Plan shall file a separate MTM report for each Geographic Market.

Standard 3: A Plan shall be operated in a manner that provides reasonable financial assurance that it can fulfill its contractual obligations to its customers.

Standard 4: A Plan shall be operated in a manner responsive to customer needs and requirements.

Standard 5: A Plan shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the Plans and ease of claims processing for customers receiving benefits outside of the Plan's Service Area.

Such programs are applicable to Blue Cross and Blue Shield Plans, and include:

- A. Inter-Plan Teleprocessing System (ITS);
- B. BlueCard Program;
- C. National Account Programs;
- D. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
- E. Inter-Plan Medicare Advantage Program.

Amended as of November 21, 2014

EXHIBIT 2

Membership Standards Page 4 of 5

- Standard 6: In addition to requirements under the national programs listed in Standard 5: Participation in National Programs, a Plan shall take such action as required to ensure its financial performance in programs and contracts of an inter-Plan nature or where the Association is a party.
- Standard 7: A Plan shall make adequate disclosure in contracting with third parties and in disseminating public statements of (i) the structure of the Blue Cross and Blue Shield System, (ii) the independent nature of every Plan, and (iii) the Plan's financial condition.
- Standard 8: A Plan shall cooperate with the Association's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Plan performance problems identified thereunder.
- Standard 9: A Plan shall obtain a rating of its financial strength from an independent rating agency approved by the Association's Board of Directors for such purpose.
- Standard 10: Notwithstanding any other provision in this License Agreement, during each year, a Plan and its Controlled Affiliate(s) engaged in providing licensable services (excluding Life Insurance and Charitable Foundation Services) shall use their best efforts to promote and build the value of the Blue Cross Marks.
- Standard 11: Neither a Plan nor any Larger Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Plan or Larger Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Amended as of June 16, 2005

EXHIBIT 2

Membership Standards Page 5 of 5

Standard 12: No provider network, or portion thereof, shall be rented or otherwise made available to a National Competitor if the Licensed Marks or Names are used in any way with such network.

A provider network may be rented or otherwise made available, provided there is no use of the Licensed Marks or Names with respect to the network being rented.

Standard 13: Each Plan shall operate in a manner to reasonably: 1) protect the security and confidentiality of Personally Identifiable Information (PII) and Protected Health Information (PHI); 2) protect the Brands from reputational damage; and 3) cooperate with BCBSA and other Plans if a data security incident or data breach occurs.

Amended as of June 18, 2015

EXHIBIT 3

GUIDELINES WITH RESPECT TO USE OF LICENSED NAME AND MARKS IN CONNECTION WITH NATIONAL ACCOUNTS

Page 1 of 3

1. The strength of the Blue Cross/Blue Cross National Accounts mechanism, and the continued provision of cost effective, quality health care benefits to National Accounts, are predicated on locally managed provider networks coordinated on a national scale in a manner consistent with effective service to National Account customers and consistent with the preservation of the integrity of the Blue Cross/Blue Shield system and the Licensed Marks. These guidelines shall be interpreted in keeping with such ends.
2. A National Account is an entity with employee and/or retiree locations in more than one Plan's Service Area. Unless otherwise agreed, a National Account is deemed located in the Service Area in which the corporate headquarters of the National Account is located. A local plant, office or division headquarters of an entity may be deemed a separate National Account when that local plant, office or division headquarters 1) has employee locations in more than one Service Area, and 2) has independent health benefit decision-making authority for the employees working at such local plant, office or division headquarters and for employees working at other locations outside the Service Area. In such a case, the local plant, office or division headquarters is a National Account that is deemed located in the Service Area in which such local plant, office or division headquarters is located. The Control Plan of a National Account is the Plan in whose Service Area the National Account is located. A participating ("Par") Plan is a Plan in whose Service Area the National Account has employee and/or retiree locations, but in which the National Account is not located. In the event that a National Account parent company consolidates health benefit-decision making for itself and its wholly-owned subsidiary companies, the parent company and the subsidiary companies shall be considered one National Account. The Control Plan for such a National Account shall be the Plan in whose Service Area the parent company headquarters is located.
3. The National Account Guidelines enunciated herein below shall be applicable only with respect to the business of new National Accounts acquired after January 1, 1991.
4. Control Plans shall utilize National Account identification cards complying with then currently effective BCBSA graphic standards in connection with all National Accounts business to facilitate administration thereof, to minimize subscriber and provider confusion, and to reflect a commitment to cooperation among Plans.

Amended as of June 12, 2003

EXHIBIT 3 Page 2 of 3

5. Disputes among Plans and/or BCBSA as to the interpretation or implementation of these Guidelines or as to other National Accounts issues shall be submitted to mediation and mandatory dispute resolution as provided in the License Agreement. For two years from the effective date of the License Agreement, however, such disputes shall be subject to mediation only, with the results of such mediation to be collected and reported in order to establish more definitive operating parameters for National Accounts business and to serve as ground rules for future binding dispute resolution.

6. The Control Plan may use the BlueCard Program (as defined by IPPC) to deliver benefits to employees and non-Medicare eligible retirees in a Participating Plan's service area if an alternative arrangement with the Participating Plan cannot be negotiated. The Participating Plan's minimum servicing requirement for those employees and non-Medicare retirees in its service area is to deliver benefits using the BlueCard Program. Account delivery is subject to the policies, provisions and procedures of the BlueCard Program.

7. For provider payments in a Participating Plan's area (on non-BlueCard claims), payment to the provider may be made by the Participating Plan or the Control Plan at the Participating Plan's option. If the Participating Plan elects to pay the provider, it may not withhold payment of a claim verified by the Control Plan or its designated processor, and payment must be in conformity with service criteria established by the Board of Directors of BCBSA (or an authorized committee thereof) to assure prompt payment, good service and minimum confusion with providers and subscribers. The Control Plan, at the Participating Plan's request, will also assure that measures are taken to protect the confidentiality of the data pertaining to provider reimbursement levels and profiles.

Amended as of June 14, 1996

EXHIBIT 3 Page 3 of 3

8. The Control Plan, in its financial agreements with a National Account, is expected to reasonably reflect the aggregate amount of differentials passed along to the Control Plan by all Participating Plans in a National Account.

9. Other than in contracting with health care providers or soliciting such contracts in areas contiguous to a Plan's Service Area in order to serve its subscribers or those of its licensed Controlled Affiliate residing or working in its Service Area, a Control Plan may not use the Licensed Marks and/or Name, as a tag line or otherwise, to negotiate directly with providers outside its Service Area.

Amended as of March 13, 2003

EXHIBIT 4

GOVERNMENT PROGRAMS AND CERTAIN OTHER USES

Page 1 of 14

1. A Plan and its licensed Controlled Affiliate may use the Licensed Marks and Name in bidding on and executing a contract to serve a Government Program, and in thereafter communicating with the Government concerning the Program. With respect, however, to such contracts entered into after the 1st day of January, 1991, the Licensed Marks and Name will not be used in communications or transactions with beneficiaries or providers in the Government Program located outside a Plan's Service Area, unless the Plan can demonstrate to the satisfaction of BCBSA's governing body that such a restriction on use of the Licensed Marks and Name will jeopardize its ability to procure the contract for the Government Program. As to both existing and future contracts for Government Programs, Plans will discontinue use of the Licensed Marks and Name as to beneficiaries and Providers outside their Service Area as expeditiously as circumstances reasonably permit. Effective January 1, 1995, except as provided in the first sentence above, all use by a Plan of the Licensed Marks and Name in Government Programs outside of the Plan's Service Area shall be discontinued. Incidental communications outside a Plan's Service Area with resident or former resident beneficiaries of the Plan, and other categories of necessary incidental communications approved by BCBSA, are not prohibited. For purposes of this Paragraph 1, the term "Government Programs" shall mean Medicare Part A, Medicare Part B and other non-risk government programs.

2. In connection with activity otherwise in furtherance of the License Agreement, a Plan and its Controlled Affiliates that are licensed to use the Licensed Marks and Name in its Service Area pursuant to the Controlled Affiliate License Agreements authorized in clauses a) through c) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Plan's Service Area in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

2.1 Common Business Communications

- a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);
- b. distributing business cards other than in marketing and selling;
- c. advertising in publications or electronic media solely to persons for employment;

Amended as of June 19, 2014

EXHIBIT 4 Page 2 of 14

2.2 Marketing Spillover

- a. advertising in print, electronic or other media which serve, as a substantial market, the Service Area of the Plan or licensed Controlled Affiliate, provided that no Plan or Controlled Affiliate may advertise outside its Service Area on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Service Area;
- b. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Plan's Service Area or that of a licensed Controlled Affiliate;

2.3 Provider Contracting

- a. contracting with health care providers or soliciting such contracts in areas contiguous to the Plan's Service Area in order to serve its subscribers or those of such licensed Controlled Affiliates residing or working in its service area;
- b. issuing a small sign containing the legal name or trade name of the Plan or such licensed Controlled Affiliates for display by a provider to identify the latter as a participating provider of the Plan or Controlled Affiliate;
- c. negotiating rates with a health care provider for services to a specific member, provided that all of the following conditions are met:
 - (1) the health care provider does not have a contract, applicable to the services rendered or to be rendered, with the Licensee (or any of the Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located; and
 - (2) the Plan or Controlled Affiliate reasonably determines that the member did/does not have a reasonable opportunity to access a participating provider whose contract applies to the services rendered or to be rendered; and
 - (3) at least one of the following circumstances exists:

Amended as of June 19, 2014

EXHIBIT 4

Page 3 of 14

- (i) the member received emergency services and the Plan or Controlled Affiliate knows or reasonably anticipates that the charges on the claim will meet or exceed \$5,000; or
 - (ii) a provider, in consultation pre- or post- treatment with the Plan or Controlled Affiliate, makes/made a treatment recommendation or referral to a non-par provider or to a par provider whose contract does not apply to the services to be rendered; or
 - (iii) the member inadvertently accessed a non-par provider or non-contracted services in the course of receiving services from a par provider (e.g., the member sees a non-par consulting specialist in a participating hospital); and
 - (4) the Licensee (and in the case of overlapping Service Areas, all of the Licensees) in whose Service Area the health care provider is located consent(s) in advance.
- d. contracting with a pharmacy management organization
("Pharmacy Intermediary") to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;

Amended as of June 19, 2014

EXHIBIT 4

Page 4 of 14

- e. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided that (1) the Plan and the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Plan's Service Area, and (2) neither the Plan's or the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Plan's Service Area;
 - f. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;
 - g. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;
 - h. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Plan's Service Area;
 - i. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Plan's Service Area;
 - j. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Plan's Service Area;
-

EXHIBIT 4 Page 5 of 14

- k. contracting with a company that operates provider sites in the Plan's Service Area, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Plan's Service Area;
- l. contracting with a company that makes health care professionals available in the Plan's Service Area (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Plan's Service Area.

2.4 Services to National Accounts

- a. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee (as those terms are defined in the Inter-Plan Programs Policies and Provisions ("IP Policies")) to offer Blue-branded Health Coverage to the National Account, offering Blue-branded Health and Wellness Programs to all members of the National Account, including members who have not enrolled in the Blue-branded Health Coverage ("non-Blue Health Coverage members"), provided that:
 - (i) the Plan and/or licensed Controlled Affiliate has no contact or interaction with providers outside of the Plan's Service Area, except as specifically provided in the IP Policies and in 2.4 (b); and
 - (ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not offer Blue-branded Health and Wellness Programs to any employees working at such local plant, office or division without the consent of such other Licensee; and
 - (iii) if the Plan and/or licensed Controlled Affiliate provides an information card to the non-Blue Health Coverage members, the card may not display the Symbols in the masthead, must contain a prominent disclosure conveying that it is not a health insurance card, and otherwise must be designed so that it is dissimilar to a Blue member identification card.

Amended as of March 26, 2015

EXHIBIT 4 Page 6 of 14

For purposes of this subparagraph a, the following definitions apply:

“Health and Wellness Program” shall mean a program that includes at least one of the following elements or a related element:

- Health Risk Assessment and/or Preventive Screenings
- Exercise and Fitness Programs
- Health and Wellness Events (e.g., attendance at a health fair, a 5K walk)
- Nutrition and Weight Management
- Health Education (e.g., smoking cessation classes)
- Prenatal and Parenting Education
- Disease or Chronic Condition Management

The above listing is intended to represent examples of the types of programs that may be offered, and other programs, including those offered through different media such as the internet or telephonically, may also be deemed Health and Wellness programs.

“Health Coverage” shall mean providing or administering medical, surgical, hospital, major medical, or catastrophic coverage, or any HMO, PPO, POS or other managed care plan for the foregoing services.

2.4 Services to National Accounts (continued)

- b. as part of a Health and Wellness Program that is otherwise compliant with Brand Regulation 4.11.4(a), contracting with a health and wellness organization to gain access to providers to deliver a discrete health and wellness event (“Event”) held at a National Account’s worksite outside of the Licensee’s Service Area, provided that:
 - (i) the services delivered at the Event are limited to fingerstick screenings for cholesterol and glucose, seasonal flu immunizations, blood pressure measurements, body mass index measurements, and other routine screenings, immunizations and measurements; and
 - (ii) neither such services nor their costs are applied as claims against any benefit plan; and
 - (iii) the Event is presented during one or more limited periods during a benefit year and is available to all employees at the worksite.

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- c. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee to offer Blue-branded Health Coverage to the National Account, performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by the National Account to its members, including benefit plans that are not underwritten or administered by the Plan, provided that:
- (i) in performing such functions, the Plan and/or licensed Controlled Affiliate does not use the Brands in any communications with health care providers outside of the Plan's Service Area, and otherwise limits its use of the Brands outside of the Service Area to communications with the account's members, the other benefit plan providers with which the account has contracted and other reasonably necessary communications to perform such functions; and
 - (ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not perform Eligibility and Enrollment functions for employees working at such local plant, office or division without the consent of such other Licensee;

For purposes of this subparagraph b, the following definitions apply: "Health Coverage" has the meaning set forth in subparagraph

2.4.a.

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“Eligibility” means services that manage the account’s eligibility data and determine or process determinations relating to eligibility for benefit plans offered by the account to its employees, including such services as:

- monitoring and auditing data to ensure that only entitled individuals are enrolled in each such benefit plan;
- review of eligibility documentation (e.g. marriage licenses, birth certificates, student status verification letters, employment records);
- identification of key member segments such as over-age dependents, part-time employees, employees reaching certain milestones (e.g. Medicare-eligible, retirees);
- termination of coverage for those individuals found to be ineligible for coverage under a benefit plan, and, if applicable, generation of a COBRA event; and
- management of “hour-banking” for union environments in which union members can bank hours to remain eligible for benefits.

“Enrollment” means services that enroll eligible individuals and their spouses/dependents or terminate or change their enrollment in the account’s benefit plans on an ongoing basis and during open enrollment periods, including such services as:

- the coordination of each step in open enrollment process from project planning and system set-up to the generation of confirmation statements;
- ongoing enrollment support for new hires and changes due to life events and work status adjustments;
- evidence of insurability (EOI) administration for life and disability coverage;
- transmission of eligibility/enrollment information to the account’s benefit plan providers;
- review and reconciliation of error reports received from the account’s benefit plan providers; and
- transmission of information to the account’s payroll system (e.g., benefit deductions, employee demographic data).

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2.5 Knowledge Sharing

- a. submitting scholarly articles authored or co-authored by the Plan or Controlled Affiliate or its respective employees for publication in peer-reviewed journals;
- b. permitting an internal representative of the Licensee (e.g., officer, employee) to speak or present at a conference or symposium outside of the Licensee's Service Area regarding either (i) healthcare financing, administration, delivery or policy, or (ii) topics within the representative's functional discipline or expertise at the Licensee, for which the event sponsor will issue communications to promote, administer, and/or recap the event that will identify the Licensee's representative as a participant. The communications outside of the Licensee's Service Area that mention the Licensee's representative shall be limited to materials and digital media provided to attendees, on-site signage, advertising in relevant trade publications, direct mail and email to attendees and prospective attendees, and the sponsor's website. Participation in any conference or symposium outside of the Licensee's Service Area may not be for the purpose of marketing or selling products or services.

If the Licensee's representative wishes to use the Brands in any manner, including use in his/her title, when participating as a speaker or presenter outside of the Licensee's Service Area about a topic that is not related to healthcare financing, administration, delivery, or policy, or to topics within the representative's functional discipline or expertise at the Licensee, the Licensee must notify BCBSA and receive prior approval from BCBSA before participating;

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2.6 Other Uses

- a. entering into a license agreement between and among BCBSA, the Plan and a debit card issuer located outside the Plan's Service Area, and entering into a corresponding operating agreement or agreements, in order to offer a debit card bearing the Licensed Marks and Name to eligible persons as defined by the aforementioned license agreement;
- b. appearing in communications issued by an independent third party to recognize outstanding performance of the Plan or Controlled Affiliate or a member of the Plan's or Controlled Affiliate's senior management as part of an established program of the third party for which the Plan has provided information to be considered for the recognition, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;
- c. to identify itself as being a joint sponsor of an event, program or activity along with other Plans or such Plans' licensed Controlled Affiliates, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;
- d. hosting meetings or events (collectively, "events") in Washington, D.C. related to policy and business issues in the Licensee's Service Area, or hosting events in conjunction with the assemblies or conventions of national political parties. Such events may not involve marketing or selling products or services. Use of the Brands outside the Licensee's Service Area in connection with such events shall be limited to materials and digital media provided to attendees and prospective attendees and onsite signage. For any such events in Washington, D.C. that are open to attendees other than government officials or their staffs, or are briefings open to all Congressional staff, or are otherwise likely to receive media coverage, the Licensee is required to provide advance notice to BCBSA. For events hosted outside of Washington, D.C. in conjunction with the assemblies or conventions of national political parties, the Licensee is required to provide advance notice to BCBSA and to the local Plan;

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- e. permitting an affiliate that is not licensed to use the Licensed Marks to identify its corporate relationship with the Plan, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time.

3. In connection with activity otherwise in furtherance of the License

Agreement, a Controlled Affiliate that is licensed to use the Licensed Marks and Name pursuant to a Controlled Affiliate License Agreement authorized in clauses d) or e) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Region (as that term is defined in such respective Controlled Affiliate License Agreements) in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

- a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);
- b. distributing business cards other than in marketing and selling;
- c. contracting with health care providers or soliciting such contracts in areas contiguous to the Region in order to serve its subscribers residing in the Region, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans in connection with such contracting unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;
- d. issuing a small sign containing the legal name or trade name of the Controlled Affiliate for display by a provider to identify the latter as a participating provider of the Controlled Affiliate, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans on such signs unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;
- e. advertising in publications or electronic media solely to persons for employment;

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- f. advertising in print, electronic or other media which serve, as a substantial market, the Region, provided that the Controlled Affiliate may not advertise outside its Region on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Region, and provided further that any such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to advertise in such media;
 - g. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Region, provided that such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to send direct mail to such zip code plus 4.
 - h. [Intentionally left blank, pending review by the Inter-Plan Programs Committee of the applicability of the case management rule to such Controlled Affiliates.]
 - i. contracting with a pharmacy management organization ("Pharmacy Intermediary") to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for the Controlled Affiliate's regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective Controlled Affiliate License Agreements, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;
 - j. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit to the Controlled Affiliate's regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective
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Controlled Affiliate License Agreements, provided that (1) the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Region, and (2) neither the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Region;

- k. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for the Controlled Affiliate's regional Medicare Advantage PPO members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;
 - l. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for the Controlled Affiliate's regional Medicare Advantage members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;
 - m. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Controlled Affiliate's Region;
 - n. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Controlled Affiliate's Region;
 - o. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Region;
 - p. contracting with a company that operates provider sites in the Region, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Region;
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- q. contracting with a company that makes health care professionals

available in the Region (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health

care professionals who are located within the Region.

4. BCBSA shall retain the right to use the Licensed Marks in conjunction with the Federal Employee Program and with any other national offering made to federal employees pursuant to the Federal Employees Health Benefits Program (FEHBP), including the right to license such use to its vendors, but only in the following manner.
- a. the Licensed Marks may only be used by BCBSA with the term “Federal Employee Program”, “Federal”, “FEP”, or similar language identifying the program as a benefit program for federal employees;
 - b. the Licensed Marks may not be used by BCBSA with the name(s) of a specific Plan or Plans and;
 - c. any use by BCBSA in conjunction with a new national FEHBP program proposed after the enactment of this amendment will require the approval of the BCBSA Board of Directors.
5. Where required by applicable state or local law or regulation, a Plan or its licensed Controlled Affiliate may submit documents that contain the Brands to, and file forms that contain the Brands with, state or local regulators in a state not included in its Service Area, provided that it gives reasonable advance notice to the local Plan of its intent to submit such documents or file such forms. Notwithstanding, in no event may a Plan or its licensed Controlled Affiliate use the Brands to register, or to obtain or maintain a license, a certificate of authority, or an equivalent document authorizing it to act as a risk-bearing entity or third party administrator in a state not included in its Service Area. If the local Plan advises BCBSA that it believes its License Agreement has been or would be violated by any submission or filing, BCBSA shall determine whether such submission or filing is required by state or local law or regulation and violates the License Agreement, subject to the Plan’s or licensed Controlled Affiliate’s rights to obtain an independent review of such determination under Paragraph 9(a) and Exhibit 5 of its License Agreement or Paragraph 8 of the Controlled Affiliate License. For purposes of this paragraph, “local Plan” is defined as each Plan whose Service Area includes all or part of the state in which the foregoing applicable state or local law or regulation has been enacted.

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MEDIATION AND MANDATORY DISPUTE RESOLUTION (MMDR) RULES

The Blue Cross and Blue Shield Plans ("Plans") and the Blue Cross Blue Shield Association ("BCBSA") recognize and acknowledge that the Blue Cross and Blue Shield system is a unique nonprofit and for-profit system offering cost effective health care financing and services. The Plans and BCBSA desire to utilize Mediation and Mandatory Dispute Resolution ("MMDR") to avoid expensive and time-consuming litigation that may otherwise occur in the federal and state judicial systems. Even MMDR should be viewed, however, as methods of last resort, all other procedures for dispute resolution having failed. Except as otherwise provided in the License Agreements, the Plans, their Controlled Affiliates and BCBSA agree to submit all disputes to MMDR pursuant to these Rules and in lieu of litigation.

1. Initiation of Proceedings

A. Pre-MMDR Efforts

Before filing a Complaint to invoke the MMDR process, the CEO of a complaining party, or his/her designated representative, shall undertake good faith efforts with the other side(s) to try to resolve any dispute.

B. Complaint

To commence a proceeding, the complaining party (or parties) shall provide by certified mail, return receipt requested, a written Complaint to the BCBSA Corporate Secretary (which shall also constitute service on BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) named therein. The Complaint shall contain:

- i. identification of the complaining party (or parties) requesting the proceeding;
- ii. identification of the respondent(s);
- iii. identification of any other persons or entities who are interested in a resolution of the dispute;
- iv. a full statement describing the nature of the dispute;
- v. identification of all of the issues that are being submitted for resolution;

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- vi. the remedy sought;
- vii. a statement as to whether the complaining party (or parties) elect(s) first to pursue Mediation;
- viii. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor; and
- ix. a statement signed by the CEO of the complaining party affirming that the CEO has undertaken efforts, or has directed efforts to be undertaken, to resolve the dispute before resorting to the MMDR process.

The complaining party (or parties) shall file and serve with the Complaint copies of all documents which the party (or parties) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

C. Answer

Within twenty (20) days after receipt of the Complaint, each respondent shall serve on BCBSA and on the complaining party (or parties);

- i. a full Answer to the aforesaid Complaint;
- ii. a statement of any Counterclaims against the complaining party (or parties), providing with respect thereto the information specified in Paragraph 1.B., above;
- iii. a statement as to whether the respondent elects to first pursue Mediation; and
- iv. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor.

The respondent(s) shall file and serve with the Answer or by the date of the Initial Conference set forth in Paragraph 3.C., below, copies of all documents which the respondent(s) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

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D. Reply To Counterclaim

Within ten (10) days after receipt of any Counterclaim, the complaining party (or parties) shall serve on BCBSA and on the responding party (or parties), a Reply to the Counterclaim. Such Reply must provide the same information required by Paragraph 1.C., above.

2. Mediation

To facilitate the mediation of disputes between or among BCBSA, the Plans and/or their Controlled Affiliates, the BCBSA Board has provided for Mediation under these Rules. Mediation may be pursued in lieu of or in an effort to obviate the Mandatory Dispute Resolution process, and all parties are strongly urged, but not required, to exhaust the mediation procedure provided for herein. In the event any party refuses to proceed with Mediation, the parties shall proceed immediately to Mandatory Dispute Resolution, as provided in Section 3.

A. Selection of Mediators

If all parties agree to pursue Mediation, they shall promptly attempt to agree upon: (i) the number of mediators desired, not to exceed three mediators; and (ii) the selection of experienced mediator(s) from an independent entity to mediate all disputes set forth in the Complaint and Answer (and Counterclaim and Reply, if any). In the event the parties are unable to agree upon the selection or number of mediators, both within five (5) days of the service of the Answer or Reply to Counterclaim, whichever is later, the BCBSA Corporate Secretary shall immediately refer the matter to a nationally recognized professional ADR organization (such as CPR or JAMS) for mediation by a single mediator to be selected by the ADR organization.

B. Binding Decision

Before the Mediation Hearing described below, the BCBSA Corporate Secretary shall contact the parties to determine whether they wish to be bound by any recommendation of the selected mediator(s) for resolution of the disputes. If all wish to be bound, the Corporate Secretary will send appropriate documentation to them for their signatures before the Mediation Hearing begins.

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C. Mediation Procedure

The Mediator(s) shall apply the mediation procedures and processes provided for herein (not the rules of the ADR organization with which they are affiliated) and shall promptly advise the parties of a scheduled Mediation Hearing date. Unless a party requests an expedited procedure, or unless all parties to the proceeding agree to one or more extensions of time, the Mediation Hearing set forth below shall be completed within forty (40) days of BCBSA's receipt of the Complaint. The selected mediator(s), unless the parties otherwise agree, shall adhere to the following procedure:

- i. Each party must be represented by its CEO or other representative who has been delegated full authority to resolve the dispute. However, parties may send additional representatives as they see fit.
- ii. Each party will be given one-half hour to present its case, beginning with the complaining party (or parties), followed by the other party or parties. The parties are free to structure their presentations as they see fit, using oral statements or direct examination of witnesses. However, neither cross-examination nor questioning of opposing representatives will be permitted. At the close of each presentation, the selected mediator(s) will be given an opportunity to ask questions of the presenters and witnesses. All parties must be present throughout the Mediation Hearing. The selected mediator(s) may extend the time allowed for each party's presentation at the Mediation Hearing. The selected mediator(s) may meet in executive session, outside the presence of the parties, or may meet with the parties separately, to discuss the controversy.
- iii. After the close of the presentations, the parties will attempt to negotiate a settlement of the dispute. If the parties desire, the selected mediator(s), or any one or more of the selected mediators, will sit in on the negotiations.

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- iv. After the close of the presentations, the selected mediator(s) may meet privately to agree upon a recommendation for resolution of the dispute which would be submitted to the parties for their consideration and approval. If the parties have previously agreed to be bound by the results of this procedure, this recommendation shall be binding upon the parties.
- v. The purpose of the Mediation Hearing is to assist the parties to settle their grievances short of mandatory dispute resolution. As a result, the Mediation Hearing has been designed to be as informal as possible. Rules of evidence shall not apply. There will be no transcript of the proceedings, and no party may make a tape recording of the Mediation Hearing.
- vi. In order to facilitate a free and open discussion, the Mediation proceeding shall remain confidential. A "Stipulation to Confidentiality" which prohibits future use of settlement offers, all position papers or other statements furnished to the selected mediator(s), and decisions or recommendations in any Mediation proceeding shall be executed by each party.
- vii. Upon request of the selected mediator(s), or one of the parties, BCBSA staff may also submit documentation at any time during the proceedings.

D. Notice of Termination of Mediation

If the Mediation cannot be completed within the prescribed or agreed time period due to the lack of cooperation of any party, as determined by the selected mediator(s), or if the Mediation does not result in a final resolution of all disputes at the Mediation Hearing or within ten (10) days after the Mediation Hearing, any party or any one of the selected mediators shall so notify the BCBSA Corporate Secretary, who shall promptly issue a Notice of Termination of Mediation to all parties, to the selected mediator(s), and to the MDR Administrator. Such notice shall serve to bring the Mediation to an end and to initiate Mandatory Dispute Resolution. Upon agreement of all parties and the mediator(s), the Mediation process may continue at the same time the MDR process is invoked. In such case, the Notice of Termination of Mediation described above serves to initiate the MDR proceeding, but does not terminate mediation proceedings, which may proceed simultaneous with the MDR proceeding.

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3. Mandatory Dispute Resolution (MDR)

If any party elects not to first pursue Mediation, or if a Notice of Termination of Mediation is issued as set forth in Paragraph 2.D., above, then the unresolved disputes set forth in any Complaint and Answer (and Counterclaim and Reply, if any) shall be subject to mandatory binding arbitration (herein referred to as “MDR”).

A. MDR Administrator

The Administrator for purposes of Mandatory Arbitration shall be an independent nationally recognized entity such as CPR or JAMS, specializing in alternative dispute resolution. In the event the parties pursued Mediation with CPR, JAMS or a similar organization, that organization also shall serve as the MDR Administrator, unless all parties notify the BCBSA Corporate Secretary in writing within two (2) days of receiving the Notice of Termination of Mediation that they wish to pursue MDR with another nationally recognized organization serving as MDR Administrator.

In the event the parties (i) did not pursue Mediation, (ii) pursued mediation with a Mediator not affiliated with an ADR organization that offers a panel of arbitrators, or (iii) all parties that pursued Mediation notified the BCBSA Corporate Secretary that they wish to have an MDR Administrator that is different from the organization with which their mediator was affiliated, they shall promptly attempt to agree on a nationally recognized ADR entity that supplies a panel of arbitrators. If they reach such agreement within five (5) days of the Notice of Termination of Mediation or receipt of the Answer or Reply to Counterclaim (whichever is later), the parties shall promptly inform the BCBSA Corporate Secretary of their agreed upon ADR organization. In the event the parties are unable to reach agreement on an MDR Administrator within that timeframe, the BCBSA Corporate Secretary shall immediately refer the matter to CPR, JAMS or a similar organization for MDR.

Any person who served as a Mediator shall not serve as an arbitrator for the same or similar dispute for purposes of MDR.

B. Rules for MDR

The rules controlling all aspects of MDR shall be exclusively those provided for herein. The rules promulgated or otherwise used by the MDR Administrator organization shall not apply.

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C. Initial Conference

Within seven (7) days after a Notice of Termination has issued or the matter has otherwise been referred to an MDR Administrator, or within five (5) days after the time for filing and serving the Answer or Reply to any Counterclaim (whichever is later) if the parties elect first not to mediate, the parties shall confer with the Administrator to discuss selecting a dispute resolution panel ("the Panel"). This conference (the "Initial Conference") may be by telephone. The parties are encouraged to agree to the composition of the Panel and to present that agreement to the Administrator at the Initial Conference. If the parties do not agree on the composition of the Panel by the time of the Initial Conference, or by any extension thereof agreed to by all parties and the Administrator, then the Panel Selection Process set forth in subparagraph D, below, shall be followed.

D. Panel Selection Process

The Administrator shall designate, prior to the Initial Conference, at least seven potential arbitrators. Each party shall be permitted to strike any designee for cause and the Administrator shall determine the sufficiency thereof in its sole discretion. The Administrator will designate a replacement for any designee so stricken. Each party shall then be permitted one peremptory strike from the list of designees. The Administrator shall set the dates for exercising all strikes, which shall be set to encourage the prompt selection of arbitrators.

After the parties exercise any designee strikes for cause and their peremptory strike against any designee of their choice, the parties shall each rank the remaining panel members in order of preference and provide the Administrator, without serving on any other party, their ranked list. The Administrator shall not disclose any party's ranked list to members of the panel or to other parties.

From the remaining designees, and after considering opportunities to maximize, so far as possible, the collectively stated arbitrator preferences provided by the parties on their ranked lists, the Administrator shall select a three member Panel. The Panel Selection Process shall be completed no later than ten (10) days after the Initial Conference.

Each Arbitrator shall be compensated at his or her normal hourly rate or, in the absence of an established rate, at a reasonable hourly rate to be promptly fixed by the Administrator for all time spent in connection with the proceedings and shall be reimbursed for any travel and other reasonable expenses.

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E. Duties Of The Arbitrators

The Panel shall promptly designate a Presiding Arbitrator for the purposes reflected below, but shall retain the power to review and modify any ruling or other action of said Presiding Arbitrator. Each Arbitrator shall be an independent Arbitrator, shall be governed by the Code of Ethics for Arbitrators in Commercial Disputes and shall at or prior to the commencement of any Arbitration Hearing take an oath to that effect. Each Arbitrator shall promptly disclose in writing to the Panel and to the parties any circumstances, whenever arising, that might cause doubt as to such Arbitrator's compliance, or ability to comply, with said Code of Ethics, and, absent resignation by such Arbitrator, the remaining Arbitrators shall determine in their sole discretion whether the circumstances so disclosed constitute grounds for disqualification and for replacement. With respect to such circumstances arising or coming to the attention of a party after an Arbitrator's selection, a party may likewise request the Arbitrator's resignation or a determination as to disqualification by the remaining Arbitrators. With respect to a sole Arbitrator, the determination as to disqualification shall be made by the Administrator.

There shall be no ex parte communication between the parties or their counsel and any member of the Panel.

F. Panel's Jurisdiction And Authority

The Panel's jurisdiction and authority shall extend to all disputes between or among the Plans, their Controlled Affiliates, and/or BCBSA, except for those disputes excepted from these MMDR procedures as set forth in the License Agreements.

With the exception of punitive or treble damages, the Panel shall have full authority to award the relief it deems appropriate to resolve the parties' disputes, including monetary awards and injunctions, mandatory or prohibitory. The Panel has no authority to award punitive or treble damages except that the Panel may allocate or assess responsibility for punitive or treble damages assessed by another tribunal. Subject to the above limitations, the Panel may, by way of example, but not of limitation:

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- i. interpret or construe the meaning of any terms, phrase or provision in any license between BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.
- ii. determine whether BCBSA, a Plan or a Controlled Affiliate has violated the terms or conditions of any license between the BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.
- iii. decide challenges as to its own jurisdiction.
- iv. issue such orders for interim relief as it deems appropriate pending Hearing and Award in any Arbitration.

It is understood that the Panel is expected to resolve issues based on governing principles of law, preserving to the maximum extent legally possible the continued integrity of the Licensed Marks and the BLUE CROSS/BLUE SHIELD system. The Panel shall apply federal law to all issues which, if asserted in the United States District Court, would give rise to federal question jurisdiction, 28 U.S.C. § 1331. The Panel shall apply Illinois law to all issues involving interpretation, performance or construction of any License Agreement or Controlled Affiliate License Agreement unless the agreement otherwise provides. As to other issues, the Panel shall choose the applicable law based on conflicts of law principles of the State of Illinois.

G. Administrative Conference

Within five (5) days of the Panel being selected, the Presiding Arbitrator shall confer with the parties and the other members of the Panel and shall schedule, in writing, a conference in which the parties and the Panel shall participate (the “Administrative Conference”). The Administrative Conference shall take place no later than fifteen (15) days after the Panel is selected. At the Administrative Conference the parties and the Panel shall discuss the scheduling of the Arbitration Hearing and any other matter appropriate to be considered, including but not limited to: any written discovery in the form of requests for production of documents or requests to admit facts; the identity of any witness whose deposition a party may desire and a showing of exceptional good cause for the taking of any such deposition; the desirability of bifurcation or other separation of the issues; the need for and the type of record of conferences and hearings, including the need for transcripts; the need for expert witnesses and

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how expert testimony should be presented; the appropriateness of motions to dismiss and/or for full or partial summary judgment; consideration of stipulations; the desirability of presenting any direct testimony in writing; and the necessity for any on-site inspection by the Panel. If the parties agree, the Administrative Conference may be by telephone.

H. Discovery

- i. Requests for Production of Documents:* All requests for the production of documents must be served no later than five (5) days after the date of the Initial Conference. Within twenty (20) days after receipt of a request for production of documents, a party shall (a) serve responses and objections to the request, (b) produce all responsive, non-privileged documents to the requesting party, and (c) to the extent any responsive documents are withheld on the grounds of attorney-client privilege or work product, produce a log identifying such documents in the manner specified in Fed. R. Civ. P. 26(b)(5). If, after reviewing a privilege log, the requesting party believes attorney-client privilege or work product protection was improperly claimed by the producing party with respect to any document, the requesting party may ask the Presiding Arbitrator to conduct an in-camera inspection of the same. With respect to documentary and other discovery produced in any MDR proceeding by BCBSA, the fact that a party's CEO or other senior officers may serve on the BCBSA Board of Directors, BCBSA Board Committees or other BCBSA work groups, task forces and the like, shall not be a basis for defeating an otherwise valid claim of attorney-client privilege or work product protection over such documentary or other discovery materials by BCBSA.
- ii. Requests for Admissions:* Requests for Admissions may be served up to twenty-one (21) days prior to the discovery cut-off set by the Presiding Arbitrator. A party served with Requests For Admissions must respond within twenty (20) days of receipt of said request. The good faith use of and response to Requests for Admissions is encouraged, and the Panel shall have full discretion, with reference to the Federal Rules of Civil Procedure, in awarding appropriate sanctions with respect to abuse of the procedure.

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- iii. Depositions:** As a general rule, the parties will not be permitted to take party or non-party deposition testimony for discovery purposes. The Presiding Arbitrator, in his or her sole discretion, shall have the authority to permit a party to take such deposition testimony upon a showing of exceptional good cause. The parties will be permitted to take de bene esse deposition¹ testimony to the fullest extent permitted by law of any witness who cannot be compelled to testify at the Arbitration Hearing. No deposition, for discovery purposes or otherwise, shall exceed three (3) hours, excluding objections and colloquy of counsel. Depositions may be recorded in any manner recognized by the Federal Rules of Civil Procedure and the parties shall specify in each notice of deposition or request for permission to take deposition testimony the manner in which such deposition shall be recorded.
- iv. Expert witness(es):** If a party intends to present the testimony of an expert witness during the oral hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2) (B) ten (10) days prior to the discovery cut-off set by the Presiding Arbitrator. If a party intends to present the testimony of a rebuttal expert witness during the Arbitration Hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)(B) within twenty (20) days after the date on which the written statement of the expert witness whose testimony is to be rebutted was produced.
- v. Discovery cut-off:** The Presiding Arbitrator shall determine the date on which the discovery period will end, but the discovery period shall not exceed thirty (30) days from the date of the Administrative Conference without the agreement of all parties.

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¹As used in these Rules, “de bene esse deposition” means a deposition that is not taken for discovery purposes, but is taken for the purpose of reading part or all of the deposition transcript into the record at the Arbitration Hearing, to the extent permitted by the Panel, because the witness cannot be compelled to testify at the Arbitration Hearing or has exercised a right provided under these Rules to provide deposition testimony in lieu of testimony at the Arbitration Hearing.

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vi. Additional discovery: Any additional discovery will be at the discretion of the Presiding Arbitrator.

vii. Discovery Disputes: Any discovery disputes shall be raised by motion to the Presiding Arbitrator, who is authorized to resolve all such disputes, and whose resolution will be binding on the parties unless modified by the Arbitration Panel. Prior to raising any discovery dispute with the Presiding Arbitrator, the parties shall meet and confer, telephonically or in person, in an attempt to resolve or narrow the dispute. If a party refuses to comply with a decision resolving a discovery dispute, the Panel, in keeping with Fed. R. Civ. P. 37, may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for resolution adversely to that party.

viii. Extensions: The time for responding to discovery requests may be extended by the Presiding Arbitrator for good and sufficient cause shown. Any request for such an extension shall be made in writing.

I. Panel Suggested Settlement/Mediation

At any point during the proceedings, the Panel at the request of any party or on its own initiative, may suggest that the parties explore settlement and that they do so at or before the conclusion of the Arbitration Hearing, and the Panel shall give such assistance in settlement negotiations as the parties may request and the Panel may deem appropriate. Alternatively, the Panel may direct the parties to endeavor to mediate their disputes as provided above, or to explore a mini-trial proceeding, or to have an independent party render a neutral evaluation of the parties' respective positions. The Panel shall enter such sanctions as it deems appropriate with respect to any party failing to pursue in good faith such Mediation or other alternate dispute resolution methods.

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J. Subpoenas on Third Parties

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq.*, and subject to Paragraph 3.G(iii) above, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan or any officer, employee or director of a third party Blue Plan, to compel deposition testimony or the production of documents, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena.

K. Arbitration Hearing

An Arbitration Hearing will be held within thirty (30) days after the Administrative Conference if no discovery is taken, or within thirty (30) days after the close of discovery, unless all parties and the Panel agree to extend the Arbitration Hearing date, or unless the parties agree in writing to waive the Arbitration Hearing. The parties may mutually agree on the location of the Arbitration Hearing. If the parties fail to agree, the Arbitration Hearing shall be held in Chicago, Illinois, or at such other location determined by the Presiding Arbitrator to be most convenient to the participants. The Panel will determine the date(s) and time(s) of the Arbitration Hearing(s) after consultation with all parties and shall provide reasonable notice thereof to all parties or their representatives.

L. Arbitration Hearing Memoranda

Twenty (20) days prior to the Arbitration Hearing, each party shall submit to the other party (or parties) and to the Panel an Arbitration Hearing Memorandum which sets forth the applicable law and any argument as to any relevant issue. The Arbitration Hearing Memorandum will supplement, and not repeat, the allegations, information and documents contained in or with the Complaint, Answer, Counterclaim and Reply, if any. Ten (10) days prior to the Arbitration Hearing, each party shall submit to each other party a list of all expert and fact witnesses (but not including rebuttal fact witness) that such party intends to have testify at the Arbitration Hearing and a brief summary of the testimony each such witness is expected to give. In addition, no later than five (5) days prior to the Arbitration, each party may submit to each other party and to the Panel a Response Arbitration Hearing Memorandum which sets forth any response to another party's Arbitration Hearing Memorandum.

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M. Notice For Testimony

Ten (10) days prior to the Arbitration Hearing, any party may serve a Notice on any other party (or parties) requesting the attendance at the Arbitration Hearing of any officer, employee or director of the other party (or parties) for the purpose of providing noncumulative testimony. If a party fails to produce one of its officers, employees or directors whose noncumulative testimony during the Arbitration Hearing is reasonably requested by an adverse party, the Panel may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for mandatory dispute resolution adversely to that party; provided, however, that a party may refuse to produce a director to testify if, within two (2) days of receiving a notice requesting the attendance of such director at the Arbitration Hearing, the party agrees to make the director available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. This Rule may not be used for the purpose of burdening or harassing any party, and the Presiding Arbitrator may impose such orders as are appropriate so as to prevent or remedy any such burden or harassment.

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq.*, twenty (20) days or more prior to the Arbitration Hearing, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan, BCBSA or any officer, employee or director of a third party Blue Plan or BCBSA for the purpose of providing noncumulative testimony at the Arbitration Hearing, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena; provided however, that a director of a third party Blue Plan or BCBSA may refuse to testify if, within two (2) days of receiving a subpoena requesting the attendance of such director at the Arbitration Hearing, the director agrees to make him/herself available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. Each Blue Plan agrees to waive, on its own behalf and on behalf of its directors and officers, any objection it otherwise might have to any such subpoena based on service, venue or extraterritoriality.

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N. Arbitration Hearing Procedures

- i. Attendance at Arbitration Hearing:* Any person having a direct interest in the proceeding is entitled to attend the Arbitration Hearing. The Presiding Arbitrator shall otherwise have the power to require the exclusion of any witness, other than a party or other essential person, during the testimony of any other witness. It shall be discretionary with the Presiding Arbitrator to determine the propriety of the attendance of any other person.
- ii. Confidentiality:* The Panel and all parties shall maintain the privacy of the Arbitration Proceeding. The parties and the Panel shall treat the Arbitration Hearing and any discovery or other proceedings or events related thereto, including any award resulting therefrom, as confidential except as otherwise necessary in connection with a judicial challenge to or enforcement of an award or unless otherwise required by law.
- iii. Stenographic Record:* Any party, or if the parties do not object, the Panel, may request that a stenographic or other record be made of any Arbitration Hearing or portion thereof. The costs of the recording and/or of preparing the transcript shall be borne by the requesting party and by any party who receives a copy thereof. If the Panel requests a recording and/or a transcript, the costs thereof shall be borne equally by the parties.
- iv. Oaths:* The Panel may require witnesses to testify under oath or affirmation administered by any duly qualified person and, if requested by any party, shall do so.
- v. Order of Arbitration Hearing:* An Arbitration Hearing shall be opened by the recording of the date, time, and place of the Arbitration Hearing, and the presence of the Panel, the parties, and their representatives, if any. The Panel may, at the beginning of the Arbitration Hearing, ask for statements clarifying the issues involved.

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Unless otherwise agreed, the complaining party (or parties) shall then present evidence to support their claim(s). The respondent(s) shall then present evidence supporting their defenses and Counterclaims, if any. The complaining party (or parties) shall then present evidence supporting defenses to the Counterclaims, if any, and rebuttal.

Witnesses for each party shall submit to questions by adverse parties and/or the Panel.

The Panel has the discretion to vary these procedures, but shall afford a full and equal opportunity to all parties for the presentation of any material and relevant evidence.

- vi. **Evidence:** The parties may offer such evidence as is relevant and material to the dispute and shall produce such evidence as the Panel may deem necessary to an understanding and resolution of the dispute. Unless good cause is shown, as determined by the Panel or agreed to by all other parties, no party shall be permitted to offer evidence at the Arbitration Hearing which was not disclosed prior to the Arbitration Hearing by that party. The Panel may receive and consider the

evidence of witnesses by affidavit upon such terms as the Panel deems appropriate.

The Panel shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence, other than enforcement of the attorney-client privilege and the work product protection, shall not be necessary. The Federal Rules of Evidence shall be considered by the Panel in conducting the Arbitration Hearing but those rules shall not be controlling. All evidence shall be taken in the presence of the Panel and all of the parties, except where any party is in default or has waived the right to be present.

Settlement offers by any party in connection with Mediation or MDR proceedings, decisions or recommendations of the selected mediators, and a party's position papers or statements furnished to the selected mediators shall not be admissible evidence or considered by the Panel without the consent of all parties.

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vii. ***Closing of Arbitration Hearing:*** The Presiding Arbitrator shall specifically inquire of all parties whether they have any further proofs to offer or witnesses to be heard. Upon receiving negative replies or if he or she is satisfied that the record is complete, the Presiding Arbitrator shall declare the Arbitration Hearing closed with an appropriate notation made on the record. Subject to being reopened as provided below, the time within which the Panel is required to make the award shall commence to run, in the absence of contrary agreement by the parties, upon the closing of the Arbitration Hearing.

With respect to complex disputes, the Panel may, in its sole discretion, defer the closing of the Arbitration Hearing for a period of up to thirty (30) days after the presentation of proofs in order to permit the parties to submit post-hearing briefs and argument, as the Panel deems appropriate, prior to making an award.

For good cause, the Arbitration Hearing may be reopened for up to thirty (30) days on the Panel's initiative, or upon application of a party, at any time before the award is made

O. Awards

An Award must be in writing and shall be made promptly by the Panel and, unless otherwise agreed by the parties or specified by law, no later than thirty (30) days from the date of closing the Arbitration Hearing. If all parties so request, the Award shall contain findings of fact and conclusions of law. The Award, and all other rulings and determinations by the Panel, may be by a majority vote.

Parties shall accept as legal delivery of the Award the placing of the Award or a true copy thereof in the mail addressed to a party or its representative at its last known address or personal service of the Award on a party or its representative.

Awards are binding only on the parties to the Arbitration and are not binding on any non-parties to the Arbitration and may not be used or cited as precedent in any other proceeding.

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After the expiration of twenty (20) days from initial delivery, the Award (with corrections, if any) shall be final and binding on the parties, and the parties shall undertake to carry out the Award without delay.

Proceedings to confirm, modify or vacate an Award shall be conducted in conformity with and controlled by the Federal Arbitration Act. 9 U.S.C. § 1, *et seq.*

P. Return of Documents

Within sixty (60) days after the Award and the conclusion of any judicial proceedings with respect thereto, each party and the Panel shall return any documents produced by any other party, including all copies thereof. If a party receives a discovery request in any other proceeding which would require it to produce any documents produced to it by any other party in a proceeding hereunder, it shall not produce such documents without first notifying the producing party and giving said party reasonable time to respond, if appropriate, to the discovery request.

4. Miscellaneous

A. Expedited Procedures

Any party to a Mediation may direct a request for an expedited Mediation Hearing to the Chairman of the Mediation Committee, to the selected Mediators, and to all other parties at any time. The Chairman of the Mediation Committee, or at his or her direction, the then selected Mediators, shall grant any request which is supported by good and sufficient reasons. If such a request is granted, the Mediation shall be completed within as short a period as practicable, as determined by the Chairman of the Mediation Committee or, at his or her direction, the then selected Mediators.

Any party to an Arbitration may direct a request for expedited proceedings to the Administrator, to the Panel, and to all other parties at any time. The Administrator, or the Presiding Arbitrator if the Panel has been selected, shall grant any such request which is supported by good and sufficient reasons. If such a request is granted, the Arbitration shall be completed within as short a time as practicable, as determined by the Administrator and/or the Presiding Arbitrator.

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B. Temporary or Preliminary Injunctive Relief

Any party may seek temporary or preliminary injunctive relief with the filing of a Complaint or at any time thereafter. If such relief is sought prior to the time that an Arbitration Panel has been selected, then the Administrator shall select a single Arbitrator who is a lawyer who has no interest in the subject matter of the dispute, and no connection to any of the parties, to hear and determine the request for temporary or preliminary injunction. If such relief is sought after the time that an Arbitration Panel has been selected, then the Arbitration Panel will hear and determine the request. The request for temporary or preliminary injunctive relief will be determined with reference to the temporary or preliminary injunction standards set forth in Fed. R. Civ. P. 65.

C. Defaults and Proceedings in the Absence of a Party

Whenever a party fails to comply with the MDR Rules in a manner deemed material by the Panel, the Panel shall fix a reasonable time for compliance and, if the party does not comply within said period, the Panel may enter an Order of default or afford such other relief as it deems appropriate. Arbitration may proceed in the event of a default or in the absence of any party who, after due notice, fails to be present or fails to obtain an extension. An Award shall not be made solely on the default or absence of a party, but the Panel shall require the party who is present to submit such evidence as the Panel may require for the making of findings, determinations, conclusions, and Awards.

D. Notice

Each party shall be deemed to have consented that any papers, notices, or process necessary or proper for the initiation or continuation of a proceeding under these rules or for any court action in connection therewith may be served on a party by mail addressed to the party or its representative at its last known address or by personal service, in or outside the state where the MDR proceeding is to be held.

The Corporate Secretary and the parties may also use facsimile transmission, telex, telegram, or other written forms of electronic communication to give the notices required by these rules.

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E. Expenses

The expenses of witnesses shall be paid by the party causing or requesting the appearance of such witnesses. All expenses of the MDR proceeding, including compensation, required travel and other reasonable expenses of the Panel, and the cost of any proof produced at the direct request of the Panel, shall be borne equally by the parties and shall be paid periodically on a timely basis, unless they agree otherwise or unless the Panel in the Award assesses such expenses, or any part thereof against any party (or parties). In exceptional cases, the Panel may award reasonable attorneys' fees as an item of expense, and the Panel shall promptly determine the amount of such fees based on affidavits or such other proofs as the Panel deems sufficient.

F. Disqualification or Disability of A Panel Member

In the event that any Arbitrator of a Panel with more than one Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the remaining Panel member(s):

- i. shall designate a replacement, subject to the right of any party to challenge such replacement for cause.
- ii. shall decide the extent to which previously held hearings shall be repeated.

If the remaining Panel members consider the proceedings to have progressed to a stage as to make replacement impracticable, the parties may agree, as an alternative to the recommencement of the Mandatory Dispute Resolution process, to resolution of the dispute by the remaining Panel members.

In the event that a single Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the Administrator shall appoint a successor, subject to the right of any party to challenge such successor for cause, and the successor shall decide the extent to which previously held proceedings shall be repeated.

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G. Extensions of Time

Subject to the provisions of Paragraph 3.H.(viii.), any time limit set forth in these Rules may be extended upon agreement of the parties and approval of: (1) the Mediator if the proceeding is then in Mediation; (2) the Administrator if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (3) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected.

H. Intervention

The Plans, their Controlled Affiliates, and BCBSA, to the extent subject to MMDR pursuant to their License Agreements, shall have the right to move to intervene in any pending Arbitration. A written motion for intervention shall be made to: (1) the Administrator, if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (2) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected. The written motion for intervention shall be delivered to the BCBSA Corporate Secretary (which shall also constitute service on the BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) which are parties to the proceeding. Any party to the proceeding can submit written objections to the motion to intervene. The motion for intervention shall be granted upon good cause shown. Intervention also may be allowed by stipulation of the parties to the Arbitration proceeding. Intervention shall be allowed upon such terms as the Arbitration Panel decides.

I. BCBSA Assistance in Resolution of Disputes

The resources and personnel of the BCBSA may be requested by any member Plan at any time to try to resolve disputes with another Plan.

J. Neutral Evaluation

The parties can voluntarily agree at any time to have an independent party render a neutral evaluation of the parties' respective positions.

Amended as of September 20, 2007

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K. Recovery of Attorney Fees and Expenses

i. Motions to Compel

Notwithstanding any other provisions of these Rules, any Party subject to the License Agreements (for purposes of this Section K and all of its subsections only hereinafter referred to collectively and individually as a “Party”) that initiates a court action or administrative proceeding solely to compel adherence to these Rules shall not be determined to have violated these Rules by initiating such action or proceeding.

ii Recovery of Fees, Expenses and Costs

The Arbitration Panel may, in its sole discretion, award a Party its reasonable attorneys’ fees, expenses and costs associated with a filing to compel adherence to these Rules and/or reasonable attorneys’ fees, expenses and costs incurred in responding to an action filed in violation of these Rules; provided, however, that neither fees, expenses, nor costs shall be awarded by the Arbitration Panel if the Party from which the award is sought can demonstrate to the Arbitration panel, in its sole discretion, that it did not violate these Rules or that it had reasonable grounds for believing that its action did not violate these Rules.

iii Requests for Reimbursement

For purposes of this Section K, any Party may request reimbursement of fees, expenses and/or costs by submitting said request in writing to the Arbitration Panel at any time before an award is delivered pursuant Paragraph to 3.O above with a copy to the Party from which reimbursement is sought, explaining why it is entitled to such reimbursement. The Party from which reimbursement is sought shall have twenty (20) days to submit a response to such request to the Arbitration Panel with a copy to the Party seeking reimbursement.

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L. Calculation of Time and Deadlines

In computing any period of time prescribed or allowed under these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not one of the aforementioned days. When the period of time prescribed is less than six (6) days, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation. As used in this rule, "legal holiday" includes New Year's Day, Martin Luther King, Jr. Day, Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day and any other day appointed as a holiday by the President or the Congress of the United States.

Amended as of September 20, 2007

BLUE SHIELD LICENSE AGREEMENT

(Includes revisions, if any, adopted by Member Plans through their September 18, 2015 meeting)

This agreement by and between Blue Cross and Blue Shield Association ("BCBSA") and The Blue Shield Plan, known as _____ (the "Plan").

Preamble

WHEREAS, the Plan and/or its predecessor(s) in interest (collectively the "Plan") had the right to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") for health care plans in its service area, which was essentially local in nature;

WHEREAS, the Plan was desirous of assuring nationwide protection of the Licensed Marks, maintaining uniform quality controls among Plans, facilitating the provision of cost effective health care services to the public and otherwise benefiting the public;

WHEREAS, to better attain such ends, the Plan and the predecessor of BCBSA executed the Agreement(s) Relating to the Collective Service Mark "Blue Shield"; and

WHEREAS, BCBSA and the Plan desire to supercede said Agreement(s) to reflect their current practices and to assure the continued integrity of the Licensed Marks and of the BLUE SHIELD system;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

Agreement

1. BCBSA hereby grants to the Plan, upon the terms and conditions of this License Agreement ("Agreement" or "Primary License Agreement", the right to use BLUE SHIELD in its trade and/or corporate name (the "Licensed Name"), and the right to use the Licensed Marks, in the sale, marketing and administration of health care plans and related services in the Service Area set forth and defined in paragraph 5 below. As used herein, health care plans and related services shall include acting as a nonprofit health care plan, a for-profit health care plan, or mutual health insurer operating on a not-for-profit or for-profit basis, under state law; financing access to health care services; when working with a bank that holds the relevant license to use the Licensed Name and Marks, offering: (i) tax-favored savings accounts for medical expenses and means for accessing such accounts, such as debit cards or checks, that are provided solely to support access to such tax-favored savings accounts, all pursuant to such license, or (ii) prepaid rewards cards that are provided for completion of a wellness program, all pursuant to such license; providing health care management and administration; administering, but not underwriting, non-health portions of Worker's Compensation insurance; delivering health care services, except hospital services (as defined in the Guidelines to Membership Standards Applicable to Regular Members); and performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by a group account to its members, including benefit plans not provided by the Plan, provided that the Plan has contracted to provide Health Coverage under the Licensed Marks to the account (as the terms "Health Coverage," "Eligibility" and "Enrollment" are defined in Exhibit 4, Paragraph 2.t.).

2. The Plan may use the Licensed Marks and Name in connection with the offering of: i) health care plans and related services in the Service Area through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License Agreement"); and ii) insurance coverages offered by life insurers under the applicable law in the Service Area, other than those which the Plan may offer in its own name, provided through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1A hereto (the "Controlled Affiliate License Agreement Applicable to Life Insurance Companies") or the Agreement attached as Exhibit 1A1 hereto (the "Controlled Affiliate Trademark License Agreement for Life and Disability Insurance Products") and further provided that the offering of such services does not and will not dilute or tarnish the unique value of the Licensed Marks and Name; and iii) administration and underwriting of Workers' Compensation Insurance Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License."); and iv) regional Medicare Advantage PPO Products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1B hereto (the "Controlled Affiliate License Agreement Applicable to Regional Medicare Advantage PPO Products"); and v) regional Medicare Part D Prescription Drug Plan products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1C hereto (the "Controlled Affiliate License Agreement Applicable to Regional Medicare Part D Prescription Drug Plan Products"). As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans and, if the entity meets the standards of Paragraph 2a.B but not Paragraph 2a.A, the entity, its owners, and persons authority to select or appoint members or board members, other than a Plan or Plans, have received written approval of BCBSA. Absent written approval by BCBSA of an alternative method of control, bona fide control shall have the meaning set forth in

Paragraphs 2a. and 2b.

2a. With respect to the Controlled Affiliate Licenses authorized in clauses

i)through iii) of Paragraph 2, bona fide control shall mean that a Plan (the “Sponsoring Plan”) authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to this Primary License Agreement with BCBSA must have:

- A. The legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; (b) to exercise control over the policy and operations of the Controlled Affiliate; (c) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or
- B. The legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; (c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan. Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:
1. Change its legal and/or trade name;
 2. Change the geographic area in which it operates;
 3. Change any of the types of businesses in which it engages;
 4. Create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;
 5. Sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;
 6. Make any loans or advances except in the ordinary course of business;

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7. Enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners of the Controlled Affiliate or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);
8. Conduct any business other than under the Licensed Marks and Name;
9. Take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks or Names.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee; or

- C. With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid products and services, the legal authority together with such other Plans (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B to Exhibit 1 attached hereto.

2b. With respect to the Controlled Affiliate License Agreements authorized in clauses iv) and v) of Paragraph 2, bona fide control shall mean that the Controlled Affiliate is organized and operated in such a manner that it meets the following requirements:

- A. The Controlled Affiliate is owned or controlled by two or more Plans authorized to use the Licensed Marks pursuant to this License

Amended as of March 26, 2015

Agreement with BCBSA (for purposes of this subparagraph A. through subparagraph C., the “Controlling Plans”); and

- B. Each Controlling Plan is authorized pursuant to this Agreement to use the Licensed Marks in a geographic area in the Region (as that term is defined in such Controlled Affiliate License Agreements) and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
- C. The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate’s governing body having not less than 100% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur; and (c) to exercise control over the policy and operations of the Controlled Affiliate. Notwithstanding anything to the contrary in (a) through (c) of this subparagraph E., the Controlled Affiliate’s establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:
1. Change its legal and/or trade names;
 2. Change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
 3. Change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
 4. Take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly- owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Amended as of March 26, 2015
(the next page is 3)

3. With respect to a Controlled Affiliate that is not licensed to use the Licensed Marks and Name, the Plan may, in communications that contain the Licensed Marks or Name, indicate its corporate relationship to the Affiliate and permit such Affiliate to indicate its corporate relationship to the Plan, solely in the circumstances, style and manner specified by BCBSA from time-to-time in regulations of general application consistent with the avoidance of confusion or mistake or the dilution or tarnishment of the Licensed Marks and Name. No rights are hereby created in any Controlled Affiliate to use the Licensed Marks or Name in its own name or otherwise.

4. The Plan recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Plan further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide. The Plan agrees (a) to maintain in good standing its membership in BCBSA; (b) promptly to pay its dues to BCBSA, said dues to represent the royalties for this License Agreement; (c) materially to comply with all applicable laws; (d) to comply with the Membership Standards Applicable to Regular Members of BCBSA, a current copy of which is attached as Exhibit 2 hereto; and (e) reasonably to permit BCBSA, upon a written, good faith request and during reasonable business hours, to inspect the Plan's books and records necessary to ascertain compliance herewith. As to other Plans and third parties, BCBSA shall maintain the confidentiality of all documents and information furnished by the Plan pursuant hereto, or pursuant to the Membership Standards, and clearly designated by the Plan as containing proprietary information of the Plan.

5. The rights hereby granted are exclusive to the Plan within the geographical area(s) served by the Plan on June 30, 1972, and/or as to which the Plan has been granted a subsequent license, which is hereby defined as the "Service Area," except that BCBSA reserves the right to use the Licensed Marks in said Service Area, and except to the extent that said Service Area may overlap areas served by one or more other licensed Blue Shield Plans as of said date or subsequent license, as to which overlapping areas the rights hereby granted are nonexclusive as to such other Plan or Plans only.

Amended as of June 19, 2014

6. Except as expressly provided by BCBSA with respect to National Accounts, Government Programs and certain other necessary and collateral uses, the current rules and regulations governing which are attached as Exhibit 3 and Exhibit 4 hereto, and are contained in other documents referenced herein, or as expressly provided herein, the Plan may not use the Licensed Marks and Name outside the Service Area or in connection with other goods and services, nor may the Plan use the Licensed Marks or Name in a manner which is intended to transfer in the Service Area the goodwill associated therewith to another mark or name. Nothing herein shall be construed to prevent the Plan from engaging in lawful activity anywhere under other marks and names not confusingly similar to the Licensed Marks and Name, provided that engaging in such activity does and will not dilute or tarnish the unique value of the Licensed Marks and Name. In addition to any and all remedies available hereunder, BCBSA may impose monetary fines on the Plan for the Plan's use of the Licensed Marks and Names outside the Service Area, and provided that the procedure used in imposing a fine is consistent with procedures specifically prescribed by BCBSA from time to time in regulations of general application. In the case of regional Medicare Advantage PPO and regional Medicare Part D Prescription Drug Plan products offered by consenting and participating Plans in a region that includes the Service Areas, or portions thereof, of more than one Plan, such fine may be imposed jointly on the consenting and participating Plans for use of the Licensed Marks and Name in any geographic area of the region in which a Plan having exclusive rights to the Licensed Marks and Name does not consent to and participate in such offering, provided that the basis for imposition of such fine is consistent with rules specifically prescribed by BCBSA from time to time in regulations of general application.

7. The Plan agrees that it will display the Licensed Marks and Name only in such form, style and manner as shall be specifically prescribed by BCBSA from time-to-time in regulations of general application in order to prevent impairment of the distinctiveness of the Licensed Marks and Name and the goodwill pertaining thereto. The Plan shall cause to appear on all materials on or in connection with which the Licensed Marks or Name are used such legends, markings and notices as BCBSA may reasonably request in order to give appropriate notice of service mark or other proprietary rights therein or pertaining thereto.

8. BCBSA agrees that: (a) it will not grant any other license effective during the term of this License Agreement for the use of the Licensed Marks or Name which is inconsistent with the rights granted to the Plan hereunder; and (b) it will not itself use the Licensed Marks in derogation of the rights of the Plan or in a manner to deprive the Plan of the full benefits of this License Agreement, provided that BCBSA shall have the right to use the Licensed Marks in conjunction with any national offering under the Federal Employees Health Benefits Program in the manner set forth in Exhibit 4, Paragraph 4 (including subparagraphs) to this License Agreement. The Plan agrees that it will not attack the title of BCBSA in and to the Licensed Marks or Name or attack the validity of the Licensed Marks or of this License Agreement. The Plan further agrees that all use by it of the Licensed Marks and Name or any similar mark or name shall inure to the benefit of BCBSA, and the Plan shall cooperate with BCBSA in effectuating the assignment to BCBSA of any service mark or trademark registrations of the Licensed Marks or any similar mark or name held by the Plan or a Controlled Affiliate of the Plan, all or any portion of which registration consists of the Licensed Marks.

Amended as of November 16, 2006

9. (a). Should the Plan fail to comply with the provisions of paragraphs 2-4, 6, 7 and/or 12, and not cure such failure within thirty (30) days of receiving written notice thereof (or commence curing such failure within such thirty day period and continue diligent efforts to complete the curing of such failure if such curing cannot reasonably be completed within such thirty day period), BCBSA shall have the right to issue a notice that the Plan is in a state of noncompliance. Except as to the termination of a Plan's License Agreement or the merger of two or more Plans, disputes as to noncompliance, and all other disputes between or among BCBSA, the Plan, other Plans and/or Controlled Affiliates, shall be submitted promptly to mediation and mandatory dispute resolution pursuant to the rules and regulations of BCBSA, a current copy of which is attached as Exhibit 5 hereto, and shall be timely presented and resolved. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. If a state of noncompliance as aforesaid is undisputed by the Plan or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the License Agreement. Except, however, as provided in paragraphs 9(d)(iii), 15(a)(i)-(viii), and 15(a)(x) below, no Plan's license to use the Licensed Marks and Name may be finally terminated for any reason without the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

(b). Notwithstanding any other provision of this License Agreement, a Plan's license to use the Licensed Marks and Name may be forthwith terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to Member Plans for: (i) failure to comply with any minimum capital or liquidity requirement under the Membership Standard on Financial Responsibility; or (ii) impending financial insolvency; or (iii) the pendency of any action instituted against the Plan seeking its dissolution or liquidation or its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property of business, unless this License Agreement has been earlier terminated under paragraph 15(a); or (iv) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans and/or the Licensed Marks.

Amended as of March 16, 2006

(c). To the extent not otherwise provided therein, neither: (i) the Membership Standards Applicable to Regular Members of BCBSA; nor (ii) the rules and regulations governing Government Programs and certain other uses; nor (iii) the rules and regulations governing mediation and mandatory dispute resolution, may be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans. The rules and regulations governing National Accounts and other national programs required by the Membership Standards Applicable to Regular Members of BCBSA (Exhibit 2) are contained, in addition to those set forth in Exhibit 3, in the following documents, as amended from time to time: (1) the Inter-Plan Programs Policies and Provisions; (2) Inter-Plan Medicare Advantage Program Policies and Provisions. The voting requirements specified in rules and regulations governing such national programs may not be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans.

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

(i) The Plan shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement and the Plan's membership in BCBSA.

(ii) The Plan shall not use the licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Plan in any securities market. The Plan shall use the Licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(iii) The Plan's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Plan knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Plan ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Plan knows, or there is an SEC filing indicating that, any Noninstitutional Investor has become the Beneficial Owner of securities representing 5% or more of the voting power of the Plan ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Plan knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner of 20% or more of the Plan's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 9(d)(iv) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Plan went public constituted the Board of Directors of the Plan (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Plan went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Plan consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Plan in a writing received by BCBSA prior to such automatic termination

Amended as of September 17, 1997

becoming effective, the provisions of this paragraph 9(d)(iii) may be waived, in whole or in part, upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 9(d)(iii)(a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Plan's license to use the Licensed Marks and Name is terminated pursuant to this Paragraph 9(d)(iii), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Plan demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(iv) The Plan shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities or (iii) such other securities as the Plan may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(v) For purposes of paragraph 9(d)(iii), the following definitions shall apply:

(a) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(b) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

Amended as of September 17, 1997

(i) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

(ii) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(iii) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (b)(ii)(B) above) or disposing of any securities of the Plan.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Plan, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(c) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

(d) "Noninstitutional Investor" means any Person who is not an Institutional Investor.

(e) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.
(The next page is page 6)

Amended as of September 17, 1997

10. This License Agreement shall remain in effect: (a) until terminated as provided herein; or (b) until this and all such other License Agreements are terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans; (c) until terminated by the Plan upon eighteen (18) months written notice to BCBSA or upon a shorter notice period approved by BCBSA in writing at its sole discretion.

11. Except as otherwise provided in paragraph 15 below or by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans, or unless this and all such other License Agreements are simultaneously terminated by force of law, the termination of this License Agreement for any reason whatsoever shall cause the reversion to BCBSA of all rights in and to the Licensed Marks and Name, and the Plan agrees that it will promptly discontinue all use of the Licensed Marks and Name, will not use them thereafter, and will promptly, upon written notice from BCBSA, change its corporate name so as to eliminate the Licensed Name therefrom.

12. The license hereby granted to Plan to use the Licensed Marks and Name is and shall be personal to the Plan so licensed and shall not be assignable by any act of the Plan, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Plan mortgage or part with possession or control of this license or any right hereunder, and the Plan shall have no right to grant any sublicense to use the Licensed Marks and Name.

13. BCBSA shall maintain appropriate service mark registrations of the Licensed Marks and BCBSA shall take such lawful steps and proceedings as may be necessary or proper to prevent use of the Licensed Marks by any person who is not authorized to use the same. Any actions or proceedings undertaken by BCBSA under the provisions of this paragraph shall be at BCBSA's sole cost and expense. BCBSA shall have the sole right to determine whether or not any legal action shall be taken on account of unauthorized use of the Licensed Marks, such right not to be unreasonably exercised. The Plan shall report any unlawful usage of the Licensed Marks to BCBSA in writing and agrees, free of charge, to cooperate fully with BCBSA's program of enforcing and protecting the service mark rights, trade name rights and other rights in the Licensed Marks.

14. The Plan hereby agrees to save, defend, indemnify and hold BCBSA And any other Plan(s) harmless from and against all claims, damages, liabilities and Costs of every kind, nature and description which may arise as a result of the activities of the Plan or of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan. BCBSA hereby agrees to save, defend, indemnify and hold the Plan and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of BCBSA.

Amended as of June 21, 2012

15. (a). This Agreement shall automatically terminate upon the occurrence of any of the following events: (i) a voluntary petition shall be filed by the Plan or by BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against the Plan or BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Plan or BCBSA respectively, or (iii) an order for relief is entered against the Plan or BCBSA in any case under the bankruptcy laws of the United States, or the Plan or BCBSA is adjudged bankrupt or insolvent (as that term is defined in the Uniform Commercial Code as enacted in the state of Illinois) by any court of competent jurisdiction, or (iv) the Plan or BCBSA makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of the Plan or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Plan or BCBSA respectively, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of the Plan's or BCBSA's property or business is appointed, or the Plan or BCBSA is ordered dissolved or liquidated, or (ix) the Plan shall fail to pay its dues and shall not cure such failure within thirty (30) days of receiving written notice thereof, or (x) if, due to regulatory action, the Plan together with any applicable Controlled Affiliate becomes unable to do business using the Names and Marks in any State or portion thereof included in its Service Area, provided that: (i) automatic termination shall not occur prior to the exhaustion by any such Plan of its rights to appeal or challenge such regulatory action; and (ii) in the event the Plan is licensed to do business using the Names and Marks in multiple States or portions of States, the termination of its License Agreement shall be solely limited to the State(s) or portions thereof in which the regulatory action applies. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Plan's or BCBSA's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 15(a)(vii) and (viii) of this Agreement.

Amended as of September 14, 2004

(b). BCBSA, or the Plans (as provided and in addition to the rights conferred in Paragraph 10(b) above), may terminate this Agreement immediately upon written notice upon the occurrence of either of the following events: (a) the Plan or BCBSA becomes insolvent (as that term is defined in the Uniform Commercial Code enacted in the state of Illinois), or (b) any final judgment against the Plan or BCBSA remains unsatisfied or unbonded of record for a period of sixty (60) days or longer.

(c). If this License Agreement is terminated as to BCBSA for any reason stated in subparagraphs 15(a) and (b) above, the ownership of the Licensed Marks shall revert to each of the Plans.

(d). Upon termination of this License Agreement or any Controlled Affiliate License Agreement of a Larger Controlled Affiliate, as defined in Exhibit 1 to this License Agreement, the following conditions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 15 (a)(x)(ii) of this Agreement, the notices, national account listing, payment and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

- (i) The terminated entity shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the terminated entity or its Controlled Affiliates under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination or, if termination is pursuant to paragraph 10(d) of this Agreement, within 15 days after the written notice to BCBSA described in paragraph 10(d).
- (ii) The terminated entity shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the terminated entity is involved (in a Control, Participating or Servicing capacity), identifying the national account and the terminated entity's role therein. For those accounts where the terminated entity is the Control Plan, the Plan must also indicate the Participating and Servicing Plans in the national account syndicate.

Amended as of June 16, 2005

- (iii) Unless the cause of termination is an event stated in paragraph 15(a) or (b) above respecting BCBSA, the Plan and its Licensed Controlled Affiliates shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. The Re-Establishment Fee shall be indexed to a base fee of \$80. The Re-Establishment Fee through December 31, 2005 shall be \$80. The Re-Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was \$278.60, \$285.00 and \$290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be \$83.27 (100% of the base fee plus \$1.84 for calendar year 2005 and \$1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (a) the end of the last fiscal year of the terminated entity which ended prior to termination or (b) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph (d)(iii) shall be due only

Amended as of June 16, 2005

to the extent that, in BCBSA's opinion, it does not cause the net worth of the Plan to fall below 100% of the Health Risk-Based Capital formula or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans), measured as of the date of termination and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plan or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Plan (and/or its Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph only to the extent that such payments exceed the amounts due to BCBSA pursuant to subparagraph 15(d)(vi) and any costs associated with reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the terminated entity.

- (iv) The terminated entity shall comply with all financial settlement procedures set forth in BCBSA's License Termination Contingency Plan, as amended from time to time and shall work diligently and in good faith with

Amended as of June 16, 2005

BCBSA, any Alternative Control Licensee or Replacement Licensee and any existing or potential new account for Blue-branded products and services to minimize the disruption of termination, and honor, to the fullest extent possible, the desire of accounts to continue to receive or obtain Blue-branded products and services through a new Licensee ("Transition"). Such diligence and good faith on the part of the terminated entity shall include, but not be limited to: (a) working cooperatively with BCBSA to protect the Names and Marks from potential harm; (b) cooperating with BCBSA's use of the Names and Marks in the terminated entity's former service area during the termination and Transition; (c) transmitting, upon the request of an existing Blue account or of BCBSA with consent and on behalf of an existing Blue account, all member and account-data relating to the Federal Employee Program to BCBSA, and all member and account data relating to other programs to an Alternative Control Licensee or Replacement Licensee; (d) working with BCBSA and the Alternative Control or Replacement Licensee with respect to potential new Blue accounts headquartered in the terminated entity's former service area; (e) continuing to service Blue accounts during the Transition; (f) continuing to comply with National Programs, Federal Employee Program and NASCO policies and procedures and all voluntary BCBSA programs, policies and performance standards, such as Away From Home Care, including being responsible for payment of all penalties for non-compliance duly levied in conformity with the License Agreements, Membership Standards, or the Federal Employee Program agreements, that may arise during the Transition; (g) maintaining and providing access to its provider networks, as defined by Federal Employee Program agreements and National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and making those networks and discounts available to members and providers who participate in National Programs and the Federal Employee Program during the Transition; (h) maintaining its technical connections and processing capabilities during the Transition; and (i) working diligently to conclude all financial settlements and account reconciliations as negotiated in the termination transition agreement.

Amended as of November 16, 2006

- (v) Notwithstanding any other provision in this Agreement, BCBSA shall have the right, with the approval of its Board of Directors, to assess additional fines against the terminated entity during the Transition in the event it fails to maintain and provide access to provider networks as defined by Federal Employee Program agreements, National Account Program Policies and Provisions, and Inter-Plans Programs Policies and Provisions, and/or pass on applicable discounts. Such fines shall be in addition to any other assessments, fees or liquidated damages payable herein, or under existing policies and programs and shall be imposed to make whole BCBSA and/or the Plans. Terminated entity shall pay any such fines to BCBSA no later than 30 days after they are approved by the Board of Directors.
- (vi) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third-party auditor to examine and audit the books and records of the terminated entity and its Licensed Controlled Affiliates to verify compliance with the terms and requirements of this paragraph 15(d).
- (vii) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.
- (viii) As to a breach of 15 (d) (i), (ii), (iii), (iv), (vi), or (vii) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 15 (d) (i), (ii), (iv), (vi), or (vii) by the Plan, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

Amended as of November 16, 2006

- (ix) In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Plan and its Licensed Controlled Affiliates shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

(e). BCBSA shall be entitled to enjoin the Plan or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this License Agreement unless the License Agreement has been terminated pursuant to paragraph 10 (d) of this Agreement upon the required six (6) month written notice.

- (f). BCBSA acknowledges that it is not the owner of assets of the Plan.

Amended as of June 16, 2006

16. This Agreement supersedes any and all other agreements between the parties with respect to the subject matter herein, and contains all of the covenants and agreements of the parties as to the licensing of the Licensed Marks and Name. This Agreement may be amended only by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.
17. If any provision or any part of any provision of this Agreement is judicially declared unlawful, each and every other provision, or any part of any provision, shall continue in full force and effect notwithstanding such judicial declaration.
18. No waiver by BCBSA or the Plan of any breach or default in performance on the part of BCBSA or the Plan or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.
- 19a. All notices provided for hereunder shall be in writing and shall be sent in duplicate by regular mail to BCBSA or the Plan at the address currently published for each by BCBSA and shall be marked respectively to the attention of the President and, if any, the General Counsel, of BCBSA or the Plan.

- 19b Except as provided in paragraphs 9(b), 9(d)(iii), 15(a), and 15(b) above, this Agreement may be terminated for a breach only upon at least 30 days' written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Member Plans.
- 19c For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2006
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20. Nothing herein contained shall be construed to constitute the parties hereto as partners or joint venturers, or either as the agent of the other, and Plan shall have no right to bind or obligate BCBSA in any way, nor shall it represent that it has any right to do so. BCBSA shall have no liability to third parties with respect to any aspect of the business, activities, operations, products, or services of the Plan.
21. This Agreement shall be governed, construed and interpreted in accordance with the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By _____

Title _____

Date _____

Plan:

By _____

Title _____

Date _____

BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT
(Includes revisions adopted by Member Plans through their September 18, 2015 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Shield Plan, known as _____ ("Plan" or "Sponsoring Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non-health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the Sponsoring Plan's net subscription revenue.

This grant of rights is non-exclusive and is limited to the Service Area served by the Plan. Subject to Paragraph 3A(3) of this Agreement, Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market, unless such Controlled Affiliate is a not-for-profit company which may use the Licensed Marks and Name, or an approved derivative therefor, to identify itself in debt securities markets. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

Amended as of March 26, 2015

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that the Sponsoring Plan has:

(1) The legal authority directly or indirectly through wholly-owned subsidiaries:

- (a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and
- (c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates;
- (iii) change any of the type(s) of businesses in which it engages;

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- (iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;
- (v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;
- (vi) make any loans or advances except in the ordinary course of business;
- (vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);
- (viii) conduct any business other than under the Licensed Marks and Name;
- (ix) take any action that Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control at least 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

- (2) The legal authority directly or indirectly through wholly-owned subsidiaries;
 - (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:
 - (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; and
 - (c) to exercise control over the policy and operations of the Controlled Affiliate.

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In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate, provided that in instances where the Sponsoring Plan formed a publicly traded Controlled Affiliate Licensee and such publicly traded Controlled Affiliate Licensee owns and controls other Controlled Affiliate Licensees, the Sponsoring Plan directly or indirectly shall own and control more than 50% of any Controlled Affiliate that is indirectly owned and controlled by the publicly traded Controlled Affiliate Licensee.

Or

(3) With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid products and services, the legal authority together with such other Plans:

- (a) to select all members of the Controlled Affiliate's governing body; and
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and
- (c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such control and ownership by Plans must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License attached hereto as Exhibit B.

3. FOR-PROFIT, PUBLICLY TRADED LICENSEES

A. The Controlled Affiliate may operate as a for-profit publicly traded company on the following conditions:

- (1) The Controlled Affiliate shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement.
- (2) The Controlled Affiliate shall provide 90 days advance written notice to BCBSA prior to the initial filing with the SEC.
- (3) The Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Controlled Affiliate in any securities market. The Controlled Affiliate shall use the Licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

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(4) The Controlled Affiliate's license to use the Licensed Marks and Name

shall automatically terminate effective: (a) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Controlled Affiliate ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Noninstitutional Investor, other than a Plan or Plans or Controlled Affiliate licensee or licensees has become the Beneficial Owner of securities representing 5% or more of the voting power of the Controlled Affiliate ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Controlled Affiliate knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner, other than a Plan or Plans or Controlled Affiliate licensee or licensees, of 20% or more of the Controlled Affiliate's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under Paragraph 3A(4) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Controlled Affiliate went public constituted the Board of Directors of the Controlled Affiliate (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Controlled Affiliate went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Controlled Affiliate consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Sponsoring Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Controlled Affiliate in a writing received by BCBSA prior to such automatic termination becoming effective, the provision of this paragraph 3A(4) may be waived, in whole or in part, upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 3A(4)(a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

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In the event that the Controlled Affiliate's license, or any other license, to use the Licensed Marks and Name is terminated pursuant to Paragraph 3A(4), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Controlled Affiliate demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(5) The Controlled Affiliate shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities, or (iii) such other securities as the Controlled Affiliate may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(6) For purposes of paragraph 3(A) above, the following definitions shall apply:

(i) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(ii) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(1) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

(2) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

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(3) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (ii)2(B) above) or disposing of any securities of the Controlled Affiliate.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding", when used with reference to a Person's Beneficial Ownership of securities of the Controlled Affiliate, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(iii) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 1 of SEC Schedule 13G as constituted on June 1, 1997.

(iv) "Noninstitutional Investor" means any Person who is not an Institutional Investor.

(v) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

4. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed

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Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this Agreement, Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name.

5. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

6. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

Amended as of September 19, 2014

7. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to: (i) Controlled Affiliate's rendering of services under the Licensed Marks and Name; or (ii) the activities of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan or Controlled Affiliate.

8. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) the Plan ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement the Plan ceases to be authorized to use the Licensed Names and Marks in the geographic area served by the Controlled Affiliate provided, however, that if the Controlled Affiliate is serving more than one State or portions thereof, the termination of this Agreement shall be limited to the State(s) or portions thereof in which the Plan's license to use the Licensed Marks and Names is terminated. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph

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8(E); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 8(B), 8(C) or 8(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 8(B), 8(C) or 8(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 8(B) and 8(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Controlled Affiliate shall no longer comply with item 2(E) above;
- (2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 10 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or
- (3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of

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the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 8(E)(3)(vii) and (viii) of this Agreement.

(4) The for-profit, publicly traded Controlled Affiliate is terminated pursuant to Paragraph 3A(4) of this Agreement. In which case, the licenses of any controlled Affiliates directly or indirectly owned by the terminated for profit, publicly traded Controlled Affiliate also shall immediately terminate as provided for in paragraph 3A(4) of this Agreement

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

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H. In the event this Agreement terminates pursuant to 8(b) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 8.G. shall not apply and the following provisions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 8(B)(ii) of this Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area.

The Re-Establishment Fee shall be indexed to a base fee of \$80. The Re-Establishment Fee through December 31, 2005 shall be \$80. The Re-Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was \$278.60, \$285.00 and \$290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be \$83.27 (100% of base fee plus \$1.84 for calendar

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year 2005 and \$1.43 for calendar year 2006. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Plan or its other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 8.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 8.M. and any cost associated with reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third party auditor to examine and audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 8.H.

(5) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

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(6) As to a breach of 8.H.(1), (2), (3), (4) or (5) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 8.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. This Agreement shall remain in effect until terminated by the Controlled Affiliate or the Plan upon not less than eighteen (18) months written notice to the Association or upon a shorter notice period approved by BCBSA in writing at its sole discretion, or until terminated as otherwise provided herein. The Plan's right to terminate without cause upon such notice is unfettered and may be exercised in the Plan's sole discretion.

J. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3. and M. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

K. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of the Plan's license agreement upon the required 18 months written notice.

L. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

M. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E) (2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 8(C) and 8(D) above shall require the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

N. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

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9. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

10. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit C.

11. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

12. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

13. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

14. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

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15. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

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16. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

17. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: _____

Date: _____

Plan:

By: _____

Date: _____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: _____

Date: _____

Amended as of March 26, 2015

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS September 2015

PREAMBLE

For purposes of definition:

- A "smaller Controlled Affiliate:" (1) comprises less than fifteen percent (15%) of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers' compensation insurance and has total premium revenue less than 15 percent of the Sponsoring Plan's net subscription revenue.
- A "larger Controlled Affiliate" comprises fifteen percent (15%) or more of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate's status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate's health and workers' compensation administration business reaches or surpasses fifteen percent (15%) of the total member enrollment of the Sponsoring Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

Amended as of September 19, 2014

EXHIBIT A (continued)

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA "Health Risk-Based Capital (HRBC)" as defined by the NAIC and state-established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and
2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers' compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

*For purposes of this calculation, The numerator equals:

Applicant Controlled Affiliate's member enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Sponsoring Plan and all other licensed Controlled Affiliates' member enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

Amended as of September 19, 2014

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

Each licensed controlled affiliate shall be subject to certain standards as determined below:

1. What percent of the licensed controlled affiliate is controlled by the Sponsoring Plan and other Plans?

More than 50% by Sponsoring Plan	50% by Sponsoring Plan	100% Plan control but less than 50% Sponsoring Plan Control and it offers solely Medicaid
↓	↓	↓
Standard 1A, 4	Standard 1B, 4	products and services Standard 1C, 4

IN ADDITION,

2. Is risk being assumed?

Yes			No	
↙	↓	↘	↙	↓
Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates
↓	↓	↓	↓	↓
Standards 7A-7E, 11	Standard 2 (Guidelines 1.1, 1.2) and Standard 11	Standard 6H	Standard 2 (Guidelines 1.1, 1.3) and Standard 11	Standard 6H

IN ADDITION,

3. Is medical care being directly provided?

YES ↓ Standard 3A	NO ↓ Standard 3B
-------------------------	------------------------

IN ADDITION,

4. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total member enrollment of Plan and its licensed Controlled Affiliates?

Yes	No
↓ Standards 6A-6J	<div> <div> ↓ Controlled Affiliate is not a former primary licensee and is not subject to Standard 1(C) Standards 5, 8, 9B, 10, 11 </div> <div> ↓ Controlled Affiliate is a former primary licensee Standards 5, 8, 9A, 10, 11 </div> <div> ↓ Controlled Affiliate is not a former primary licensee and is subject to Standard 1(C) and does not elect to participate in BCBSA National programs Standards 5, 8, 9B, 11 </div> </div>

EXHIBIT A (continued)

Standard 1 - Organization and Governance

1A.)The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA, Sponsoring Plan”), has the legal authority, directly or indirectly through wholly-owned subsidiaries: 1) to select members of the Controlled Affiliate’s governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate.

1B.)The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA, (the “Sponsoring Plan”), has the legal authority, directly or indirectly through wholly-owned subsidiaries:

- 1) to select members of the Controlled Affiliate’s governing body having not less than 50% voting control thereof; and
- 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; and
- 3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan.

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EXHIBIT A (continued)

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

- change the geographic area in which it operates
- change its legal and/or trade names
- change any of the types of businesses in which it engages
- create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- make any loans or advances except in the ordinary course of business
- enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- conduct any business other than under the Licensed Marks and Name
- take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate.

1C.) The Standard for 100% Plan control but less than 50% Sponsoring Plan Control:

A Controlled Affiliate shall be organized and operated in such a manner that (i) it offers solely Medicaid products and services; and (ii) a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA (the "Sponsoring Plan,") has the legal authority together with Other Plans:

Amended September 19, 2014

- 1) to select all members of the Controlled Affiliate's governing body; and
- 2) to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; and
- 3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License.

Amended September 19, 2014

EXHIBIT A (continued)

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk-assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk-assuming Controlled Affiliate ceases operations for any reason, Sponsoring Plan will provide for services to its customers. The requirements of the preceding two sentences shall apply to all lines of business unless a line of business is specially exempted from the requirement(s) by the BCBSA Board of Directors.

Standard 3 - State Licensure/Certification

3A.) The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.) The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Amended as of September 19, 2014

EXHIBIT A (continued)

Standard 5 - Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its Sponsoring licensed Plan shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Other Standards for Larger Controlled Affiliates Standards 6(A) - (I) that follow apply to larger Controlled

Affiliates. Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost-effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Amended as of September 19, 2014

EXHIBIT A (continued)

Such programs are applicable to licensees, and include:

1. BlueCard Program;
2. Inter-Plan Teleprocessing System (ITS);
3. National Account Programs;
4. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
5. Inter-Plan Medicare Advantage Program.

Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter-licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Local and National Best Efforts

Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this License Agreement, during each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Shield Mark.

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Amended as of November 21, 2014

EXHIBIT A (continued)

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

- A) BCBSA Controlled Affiliate Licensure Information Request; and
- B) Biennial trade name and service mark usage material, including disclosure material; and
- C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and
- D) Semi-annual "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

Amended as of November 17, 2011

EXHIBIT A (continued)

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 - Other Standards for Risk-Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) - (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

- A. BCBSA Controlled Affiliate Licensure Information Request; and
- B. Biennial trade name and service mark usage materials, including disclosure materials; and
- C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk-Based Capital Worksheets for Property and Casualty Insurers; and
- D. Quarterly Estimated Risk-Based Capital for Property and Casualty Insurers, Insurance Department Examination Report; and

Amended as of November 17, 2011

EXHIBIT A (continued)

- E. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and
- F. Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended as of November 16, 2000

EXHIBIT A (continued)

Standard 8 - Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

A smaller controlled affiliate that formerly was a Primary Licensee shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of November 21, 2014

EXHIBIT A (continued)

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

C. Reporting requirements include:

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

Amended as of June 13, 2002

Exhibit A (continued)

Standard 9(B) - Participation in National Programs by Smaller Controlled Affiliates

A smaller controlled affiliate shall participate in national programs in accordance with BlueCard and other relevant Policies and Provisions shall effectively and efficiently participate in national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of June 20, 2013

EXHIBIT A (continued)

Standard 10 - Participation in Inter-Plan Medicare Advantage Program

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

A. Inter-Plan Medicare Advantage Program.

Standard 11: Participation in Master Business Associate Agreement by Smaller Controlled Affiliate Licensees

Effective April 14, 2003, all smaller controlled affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of September 19, 2014

EXHIBIT B

**ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES
LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1C.**

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Cross Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association

("Licensor"), _____ ("Controlled Affiliate Licensee")

and _____ ("Sponsoring Plan")

dated the ____ day of _____, ____ ("Agreement"). The parties to this Addendum are Licensor, Controlled Affiliate Licensee, Sponsoring Plan, and the undersigned other Plans ("Other Plans"). This Addendum is made and shall be deemed effective as of the date of the Agreement.

WHEREAS, the Sponsoring Plan asserts that it can serve the Medicaid market in its Service Area more efficiently and with less risk though a Medicaid enterprise jointly owned and controlled with other Plans than through a wholly owned and controlled Medicaid enterprise;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1C. permits the licensing of a Controlled Affiliate that is less than 50% owned and controlled by the Sponsoring Plan but which is 100% owned and controlled by Plans including the Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan and all such other owning and controlling Plans enter into this Addendum.;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. The Sponsoring Plan shall participate operationally in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that participation may take many forms, one of which should be providing a network of providers in the Service Area of the Controlled Affiliate for the Medicaid services being offered under the Agreement and being involved in network development and provider relations.
2. Each of the Other Plans agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it will not take any action, either individually or

3. jointly with any of the Other Plans, that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with any of the Other Plans, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.
4. Each of the Other Plans acknowledges that it has reviewed the Agreement and understands that Sponsoring Plan has the right to terminate the Agreement without cause upon notice as provided in Paragraph 7 of the Agreement, and that such right is unfettered and may be exercised by Sponsoring Plan in its sole discretion.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By: _____

[Controlled Affiliate Licensee]

By: _____

[Sponsoring Plan]

By: _____

[Other Plan 1]

By: _____

[Other Plan 2]

By: _____

Amended as of September 19, 2014

EXHIBIT C

ROYALTY FORMULA FOR SECTION 9 OF THE CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of \$5,000 per license for a Controlled Affiliate subject to Standard 7.

Amended as of September, 19, 2014

EXHIBIT C (continued)

FOR NONRISK PRODUCTS:

For third-party administrative business, an amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For non-third party administrative business (e.g., case management, provider networks, etc.), an amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

- 1) An annual fee of \$5,000 per license for a Controlled Affiliate subject to Standard 6 D.
- 2) An annual fee of \$2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Amended as of September 19, 2014

CONTROLLED AFFILIATE LICENSE AGREEMENT APPLICABLE TO LIFE INSURANCE COMPANIES

(Includes revisions adopted by Member Plans through their September 18, 2015 meeting)

This agreement by and among Blue Cross and Blue Shield Association
("BCBSA") _____ ("Controlled Affiliate"), a
Controlled Affiliate of the Blue Shield Plan(s), known as
_____ ("Plan").

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, the Plan and the Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name");

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Controlled Affiliate the exclusive right to use the licensed Marks and Names in connection with and only in connection with those life insurance and related services authorized by applicable state law, other than health care plans and related services (as defined in the Plan's License Agreements with BCBSA) which services are not separately licensed to Controlled Affiliate by BCBSA, in the Service Area served by the Plan, except that BCBSA reserves the right to use the Licensed Marks and Name in said Service Area, and except to the extent that said Service Area may overlap the area or areas served by one or more other licensed Blue Shield Plans as of the date of this License as to which overlapping areas the rights hereby granted are non-exclusive as to such other Plan or Plans and their respective Licensed Controlled Affiliates only. Controlled Affiliate cannot use the Licensed Marks or Name outside the Service Area or in its legal or trade name; provided, however, that if and only for so long as Controlled Affiliate also holds a Blue Shield Affiliate License Agreement applicable to health care plans and related services, Controlled Affiliate may use the Licensed Marks and Name in its legal and trade name according to the terms of such license agreement.

Amended as of June 12, 2003

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in relation to the sale, marketing and rendering of authorized products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A as it may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having not less than 51% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Plan or Plans shall own at least 51% of any for-profit Controlled Affiliate. If the Controlled Affiliate is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items (a) and (c) above, proxies representing 51% of the votes at any meeting of the policyholders and shall demonstrate that there is no reason to believe this such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

3. SERVICE MARK USE

Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks, and shall comply with such rules (applicable to all Controlled Affiliates licensed to use the Marks) relative to service mark use, as are issued from time-to-time by BCBSA. If there is any public reference to the affiliation between the Plan and the Controlled Affiliate, all of the Controlled Affiliate's licensed services in the Service Area of the Plan shall be rendered under the Licensed Marks. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENTS

Controlled Affiliate shall promptly notify Plan and BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate hereby agrees to save, defend, indemnify and hold Plan and BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Controlled Affiliate's rendering of health care services under the Licensed Marks.

7. LICENSE TERM

The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods upon evidence satisfactory to the Plan and BCBSA that Controlled Affiliate meets the then applicable quality control standards, unless one of the parties hereto notifies the other party of the termination hereof at least sixty (60) days prior to expiration of any license period.

This Agreement may be terminated by the Plan or by BCBSA for cause at any time provided that Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Controlled Affiliate's failure to abide by the quality control provisions of Paragraph 2, above, shall be considered a proper ground for cancellation of this Agreement.

This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

A. Controlled Affiliate shall no longer comply with Standard No. 1 (Organization and Governance) of Exhibit A or, following an opportunity to cure, with the remaining quality control provisions of Exhibit A, as it may be amended from time-to-time; or

B. Plan ceases to be authorized to use the Licensed Marks; or

C. Appropriate dues for Controlled Affiliate pursuant to item 8 hereof, which are the royalties for this License Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks including any use in its trade name.

In the event of any disagreement between Plan and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of the Blue Cross and Blue Shield Association and provide instruction on how the customer can contact the Blue Cross and Blue Shield Association or a designated licensee to obtain further information on securing coverage. The written notification required by this paragraph shall be in writing and in a form approved by the Association. The Association shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. DUES

Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars (\$5,000) per license, plus
 - .05% of gross revenue per year from branded group products, plus
 - .5% of gross revenue per year from branded individual products plus
 - .14% of gross revenue per year from branded individual annuity products.
-

The foregoing percentages shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® license are issued to the same entity. In the event that any License period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Plan will promptly and timely transmit to BCBSA all dues owed by Controlled Affiliate as determined by the above formula and if Plan shall fail to do so, Controlled Affiliate shall pay such dues directly.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

9A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

10. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

Amended as of November 20, 1997

11. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by a writing executed by all parties.

12. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way effect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

13. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

Amended as of June 16, 2005

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: ____

Date: ____

Controlled Affiliate

By: _____

Date: _____

Plan

By: _____

Date: _____

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS LIFE INSURANCE COMPANIES

Page 1 of 2

PREAMBLE

The standards for licensing Life Insurance Companies (Life and Health Insurance companies, as defined by state statute) are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote of all Plans. Each Licensed Plan is required to use a standard controlled affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Life Insurance Company maintains compliance with the license standards.

An organization meeting the following standards shall be eligible for a license to use the Licensed Marks within the service area of its sponsoring Licensed Plan to the extent and the manner authorized under the Controlled Affiliate License applicable to Life Insurance Companies and the principal license to the Plan.

Standard 1 - Organization and Governance

The LIC shall be organized and operated in such a manner that it is controlled by a licensed Plan or Plans which have, directly or indirectly: 1) not less than 51% of the voting control of the LIC; and 2) the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the LIC with which it does not concur; and 3) operational control of the LIC.

If the LIC is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items 1 and 2 above, proxies representing at least 51% of the votes at any policyholder meeting and shall demonstrate that there is no reason to believe such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

Standard 2 - State Licensure

The LIC must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life and health insurance company in each state in which the LIC does business.

Standard 3 - Records and Examination

The LIC and its sponsoring licensed Plan(s) shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the LIC as may be required in order to establish compliance with the license agreement.

EXHIBIT A

**CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES**

Page 2 of 2

LIC and its sponsoring licensed Plan(s) shall permit BCBSA to examine the affairs of the LIC and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the sponsoring Plan(s).

Standard 4 - Mediation

The LIC and its sponsoring Plan(s) shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed controlled affiliate, a licensed Plan or BCBSA.

Standard 5 - Financial Responsibility

The LIC shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with Affiliate License Performance Response Process Protocol

The LIC and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing LIC compliance problems identified thereunder.

**CONTROLLED AFFILIATE
TRADEMARK LICENSE AGREEMENT
FOR LIFE AND DISABILITY INSURANCE PRODUCTS**

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____, ("Life and Disability Controlled Affiliate") which is a company offering life and disability insurance products owned and controlled by _____, _____, _____ (individually, "Sponsoring Plan" and when referred to collectively, "Sponsoring Plans").

Whereas, BCBSA is the owner of the BLUE CROSS and BLUE SHIELD word and design service marks and any derivatives thereof ("Licensed Marks");

Whereas, each Sponsoring Plan is licensed separately by BCBSA to use one or more of the Licensed Marks in a particular Service Area;

Whereas, the Sponsoring Plans and the Life and Disability Controlled Affiliate desire that the latter be entitled to use the appropriate Licensed Marks in connection with life and disability insurance products in some or all of such Sponsoring Plans' Service Areas and in the Service Areas of other Regular Member Plans, as defined in the BCBSA By-laws, ("Blue Plans") consistent with the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

A. Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Life and Disability Controlled Affiliate the limited right to use the Licensed Marks in connection with and only in connection with the following life and disability insurance products authorized by state law: (1) Group: Term Life, Long Term Disability, Whole Life, Benefit Life, Universal Life; (2) Individual: Term Life, Whole Life, Dependent Life, Spouse Life; (3) Other: Disability Income, Short Term Disability, Long Term Disability, Income Replacement; and (4) such other life and disability products approved by BCBSA in writing ("Licensed Products") in the Service Areas served by the Sponsoring Plans or in the Service Area or Areas of one or more other licensed Blue Plans, provided that such Blue Plans have consented to such use as authorized by this Agreement. Life and Disability Controlled Affiliate may not use the Licensed Marks in its legal or trade name.

B. Notwithstanding that the license granted to Life and Disability Controlled Affiliate is a license to use all of the Licensed Marks, Life and Disability Controlled Affiliate may only use those of the Licensed Marks in the Service Area of a Sponsoring Plan or other consenting Blue Plan as described below that such Plan is authorized to use as a Blue Plan pursuant to its separate license agreements with BCBSA.

C. Life and Disability Controlled Affiliate may use the Licensed Marks in the Service Areas of Sponsoring Plans or in the Service Area of a Blue Plan that is not a signatory to this Agreement only after such Sponsoring Plan(s) or non-signatory Blue Plan consents to such use by executing a written consent in substantially the same form as the Consent Agreement attached as Exhibit B.

D. The following provisions apply with respect to Consent Agreements once such agreements have been fully and properly executed:

(1) All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in the Service Area of Sponsoring Plan or consenting Blue Plan (hereinafter, such consenting Sponsoring Plan or consenting Blue Plan collectively referred to "Consenting Plan(s)") must clearly identify the Consenting Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");

(2) To the extent the Consenting Plan has separate divisions or other Affiliates that use the Licensed Marks in distinct geographic areas within its Service Area, consent obtained under this Agreement may be limited to one or more of such specific geographic areas as specified by the Consenting Plan in its signed Consent Agreement. For purposes of this entire Agreement, all references to the Service Area of a Sponsoring Plan, Blue Plan or Consenting Plan may include the entire Service Area or a distinct geographic area within such Service Area as specified in this Section 1 D (2);

(3) Where BCBSA has licensed two or more Blue Plans to use the same Licensed Marks in the same Service Area, in addition to the requirements set forth in Section D (1) above, the sales, marketing and advertising materials referenced in such section above must be communicated to the Consenting Plan's existing and prospective accounts through or with the approval of such Consenting Plan, and the personnel of such Consenting Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the Consenting Plan;

(4) Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the Consenting Plan has been granted by BCBSA the license to use under its Blue Plan license agreements (for example, if a Consenting Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

(5) If a Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless BCBSA and the Consenting Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

2. QUALITY CONTROL

A. Life and Disability Controlled Affiliate agrees to use the Licensed Marks only in relation to the sale, marketing and administration of the Licensed Products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A and the Guidelines to Administer the Standards for Trademark License Agreement for Life and Disability Insurance Products attached thereto.

B. Life and Disability Controlled Affiliate agrees that BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Life and Disability Controlled Affiliate's rendering of service and use of the Licensed Marks.

C. Life and Disability Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by BCBSA) a report to BCBSA demonstrating Life and Disability Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Life and Disability Controlled Affiliate is defined as: An entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance

thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

3. SERVICE MARK USE

Life and Disability Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and shall ensure all uses of the Licensed Marks comply with the BCBSA Brand Regulations, as amended by BCBSA from time to time. Life and Disability Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Life and Disability Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

The license hereby granted to Life and Disability Controlled Affiliate to use the Licensed Marks is and shall be personal to Life and Disability Controlled Affiliate and shall not be assignable by any act of the Life and Disability Controlled Affiliate, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Life and Disability Controlled Affiliate mortgage or part with possession or control of this license or any right hereunder, and the Life and Disability Controlled Affiliate shall have no right to grant any sublicense to use the Licensed Marks.

5. INFRINGEMENTS

Life and Disability Controlled Affiliate shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Life and Disability Controlled Affiliate shall not be entitled to require BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Life and Disability Controlled Affiliate agrees to render to BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA. BCBSA shall have sole control of the defense and resolution of any claim of infringement brought or threatened by others.

6. LIABILITY INDEMNIFICATION

Life and Disability Controlled Affiliate hereby agrees to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Life and Disability Controlled Affiliate's conduct.

7. LICENSE TERM

A. The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods, unless either BCBSA or Life and Disability Controlled Affiliate notifies the other party in writing of the termination hereof at least sixty (60) days prior to expiration of any license period.

B. This Agreement may be terminated by BCBSA for cause at any time provided that Life and Disability Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Life and Disability Controlled Affiliate's failure to abide by the conditions regarding use of the Licensed Marks set forth in Section 1 of this Agreement or the quality control provisions of Section 2 (other than with respect to Section 2 D which is subject to immediate termination as stated in Section 7 C (1) below) shall be considered proper grounds for termination of this Agreement.

C. This Agreement and all of Life and Disability Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Life and Disability Controlled Affiliate shall no longer comply with Section 2 D (or Standard No. 1 (Organization and Governance) of Exhibit A); or
- (2) Any Sponsoring Plan ceases to be authorized to use the Licensed Marks; or
- (3) Appropriate fees for Life and Disability Controlled Affiliate pursuant to Section 8 of this Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Life and Disability Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks.

In the event of any disagreement between Life and Disability Controlled Affiliate and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Life and Disability Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. ROYALTIES

Life and Disability Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars (\$5,000) per license, plus
- .05% of gross revenue per year from group products sold under the Licensed Marks, plus
- .5% of gross revenue per year from individual products sold under the Licensed Marks

In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Life and Disability Controlled Affiliate will promptly and timely transmit to BCBSA all fees owed by Life and Disability Controlled Affiliate as determined by the above formula.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between any Sponsoring Plan and Life and Disability Controlled Affiliate or between among them and/or BCBSA.

10. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the

Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by: (a) a writing signed by all parties; or (b) a writing approved by the affirmative vote of three-fourths of the Blue Plans and three-fourths of the total then current weighted vote of all the Blue Plans as officially recorded by the BCBSA Corporate Secretary. Upon such adoption by the Blue Plans, this Agreement and all other Trademark License Agreements for Life and Disability Insurance Products then in effect shall simultaneously be amended.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Life and Disability Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: __

Date: __

Life and Disability Controlled Affiliate:

By: __

Date: __

Sponsoring Plan:

By: __

Date: __

Name: __

Sponsoring Plan:

By: __

Date: __

Name: __

[Add other Sponsoring Plans as necessary]

EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS Page 1 of 2

Standard 1 - Organization and Governance

Any Life and Disability Controlled Affiliate licensed under the Trademark License Agreement for Life and Disability Insurance Products ("licensee") shall be organized and operated in such a manner that it is an entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

Standard 2 - State Licensure

The licensee must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life company in each state in which the licensee does business.

Standard 3 - Records and Examination

The licensee shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the licensee as may be required in order to establish compliance with the Agreement. The licensee shall permit BCBSA to examine the affairs of the licensee and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the Sponsoring Plan(s).

Standard 4 - Mediation

The licensee, its Sponsoring Plan(s) and all consenting Blue Plans shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed Life and Disability Controlled Affiliate, a Sponsoring Plan and or consenting Blue Plan or BCBSA.

EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS Page 2 of 2

Standard 5 - Financial Responsibility

The licensee shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with BCBSA Governance

The licensee shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of and in addressing licensee compliance problems that may be identified in connection with the operation or administration of the Trademark License Agreement for Life and Disability Insurance Products.

EXHIBIT B

CONSENT AGREEMENT

This Consent Agreement is made and entered into by and among the undersigned Blue Plan, and _____ (“Life and Disability Controlled Affiliate”), and the Blue Cross and Blue Shield Association (“BCBSA”) and shall be deemed effective on _____ (“Effective Date”).

Whereas, BCBSA owns the Blue Cross and Blue Shield word and design service marks and any derivative mark thereof (the “Brands”);

Whereas, the undersigned Blue Plan is licensed to use one or more of the Brands within a specific geographic area (“Service Area”);

Whereas Life and Disability Controlled Affiliate is licensed by BCBSA to use one or more of the Brands to offer life and disability insurance products (“Products”) as defined and authorized in the Trademark License Agreement for Life and Disability Insurance Products (“Life and Disability License Agreement”);

Whereas neither the Blue Plan nor its affiliates offer the Products under any of the Brands in such Blue Plan’s Service Area or portion thereof where Blue Plan has consented to sale of the Products by Life and Disability Controlled Affiliate; and

Whereas BCBSA and the undersigned Blue Plan desire to consent to Life and Disability Controlled Affiliate’s use of the Brands in Blue Plan’s Service Area consistent with the terms of the Life and Disability License Agreement and this Consent Agreement.

Now, therefore, in consideration of the obligations and conditions stated in this Agreement, Blue Plan, Life and Disability Controlled Affiliate and BCBSA agree as follows:

1. Life and Disability Controlled Affiliate may market, sell, administer and underwrite the Products in Blue Plan’s Service Area under the Brands licensed to Blue Plan in such Service Area subject to the terms of this Consent Agreement, the Life and Disability License Agreement and Blue Plan’s license agreement(s) with BCBSA. Life and Disability Controlled Affiliate’s rights under the Brands to offer the Products under the Brands are limited to offering the Products only under the Brand(s) licensed to the consenting Blue Plan.
2. Life and Disability Controlled Affiliate shall work with the undersigned Blue Plan to develop a written sales and marketing agreement that identifies the relationship between it and Blue Plan for the sales,

marketing and customer service for the Products. The term of the sales and marketing agreement shall be the same as the term of this Consent Agreement.

3. All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in a consenting Blue Plan's Service Area must clearly identify the consenting Blue Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");
 4. Life and Disability Controlled Affiliate may use the Brands to sell the Products in the following Service Area or portion thereof as designated by Blue Plan:

 5. If two or more Blue Plans to use the same Licensed Marks in the same Service Area, Life and Disability Controlled Affiliate shall work with the consenting Blue Plan in the following manner: (a) the sales, marketing and advertising materials must be communicated to the consenting Blue Plan's existing and prospective accounts through or with the approval of such Blue Plan, and (b) the personnel of such Blue Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the consenting Blue Plan;
 6. Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the consenting Blue Plan has been granted by BCBSA the license to use under its license agreement (for example, if a consenting Blue Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).
 7. If this Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless each BCBSA and the Blue Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.
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8. The term of this Consent Agreement shall be one year from the Effective Date. Unless either Blue Plan or Life and Disability Controlled Affiliate provides the other party with written notice of its desire not to renew this Consent Agreement at least 60 days prior to expiration of the term or any extended term or unless terminated as provided in Paragraph 9 below, this Consent Agreement shall automatically renew for subsequent one year periods.
9. This Consent Agreement may be terminated as follows:
- A. Upon mutual written consent of Life and Disability Controlled Affiliate and Blue Plan;
 - B. By Blue Plan or Life and Disability Controlled Affiliate upon 60 days advance written notice to the non-terminating party and BCBSA; or
 - C. By Blue Plan immediately if Life and Disability Controlled Affiliate does not comply with this Consent Agreement or the sales protocol agreement.
10. This Consent Agreement shall automatically terminate if Blue Plan's primary licensee agreement terminates for any reason or if the Life and Disability License Agreement terminates for any reason.

Agreed and Accepted by:

[Blue Plan]:

By: _____

Title: _____

BLUE CROSS AND BLUE SHIELD ASSOCIATION:

By: _____

Title: _____

LIFE AND DISABILITY CONTROLLED AFFILIATE:

By: _____

Title: _____

Exhibit 1B

BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS
(Adopted by Member Plans at their September 18, 2015)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Advantage PPO products in geographic regions designated by CMS (hereafter "regional MAPPO products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name") to offer regional MAPPO products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional MAPPO products and related services.

This grant of rights is non-exclusive and is limited to the following states:

_____ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

- A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.
- B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.
- C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.
- D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.
- E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:
- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
 - (2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
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(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

- (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
- (c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional MAPPO products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Shield License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking

appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Controlled Affiliate shall no longer comply with item 2(E) above;
 - (2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or
 - (3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or
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proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall

have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x) (ii) of the Blue Shield License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to \$25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the

foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other

Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the

Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: _____

Date: _____

Controlling Plan:

By: __

Date: __

Controlling Plan:

By: __

Date: __

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: __

Date: __

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS September 2015

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Advantage PPO Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
 - (2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
 - (3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:
 - (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
 - (b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
 - (c) exercise control over the policy and operations of the Controlled Affiliate; and
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EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

- a. the structure of the Blue Cross and Blue Shield System; and
- b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Shield Marks.

Standard 7 - Participation in Certain National Programs

A Controlled Affiliate shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area.

National program requirements include:

- a. Inter-Plan Teleprocessing System (ITS); and
- b. Inter-Plan Medicare Advantage Program.

Standard 8 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of November 15, 2007

EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional MAPPO products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

Exhibit 1C

**BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN
PRODUCTS**

(Adopted by Member Plans at their September 18, 2015 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Part D Prescription Drug Plan products in geographic regions designated by CMS (hereafter "regional PDP products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name") to offer regional PDP products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional PDP products and related services.

This grant of rights is non-exclusive and is limited to the following states:

_____ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

- A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.
- B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.
- C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.
- D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.
- E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:
- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
 - (2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
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- (3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

- (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
- (c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional PDP products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Shield License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to

complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Controlled Affiliate shall no longer comply with item 2(E) above;
 - (2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or
 - (3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim
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trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Shield License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to \$25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license

termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: __

Date: __

Controlling Plan:

By: __

Date: __

Controlling Plan:

By: __

Date: __

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: __

Date: __

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS September 2015

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Part D Prescription Drug Plan Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
 - (2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
 - (3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:
 - (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
 - (b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
 - (c) exercise control over the policy and operations of the Controlled Affiliate; and
-

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

- a. the structure of the Blue Cross and Blue Shield System; and
- b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Shield Marks.

Standard 7 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional PDP products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

EXHIBIT 2

Membership Standards Page 1 of 5

Preamble

The Membership Standards apply to all organizations seeking to become or to continue as Regular Members of the Blue Cross and Blue Shield Association. Any organization seeking to become a Regular Member must be found to be in substantial compliance with all Membership Standards at the time membership is granted and the organization must be found to be in substantial compliance with all Membership Standards for a period of two (2) years preceding the date of its application. If Membership is sought by an entity which controls or is controlled by one or more Plans, such compliance shall be determined on the basis of compliance by such Plan or Plans.

The Regular Member Plans shall have authority to interpret these Standards.

A Regular Member Plan that operates as a "Shell Holding Company" is defined as an entity that assumes no underwriting risk and has less than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) and less than 5% of the consolidated enterprise net general and administrative expenses.

A Regular Member Plan that operates as a "Hybrid Holding Company" is defined as an entity that assumes no underwriting risk and has either more than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) or more than 5% of the consolidated enterprise net general and administrative expenses.

Standard 1: A Plan shall maintain a governing Board, which shall control the

Plan and ensure that the Plan follows appropriate practices of corporate governance. A Plan's Board shall not be controlled by any special interest group, shall make an annual determination that a majority of its directors are independent, and shall act in the best interest of its Corporation and its customers. The Board shall be composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Amended as of March 15, 2007

EXHIBIT 2

Membership Standards

Page 2 of 5

- Standard 2: A Plan shall furnish to the Association on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between the Association and the Plans. Such reports and records are the following:
- A. BCBSA Membership Information Request;
 - B. Biennial trade name and service mark usage material, including disclosure material under Standard 7;
 - C. Changes in the governance of the Plan, including changes in a Plan's Charter, Articles of Incorporation, or Bylaws, changes in a Plan's Board composition, or changes in the identity of the Plan's Principal Officers;
 - D. Quarterly Financial Report, Semi-annual "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC, Annual Budget, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), Plan, Subsidiary and Affiliate Report; and
 - Plans that are a Shell Holding Company as defined in the Preamble hereto are required to furnish only a calendar year-end "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC.

Amended as of November 17, 2011

EXHIBIT 2

Membership Standards Page 3 of 5

E. Quarterly Enrollment Report, Quarterly Member Touchpoint Measures Index (MTM) through 12/31/2011, and Semiannual MTM Index starting 1/1/2012 and thereafter.

- For purposes of MTM reporting only, a Plan shall file a separate MTM report for each Geographic Market.

Standard 3: A Plan shall be operated in a manner that provides reasonable financial assurance that it can fulfill its contractual obligations to its customers.

Standard 4: A Plan shall be operated in a manner responsive to customer needs and requirements.

Standard 5: A Plan shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the Plans and ease of claims processing for customers receiving benefits outside of the Plan's Service Area.

Such programs are applicable to Blue Cross and Blue Shield Plans, and include:

- A. Inter-Plan Teleprocessing System (ITS);
- B. BlueCard Program;
- C. National Account Programs;
- D. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
- E. Inter-Plan Medicare Advantage Program.

Amended as of November 21, 2014

EXHIBIT 2

Membership Standards Page 4 of 5

- Standard 6: In addition to requirements under the national programs listed in Standard 5: Participation in National Programs, a Plan shall take such action as required to ensure its financial performance in programs and contracts of an inter-Plan nature or where the Association is a party.
- Standard 7: A Plan shall make adequate disclosure in contracting with third parties and in disseminating public statements of (i) the structure of the Blue Cross and Blue Shield System, (ii) the independent nature of every Plan, and (iii) the Plan's financial condition.
- Standard 8: A Plan shall cooperate with the Association's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Plan performance problems identified thereunder.
- Standard 9: A Plan shall obtain a rating of its financial strength from an independent rating agency approved by the Association's Board of Directors for such purpose.
- Standard 10: Notwithstanding any other provision in this License Agreement, during each year, a Plan and its Controlled Affiliate(s) engaged in providing licensable services (excluding Life Insurance and Charitable Foundation Services) shall use their best efforts to promote and build the value of the Blue Shield Marks.
- Standard 11: Neither a Plan nor any Larger Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Plan or Larger Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.
- Amended as of June 16, 2005**
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EXHIBIT 2

Membership Standards Page 5 of 5

Standard 12: No provider network, or portion thereof, shall be rented or otherwise made available to a National Competitor if the Licensed Marks or Names are used in any way with such network.

A provider network may be rented or otherwise made available, provided there is no use of the Licensed Marks or Names with respect to the network being rented.

Standard 13: Each Plan shall operate in a manner to reasonably: 1) protect the security and confidentiality of Personally Identifiable Information (PII) and Protected Health Information (PHI); 2) protect the Brands from reputational damage; and 3) cooperate with BCBSA and other Plans if a data security incident or data breach occurs.

Amended as of June 18, 2015

EXHIBIT 3

GUIDELINES WITH RESPECT TO USE OF LICENSED NAME AND MARKS IN CONNECTION WITH NATIONAL ACCOUNTS

Page 1 of 3

1. The strength of the Blue Cross/Blue Shield National Accounts mechanism, and the continued provision of cost effective, quality health care benefits to National Accounts, are predicated on locally managed provider networks coordinated on a national scale in a manner consistent with effective service to National Account customers and consistent with the preservation of the integrity of the Blue Cross/Blue Shield system and the Licensed Marks. These guidelines shall be interpreted in keeping with such ends.
2. A National Account is an entity with employee and/or retiree locations in more than one Plan's Service Area. Unless otherwise agreed, a National Account is deemed located in the Service Area in which the corporate headquarters of the National Account is located. A local plant, office or division headquarters of an entity may be deemed a separate National Account when that local plant, office or division headquarters 1) has employee locations in more than one Service Area, and 2) has independent health benefit decision-making authority for the employees working at such local plant, office or division headquarters and for employees working at other locations outside the Service Area. In such a case, the local plant, office or division headquarters is a National Account that is deemed located in the Service Area in which such local plant, office or division headquarters is located. The Control Plan of a National Account is the Plan in whose Service Area the National Account is located. A participating ("Par") Plan is a Plan in whose Service Area the National Account has employee and/or retiree locations, but in which the National Account is not located. In the event that a National Account parent company consolidates health benefit-decision making for itself and its wholly-owned subsidiary companies, the parent company and the subsidiary companies shall be considered one National Account. The Control Plan for such a National Account shall be the Plan in whose Service Area the parent company headquarters is located.
3. The National Account Guidelines enunciated herein below shall be applicable only with respect to the business of new National Accounts acquired after January 1, 1991.
4. Control Plans shall utilize National Account identification cards complying with then currently effective BCBSA graphic standards in connection with all National Accounts business to facilitate administration thereof, to minimize subscriber and provider confusion, and to reflect a commitment to cooperation among Plans.

Amended as of June 12, 2003

Exhibit 3 Page 2 of 3

5. Disputes among Plans and/or BCBSA as to the interpretation or implementation of these Guidelines or as to other National Accounts issues shall be submitted to mediation and mandatory dispute resolution as provided in the License Agreement. For two years from the effective date of the License Agreement, however, such disputes shall be subject to mediation only, with the results of such mediation to be collected and reported in order to establish more definitive operating parameters for National Accounts business and to serve as ground rules for future binding dispute resolution.

6. The Control Plan may use the BlueCard Program (as defined by IPPC) to deliver benefits to employees and non-Medicare eligible retirees in a Participating Plan's service area if an alternative arrangement with the Participating Plan cannot be negotiated. The Participating Plan's minimum servicing requirement for those employees and non-Medicare retirees in its service area is to deliver benefits using the BlueCard Program. Account delivery is subject to the policies, provisions and procedures of the BlueCard Program.

7. For provider payments in a Participating Plan's area (on non-BlueCard claims), payment to the provider may be made by the Participating Plan or the Control Plan at the Participating Plan's option. If the Participating Plan elects to pay the provider, it may not withhold payment of a claim verified by the Control Plan or its designated processor, and payment must be in conformity with service criteria established by the Board of Directors of BCBSA (or an authorized committee thereof) to assure prompt payment, good service and minimum confusion with providers and subscribers. The Control Plan, at the Participating Plan's request, will also assure that measures are taken to protect the confidentiality of the data pertaining to provider reimbursement levels and profiles.

Amended as of June 14, 1996

Exhibit 3 Page 3 of 3

8. The Control Plan, in its financial agreements with a National Account, is expected to reasonably reflect the aggregate amount of differentials passed along to the Control Plan by all Participating Plans in a National Account.

9. Other than in contracting with health care providers or soliciting such contracts in areas contiguous to a Plan's Service Area in order to serve its subscribers or those of its licensed Controlled Affiliate residing or working in its Service Area, a Control Plan may not use the Licensed Marks and/or Name, as a tag line or otherwise, to negotiate directly with providers outside its Service Area.

Amended as of March 13, 2003

EXHIBIT 4

GOVERNMENT PROGRAMS AND CERTAIN OTHER USES

Page 1 of 14

1. A Plan and its licensed Controlled Affiliate may use the Licensed Marks and Name in bidding on and executing a contract to serve a Government Program, and in thereafter communicating with the Government concerning the Program. With respect, however, to such contracts entered into after the 1st day of January, 1991, the Licensed Marks and Name will not be used in communications or transactions with beneficiaries or providers in the Government Program located outside a Plan's Service Area, unless the Plan can demonstrate to the satisfaction of BCBSA's governing body that such a restriction on use of the Licensed Marks and Name will jeopardize its ability to procure the contract for the Government Program. As to both existing and future contracts for Government Programs, Plans will discontinue use of the Licensed Marks and Name as to beneficiaries and Providers outside their Service Area as expeditiously as circumstances reasonably permit. Effective January 1, 1995, except as provided in the first sentence above, all use by a Plan of the Licensed Marks and Name in Government Programs outside of the Plan's Service Area shall be discontinued. Incidental communications outside a Plan's Service Area with resident or former resident beneficiaries of the Plan, and other categories of necessary incidental communications approved by BCBSA, are not prohibited. For purposes of this Paragraph 1, the term "Government Programs" shall mean Medicare Part A, Medicare Part B and other non-risk government programs.

2. In connection with activity otherwise in furtherance of the License Agreement, a Plan and its Controlled Affiliates that are licensed to use the Licensed Marks and Name in its Service Area pursuant to the Controlled Affiliate License Agreements authorized in clauses a) through c) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Plan's Service Area in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

2.1 Common Business Communications

- a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);
- b. distributing business cards other than in marketing and selling;
- c. advertising in publications or electronic media solely to persons for employment;

Amended as of June 19, 2014

EXHIBIT 4 Page 2 of 14

2.2 Marketing Spillover

- a. advertising in print, electronic or other media which serve, as a substantial market, the Service Area of the Plan or licensed Controlled Affiliate, provided that no Plan or Controlled Affiliate may advertise outside its Service Area on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Service Area;
- b. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Plan's Service Area or that of a licensed Controlled Affiliate;

2.3 Provider Contracting

- a. contracting with health care providers or soliciting such contracts in areas contiguous to the Plan's Service Area in order to serve its subscribers or those of such licensed Controlled Affiliates residing or working in its service area;
- b. issuing a small sign containing the legal name or trade name of the Plan or such licensed Controlled Affiliates for display by a provider to identify the latter as a participating provider of the Plan or Controlled Affiliate;
- c. negotiating rates with a health care provider for services to a specific member, provided that all of the following conditions are met:
 - (1) the health care provider does not have a contract, applicable to the services rendered or to be rendered, with the Licensee (or any of the Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located; and
 - (2) the Plan or Controlled Affiliate reasonably determines that the member did/does not have a reasonable opportunity to access a participating provider whose contract applies to the services rendered or to be rendered; and
 - (3) at least one of the following circumstances exists:

Amended as of June 19, 2014

EXHIBIT 4

Page 3 of 14

- (i) the member received emergency services and the Plan or Controlled Affiliate knows or reasonably anticipates that the charges on the claim will meet or exceed \$5,000; or
 - (ii) a provider, in consultation pre- or post- treatment with the Plan or Controlled Affiliate, makes/made a treatment recommendation or referral to a non-par provider or to a par provider whose contract does not apply to the services to be rendered; or
 - (iii) the member inadvertently accessed a non-par provider or non-contracted services in the course of receiving services from a par provider (e.g., the member sees a non-par consulting specialist in a participating hospital); and
- (4) the Licensee (and in the case of overlapping Service Areas, all of the Licensees) in whose Service Area the health care provider is located consent(s) in advance.
- d. contracting with a pharmacy management organization (“Pharmacy Intermediary”) to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan’s or licensed Controlled Affiliate’s members nationwide, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;

Amended as of June 19, 2014

EXHIBIT 4

Page 4 of 14

- e. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided that (1) the Plan and the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Plan's Service Area, and (2) neither the Plan's or the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Plan's Service Area;
 - f. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;
 - g. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;
 - h. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Plan's Service Area;
 - i. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Plan's Service Area;
 - j. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Plan's Service Area;
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EXHIBIT 4 Page 5 of 14

- k. contracting with a company that operates provider sites in the Plan's Service Area, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Plan's Service Area;
- l. contracting with a company that makes health care professionals available in the Plan's Service Area (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Plan's Service Area.

2.4 Services to National Accounts

- a. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee (as those terms are defined in the Inter-Plan Programs Policies and Provisions ("IP Policies")) to offer Blue-branded Health Coverage to the National Account, offering Blue-branded Health and Wellness Programs to all members of the National Account, including members who have not enrolled in the Blue-branded Health Coverage ("non-Blue Health Coverage members"), provided that:
 - (i) the Plan and/or Licensed Controlled Affiliate has no contact or interaction with providers outside of the Plan's Service Area, except as specifically provided in the IP Policies and in 2.4(b); and
 - (ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not offer Blue-branded Health and Wellness Programs to any employees working at such local plant, office or division without the consent of such other Licensee; and
 - (iii) if the Plan and/or licensed Controlled Affiliate provides an information card to the non-Blue Health Coverage members, the card may not display the Symbols in the masthead, must contain a prominent disclosure conveying that it is not a health insurance card, and otherwise must be designed so that it is dissimilar to a Blue member identification card.

Amended as of March 26, 2015

EXHIBIT 4 Page 6 of 14

For purposes of this subparagraph a, the following definitions apply:

“Health and Wellness Program” shall mean a program that includes at least one of the following elements or a related element:

- Health Risk Assessment and/or Preventive Screenings
- Exercise and Fitness Programs
- Health and Wellness Events (e.g., attendance at a health fair, a 5K walk)
- Nutrition and Weight Management
- Health Education (e.g., smoking cessation classes)
- Prenatal and Parenting Education
- Disease or Chronic Condition Management

The above listing is intended to represent examples of the types of programs that may be offered, and other programs, including those offered through different media such as the internet or telephonically, may also be deemed Health and Wellness programs.

“Health Coverage” shall mean providing or administering medical, surgical, hospital, major medical, or catastrophic coverage, or any HMO, PPO, POS or other managed care plan for the foregoing services.

2.4 Services to National Accounts (continued)

- b. as part of a Health and Wellness Program that is otherwise compliant with Brand Regulation 4.11.4(a), contracting with a health and wellness organization to gain access to providers to deliver a discrete health and wellness event (“Event”) held at a National Account’s worksite outside of the Licensee’s Service Area, provided that:
 - (i) the services delivered at the Event are limited to fingerstick screenings for cholesterol and glucose, seasonal flu immunizations, blood pressure measurements, body mass index measurements, and other routine screenings, immunizations and measurements; and
 - (ii) neither such services nor their costs are applied as claims against any benefit plan; and
 - (iii) the Event is presented during one or more limited periods during a benefit year and is available to all employees at the worksite.

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- c. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee to offer Blue-branded Health Coverage to the National Account, performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by the National Account to its members, including benefit plans that are not underwritten or administered by the Plan, provided that:
- (i) in performing such functions, the Plan and/or licensed Controlled Affiliate does not use the Brands in any communications with health care providers outside of the Plan's Service Area, and otherwise limits its use of the Brands outside of the Service Area to communications with the account's members, the other benefit plan providers with which the account has contracted and other reasonably necessary communications to perform such functions; and
 - (ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not perform Eligibility and Enrollment functions for employees working at such local plant, office or division without the consent of such other Licensee;

For purposes of this subparagraph b, the following definitions apply: "Health Coverage" has the meaning set forth in subparagraph

2.4.a.

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“Eligibility” means services that manage the account’s eligibility data and determine or process determinations relating to eligibility for benefit plans offered by the account to its employees, including such services as:

- monitoring and auditing data to ensure that only entitled individuals are enrolled in each such benefit plan;
- review of eligibility documentation (e.g. marriage licenses, birth certificates, student status verification letters, employment records);
- identification of key member segments such as over-age dependents, part-time employees, employees reaching certain milestones (e.g. Medicare-eligible, retirees);
- termination of coverage for those individuals found to be ineligible for coverage under a benefit plan, and, if applicable, generation of a COBRA event; and
- management of “hour-banking” for union environments in which union members can bank hours to remain eligible for benefits.

“Enrollment” means services that enroll eligible individuals and their spouses/dependents or terminate or change their enrollment in the account’s benefit plans on an ongoing basis and during open enrollment periods, including such services as:

- the coordination of each step in open enrollment process from project planning and system set-up to the generation of confirmation statements;
- ongoing enrollment support for new hires and changes due to life events and work status adjustments;
- evidence of insurability (EOI) administration for life and disability coverage;
- transmission of eligibility/enrollment information to the account’s benefit plan providers;
- review and reconciliation of error reports received from the account’s benefit plan providers; and
- transmission of information to the account’s payroll system (e.g., benefit deductions, employee demographic data).

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2.5 Knowledge Sharing

- a. submitting scholarly articles authored or co-authored by the Plan or Controlled Affiliate or its respective employees for publication in peer-reviewed journals;
- b. permitting an internal representative of the Licensee (e.g., officer, employee) to speak or present at a conference or symposium outside of the Licensee's Service Area regarding either (i) healthcare financing, administration, delivery or policy, or (ii) topics within the representative's functional discipline or expertise at the Licensee, for which the event sponsor will issue communications to promote, administer, and/or recap the event that will identify the Licensee's representative as a participant. The communications outside of the Licensee's Service Area that mention the Licensee's representative shall be limited to materials and digital media provided to attendees, on-site signage, advertising in relevant trade publications, direct mail and email to attendees and prospective attendees, and the sponsor's website, Participation in any conference or symposium outside of the Licensee's Service Area may not be for the purpose of marketing or selling products or services.

If the Licensee's representative wishes to use the Brands in any manner, including use in his/her title, when participating as a speaker or presenter outside of the Licensee's Service Area about a topic that is not related to healthcare financing, administration, delivery, or policy, or to topics within the representative's functional discipline or expertise at the Licensee, the Licensee must notify BCBSA and receive prior approval from BCBSA before participating.

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2.6 Other Uses

- a. entering into a license agreement between and among BCBSA, the Plan and a debit card issuer located outside the Plan's Service Area, and entering into a corresponding operating agreement or agreements, in order to offer a debit card bearing the Licensed Marks and Name to eligible persons as defined by the aforementioned license agreement;
- b. appearing in communications issued by an independent third party to recognize outstanding performance of the Plan or Controlled Affiliate or a member of the Plan's or Controlled Affiliate's senior management as part of an established program of the third party for which the Plan has provided information to be considered for the recognition, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;
- c. to identify itself as being a joint sponsor of an event, program or activity along with other Plans or such Plans' licensed Controlled Affiliates, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;
- d. hosting meetings or events (collectively, "events") in Washington, D.C. related to policy and business issues in the Licensee's Service Area, or hosting events in conjunction with the assemblies or conventions of national political parties. Such events may not involve marketing or selling products or services. Use of the Brands outside the Licensee's Service Area in connection with such events shall be limited to materials and digital media provided to attendees and prospective attendees and onsite signage. For any such events in Washington, D.C. that are open to attendees other than government officials or their staffs, or are briefings open to all Congressional staff, or are otherwise likely to receive media coverage, the Licensee is required to provide advance notice to BCBSA. For events hosted outside of Washington, D.C. in conjunction with the assemblies or conventions of national political parties, the Licensee is required to provide advance notice to BCGSA and to the local Plan;

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- e. permitting an affiliate that is not licensed to use the Licensed Marks to identify its corporate relationship with the Plan, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time.

3. In connection with activity otherwise in furtherance of the License Agreement, a Controlled Affiliate that is licensed to use the Licensed Marks and Name pursuant to a Controlled Affiliate License Agreement authorized in clauses d) or e) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Region (as that term is defined in such respective Controlled Affiliate License Agreements) in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

- a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);
- b. distributing business cards other than in marketing and selling;
- c. contracting with health care providers or soliciting such contracts in areas contiguous to the Region in order to serve its subscribers residing in the Region, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans in connection with such contracting unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;
- d. issuing a small sign containing the legal name or trade name of the Controlled Affiliate for display by a provider to identify the latter as a participating provider of the Controlled Affiliate, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans on such signs unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;
- e. advertising in publications or electronic media solely to persons for employment;

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- f. advertising in print, electronic or other media which serve, as a substantial market, the Region, provided that the Controlled Affiliate may not advertise outside its Region on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Region, and provided further that any such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to advertise in such media;
 - g. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Region, provided that such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to send direct mail to such zip code plus 4.
 - h. [Intentionally left blank, pending review by the Inter-Plan Programs Committee of the applicability of the case management rule to such Controlled Affiliates.]
 - i. contracting with a pharmacy management organization ("Pharmacy Intermediary") to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for the Controlled Affiliate's regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective Controlled Affiliate License Agreements, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;
 - j. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit to the Controlled Affiliate's regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective
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Controlled Affiliate License Agreements, provided that (1) the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Region, and (2) neither the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Region;

- k. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for the Controlled Affiliate's regional Medicare Advantage PPO members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;
 - l. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for the Controlled Affiliate's regional Medicare Advantage members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;
 - m. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Controlled Affiliate's Region;
 - n. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Controlled Affiliate's Region;
 - o. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Region;
 - p. contracting with a company that operates provider sites in the Region, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Region;
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- q. contracting with a company that makes health care professionals

available in the Region (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Region.

4. BCBSA shall retain the right to use the Licensed Marks in conjunction with the Federal Employee Program and with any other national offering made to federal employees pursuant to the Federal Employees Health Benefits Program (FEHBP), including the right to license such use to its vendors, but only in the following manner.

- a. the Licensed Marks may only be used by BCBSA with the term “Federal Employee Program”, “Federal”, “FEP”, or similar language identifying the program as a benefit program for federal employees;
- b. the Licensed Marks may not be used by BCBSA with the name(s) of a specific Plan or Plans and;
- c. any use by BCBSA in conjunction with a new national FEHBP

program proposed after the enactment of this amendment will require the approval of the BCBSA Board of Directors.

5. Where required by applicable state or local law or regulation, a Plan or its licensed Controlled Affiliate may submit documents that contain the Brands to, and file forms that contain the Brands with, state or local regulators in a state not included in its Service Area, provided that it gives reasonable advance notice to the local Plan of its intent to submit such documents or file such forms. Notwithstanding, in no event may a Plan or its licensed Controlled Affiliate use the Brands to register, or to obtain or maintain a license, a certificate of authority, or an equivalent document authorizing it to act as a risk-bearing entity or third party administrator in a state not included in its Service Area. If the local Plan advises BCBSA that it believes its License Agreement has been or would be violated by any submission or filing, BCBSA shall determine whether such submission or filing is required by state or local law or regulation and violates the License Agreement, subject to the Plan’s or licensed Controlled Affiliate’s rights to obtain an independent review of such determination under Paragraph 9(a) and Exhibit 5 of its License Agreement or Paragraph 8 of the Controlled Affiliate License. For purposes of this paragraph, “local Plan” is defined as each Plan whose Service Area includes all or part of the state in which the foregoing applicable state or local law or regulation has been enacted.

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MEDIATION AND MANDATORY DISPUTE RESOLUTION (MMDR) RULES

The Blue Cross and Blue Shield Plans ("Plans") and the Blue Cross Blue Shield Association ("BCBSA") recognize and acknowledge that the Blue Cross and Blue Shield system is a unique nonprofit and for-profit system offering cost effective health care financing and services. The Plans and BCBSA desire to utilize Mediation and Mandatory Dispute Resolution ("MMDR") to avoid expensive and time-consuming litigation that may otherwise occur in the federal and state judicial systems. Even MMDR should be viewed, however, as methods of last resort, all other procedures for dispute resolution having failed. Except as otherwise provided in the License Agreements, the Plans, their Controlled Affiliates and BCBSA agree to submit all disputes to MMDR pursuant to these Rules and in lieu of litigation.

1. Initiation of Proceedings

A. Pre-MMDR Efforts

Before filing a Complaint to invoke the MMDR process, the CEO of a complaining party, or his/her designated representative, shall undertake good faith efforts with the other side(s) to try to resolve any dispute.

B. Complaint

To commence a proceeding, the complaining party (or parties) shall provide by certified mail, return receipt requested, a written Complaint to the BCBSA Corporate Secretary (which shall also constitute service on BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) named therein. The Complaint shall contain:

- i. identification of the complaining party (or parties) requesting the proceeding;
- ii. identification of the respondent(s);
- iii. identification of any other persons or entities who are interested in a resolution of the dispute;
- iv. a full statement describing the nature of the dispute;
- v. identification of all of the issues that are being submitted for resolution;

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- vi. the remedy sought;
- vii. a statement as to whether the complaining party (or parties) elect(s) first to pursue Mediation;
- viii. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor; and
- ix. a statement signed by the CEO of the complaining party affirming that the CEO has undertaken efforts, or has directed efforts to be undertaken, to resolve the dispute before resorting to the MMDR process.

The complaining party (or parties) shall file and serve with the Complaint copies of all documents which the party (or parties) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

C. Answer

Within twenty (20) days after receipt of the Complaint, each respondent shall serve on BCBSA and on the complaining party (or parties):

- i. a full Answer to the aforesaid Complaint;
- ii. a statement of any Counterclaims against the complaining party (or parties), providing with respect thereto the information specified in Paragraph 1.B., above;
- iii. a statement as to whether the respondent elects to first pursue Mediation; and
- iv. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor.

The respondent(s) shall file and serve with the Answer or by the date of the Initial Conference set forth in Paragraph 3.C., below, copies of all documents which the respondent(s) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

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D. Reply To Counterclaim

Within ten (10) days after receipt of any Counterclaim, the complaining party (or parties) shall serve on BCBSA and on the responding party (or parties) a Reply to the Counterclaim. Such Reply must provide the same information required by Paragraph 1.C., above.

2. Mediation

To facilitate the mediation of disputes between or among BCBSA, the Plans and/or their Controlled Affiliates, the BCBSA Board has provided for Mediation under these Rules. Mediation may be pursued in lieu of or in an effort to obviate the Mandatory Dispute Resolution process, and all parties are strongly urged, but not required, to exhaust the mediation procedure provided for herein. In the event any party refuses to proceed with Mediation, the parties shall proceed immediately to Mandatory Dispute Resolution, as provided in Section 3.

A. Selection of Mediators

If all parties agree to pursue Mediation, they shall promptly attempt to agree upon: (i) the number of mediators desired, not to exceed three mediators; and (ii) the selection of experienced mediator(s) from an independent entity to mediate all disputes set forth in the Complaint and Answer (and Counterclaim and Reply, if any). In the event the parties are unable to agree upon the selection or number of mediators, both within five (5) days of the service of the Answer or Reply to Counterclaim, whichever is later, the BCBSA Corporate Secretary shall immediately refer the matter to a nationally recognized professional ADR organization (such as CPR or JAMS) for mediation by a single mediator to be selected by the ADR organization.

B. Binding Decision

Before the Mediation Hearing described below, the BCBSA Corporate Secretary shall contact the parties to determine whether they wish to be bound by any recommendation of the selected mediator(s) for resolution of the disputes. If all wish to be bound, the Corporate Secretary will send appropriate documentation to them for their signatures before the Mediation Hearing begins.

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C. Mediation Procedure

The Mediator(s) shall apply the mediation procedures and processes provided for herein (not the rules of the ADR organization with which they are affiliated) and shall promptly advise the parties of a scheduled Mediation Hearing date. Unless a party requests an expedited procedure, or unless all parties to the proceeding agree to one or more extensions of time, the Mediation Hearing set forth below shall be completed within forty (40) days of BCBSA's receipt of the Complaint. The selected mediator(s), unless the parties otherwise agree, shall adhere to the following procedure:

- i. Each party must be represented by its CEO or other representative who has been delegated full authority to resolve the dispute. However, parties may send additional representatives as they see fit.
- ii. Each party will be given one-half hour to present its case, beginning with the complaining party (or parties), followed by the other party or parties. The parties are free to structure their presentations as they see fit, using oral statements or direct examination of witnesses. However, neither cross-examination nor questioning of opposing representatives will be permitted. At the close of each presentation, the selected mediator(s) will be given an opportunity to ask questions of the presenters and witnesses. All parties must be present throughout the Mediation Hearing. The selected mediator(s) may extend the time allowed for each party's presentation at the Mediation Hearing. The selected mediator(s) may meet in executive session, outside the presence of the parties, or may meet with the parties separately, to discuss the controversy.
- iii. After the close of the presentations, the parties will attempt to negotiate a settlement of the dispute. If the parties desire, the selected mediators, or any one or more of the selected mediator(s), will sit in on the negotiations.

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- iv. After the close of the presentations, the selected mediator(s) may meet privately to agree upon a recommendation for resolution of the dispute which would be submitted to the parties for their consideration and approval. If the parties have previously agreed to be bound by the results of this procedure, this recommendation shall be binding upon the parties.
- v. The purpose of the Mediation Hearing is to assist the parties to settle their grievances short of mandatory dispute resolution. As a result, the Mediation Hearing has been designed to be as informal as possible. Rules of evidence shall not apply. There will be no transcript of the proceedings, and no party may make a tape recording of the Mediation Hearing.
- vi. In order to facilitate a free and open discussion, the Mediation proceeding shall remain confidential. A "Stipulation to Confidentiality" which prohibits future use of settlement offers, all position papers or other statements furnished to the selected mediator(s), and decisions or recommendations in any Mediation proceeding shall be executed by each party.
- vii. Upon request of the selected mediator(s), or one of the parties, BCBSA staff may also submit documentation at any time during the proceedings.

D. Notice of Termination of Mediation

If the Mediation cannot be completed within the prescribed or agreed time period due to the lack of cooperation of any party, as determined by the selected mediator(s), or if the Mediation does not result in a final resolution of all disputes at the Mediation Hearing or within ten (10) days after the Mediation Hearing, any party or any one of the selected mediator(s) shall so notify the BCBSA Corporate Secretary, who shall promptly issue a Notice of Termination of Mediation to all parties, to the selected mediator(s), and to the MDR Administrator. Such notice shall serve to bring the Mediation to an end and to initiate Mandatory Dispute Resolution. Upon agreement of all parties and the mediator(s), the Mediation process may continue at the same time the MDR process is invoked. In such case, the Notice of Termination of Mediation described above serves to initiate the MDR proceeding, but does not terminate mediation proceedings, which may proceed simultaneous with the MDR proceeding.

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3. Mandatory Dispute Resolution (MDR)

If any party elects not to first pursue Mediation, or if a Notice of Termination of Mediation is issued as set forth in Paragraph 2.D., above, then the unresolved disputes set forth in any Complaint and Answer (and Counterclaim and Reply, if any) shall be subject to mandatory binding arbitration (herein referred to as “MDR”).

A. MDR Administrator

The Administrator for purposes of Mandatory Arbitration shall be an independent nationally recognized entity such as CPR or JAMS, specializing in alternative dispute resolution. In the event the parties pursued Mediation with CPR, JAMS or a similar organization, that organization also shall serve as the MDR Administrator, unless all parties notify the BCBSA Corporate Secretary in writing within two (2) days of receiving the Notice of Termination of Mediation that they wish to pursue MDR with another nationally recognized organization serving as MDR Administrator.

In the event the parties (i) did not pursue Mediation, (ii) pursued mediation with a Mediator not affiliated with an ADR organization that offers a panel of arbitrators, or (iii) all parties that pursued Mediation notified the BCBSA Corporate Secretary that they wish to have an MDR Administrator that is different from the organization with which their mediator was affiliated, they shall promptly attempt to agree on a nationally recognized ADR entity that supplies a panel of arbitrators. If they reach such agreement within five (5) days of the Notice of Termination of Mediation or receipt of the Answer or Reply to Counterclaim (whichever is later), the parties shall promptly inform the BCBSA Corporate Secretary of their agreed upon ADR organization. In the event the parties are unable to reach agreement on an MDR Administrator within that timeframe, the BCBSA Corporate Secretary shall immediately refer the matter to CPR, JAMS or a similar organization for MDR.

Any person who served as a Mediator shall not serve as an arbitrator for the same or similar dispute for purposes of MDR.

B. Rules for MDR

The rules controlling all aspects of MDR shall be exclusively those provided for herein. The rules promulgated or otherwise used by the MDR Administrator organization shall not apply.

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C. Initial Conference

Within seven (7) days after a Notice of Termination has issued, or the matter has otherwise been referred to an MDR Administrator, or within five (5) days after the time for filing and serving the Answer or Reply to any Counterclaim (whichever is later) if the parties elect first not to mediate, the parties shall confer with the Administrator to discuss selecting a dispute resolution panel ("the Panel"). This conference (the "Initial Conference") may be by telephone. The parties are encouraged to agree to the composition of the Panel and to present that agreement to the Administrator at the Initial Conference. If the parties do not agree on the composition of the Panel by the time of the Initial Conference, or by any extension thereof agreed to by all parties and the Administrator, then the Panel Selection Process set forth in subparagraph D, below, shall be followed.

D. Panel Selection Process

The Administrator shall designate, prior to the Initial Conference, at least seven potential arbitrators. Each party shall be permitted to strike any designee for cause and the Administrator shall determine the sufficiency thereof in its sole discretion. The Administrator will designate a replacement for any designee so stricken. Each party shall then be permitted one preemptory strike from the list of designees. The Administrator shall set the dates for exercising all strikes, which shall be set to encourage the prompt selection of arbitrators.

After the parties exercise any designee strikes for cause and their preemptory strike against any designee of their choice, the parties shall each rank the remaining panel members in order of preference and provide the Administrator, without serving on any other party, their ranked list. The Administrator shall not disclose any party's ranked list to members of the panel or to other parties.

From the remaining designees, and after considering opportunities to maximize, so far as possible, the collectively stated arbitrator preferences provided by the parties on their ranked lists, the Administrator shall select a three member Panel. The Panel Selection Process shall be completed no later than ten (10) days after the Initial Conference.

Each Arbitrator shall be compensated at his or her normal hourly rate or, in the absence of an established rate, at a reasonable hourly rate to be promptly fixed by the Administrator for all time spent in connection with the proceedings and shall be reimbursed for any travel and other reasonable expenses.

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E. Duties Of The Arbitrators

The Panel shall promptly designate a Presiding Arbitrator for the purposes reflected below, but shall retain the power to review and modify any ruling or other action of said Presiding Arbitrator. Each Arbitrator shall be an independent Arbitrator, shall be governed by the Code of Ethics for Arbitrators in Commercial Disputes, and shall at or prior to the commencement of any Arbitration Hearing take an oath to that effect. Each Arbitrator shall promptly disclose in writing to the Panel and to the parties any circumstances, whenever arising, that might cause doubt as to such Arbitrator's compliance, or ability to comply, with said Code of Ethics, and, absent resignation by such Arbitrator, the remaining Arbitrators shall determine in their sole discretion whether the circumstances so disclosed constitute grounds for disqualification and for replacement. With respect to such circumstances arising or coming to the attention of a party after an Arbitrator's selection, a party may likewise request the Arbitrator's resignation or a determination as to disqualification by the remaining Arbitrators. With respect to a sole Arbitrator, the determination as to disqualification shall be made by the Administrator.

There shall be no ex parte communication between the parties or their counsel and any member of the Panel.

F. Panel's Jurisdiction And Authority

The Panel's jurisdiction and authority shall extend to all disputes between or among the Plans, their Controlled Affiliates, and/or BCBSA, except for those disputes excepted from these MMDR procedures as set forth in the License Agreements.

With the exception of punitive or treble damages, the Panel shall have full authority to award the relief it deems appropriate to resolve the parties' disputes, including monetary awards and injunctions, mandatory or prohibitory. The Panel has no authority to award punitive or treble damages except that the Panel may allocate or assess responsibility for punitive or treble damages assessed by another tribunal. Subject to the above limitations, the Panel may, by way of example, but not of limitation:

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- i. interpret or construe the meaning of any terms, phrase or provision in any license between BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.
- ii. determine whether BCBSA, a Plan or a Controlled Affiliate has violated the terms or conditions of any license between the BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.
- iii. decide challenges as to its own jurisdiction.
- iv. issue such orders for interim relief as it deems appropriate pending Hearing and Award in any Arbitration.

It is understood that the Panel is expected to resolve issues based on governing principles of law, preserving to the maximum extent legally possible the continued integrity of the Licensed Marks and the BLUE CROSS/BLUE SHIELD system. The Panel shall apply federal law to all issues which, if asserted in the United States District Court, would give rise to federal question jurisdiction, 28 U.S.C. § 1331. The Panel shall apply Illinois law to all issues involving interpretation, performance or construction of any License Agreement or Controlled Affiliate License Agreement unless the agreement otherwise provides. As to other issues, the Panel shall choose the applicable law based on conflicts of law principles of the State of Illinois.

G. Administrative Conference

Within five (5) days of the Panel being selected, the Presiding Arbitrator shall confer with the parties and the other members of the Panel and shall schedule, in writing, a conference in which the parties and the Panel shall participate (the “Administrative Conference”). The Administrative Conference shall take place no later than fifteen (15) days after the Panel is selected. At the Administrative Conference the parties and the Panel shall discuss the scheduling of the Arbitration Hearing and any other matter appropriate to be considered, including but not limited to: any written discovery in the form of requests for production of documents or requests to admit facts; the identity of any witness whose deposition a party may desire and a showing of exceptional good cause for the taking

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of any such deposition; the desirability of bifurcation or other separation of the issues; the need for and the type of record of conferences and hearings, including the need for transcripts; the need for expert witnesses and how expert testimony should be presented; the appropriateness of motions to dismiss and/or for full or partial summary judgment; consideration of stipulations; the desirability of presenting any direct testimony in writing; and the necessity for any on-site inspection by the Panel. If the parties agree, the Administrative Conference may be by telephone.

H. Discovery

- i. Requests for Production of Documents:* All requests for the production of documents must be served no later than five (5) days after the date of the Initial Conference. Within twenty (20) days after receipt of a request for production of documents, a party shall (a) serve responses and objections to the request, (b) produce all responsive, non-privileged documents to the requesting party, and (c) to the extent any responsive documents are withheld on the grounds of attorney-client privilege or work product, produce a log identifying such documents in the manner specified in Fed. R. Civ. P. 26(b)(5). If, after reviewing a privilege log, the requesting party believes attorney-client privilege or work product protection was improperly claimed by the producing party with respect to any document, the requesting party may ask the Presiding Arbitrator to conduct an in-camera inspection of the same. With respect to documentary and other discovery produced in any MDR proceeding by BCBSA, the fact that a party's CEO or other senior officers may serve on the BCBSA Board of Directors, BCBSA Board Committees or other BCBSA work groups, task forces and the like, shall not be a basis for defeating an otherwise valid claim of attorney-client privilege or work product protection over such documentary or other discovery materials by BCBSA.
- ii. Requests for Admissions:* Requests for Admissions may be served up to twenty-one (21) days prior to the discovery cut-off set by the Presiding Arbitrator. A party served with Requests For Admissions must respond within twenty (20) days of receipt of said request. The good faith use of and response to Requests for Admissions is encouraged, and the Panel shall have full discretion, with reference to the Federal Rules of Civil Procedure, in awarding appropriate sanctions with respect to abuse of the procedure.

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iii. Depositions: As a general rule, the parties will not be permitted to take party or non-party deposition testimony for discovery

purposes. The Presiding Arbitrator, in his or her sole discretion, shall have the authority to permit a party to take such deposition testimony upon a showing of exceptional good cause. The parties will be permitted to take de bene esse deposition¹ testimony to the fullest extent permitted by law of any witness who cannot be compelled to testify at the Arbitration Hearing. No deposition, for discovery purposes or otherwise, shall exceed three (3) hours, excluding objections and colloquy of counsel. Depositions may be recorded in any manner recognized by the Federal Rules of Civil Procedure and the parties shall specify in each notice of deposition or request for permission to take deposition testimony the manner in which such deposition shall be recorded.

iv. Expert witness(es): If a party intends to present the testimony of an expert witness during the oral hearing, it shall provide all other parties with a written statement setting forth the information

required to be provided by Fed. R. Civ. P. 26(a)(2)(B) ten (10) days prior to the discovery cut-off set by the Presiding Arbitrator. If a party intends to present the testimony of a rebuttal expert witness during the Arbitration Hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)(B) within twenty (20) days after the date on which the written statement of the expert witness whose testimony is to be rebutted was produced.

v. Discovery cut-off: The Presiding Arbitrator shall determine the date on which the discovery period will end, but the discovery period shall not exceed thirty (30) days from the date of the Administrative Conference without the agreement of all parties.

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¹ As used in these Rules, "de bene esse deposition" means a deposition that is not taken for discovery purposes, but is taken for the purposes of reading part or all of the deposition transcript into the record at the Arbitration Hearing, to the extent permitted by the Panel, because the witness cannot be compelled to testify at the Arbitration Hearing or has exercised a right provided under these Rules to provide deposition testimony in lieu of testimony at the Arbitration Hearing.

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vi. Additional discovery: Any additional discovery will be at the discretion of the Presiding Arbitrator.

vii. Discovery Disputes: Any discovery disputes shall be raised by motion to the Presiding Arbitrator, who is authorized to resolve all such disputes, and whose resolution will be binding on the parties unless modified by the Arbitration Panel. Prior to raising any discovery dispute with the Presiding Arbitrator, the parties shall meet and confer, telephonically or in person, in an attempt to resolve or narrow the dispute. If a party refuses to comply with a decision resolving a discovery dispute, the Panel, in keeping with Fed. R. Civ. P. 37, may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for resolution adversely to that party.

viii. Extensions: The time for responding to discovery requests may be extended by the Presiding Arbitrator for good and sufficient cause shown. Any request for such an extension shall be made in writing.

I. Panel Suggested Settlement/Mediation

At any point during the proceedings, the Panel at the request of any party or on its own initiative, may suggest that the parties explore settlement and that they do so at or before the conclusion of the Arbitration Hearing, and the Panel shall give such assistance in settlement negotiations as the parties may request and the Panel may deem appropriate. Alternatively, the Panel may direct the parties to endeavor to mediate their disputes as provided above, or to explore a mini-trial proceeding, or to have an independent party render a neutral evaluation of the parties' respective positions. The Panel shall enter such sanctions as it deems appropriate with respect to any party failing to pursue in good faith such Mediation or other alternate dispute resolution methods.

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J. Subpoenas on Third Parties

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq.*, and subject to Paragraph 3.G(iii) above, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan or any officer, employee or director of a third party Blue Plan, to compel deposition testimony or the production of documents, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena.

K. Arbitration Hearing

An Arbitration Hearing will be held within thirty (30) days after the Administrative Conference if no discovery is taken, or within thirty (30) days after the close of discovery, unless all parties and the Panel agree to extend the Arbitration Hearing date, or unless the parties agree in writing to waive the Arbitration Hearing. The parties may mutually agree on the location of the Arbitration Hearing. If the parties fail to agree, the Arbitration Hearing shall be held in Chicago, Illinois, or at such other location determined by the Presiding Arbitrator to be most convenient to the participants. The Panel will determine the date(s) and time(s) of the Arbitration Hearing(s) after consultation with all parties and shall provide reasonable notice thereof to all parties or their representatives.

L. Arbitration Hearing Memoranda

Twenty (20) days prior to the Arbitration Hearing, each party shall submit to the other party (or parties) and to the Panel an Arbitration Hearing Memorandum which sets forth the applicable law and any argument as to any relevant issue. The Arbitration Hearing Memorandum will supplement, and not repeat, the allegations, information and documents contained in or with the Complaint, Answer, Counterclaim and Reply, if any. Ten (10) days prior to the Arbitration Hearing, each party shall submit to each other party a list of all expert and fact witnesses (but not including rebuttal fact witness) that such party intends to have testify at the Arbitration Hearing and a brief summary of the testimony each such witness is expected to give. In addition, no later than five (5) days prior to the Arbitration, each party may submit to each other party and to the Panel a Response Arbitration Hearing Memorandum which sets forth any response to another party's Arbitration Hearing Memorandum.

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M. Notice For Testimony

Ten (10) days prior to the Arbitration Hearing, any party may serve a Notice on any other party (or parties) requesting the attendance at the Arbitration Hearing of any officer, employee or director of the other party (or parties) for the purpose of providing noncumulative testimony. If a party fails to produce one of its officers, employees or directors whose noncumulative testimony during the Arbitration Hearing is reasonably requested by an adverse party, the Panel may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for mandatory dispute resolution adversely to that party; provided, however, that a party may refuse to produce a director to testify if, within two (2) days of receiving a notice requesting the attendance of such director at the Arbitration Hearing, the party agrees to make the director available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. This Rule may not be used for the purpose of burdening or harassing any party, and the Presiding Arbitrator may impose such orders as are appropriate so as to prevent or remedy any such burden or harassment.

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq.*, twenty (20) days or more prior to the Arbitration Hearing, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan, BCBSA or any officer, employee or director of a third party Blue Plan or BCBSA for the purpose of providing noncumulative testimony at the Arbitration Hearing, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena; provided however, that a director of a third party Blue Plan or BCBSA may refuse to testify if, within two (2) days of receiving a subpoena requesting the attendance of such director at the Arbitration Hearing, the director agrees to make him/herself available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. Each Blue Plan agrees to waive, on its own behalf and on behalf of its directors and officers, any objection it otherwise might have to any such subpoena based on service, venue or extraterritoriality.

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N. Arbitration Hearing Procedures

- i. Attendance at Arbitration Hearing:* Any person having a direct interest in the proceeding is entitled to attend the Arbitration Hearing. The Presiding Arbitrator shall otherwise have the power to require the exclusion of any witness, other than a party or other essential person, during the testimony of any other witness. It shall be discretionary with the Presiding Arbitrator to determine the propriety of the attendance of any other person.
- ii. Confidentiality:* The Panel and all parties shall maintain the privacy of the Arbitration Proceeding. The parties and the Panel shall treat the Arbitration Hearing and any discovery or other proceedings or events related thereto, including any award resulting therefrom, as confidential except as otherwise necessary in connection with a judicial challenge to or enforcement of an award or unless otherwise required by law.
- iii. Stenographic Record:* Any party, or if the parties do not object, the Panel, may request that a stenographic or other record be made of any Arbitration Hearing or portion thereof. The costs of the recording and/or of preparing the transcript shall be borne by the requesting party and by any party who receives a copy thereof. If the Panel requests a recording and/or a transcript, the costs thereof shall be borne equally by the parties.
- iv. Oaths:* The Panel may require witnesses to testify under oath or affirmation administered by any duly qualified person and, if requested by any party, shall do so.
- v. Order of Arbitration Hearing:* An Arbitration Hearing shall be opened by the recording of the date, time, and place of the Arbitration Hearing, and the presence of the Panel, the parties, and their representatives, if any. The Panel may, at the beginning of the Arbitration Hearing, ask for statements clarifying the issues involved.

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Unless otherwise agreed, the complaining party (or parties) shall then present evidence to support their claim(s). The respondent(s) shall then present evidence supporting their defenses and Counterclaims, if any. The complaining party (or parties) shall then present evidence supporting defenses to the Counterclaims, if any, and rebuttal.

Witnesses for each party shall submit to questions by adverse parties and/or the Panel.

The Panel has the discretion to vary these procedures, but shall afford a full and equal opportunity to all parties for the presentation of any material and relevant evidence.

- vi. **Evidence:** The parties may offer such evidence as is relevant and material to the dispute and shall produce such evidence as the Panel may deem necessary to an understanding and resolution of the dispute. Unless good cause is shown, as determined by the Panel or agreed to by all other parties, no party shall be permitted to offer evidence at the Arbitration Hearing which was not disclosed prior to the Arbitration Hearing by that party. The Panel may receive and consider the evidence of witnesses by affidavit upon such terms as the Panel deems appropriate.

The Panel shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence, other than enforcement of the attorney-client privilege and the work product protection, shall not be necessary. The Federal Rules of Evidence shall be considered by the Panel in conducting the Arbitration Hearing but those rules shall not be controlling. All evidence shall be taken in the presence of the Panel and all of the parties, except where any party is in default or has waived the right to be present.

Settlement offers by any party in connection with Mediation or MDR proceedings, decisions or recommendations of the selected mediators, and a party's position papers or statements furnished to the selected mediators shall not be admissible evidence or considered by the Panel without the consent of all parties.

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vii. ***Closing of Arbitration Hearing:*** The Presiding Arbitrator shall specifically inquire of all parties whether they have any further proofs to offer or witnesses to be heard. Upon receiving negative replies or if he or she is satisfied that the record is complete, the Presiding Arbitrator shall declare the Arbitration Hearing closed with an appropriate notation made on the record. Subject to being reopened as provided below, the time within which the Panel is required to make the award shall commence to run, in the absence of contrary agreement by the parties, upon the closing of the Arbitration Hearing.

With respect to complex disputes, the Panel may, in its sole discretion, defer the closing of the Arbitration Hearing for a period of up to thirty (30) days after the presentation of proofs in order to permit the parties to submit post-hearing briefs and argument, as the Panel deems appropriate, prior to making an award.

For good cause, the Arbitration Hearing may be reopened for up to thirty (30) days on the Panel's initiative, or upon application of a party, at any time before the award is made

O. Awards

An Award must be in writing and shall be made promptly by the Panel and, unless otherwise agreed by the parties or specified by law, no later than thirty (30) days from the date of closing the Arbitration Hearing. If all parties so request, the Award shall contain findings of fact and conclusions of law. The Award, and all other rulings and determinations by the Panel, may be by a majority vote.

Parties shall accept as legal delivery of the Award the placing of the Award or a true copy thereof in the mail addressed to a party or its representative at its last known address or personal service of the Award on a party or its representative.

Awards are binding only on the parties to the Arbitration and are not binding on any non-parties to the Arbitration and may not be used or cited as precedent in any other proceeding.

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After the expiration of twenty (20) days from initial delivery, the Award (with corrections, if any) shall be final and binding on the parties, and the parties shall undertake to carry out the Award without delay.

Proceedings to confirm, modify or vacate an Award shall be conducted in conformity with and controlled by the Federal Arbitration Act, 9 U.S.C. § 1, *et seq.*

P. Return of Documents

Within sixty (60) days after the Award and the conclusion of any judicial proceedings with respect thereto, each party and the Panel shall return any documents produced by any other party, including all copies thereof. If a party receives a discovery request in any other proceeding which would require it to produce any documents produced to it by any other party in a proceeding hereunder, it shall not produce such documents without first notifying the producing party and giving said party reasonable time to respond, if appropriate, to the discovery request.

4. Miscellaneous

A. Expedited Procedures

Any party to a Mediation may direct a request for an expedited Mediation Hearing to the Chairman of the Mediation Committee, to the selected Mediators, and to all other parties at any time. The Chairman of the Mediation Committee, or at his or her direction, the then selected Mediators, shall grant any request which is supported by good and sufficient reasons. If such a request is granted, the Mediation shall be completed within as short a period as practicable, as determined by the Chairman of the Mediation Committee or, at his or her direction, the then selected Mediators.

Any party to an Arbitration may direct a request for expedited proceedings to the Administrator, to the Panel, and to all other parties at any time. The Administrator, or the Presiding Arbitrator if the Panel has been selected, shall grant any such request which is supported by good and sufficient reasons. If such a request is granted, the Arbitration shall be completed within as short a time as practicable, as determined by the Administrator and/or the Presiding Arbitrator.

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B. Temporary or Preliminary Injunctive Relief

Any party may seek temporary or preliminary injunctive relief with the filing of a Complaint or at any time thereafter. If such relief is sought prior to the time that an Arbitration Panel has been selected, then the Administrator shall select a single Arbitrator who is a lawyer who has no interest in the subject matter of the dispute, and no connection to any of the parties, to hear and determine the request for temporary or preliminary injunction. If such relief is sought after the time that an Arbitration Panel has been selected, then the Arbitration Panel will hear and determine the request. The request for temporary or preliminary injunctive relief will be determined with reference to the temporary or preliminary injunction standards set forth in Fed. R. Civ. P. 65.

C. Defaults and Proceedings in the Absence of a Party

Whenever a party fails to comply with the MDR Rules in a manner deemed material by the Panel, the Panel shall fix a reasonable time for compliance and, if the party does not comply within said period, the Panel may enter an Order of default or afford such other relief as it deems appropriate. Arbitration may proceed in the event of a default or in the absence of any party who, after due notice, fails to be present or fails to obtain an extension. An Award shall not be made solely on the default or absence of a party, but the Panel shall require the party who is present to submit such evidence as the Panel may require for the making of findings, determinations, conclusions, and Awards.

D. Notice

Each party shall be deemed to have consented that any papers, notices, or process necessary or proper for the initiation or continuation of a proceeding under these rules or for any court action in connection therewith may be served on a party by mail addressed to the party or its representative at its last known address or by personal service, in or outside the state where the MDR proceeding is to be held.

The Corporate Secretary and the parties may also use facsimile transmission, telex, telegram, or other written forms of electronic communication to give the notices required by these rules.

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E. Expenses

The expenses of witnesses shall be paid by the party causing or requesting the appearance of such witnesses. All expenses of the MDR proceeding, including compensation, required travel and other reasonable expenses of the Panel, and the cost of any proof produced at the direct request of the Panel, shall be borne equally by the parties and shall be paid periodically on a timely basis, unless they agree otherwise or unless the Panel in the Award assesses such expenses, or any part thereof against any party (or parties). In exceptional cases, the Panel may award reasonable attorneys' fees as an item of expense, and the Panel shall promptly determine the amount of such fees based on affidavits or such other proofs as the Panel deems sufficient.

F. Disqualification or Disability of A Panel Member

In the event that any Arbitrator of a Panel with more than one Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the remaining Panel member(s):

- i. shall designate a replacement, subject to the right of any party to challenge such replacement for cause.
- ii. shall decide the extent to which previously held hearings shall be repeated.

If the remaining Panel members consider the proceedings to have progressed to a stage as to make replacement impracticable, the parties may agree, as an alternative to the recommencement of the Mandatory Dispute Resolution process, to resolution of the dispute by the remaining Panel members.

In the event that a single Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the Administrator shall appoint a successor, subject to the right of any party to challenge such successor for cause, and the successor shall decide the extent to which previously held proceedings shall be repeated.

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G. Extensions of Time

Subject to the provisions of Paragraph 3.H.(viii), any time limit set forth in these Rules may be extended upon agreement of the parties and approval of: (1) the Mediator if the proceeding is then in Mediation; (2) the Administrator if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (3) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected.

H. Intervention

The Plans, their Controlled Affiliates, and BCBSA, to the extent subject to MMDR pursuant to their License Agreements, shall have the right to move to intervene in any pending Arbitration. A written motion for intervention shall be made to: (1) the Administrator, if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (2) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected. The written motion for intervention shall be delivered to the BCBSA Corporate Secretary (which shall also constitute service on the BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) which are parties to the proceeding. Any party to the proceeding can submit written objections to the motion to intervene. The motion for intervention shall be granted upon good cause shown. Intervention also may be allowed by stipulation of the parties to the Arbitration proceeding. Intervention shall be allowed upon such terms as the Arbitration Panel decides.

I. BCBSA Assistance In Resolution of Disputes

The resources and personnel of the BCBSA may be requested by any member Plan at any time to try to resolve disputes with another Plan.

J. Neutral Evaluation

The parties can voluntarily agree at any time to have an independent party render a neutral evaluation of the parties' respective positions.

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K. Recovery of Attorney Fees and Expenses

i. Motions to Compel

Notwithstanding any other provisions of these Rules, any Party subject to the License Agreements (for purposes of this Section K and all of its subsections only hereinafter referred to collectively and individually as a “Party”) that initiates a court action or administrative proceeding solely to compel adherence to these Rules shall not be determined to have violated these Rules by initiating such action or proceeding.

ii Recovery of Fees, Expenses and Costs

The Arbitration Panel may, in its sole discretion, award a Party its reasonable attorneys’ fees, expenses and costs associated with a filing to compel adherence to these Rules and/or reasonable attorneys’ fees, expenses and costs incurred in responding to an action filed in violation of these Rules; provided, however, that neither fees, expenses, nor costs shall be awarded by the Arbitration Panel if the Party from which the award is sought can demonstrate to the Arbitration panel, in its sole discretion, that it did not violate these Rules or that it had reasonable grounds for believing that its action did not violate these Rules.

iii Requests for Reimbursement

For purposes of this Section K, any Party may request reimbursement of fees, expenses and/or costs by submitting said request in writing to the Arbitration Panel at any time before an award is delivered pursuant to Paragraph 3.O above, with a copy to the Party from which reimbursement is sought, explaining why it is entitled to such reimbursement. The Party from which reimbursement is sought shall have twenty (20) days to submit a response to such request to the Arbitration Panel with a copy to the Party seeking reimbursement.

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L. Calculation of Time and Deadlines

In computing any period of time prescribed or allowed under these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not one of the aforementioned days. When the period of time prescribed is less than six (6) days, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation. As used in this rule, "legal holiday" includes New Year's Day, Martin Luther King, Jr. Day, Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day and any other day appointed as a holiday by the President or the Congress of the United States.

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<i>Legal Name</i>	<i>State</i>
American Imaging Management, Inc. (d/b/a AIM Specialty Health)	Illinois
AMERIGROUP Community Care of New Mexico, Inc.	New Mexico
AMERIGROUP Corporation (d/b/a AMERIGROUP CORPORATION; AGP Corporation; AMGP; AMGP Corporation; AMGP Missouri, Inc.; Amerigroup)	Delaware
AMERIGROUP Florida, Inc. (d/b/a AMERIGROUP Community Care)	Florida
Amerigroup Insurance Company	Texas
Amerigroup Iowa, Inc.	Iowa
Amerigroup Kansas, Inc.	Kansas
AMERIGROUP Louisiana, Inc. (d/b/a AMERIGROUP Community Care)	Louisiana
AMERIGROUP Maryland, Inc. (d/b/a AMERIGROUP Community Care)	Maryland
AMERIGROUP Nevada, Inc. (d/b/a AMERIGROUP Community Care)	Nevada
AMERIGROUP New Jersey, Inc. (d/b/a AMERIGROUP Community Care)	New Jersey
AMERIGROUP Ohio, Inc. (d/b/a AMERIGROUP Community Care)	Ohio
Amerigroup Services, Inc.	Virginia
AMERIGROUP Tennessee, Inc. (d/b/a AMERIGROUP Community Care)	Tennessee
AMERIGROUP Texas, Inc. (d/b/a AMERIGROUP Community Care)	Texas
AMERIGROUP Washington, Inc.	Washington
AMGP Georgia Managed Care Company, Inc. (d/b/a AMERIGROUP; AMERIGROUP Community Care; AMERIGROUP Georgia; AMGP Georgia)	Georgia
Anthem Blue Cross Life and Health Insurance Company	California
Anthem Financial, Inc.	Delaware
Anthem Health Insurance Company of Nevada	Nevada
Anthem Health Plans of Kentucky, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Kentucky
Anthem Health Plans of Maine, Inc. (d/b/a Anthem Blue Cross and Blue Shield and Associated Hospital Service)	Maine
Anthem Health Plans of New Hampshire, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	New Hampshire
Anthem Health Plans of Virginia, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Virginia
Anthem Health Plans, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Connecticut
Anthem Holding Corp. (d/b/a Anthem Properties, Inc.)	Indiana
Anthem Insurance Companies, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Indiana
Anthem Kentucky Managed Care Plan, Inc. (d/b/a Anthem Blue Cross and Blue Shield Medicaid)	Kentucky
Anthem Life & Disability Insurance Company	New York
Anthem Life Insurance Company	Indiana
Anthem Southeast, Inc.	Indiana
Anthem UM Services, Inc.	Indiana
Anthem Workers' Compensation, LLC	Indiana
Arcus Enterprises, Inc.	Delaware
ARCUS HealthyLiving Services, Inc.	Indiana
Associated Group, Inc.	Indiana
ATH Holding Company, LLC	Indiana
Better Health, Inc.	Florida
Blue Cross and Blue Shield of Georgia, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Georgia
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Georgia

<i>Legal Name</i>	<i>State</i>
Blue Cross Blue Shield of Wisconsin (d/b/a Anthem Blue Cross and Blue Shield)	Wisconsin
Blue Cross of California (d/b/a Anthem Blue Cross)	California
Blue Cross of California Partnership Plan, Inc.(d/b/a Anthem Blue Cross Partnership Plan)	California
CareMore Health Group, Inc.	Delaware
CareMore Health Plan	California
CareMore Health Plan of Arizona, Inc.	Arizona
CareMore Health Plan of Georgia, Inc.	Georgia
CareMore Health Plan of Nevada	Nevada
CareMore Health Plan of Texas, Inc.	Texas
CareMore Health System	California
CareMore Holdings, Inc.	Delaware
CareMore IPA of New York, LLC	New York
CareMore Medical Management Company, a California Limited Partnership	California
CareMore Services Company, LLC	Indiana
CareMore, LLC	Indiana
Cerulean Companies, Inc.	Georgia
Claim Management Services, Inc.(d/b/a Anthem Blue Cross and Blue Shield)	Wisconsin
Community Insurance Company (d/b/a Anthem Blue Cross and Blue Shield)	Ohio
Compcare Health Services Insurance Corporation (d/b/a Anthem Blue Cross and Blue Shield)	Wisconsin
Crossroads Acquisition Corp.	Delaware
DeCare Analytics, LLC	Minnesota
DeCare Dental Health International, LLC	Minnesota
DeCare Dental Insurance Ireland, Ltd.	Ireland
DeCare Dental Networks, LLC	Minnesota
DeCare Dental, LLC	Minnesota
DeCare Operations Ireland, Limited	Ireland
DeCare Systems Ireland, Limited	Ireland
Designated Agent Company, Inc. (d/b/a Access Insurance Agency, Inc.)	Kentucky
EHC Benefits Agency, Inc.	New York
Empire HealthChoice Assurance, Inc. (d/b/a Empire Blue Cross; Empire Blue Cross Blue Shield)	New York
Empire HealthChoice HMO, Inc. (d/b/a Empire Blue Cross HMO; Empire Blue Cross Blue Shield HMO)	New York
Forty-Four Forty-Four Forest Park Redevelopment Corporation	Missouri
Golden West Health Plan, Inc.	California
Government Health Services, LLC	Wisconsin
Greater Georgia Life Insurance Company (d/b/a Anthem Life)	Georgia
Health Core, Inc.	Delaware
Health Management Corporation (d/b/a LiveHealth Online; HMC of Virginia; Health Management of Virginia)	Virginia
Health Ventures Partner, L.L.C.	Illinois
HealthKeepers, Inc.	Virginia
HealthLink HMO, Inc. (d/b/a HealthLink HMO)	Missouri
HealthLink, Inc.	Illinois
HealthPlus HP, LLC (d/b/a Empire BlueCross BlueShield HealthPlus)	New York
Healthy Alliance Life Insurance Company (d/b/a Anthem Blue Cross and Blue Shield)	Missouri
HMO Colorado, Inc. (d/b/a HMO Colorado; HMO Nevada)	Colorado

<i>Legal Name</i>	<i>State</i>
HMO Missouri, Inc. (d/b/a Amerigroup Missouri; Anthem Blue Cross and Blue Shield)	Missouri
Imaging Management Holdings, LLC	Delaware
Imaging Providers of Texas	Texas
Matthew Thornton Health Plan, Inc.	New Hampshire
Meridian Resource Company, LLC	Wisconsin
National Government Services, Inc. (d/b/a NGS of Indiana)	Indiana
National Telehealth Network, LLC	Delaware
Park Square Holdings, Inc.	California
Park Square I, Inc.	California
Park Square II, Inc.	California
PHP Holdings, Inc.	Florida
R & P Realty, Inc.	Missouri
Resolution Health, Inc. (d/b/a Delaware Resolution Health, Inc.)	Delaware
RightCHOICE Managed Care, Inc. (d/b/a RightCHOICE Benefit Administrators; Anthem Blue Cross and Blue Shield)	Delaware
Rocky Mountain Hospital and Medical Service, Inc.(d/b/a Anthem Blue Cross and Blue Shield)	Colorado
SellCore, Inc. (d/b/a SellCore Insurance Services, Inc.)	Delaware
Simply Healthcare Holdings, Inc.	Florida
Simply Healthcare Plans, Inc. (d/b/a Clear Health Alliance)	Florida
Southeast Services, Inc.	Virginia
State Sponsored Business UM Services, Inc.	Indiana
The Anthem Companies of California, Inc.	California
The Anthem Companies, Inc.	Indiana
Tidgewell Associates, Inc.	Maryland
TrustSolutions, LLC	Wisconsin
UNICARE Health Plan of West Virginia, Inc.	West Virginia
UNICARE Health Plans of Texas, Inc.	Texas
UNICARE Illinois Services, Inc.	Illinois
UniCare Life & Health Insurance Company	Indiana
UNICARE National Services, Inc.	Delaware
UniCare Specialty Services, Inc.	Delaware
UtiliMED IPA, Inc.	New York
WellPoint Acquisition, LLC	Indiana
WellPoint Behavioral Health, Inc.	Delaware
WellPoint California Services, Inc.	Delaware
WellPoint Dental Services, Inc.	Delaware
WellPoint Holding Corp.	Delaware
WellPoint Information Technology Services, Inc.	California
WellPoint Insurance Services, Inc.	Hawaii
WellPoint Military Care Corporation	Indiana
WellPoint Partnership Plan, LLC	Illinois
WPMI (Shanghai) Enterprise Service Co., Ltd.	China
WPMI, LLC	Delaware

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the following Registration Statements:

- Form S-8 No. 333-73516 and Form S-8 No. 333-110503 pertaining to the Anthem 2001 Stock Incentive Plan;
- Form S-8 No. 333-84906 and Form S-8 No. 333-129334 pertaining to the Anthem 401(k) Plan;
- Form S-8 No. 333-159830 pertaining to the Anthem Incentive Compensation Plan;
- Form S-8 No. 333-156099 pertaining to the Anthem, Inc. Employee Stock Purchase Plan;
- Form S-8 No. 333-185675 pertaining to the AMERIGROUP Corporation 2009 Equity Incentive Plan;
- Post-Effective Amendment No. 1 to Form S-3 No. 333-200749 pertaining to the Anthem, Inc. registration of senior debt securities, subordinated debt securities, preferred stock, common stock, depositary shares, warrants, rights, stock purchase contracts and stock purchase units; and
- Form S-4 No. 333-207218 pertaining to the Anthem, Inc. registration of shares of common stock and the joint Proxy Statement of Anthem, Inc. and Cigna Corporation

of our report dated February 19, 2016, with respect to the consolidated financial statements and schedule of Anthem, Inc., and the effectiveness of internal control over financial reporting of Anthem, Inc., included in its Annual Report (Form 10-K) for the year ended December 31, 2015.

/S/ ERNST & YOUNG LLP
Indianapolis, Indiana
February 19, 2016

**CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, Joseph R. Swedish, certify that:

1. I have reviewed this report on Form 10-K of Anthem, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):
 - a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 19, 2016

/s/ JOSEPH R. SWEDISH

Chairman, President and
Chief Executive Officer

**CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, Wayne S. DeVeydt, certify that:

1. I have reviewed this report on Form 10-K of Anthem, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):
 - a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 19, 2016

/s/ WAYNE S. DEVEYDT

Executive Vice President and
Chief Financial Officer

**CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report of Anthem, Inc. (the "Company") on Form 10-K for the period ended December 31, 2015 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Joseph R. Swedish, Chairman, President and Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

- (1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
- (2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JOSEPH R. SWEDISH

Joseph R. Swedish
Chairman, President and Chief Executive Officer
February 19, 2016

**CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report of Anthem, Inc. (the "Company") on Form 10-K for the period ended December 31, 2015 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Wayne S. DeVeydt, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

- (1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
- (2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ WAYNE S. DEVEYDT

Wayne S. DeVeydt
Executive Vice President and Chief Financial Officer
February 19, 2016

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

(Mark One)

☒

**ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE
SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2014
OR

☐

**TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE
SECURITIES EXCHANGE ACT OF 1934**

For the transition period from _____ to _____
Commission file number: 001-16751

ANTHEM, INC.

(Exact name of registrant as specified in its charter)

INDIANA

(State or other jurisdiction of
incorporation or organization)

35-2145715

(I.R.S. Employer Identification Number)

**120 MONUMENT CIRCLE
INDIANAPOLIS, INDIANA**

(Address of principal executive offices)

46204

(Zip Code)

Registrant's telephone number, including area code: **(317) 488-6000**

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	Name of each exchange on which registered
Common Stock, Par Value \$0.01	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: NONE

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer", and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☒ Accelerated filer ☐

Non-accelerated filer ☐ (Do not check if a smaller reporting company) Smaller reporting company ☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all Directors and executive officers of the registrant are "affiliates") as of June 30, 2014 was approximately \$29,462,836,859.

As of February 5, 2015, 266,787,463 shares of the Registrant's Common Stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Part III of this Annual Report on Form 10-K incorporates by reference information from the registrant's Definitive Proxy Statement for the Annual Meeting of Shareholders to be held May 13, 2015.

Anthem, Inc.
Annual Report on Form 10-K
For the Year Ended December 31, 2014

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This Annual Report on Form 10-K, including Management's Discussion and Analysis of Financial Condition and Results of Operations, contains forward-looking statements, within the meaning of the Private Securities Litigation Reform Act of 1995, that reflect our views about future events and financial performance. When used in this report, the words "may," "will," "should," "anticipate," "estimate," "expect," "plan," "believe," "feel," "predict," "project," "potential," "intend" and similar expressions are intended to identify forward-looking statements, which are generally not historical in nature. Forward-looking statements include, but are not limited to, financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Forward-looking statements are subject to known and unknown risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. You are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. You are also urged to carefully review and consider the various disclosures made by us, which attempt to advise interested parties of the factors that affect our business, including "Risk Factors" set forth in Part I, Item 1A hereof and our reports filed with the U.S. Securities and Exchange Commission, or SEC, from time to time. Except to the extent otherwise required by federal securities laws, we do not undertake any obligation to republish revised forward-looking statements to reflect events or circumstances after the date hereof or to reflect the occurrence of unanticipated events.

On November 5, 2014, the shareholders of the Company approved a proposal to amend our articles of incorporation to change our name to Anthem, Inc. from WellPoint, Inc. The name change was effective December 2, 2014. References in this Annual Report on Form 10-K to the terms "we," "our," "us," "Anthem" or the "Company" refer to Anthem, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries.

PART I

ITEM 1. BUSINESS.

General

We are one of the largest health benefits companies in terms of medical membership in the United States, serving 37.5 million medical members through our affiliated health plans as of December 31, 2014. We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as BCBS in 10 New York City metropolitan and surrounding counties, and as Blue Cross or BCBS in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield, or Empire Blue Cross (in our New York service areas). We also conduct business through arrangements with other BCBS licensees in the states of South Carolina and Texas. We conduct business through our AMERIGROUP Corporation, or Amerigroup, subsidiary, in Florida, Georgia, Kansas, Louisiana, Maryland, Nevada, New Jersey, New Mexico, New York, Tennessee, Texas and Washington. We also serve customers throughout the country as HealthLink, UniCare (including a non-risk arrangement with the state of Massachusetts), and in certain Arizona, California, Nevada, New York and Virginia markets through our CareMore Health Group, Inc., or CareMore, subsidiary. We are licensed to conduct insurance operations in all 50 states through our subsidiaries.

In February 2015, we reported that we were the target of a sophisticated external cyber attack. The attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many of our current and former members and employees. We are in the process of determining the extent of this cyber attack and are supporting federal law enforcement efforts to identify the responsible parties. For additional information about the cyber attack, see Note 13, "Commitments and Contingencies - *Data Breach*," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

On February 17, 2015, we completed our acquisition of Simply Healthcare Holdings, Inc., or Simply Healthcare, a leading managed care company for people enrolled in Medicaid and Medicare programs in the state of Florida. This acquisition, which was originally announced on December 22, 2014, aligns with our strategy for continued growth in our Government Business segment. As a result, we will, through our affiliated Medicaid and Medicare plans, serve more than half a million members in the state of Florida.

We have a vision of becoming America's valued health partner. Together we are transforming health care with trusted and caring solutions and as a result, we focus on delivering quality products and services that give members access to the care they need. With an unyielding commitment to meeting the needs of our diverse customers, we are guided by the following values:

- Accountable
- Caring
- Easy to do business with
- Innovative
- Trustworthy

We offer a broad spectrum of network-based managed care plans to large and small employer, individual, Medicaid and Medicare markets. Our managed care plans include: preferred provider organizations, or PPOs; health maintenance organizations, or HMOs; point-of-service, or POS, plans; traditional indemnity plans and other hybrid plans, including consumer-driven health plans, or CDHPs; and hospital only and limited benefit products. In addition, we provide a broad array of managed care services to self-funded customers, including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services. We provide an array of specialty and other insurance products and services such as dental, vision, life

and disability insurance benefits, radiology benefit management and analytics-driven personal health care. We also provide services to the federal government in connection with the Federal Employee Program, or FEP. We also sold contact lenses, eyeglasses and other ocular products through our 1-800 CONTACTS, Inc., or 1-800 CONTACTS, business which was divested on January 31, 2014.

The increased focus on health care costs by employers, the government and consumers has continued to drive the growth of alternatives to traditional indemnity health insurance. HMO, PPO and hybrid plans, such as POS plans and CDHPs, are among the various forms of managed care products that have been developed. Through these types of products, insurers attempt to contain the cost of health care by negotiating contracts with hospitals, physicians and other providers to deliver high quality health care to members at favorable rates. These products usually feature medical management and other quality and cost optimization measures such as pre-admission review and approval for certain non-emergency services, pre-authorization of outpatient surgical procedures, network credentialing to determine that network doctors and hospitals have the required certifications and expertise, and various levels of care management programs to help members better understand and navigate the health care system. In addition, providers may have incentives to achieve certain quality measures, may share medical cost risk or may have other incentives to deliver quality medical services in a cost-effective manner. Also, certain plans offer members incentives for healthy behaviors, such as smoking cessation and weight management. Members are charged periodic, prepaid premiums and generally pay co-payments, coinsurance and/or deductibles when they receive services. While the distinctions between the various types of plans have lessened over recent years, PPO, POS and CDHP products generally provide reduced benefits for out-of-network services, while traditional HMO products generally provide little to no reimbursement for non-emergency out-of-network utilization, but often offer more generous benefit coverage. An HMO plan may also require members to select one of the network primary care physicians to coordinate their care and approve any specialist or other services.

Economic factors and greater consumer and employer sophistication and accountability have resulted in an increased demand for choice in both product/benefit designs and provider network configurations. As a result we continue to offer our broad access PPO networks with multiple benefit designs, but are also focused on leveraging our emerging provider collaboration initiatives with our Accountable Care Organization, or ACO, partnerships to develop both narrow and tiered network offerings. This array of network and product configurations allows both the employer and the employee to design and select the combination of benefit designs (e.g., traditional PPOs, high deductibles, HRAs, HSAs, gatekeeper based products, tiered copays) and networks (e.g., broad, narrow, tiered, closed and open) that optimize choice, quality and price at the consumer, employer and market level. We believe we are well-positioned in each of our states to respond to these market preferences.

For our fully-insured products, we charge a premium and assume all of the health care risk. Under self-funded and partially-insured products, we charge a fee for services, and the employer or plan sponsor reimburses us for all or most of the health care costs. In addition, we charge a premium to provide administrative services to Large Group employers that maintain self-funded health plans and we underwrite stop loss insurance for self-funded plans.

Our medical membership includes seven different customer types:

- Local Group
- Individual
- National Accounts
- BlueCard®
- Medicare
- Medicaid
- FEP

BCBS-branded business generally refers to members in our service areas licensed by the BCBSA. Non-BCBS-branded business refers to members in our non-BCBS-branded Amerigroup and CareMore plans, as well as HealthLink and UniCare members. In addition to the above medical membership, we also serve customers who purchase one or more of our other products or services that are often ancillary to our health business.

Our products are generally developed and marketed with an emphasis on the differing needs of our customers. In particular, our product development and marketing efforts take into account the differing characteristics between the various customers served by us, as well as the unique needs of educational and public entities, labor groups, federal employee health and benefit programs, national employers and state-run programs servicing low-income, high-risk and under-served markets. Each business unit is responsible for product design, pricing, enrolling, underwriting and servicing customers in specific customer types. Overall, we seek to establish pricing and product designs to provide value for our customers while achieving an appropriate level of profitability for each of our customer categories balanced with the competitive objective to grow market share. We believe that one of the keys to our success has been our focus on these distinct customer types, which better enables us to develop benefit plans and services that meet our customers' unique needs.

We market our products through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships for Individual and Medicare customers, and for certain Local Group customers with a smaller employee base. Products for National Accounts and Local Group customers with a larger employee base are generally sold through independent brokers or consultants retained by the customer and working with industry specialists from our in-house sales force. In the Individual and Small Group markets, we offer on-exchange products through state or federally facilitated marketplaces, referred to as public exchanges; and off-exchange products. Federal premium subsidies are available only for certain members who purchase certain public exchange products.

Each of the BCBS member companies, of which there were 37 independent primary licensees as of December 31, 2014, works cooperatively in a number of ways that create significant market advantages, especially when competing for very large multi-state employer groups. As a result of this cooperation, each BCBS member company is able to take advantage of other BCBS licensees' substantial provider networks and discounts when any BCBS member works or travels outside of the state in which their policy is written. This program is referred to as BlueCard® and is a source of revenue when we provide member services in the states where we are the BCBS licensee to individuals who are customers of BCBS plans not affiliated with us. This program also provides a national provider network for our members when they travel to other states.

For additional information describing each of our customer types, detailed marketing efforts and changes in medical membership over the last three years, see Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

Our results of operations depend in large part on accurately predicting health care costs and our ability to manage future health care costs through adequate product pricing, medical management, product design and negotiation of favorable provider contracts.

The aging of the population and other demographic characteristics and advances in medical technology continue to contribute to rising health care costs. Our managed care plans and products are designed to encourage providers and members to participate in quality, cost-effective health benefit programs by using the full range of our innovative medical management services, quality initiatives and financial incentives. Our significant market share and high business retention rates enable us to realize the long-term benefits of investing in preventive and early detection programs. Our ability to provide cost-effective health benefits products and services is enhanced through a disciplined approach to internal cost containment, prudent management of our risk exposure and successful integration of acquired businesses. In addition, our ability to manage selling, general and administrative costs continues to be a driver of our overall profitability.

Our future results of operations will also be impacted by certain external forces and resulting changes in our business model and strategy. In 2010, the Patient Protection and Affordable Care Act, or ACA, as well as the Health Care and Education Reconciliation Act of 2010, or collectively, Health Care Reform, became law, causing significant changes to the U.S. health care system. Since then, significant regulations have been enacted by the U.S. Department of Health and Human Services, or HHS, the Department of Labor and the Department of the Treasury. The legislation and regulations are far-reaching and are intended to expand access to health insurance coverage over time by increasing the eligibility thresholds for most state Medicaid programs and providing certain other individuals and small businesses with tax credits to subsidize a portion of the cost of health insurance coverage. As a result of the complexity of the law, its impact on health care in the United States and the continuing modification and interpretation of Health Care Reform rules, we continue to analyze and refine our estimates of the ultimate impact of Health Care Reform on our business, cash flows, financial condition and results of operations. Health Care Reform provides growth opportunities for health insurers, but also introduces new risks and

uncertainties, and required changes in the way products are designed, underwritten, priced, distributed and administered. For additional discussion, see "Regulation," herein and Part I, Item 1A "Risk Factors" in this Annual Report on Form 10-K.

In addition to the external forces discussed in the preceding paragraph, our results of operations are impacted by levels and mix of membership. In recent history, we experienced membership declines due to unfavorable economic conditions driving increased unemployment. In addition, we believe the self-insured portion of our group membership base will continue to increase as a percentage of total group membership. These membership trends could have a material adverse effect on our future results of operations. See Part I, Item 1A "Risk Factors" and Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

Private exchanges have recently gained significant visibility in the marketplace based on the promise of helping employers reduce costs, increase consumer engagement and manage the complexities created by the ACA and other market forces. While private exchanges have been a distribution channel in the Medicare and Individual markets for some time, the heightened level of activity and investment among the consulting and broker communities and other health insurance carriers has generated an increasing level of interest among employers in the Commercial market. To date, adoption levels have been lower than analyst predictions, but expectations for significant longer term growth remain. While the ultimate volume, pace of growth and winning business models remain highly uncertain, we believe private exchanges will provide opportunities for growth and will serve a significant role in our future strategy.

Our approach to the private exchange market has been broad-based and we believe we are well positioned to adapt with the market as it evolves. In 2011, we jointly acquired Bloom Health with Health Care Service Corporation and Blue Cross Blue Shield of Michigan, and today it offers this advanced consumer experience platform to employers as Anthem Health Marketplace. We also currently participate in four large national consultant-led exchanges, several regional broker-led exchanges and various individual, commercial and Medicare exchanges. Although overall private exchange activity has been limited, we have experienced positive membership gains among early adopters, reinforcing the strength of our market position and the value we deliver to employers and consumers. We will continue to assess this highly dynamic market, build out internal capabilities and enhance partnerships to ensure we are best positioned to capitalize on future growth.

We continue to believe health care is local and that we have the strong local presence required to understand and meet local customer needs. We believe we are well-positioned to deliver what customers want: innovative, choice-based and affordable products; distinctive service; simplified transactions; and better access to information for quality care. Our local presence, combined with our national expertise, has created opportunities for collaborative programs that reward physicians and hospitals for clinical quality and excellence. We feel that our commitment to health improvement and care management provides added value to customers and health care professionals. We believe that an essential ingredient for practical and sustainable improvements in health care is raising health care quality while managing costs for total cost affordability. We have identified initiatives that we believe will deliver better health care while reducing costs. These include driving innovation in paying and partnering with providers to compel improved cost, quality and health along with finding new, effective ways to manage risk and engage the member as a consumer. In addition, we seek to achieve efficiencies from our national scale while optimizing service performance for our customers. Finally, we seek to continue to rationalize our portfolio of businesses and products, and align our investments to capitalize on new opportunities to drive growth in both our existing and new markets in the future.

We continue to enhance interactions with customers, providers, brokers, agents, employees and other stakeholders through web-enabled technology and improving internal operations. Our approach includes not only sales and distribution of health benefits products on the Internet, but also implementation of advanced capabilities that improve services benefiting customers, agents, brokers, and providers while optimizing administrative costs. These enhancements can also help improve the quality, coordination and safety of health care through increased communications between patients and their physicians.

We intend to continue pursuing our vision of becoming America's valued health partner by transforming health care with trusted and caring solutions and by delivering quality products and services that give members access to the care they need. At the same time, we will focus on earnings per share, or EPS, growth through organic membership gains, improvements in our operating cost structure, strategic acquisitions and the efficient use of capital.

Significant Transactions

While Health Care Reform has caused significant changes to the U.S. health care system in recent years, the more significant transactions that have occurred over the last five years that have impacted or will impact our capital structure or that have or will influence how we conduct our business operations include:

- Acquisition of Simply Healthcare (2015);
- Use of Capital—Board of Directors declaration of dividends on common stock (2011 through 2014) and a 42.9% increase in the quarterly dividend to \$0.6250 per share (2015); authorization for repurchases of our common stock (2014 and prior); and debt repurchases and new debt issuance (2014 and prior);
- Acquisition of Amerigroup and the related debt issuance (2012);
- Acquisition of 1-800 CONTACTS (2012) and subsequent divestiture (2014); and
- Acquisition of CareMore (2011).

For additional information regarding certain of these transactions, see Note 3, “Business Acquisitions and Divestitures,” Note 12, “Debt,” and Note 14, “Capital Stock,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Competition

The managed care industry is highly competitive, both nationally and in our local markets. Competition continues to be intense due to aggressive marketing, business consolidations, a proliferation of new products, the impact of Health Care Reform, and increased quality awareness and price sensitivity among customers.

Managed care industry participants compete for customers mainly on the following factors:

- quality of service;
- price;
- access to provider networks;
- access to care management and wellness programs, including health information;
- innovation, breadth and flexibility of products and benefits;
- reputation (including National Committee on Quality Assurance, or NCQA, accreditation status);
- brand recognition; and
- financial stability.

Over the last few years, a health plan’s ability to interact with employers, members and other third parties (including health care professionals) via the Internet has become a more important competitive factor, and we have made significant investments in technology to enhance our electronic interaction with providers, employers, members and third parties.

We believe our exclusive right to market products under the most recognized brand in the industry, BCBS, in our most significant markets provides us with an advantage over our competition. Our provider networks in our markets enable us to achieve efficiencies and distinctive service levels enabling us to offer a broad range of health benefits to our customers on a more cost-effective basis than many of our competitors. We strive to distinguish our products through provider access, service, care management, product value and brand recognition.

Pricing in our Commercial and Specialty Business segment (defined below), including our Individual and Small Group lines of business, remains competitive, but rational, and we strive to price our health care benefit products consistent with anticipated underlying medical trends. We believe our pricing strategy, based on predictive modeling, proprietary research and data-driven processes, as well as our overall investments for Health Care Reform, have positioned us to benefit from the potential growth opportunities available in fully-insured commercial products as a result of Health Care Reform. While the ultimate level of public exchange enrollment cannot be predicted, we have experienced a greater number of policy

applications for new members through the public exchanges than expected, including geographical regions with lower price competition. The public exchanges may increase the risk that our products will be selected by individuals who have a higher risk profile or utilization rate than the pool of participants we anticipated when we established the pricing for these public exchange products. However, the risk characteristics of new applicants in 2014 tracked closely to the risk levels utilized in the development of our pricing assumptions. Although it is not yet clear whether our products sold on the public exchanges will be more or less profitable products, we believe that our pricing strategy, brand name and network quality will provide a strong foundation for commercial risk membership growth opportunities in the future.

To build our provider networks, we compete with other health benefits plans for the best contracts with hospitals, physicians and other providers. We believe that physicians and other providers primarily consider member volume, reimbursement rates, timeliness of reimbursement and administrative service capabilities along with the reduction of non-value added administrative tasks when deciding whether to contract with a health benefits plan.

At the sales and distribution level, we compete for qualified agents and brokers to recommend and distribute our products. Strong competition exists among insurance companies and health benefits plans for agents and brokers with demonstrated ability to secure new business and maintain existing accounts. We believe that the quality and price of our products, support services, reputation and prior relationships, along with a reasonable commission structure are the factors agents and brokers consider in choosing whether to market our products. We believe that we have good relationships with our agents and brokers, and that our products, support services and commission structure compare favorably to those of our competitors in all of our markets. Typically, we are the largest competitor in each of our Blue-branded markets and, thus, are a closely watched target by other insurance competitors.

Reportable Segments

We currently manage our operations through three reportable segments: Commercial and Specialty Business, Government Business and Other. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, merger and acquisition activity and changing laws and regulations. Therefore, these reportable segments may change in the future.

Our Commercial and Specialty Business and Government Business segments both offer a diversified mix of managed care products, including PPOs, HMOs, traditional indemnity benefits and POS plans, as well as a variety of hybrid benefit plans including CDHPs, hospital only and limited benefit products.

Our Commercial and Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial and Specialty Business segment offer fully-insured health products; provide a broad array of managed care services to self-funded customers including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services; and provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal health care guidance.

Our Government Business segment includes Medicare and Medicaid businesses, National Government Services, or NGS, and services provided to the federal government in connection with FEP. Medicare business includes services such as Medicare Advantage, Medicare Part D, and Medicare Supplement. Medicaid business includes our managed care alternatives through publicly funded health care programs, including Medicaid; Temporary Assistance for Needy Family programs, or TANF; programs for seniors and people with disabilities, or SPD; programs for long-term services and support, or LTSS; Children's Health Insurance Programs, or CHIP; and ACA-related Medicaid expansion programs. NGS acts as a Medicare contractor in several regions across the nation.

Our Other segment includes other businesses that do not meet the quantitative thresholds for an operating segment as defined by Financial Accounting Standards Board, or FASB, guidance, as well as corporate expenses not allocated to the other reportable segments.

Through our participation in various federal government programs, we generated approximately 21.0%, 20.3% and 23.7% of our total consolidated revenues from agencies of the U.S. government for the years ended December 31, 2014, 2013

and 2012, respectively. These revenues are contained in the Government Business segment. An immaterial amount of our total consolidated revenues are derived from activities outside of the U.S.

For additional information regarding the operating results of our segments, see Part II, Item 7 “Management’s Discussion and Analysis of Financial Condition and Results of Operations” and Note 19, “Segment Information,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Products and Services

A general description of our products and services is provided below:

Preferred Provider Organization: PPO products offer the member an option to select any health care provider, with benefits reimbursed by us at a higher level when care is received from a participating network provider. Coverage is subject to co-payments or deductibles and coinsurance, with member cost sharing usually limited by out-of-pocket maximums.

Consumer-Driven Health Plans: CDHPs provide consumers with increased financial responsibility, choice and control regarding how their health care dollars are spent. Generally, CDHPs combine a high-deductible PPO plan with an employer-funded and/or employee-funded personal care account, which may result in tax benefits to the employee. Some or all of the dollars remaining in the personal care account at year-end can be rolled over to the next year for future health care needs.

Traditional Indemnity: Indemnity products offer the member an option to select any health care provider for covered services. Coverage is subject to deductibles and coinsurance, with member cost sharing usually limited by out-of-pocket maximums.

Health Maintenance Organization: HMO products include comprehensive managed care benefits, generally through a participating network of physicians, hospitals and other providers. A member in one of our HMOs must typically select a primary care physician, or PCP, from our network. PCPs generally are family practitioners, internists or pediatricians who provide necessary preventive and primary medical care, and are generally responsible for coordinating other necessary health care services. We offer HMO plans with varying levels of co-payments, which result in different levels of premium rates.

Point-of-Service: POS products blend the characteristics of HMO, PPO and indemnity plans. Members can have comprehensive HMO-style benefits through participating network providers with minimum out-of-pocket expenses (co-payments) and also can go directly, without a referral, to any provider they choose, subject to, among other things, certain deductibles and coinsurance. Member cost sharing is limited by out-of-pocket maximums.

ACA Public Exchange and Off-Exchange Products: The ACA required the modification of existing products and development of new products to meet the requirements of the legislation, subject to certain transitional relief. Individual and Small Group products cover essential health benefits as defined in the ACA along with many other requirements and cost sharing features. Individual and Small Group products offered on and off the public exchanges meet the definition of the “metal” product requirements (bronze, silver, gold and platinum) and each metal product must satisfy a specific actuarial value. Health insurers participating on the public exchanges must offer at least one silver and one gold product.

In our Individual markets we offer bronze, silver and gold products, both on and off the public exchanges, in the states of California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. Additionally, we offer platinum products, both on and off the public exchanges, in the states of California and New York.

In our Small Group markets, we offer bronze, silver and gold products, both on and off the public exchanges, in the states of Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, New Hampshire, Ohio and Virginia and we offer bronze, silver and gold products, off the public exchanges, in the states of California, New York and Wisconsin. Additionally, we offer platinum products, off the public exchanges, in the states of California, Colorado, Connecticut, Georgia, Maine, New Hampshire, Missouri and Virginia.

Administrative Services: In addition to fully-insured products, we provide administrative services to Large Group employers that maintain self-funded health plans. These administrative services include underwriting, actuarial services, medical cost management, disease management, wellness programs, claims processing and other administrative services for self-funded employers. Self-funded health plans are also able to use our provider networks and to realize savings through our

negotiated provider arrangements, while allowing employers the ability to design certain health benefit plans in accordance with their own requirements and objectives. We also underwrite stop loss insurance for self-funded plans.

BlueCard®: BlueCard® host members are generally members who reside in or travel to a state in which an Anthem subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer sponsored health plan serviced by a non-Anthem controlled BCBS licensee, which is the “home” plan. We perform certain administrative functions for BlueCard® host members, for which we receive administrative fees from the BlueCard® members’ home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan.

Medicare Plans: We offer a wide variety of plans, products and options to individuals age 65 and older such as Medicare supplement plans, Medicare Advantage (including private fee-for-service plans and special needs plans), Medicare Part D Prescription Drug Plans, or Medicare Part D, and Medicare-Medicaid Plans, or MMPs. Medicare supplement plans typically pay the difference between health care costs incurred by a beneficiary and amounts paid by Medicare. Medicare Advantage plans provide Medicare beneficiaries with a managed care alternative to traditional Medicare and often include a Medicare Part D benefit. In addition, our Medicare Advantage special needs plans provide tailored benefits to Medicare beneficiaries who have chronic diseases and also cover certain dual eligible customers, who are low-income seniors and persons under age 65 with disabilities who are enrolled in MMPs. Medicare Part D offers a prescription drug plan to Medicare and MMP beneficiaries. MMPs are managed care products serving members who are dually eligible for Medicaid and Medicare. We offer these plans to customers through our health benefit subsidiaries throughout the country, including Amerigroup and CareMore.

Individual Plans: We offer a full range of health insurance plans with a variety of options and deductibles for individuals under age 65 who are not covered by employer-sponsored coverage. Some of our products target certain demographic populations such as uninsured younger individuals between the ages of 19 and 29, families, those transitioning between jobs or early retirees. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the Internet. Individual business is sold on a fully-insured basis. We offer public exchange products and off-exchange products. Federal premium subsidies are available only for certain public exchange products. Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network, and the efficiency of administration.

Medicaid Plans and Other State-Sponsored Programs: We have contracts to serve members enrolled in publicly funded health care programs, including Medicaid, TANF, SPD, LTSS, CHIP, and ACA-related Medicaid expansion programs. The Medicaid program makes federal matching funds available to all states for the delivery of health care benefits for low income and/or high medical risk individuals. These programs are managed by the individual states based on broad federal guidelines. TANF is a state and federally funded program designed for the population consisting primarily of low-income children and their guardians. SPD is a federal income supplement program designed for Supplemental Security Income recipients, however, states can broaden eligibility criteria. This population consists of low-income seniors and people with disabilities. LTSS is a state and federally funded program that offers states a broad and flexible set of program design options and refers to the delivery of long-term services and support for our members who receive home and community- or institution-based services for long-term care. CHIP is a state and federally funded program that provides health care coverage to children not otherwise covered by Medicaid or other insurance programs. Our Medicaid plans also cover certain dual eligible customers, as previously described above, who also receive Medicare benefits. We provide Medicaid and other State-Sponsored services in California, Florida, Georgia, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Nevada, New Jersey, New York, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia and Wisconsin.

Pharmacy Products: We market and sell an integrated prescription drug product to both fully-insured and self-funded customers through our health benefit subsidiaries throughout the country. This comprehensive product includes features such as drug formularies, a pharmacy network and maintenance of a prescription drug database and mail order capabilities. Since December 1, 2009, we have delegated certain functions and administrative services related to our integrated prescription drug products to Express Scripts, Inc., or Express Scripts, under a ten year contract, excluding some Amerigroup subsidiaries and certain self-insured members, which have exclusive agreements with different pharmacy benefit management, or PBM, service providers. It is expected that those Amerigroup subsidiaries will complete their transition to the Express Scripts agreement during 2015. Express Scripts manages the network of pharmacy providers, operates mail order pharmacies and

processes prescription drug claims on our behalf, while we sell and support the product for clients, make formulary decisions and set drug benefit design strategy and provide front line member support.

Life Insurance: We offer an array of competitive individual and group life insurance benefit products to both Large Group and Small Group customers in conjunction with our health plans. The life products include term life and accidental death and dismemberment.

Disability: We offer short-term and long-term disability products, usually in conjunction with our health plans.

Radiology Benefit Management: We offer outpatient diagnostic imaging management services to health plans. These services include utilization management for advanced diagnostic imaging procedures, network development and optimization, patient safety, claims adjudication and provider payment.

Personal Health Care Guidance: We offer leading evidence-based and analytics-driven personal health care guidance. These services help improve the quality, coordination and safety of health care, enhance communications between patients and their physicians, and reduce medical costs.

Dental: Our dental plans include networks in certain states in which we operate. Many of the dental benefits are provided to customers enrolled in our health plans and are offered on both a fully-insured and self-funded basis. Our members also have access to additional dental providers through our participation in the National Dental GRID, a national dental network developed by and for BCBS plans. The National Dental GRID includes dentists in all 50 states and provides multi-state customers with a national solution providing in-network discounts across the country. Additionally, we offer managed dental services to other health care plans to assist those plans in providing dental benefits to their customers.

Vision Services and Products: Our vision plans include networks within the states in which we operate. Many of the vision benefits are provided to customers enrolled in our health plans and are offered on both a fully-insured and self-funded basis. In addition to vision plans, we sold contact lenses, eyeglasses and other ocular products through our 1-800 CONTACTS subsidiary which we divested on January 31, 2014.

Medicare Administrative Operations: Through our subsidiary, NGS, we serve as a fiscal intermediary, carrier and Medicare administrative contractor providing administrative services for the Medicare program, which generally provides coverage for persons who are 65 or older and for persons who are disabled or with end-stage renal disease. Part A of the Medicare program provides coverage for services provided by hospitals, skilled nursing facilities and other health care facilities. Part B of the Medicare program provides coverage for services provided by physicians, physical and occupational therapists and other professional providers, as well as certain durable medical equipment and medical supplies.

Networks and Provider Relations

Our relationships with physicians, hospitals and professionals that render health care services to our members are guided by local, regional and national standards for network development, reimbursement and contract methodologies. While following industry standards, we are simultaneously seeking to lead transformation efforts within our health care system, moving from our current fragmented model premised on episodic intervention to one based on proactive, coordinated care built around the needs of the patient. A key element of this transformation involves a transition from traditional fee-for-service payment models to models where providers are paid based on the value, both in quality and affordability, of the care they deliver.

We establish "market-based" hospital reimbursement payments that we believe are fair, but aggressive, and among the most competitive in the market. We also seek to ensure that physicians in our network are paid in a timely manner at appropriate rates. In many instances, we deploy multi-year contracting strategies, including case rates or fixed rates, to limit our exposure to medical cost inflation and to increase cost predictability. We maintain both broad and narrow provider networks to ensure member choice, based on both price and access needs, while implementing programs designed to improve the quality of care our members receive. Increasingly, we are supplementing our broad based networks with smaller or more cost-effective networks that are designed to be attractive to a more price-sensitive customer segment, such as public exchange customers.

Our reimbursement strategies vary across markets and depend on the degree of consolidation and integration of physician groups and hospitals. Fee-for-service is currently our predominant reimbursement methodology for physicians, but

as noted above, we are transitioning providers to value-based payment contracts. More traditional physician fee schedules are developed at the state level based on an assessment of several factors and conditions, including the Centers for Medicare & Medicaid Services, or CMS, resource-based relative value system, or RBRVS, medical practice cost inflation and physician supply. We utilize CMS RBRVS fee schedules as a reference point for fee schedule development and analysis. The RBRVS structure was developed, maintained, and updated by CMS and is used by the Medicare program and other major payers. In addition, we have implemented and continue to expand physician incentive contracting, or “pay for performance”, which ties physician payment levels to performance on clinical measures.

While we generally do not delegate full financial responsibility to our physician providers in the form of capitation-based reimbursement, there are certain markets where the market dynamics result in this being a useful method to lower costs and reduce underwriting risk, thus we do utilize this payment method in those markets.

Our hospital contracts provide for a variety of reimbursement arrangements depending on local market dynamics and current hospital utilization efficiency. Most hospitals are reimbursed a fixed amount per day or reimbursed a per-case amount, per admission, for inpatient covered services. A small percentage of hospitals, primarily rural, sole community hospitals, are reimbursed on a discount from approved charge basis for covered services. Our “per-case” reimbursement methods utilize many of the same attributes contained in Medicare’s Diagnosis Related Groups, or DRG, methodology. Hospital outpatient services are reimbursed by fixed case rates, fee schedules or percent of approved charges. Our hospital contracts recognize unique hospital attributes, such as academic medical centers or community hospitals, and the volume of care performed for our members. To improve predictability of expected costs, we frequently use a multi-year contracting approach with providers. In addition, the majority of our hospital contracts include a “pay for performance” component where reimbursement levels are linked to improved clinical performance, patient safety and medical error reduction.

Although fee-for-service combined with pay for performance remains our predominant payment model today, our provider engagement and contracting strategies are moving away from “unit price” or volume-based payment models to payment models that align compensation with the value delivered as measured by health care, quality and cost. We launched the most significant of these efforts, our Enhanced Personal Health Care program, in the fourth quarter of 2012. This program augments traditional fee-for-service with shared savings opportunities for providers when actual health care costs are below projected costs, and providers meet specific quality measures. The quality measures are based on nationally accepted, credible standards (e.g. NCQA, the American Diabetes Association and the American Academy of Pediatrics) and span preventive, acute and chronic care. We understand, however, that payment incentives alone are insufficient to create the large-scale, system-wide transformation required to achieve meaningful impacts on cost, quality and member experience. Accordingly, we invested in care delivery transformation and population health management support structures to help providers succeed under value-based payment models. This support includes our web-based population health management technology and teams of dedicated expert consultants who work alongside providers, sharing best practices, and helping them leverage our data to the benefit of their patients. In some of these arrangements, participating physician practices receive a per-member, per-month clinical coordination fee to compensate them for important care management activities that occur outside of the patient visit, (e.g. purchasing an electronic health record or hiring care management nurses) all of which have been shown to reduce healthcare costs and improve care outcomes. Since the launch of Enhanced Personal Health Care, we now have arrangements with provider organizations covering nearly 40% of our primary care physicians and have rolled this program out in each of the fourteen states where we operate as a licensee of the BCBSA.

Medical Management Programs

Our medical management programs include a broad array of activities that facilitate improvements in the quality of care provided to our members and promote cost-effective medical care. These medical management activities and programs are administered and directed by physicians and trained nurses. The goals of our medical management strategies are to ensure that the care delivered to our members is supported by appropriate medical and scientific evidence, is received on a timely basis and occurs in the most appropriate location.

Precertification: A traditional medical management program involves assessment of the appropriateness of certain hospitalizations and other medical services prior to the service being rendered. For example, precertification is used to determine whether a set of hospital and medical services is being appropriately applied to the member’s clinical condition, in accordance with criteria for medical necessity as that term is defined in the member’s benefits contract. All of our health plans have implemented precertification programs for common high-tech radiology studies, including cardiac diagnostic

testing, addressing an area of historically significant cost trends. Through our AIM Specialty Health, or AIM, subsidiary we promote appropriate, safe and affordable member care in imaging as well as oncology, sleep management and specialty pharmacy benefits. These expanded specialty benefit management solutions leverage clinical expertise and technology to engage our provider communities and members in more effective and efficient use of outpatient services.

Care Coordination: Another traditional medical management strategy we use is care coordination, which is based on nationally recognized criteria developed by third-party medical specialists. With inpatient care coordination, the requirements and intensity of services during a patient's hospital stay are reviewed, at times by an onsite skilled nurse professional in collaboration with the hospital's medical and nursing staff, in order to coordinate care and determine the most effective transition of care from the hospital setting. In addition, guidance for many continued stay cases is reviewed with physician medical directors to ensure appropriate utilization of medical services. We also coordinate care for outpatient services to help ensure that patients with chronic conditions who receive care from multiple physicians are able to manage the exchange of information between physicians and coordinate office visits to their physicians.

Case Management: We have implemented a medical management strategy focused on identifying the small percentage of the membership that will require a high level of intervention to manage their health care needs. The registered nurses and medical directors focus on members likely to be readmitted to the hospital and help them coordinate their care through pharmacy compliance, post-hospital care, follow-up visits to see their physician and support in their home.

Formulary management: We have developed formularies, which are selections of drugs based on clinical quality and effectiveness. A pharmacy and therapeutics committee of physicians uses scientific and clinical evidence to ensure that our members have access to the appropriate drug therapies.

Medical policy: A medical policy group, comprised of physician leaders from various areas of the country, working in cooperation with academic medical centers, practicing community physicians and medical specialty organizations such as the American College of Radiology and national organizations such as the Centers for Disease Control and Prevention and the American Cancer Society, determines our national policy for the application of new medical technologies and treatments.

Quality programs: We are actively engaged with our hospital and physician networks to enable them to improve medical and surgical care and achieve better outcomes for our members. We endorse, encourage and incentivize hospitals and physicians to support national initiatives to improve the quality of clinical care and patient outcomes and to reduce medication errors and hospital infections. We have demonstrated our leadership in developing hospital quality programs.

External review procedures: We work with outside experts through a process of external review to provide our members scientifically and clinically, evidence-based medical care. When we receive member concerns, we have formal appeals procedures that ultimately allow coverage disputes related to medical necessity decisions under the benefits contract to be settled by independent expert physicians.

Service management: In HMO and POS networks, primary care physicians serve as the overall coordinators of members' health care needs by providing an array of preventive health services and overseeing referrals to specialists for appropriate medical care. In PPO networks, patients have access to network physicians without a primary care physician serving as the coordinator of care.

Estimate Your Cost & Anthem Care Comparison: These health care provider comparison tools disclose typical cost estimates and quality data for common services at contracted providers, with cost estimates accounting for facility, professional and ancillary services. The cost estimates bundle related services typically performed at the time of the procedure, not just for the procedure itself. Users can review cost data for over 350 procedures in 49 states. The Estimate Your Cost tool also includes member out-of-pocket cost estimates based on a member's own benefit coverage, deductible, and out of pocket maximum. We also offer information on overall facility ratings and patient experience using trusted third party data. We continue to work on enhancing and evolving our tools to assist members in making informed and value-based health care decisions. In addition, we collaborate with an external independent vendor to support employers wanting to purchase a transparency and consumer engagement web solution with certain additional functionality.

Personal Health Care Guidance: These services help improve the quality, coordination and safety of health care, enhance communications between patients and their physicians, and reduce medical costs. Examples of services include

member and physician messaging, providing access to evidence-based medical guidelines, physician quality profiling, and other consulting services.

Anthem Health Guide: Anthem Health Guide integrates customer service with clinical and wellness coaching to provide easier navigation of health care services for our members. Members are supported by a team of nurses, coaches, educators, and social workers using voice, click-to-chat, secure email and mobile technology. Our Smart Engagement Platform supports this integrated team using our smart engagement triggers for speech recognition, preventative and clinical gaps in care and highlighting when we have members who are identified for current health care support. This caring team of professionals also supports our members with our shared decision making support portfolio.

Care Management Programs

We continue to expand our *360° Health* suite of integrated care management programs and tools. *360° Health* offers the following programs, among others, that have been proven to increase quality and reduce medical costs for our members:

ConditionCare and *FutureMoms* are care management and maternity management programs that serve as adjuncts to physician care. Skilled nurse professionals with added support from our team of dietitians, social workers, pharmacists, health educators and other health professionals help participants understand their condition, their doctor's orders and how to become a better self-manager of their condition. We also offer members infertility consultation through our *SpecialOffers@Anthem* program, a comprehensive and integrated assembly of discounted health and wellness products and services from a variety of the nation's leading retailers.

24/7 NurseLine offers access to qualified, registered nurses anytime. This allows our members to make informed decisions about the appropriate level of care and avoid unnecessary worry. This program also includes a referral process to the nearest urgent care facility, a robust audiotape library, accessible by phone, with more than 400 health and wellness topics, as well as on-line health education topics designed to educate members about symptoms and treatment of many common health concerns.

ComplexCare is an advanced care management program that reaches out to participants with multiple health care issues who are at risk for frequent and high levels of medical care in order to offer support and assistance in managing their health care needs. *ComplexCare* identifies candidates through claims analysis using predictive modeling techniques, the use of health risk assessment data, utilization management reports and referrals from a physician or one of our other programs, such as the *24/7 NurseLine*.

MyHealth Advantage utilizes integrated information systems and sophisticated data analytics to help our members improve their compliance with evidence-based care guidelines, providing personal care notes that alert members to potential gaps in care, enable more prudent health care choices, and assist in the realization of member out-of-pocket cost savings. Key opportunities are also shared with physicians through *Availity®* at the time of membership eligibility verification. *Availity®* is an electronic data interchange system that allows for the exchange of health information among providers over a secure network.

MyHealth Coach provides our members with a professional guide who helps them navigate the health care system and make better decisions about their well-being. *MyHealth Coach* proactively reaches out to people who are at risk for serious health issues or have complex health care needs. Our health coaches help participants understand and manage chronic conditions, handle any health and wellness related services they need and make smart lifestyle choices.

HealthyLifestyles helps employees transform unhealthy habits into positive ones by focusing on behaviors that can have a positive effect on their health and their employer's financial well-being. *HealthyLifestyles* programs include smoking cessation, weight management, stress management, physical activity and diet and nutrition.

MyHealth@Anthem is our secure web-based solution, complementing other programs by reinforcing telephonic coaching and mail campaigns. The website engages participants in regularly assessing their health status, gives them feedback about their progress, and tracks important health measures such as blood pressure, weight and blood glucose levels.

Behavioral Health Case Management provides oversight of the delivery of mental health and substance abuse services as an integrated component of the health plan. The program assists providers and members with referrals, transitional care, episodic emergency care and other needs.

Employee Assistance Programs provide many resources that allow members to balance work and personal life by providing quick and easy access to confidential resources to help meet the challenges of daily life. Examples of services available in person as well as via telephone or internet are counseling for child care, health and wellness, financial issues, legal issues, adoption and daily living.

Health Care Quality Initiatives

Increasingly, the health care industry is able to define quality health care based on preventive health measurements, outcomes of care and optimal care management for chronic disease. A key to our success has been our ability to work with our network physicians and hospitals to improve the quality and outcomes of the health care services provided to our members. Our ability to promote quality medical care has been recognized by the NCQA, the largest and most respected national accreditation program for managed care health plans.

Several quality health care measures, including the Healthcare Effectiveness Data and Information Set, or HEDIS®, have been incorporated into the NCQA's accreditation processes. HEDIS® measures range from preventive services, such as screening mammography and pediatric immunization, to elements of care, including decreasing the complications of diabetes and improving treatment for patients with heart disease. For health plans, NCQA's highest accreditation status of Excellent is granted only to those plans that demonstrate levels of service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. Plans earning this accreditation level must also achieve HEDIS® results that are in the highest range of national or regional performance. Details for each of our plans' accreditation levels can be found at www.ncqa.org.

We have created an innovative program called the State Health Index, or SHI, to quantify and track our success in improving the health of our communities. SHI presents a comprehensive picture of a community's health in the 24 states served by our affiliated health plans. It is compiled from public data and includes 14 health indicators in four domains: Maternity Care, Preventive Care, Lifestyle, and Morbidity/Mortality. The metrics are utilized to identify opportunities for health improvement and leverage our strengths to build partnerships with community coalitions, patient advocacy organizations, and local and state public health departments. We analyze states' performance measures and prioritize measures for focused improvement. Together with Anthem Foundation, Inc. and state leadership, we create or enhance programs to improve the health of the entire population in these states - not just for our members.

Our wholly-owned health outcomes research subsidiary, HealthCore, Inc., or HealthCore, generates consistent and actionable evidence to support decision making while helping to guide fresh initiatives for a range of stakeholders in the healthcare industry. By leveraging a rich array of medical and pharmacy utilization data queried from administrative claims, patients surveys, medical charts and laboratory diagnostics, among other health records, HealthCore's multi-disciplinary research teams uncover a broad spectrum of safety, effectiveness, pharmacoepidemiology, and health economics evidence. HealthCore's real world evidence and comparative effectiveness research, among others, have played roles in the product planning and development campaigns of biotechnology and pharmaceutical companies, and today it lists most of the leading biologics and drug manufacturers as clients or alliance partners. Its health plan research has led to better insights into evidence-based treatment approaches, the development of value-based initiatives to drive access and adherence to treatment, and the crafting of incentives to modify patient and provider behavior. One of HealthCore's predominant initiatives is its governmental and academic collaborations that include cooperation with some of the country's top universities and federal agencies, including the Food and Drug Administration and the Centers of Disease Control of the National Institutes of Health, and it is an active contributor to the safety surveillance Sentinel program. As a notable contributor to the health outcomes evidence base, HealthCore's research findings are broadly disseminated during presentations at national and international medical meetings and are published in a variety of respected peer-reviewed medical and health services journals.

Our AIM subsidiary supports quality by implementing clinical appropriateness and patient safety solutions for advanced imaging procedures, cardiology, sleep medicine, specialty pharmaceuticals and oncology, including drugs covered under medical benefit and radiation therapy. These programs, based on widely accepted clinical guidelines, promote the most appropriate use of diagnostic and therapeutic services to improve the quality of overall health care delivered to our members and members of other health plans that are covered under AIM's programs. To provide additional impact to its clinical appropriateness program, AIM has also implemented a provider assessment program, OptiNet®, which promotes more informed selection of diagnostic imaging and testing facilities by providing cost and facility information to physician offices at the point that a procedure is ordered. We have also leveraged AIM's provider network assessment information to

proactively engage and educate our members about imaging providers and sleep testing choices based on site capabilities and cost differences. This program is another example of how we facilitate improvements in the quality of care provided to our members and promote cost effective medical care. In addition, AIM radiology, cardiology, sleep medicine, radiation therapy, network assessment and member engagement solutions have been evaluated as quality improvement expenses under the National Association of Insurance Commissioners, or NAIC, medical loss ratio, or MLR, regulations. Fees for these programs can be included in calculations of a health plan's MLR.

Our wholly-owned analytics-driven subsidiary, Resolution Health, Inc., or RHI, delivers programs to improve the safety, quality and coordination of health care for our members. RHI uses evidence-based proprietary rules and algorithms based on established clinical guidelines and standards of independent accreditation organizations, medical specialty societies, and government agencies such as the National Quality Forum, or NQF, and NCQA. RHI analyzes claims and other data to identify actions that can improve health outcomes at the individual member level. When appropriate, RHI delivers personalized confidential messages ("Personalized Health Insights") to members, providers and care managers. RHI's Personalized Health Insights support total population health management and the results of RHI analyses are used across our enterprise to support HEDIS and other clinical quality measures.

Pricing and Underwriting of Our Products

We price our products based on our assessment of current health care claim costs and emerging health care cost trends, combined with charges for administrative expenses, risk and profit, including charges for ACA taxes and fees. We continually review our product designs and pricing guidelines on a national and regional basis so that our products remain competitive and consistent with our profitability goals and strategies.

In applying our pricing to each employer group and customer, we maintain consistent, competitive, disciplined underwriting standards. We employ our proprietary accumulated actuarial data in determining underwriting and pricing parameters. Where allowed by law and regulation, we underwrite large groups based on each group's aggregate claim experience. Also, we employ credit underwriting procedures with respect to our self-funded products.

In most circumstances, our pricing and underwriting decisions follow a prospective rating process in which a fixed premium is determined at the beginning of the contract period. For fully-insured business, any deviation, favorable or unfavorable, from the medical costs assumed in determining the premium is our responsibility. Some of our larger groups employ retrospective rating reviews, where positive experience is partially refunded to the group, and negative experience is charged against a rate stabilization fund established from the group's favorable experience, or charged against future favorable experience.

BCBSA Licenses

We are a party to license agreements with the BCBSA that entitle us to the exclusive, and in certain areas, non-exclusive use of the Blue Cross and Blue Shield names and marks in assigned geographic territories. BCBSA is a national trade association of Blue Cross and Blue Shield licensees, the primary function of which is to promote and preserve the integrity of the BCBS names and marks, as well as provide certain coordination among the member companies. Each BCBSA licensee is an independent legal organization and is not responsible for obligations of other BCBSA member organizations. We have no right to market products and services using the BCBS names and marks outside of the states in which we are licensed to sell BCBS products. We are required to pay an annual license fee to the BCBSA based on enrollment and also to comply with various operational, governance and financial standards set forth in the licenses.

We believe that we and our licensed affiliates are currently in compliance with these standards. The standards under the license agreements may be modified in certain instances by the BCBSA. See Part I, Item 1A "Risk Factors" in this Annual Report on Form 10-K for additional details of our licensing requirements and the impact if we were not to comply with these license agreements.

Regulation

General

Our operations are subject to comprehensive and detailed state, federal and international regulation throughout the jurisdictions in which we do business. As discussed below, the regulatory aspects of the U.S. health care system have been and will continue to be significantly affected by Health Care Reform. Supervisory agencies, including state health, insurance and corporation departments, have broad authority to:

- grant, suspend and revoke licenses to transact business;
- regulate many aspects of our products and services;
- monitor our solvency and reserve adequacy;
- scrutinize our investment activities on the basis of quality, diversification and other quantitative criteria; and
- impose monetary and criminal sanctions for non-compliance with regulatory requirements.

To carry out these tasks, these regulators periodically examine our operations and accounts.

Regulation of Insurance Company and HMO Business Activity

The governments of the states in which we conduct business, as well as the federal government, have adopted laws and regulations that govern our business activities in various ways. Further, Health Care Reform has resulted in increased federal regulation that significantly impacts our business. These laws and regulations, which vary significantly from state to state and on the federal level, restrict how we conduct our businesses and result in additional burdens and costs to us. Areas of governmental regulation include but are not limited to:

- medical loss ratios;
- tax deductibility of certain compensation and Health Care Reform related fees;
- licensure;
- premium rates;
- benefits;
- eligibility requirements;
- guaranteed availability and renewability;
- service areas;
- market conduct;
- sales and marketing activities, including use and compensation of brokers and other distribution channels;
- quality assurance procedures;
- plan design and disclosures, including mandated benefits;
- underwriting, marketing, pricing and rating restrictions for insurance products;
- utilization review activities;
- prompt payment of claims;
- member rights and responsibilities;
- collection, access or use of protected health information;
- data reporting, including financial data and standards for electronic transactions;
- payment of dividends;
- provider rates of payment;

- surcharges on provider payments;
- provider contract forms;
- provider access standards;
- premium taxes, assessments for the uninsured and/or underinsured, insolvency guaranty payments, federal taxes, public exchange fees and premium stabilization programs;
- member and provider complaints and appeals;
- financial condition (including reserves and minimum capital or risk based capital requirements and investments);
- reimbursement or payment levels for government funded business; and
- corporate governance and financial reporting.

These state and federal laws and regulations are subject to amendments and changing interpretations in each jurisdiction.

States generally require health insurers and HMOs to obtain a certificate of authority prior to commencing operations. If we were to establish a health insurance company or an HMO in any jurisdiction where we do not presently operate, we generally would have to obtain such a certificate. The time necessary to obtain such a certificate varies from jurisdiction to jurisdiction. Each health insurer and HMO must file periodic financial and operating reports with the states in which it does business. In addition, health insurers and HMOs are subject to state examination and periodic license renewal. The health benefits business also may be adversely impacted by court and regulatory decisions that expand the interpretations of existing statutes and regulations. It is uncertain whether we can recoup, through higher premiums or other measures, the increased costs of mandated benefits or other increased costs caused by potential legislation, regulation or court rulings. See Part I, Item 1A "Risk Factors" in this Annual Report on Form 10-K.

Patient Protection and Affordable Care Act

The ACA has created significant changes and will continue to create significant changes for health insurance markets for the next several years. Specifically, many of the near-term changes were effective for certain groups and individuals on their first renewal on or after September 2010, including a prohibition on lifetime limits, certain annual limits, member cost-sharing on specified preventive benefits, pre-existing condition exclusions for children, increased restrictions on rescinding coverage and extension of coverage of dependents to the age of 26. Certain requirements for insurers were also effective in 2011, including changes to Medicare Advantage payments and the minimum MLR provision that requires insurers to pay rebates to customers when insurers do not meet or exceed the specified MLR thresholds. Most of the provisions of the ACA with more significant effects on the health insurance marketplace, both state and federal, went into effect on January 1, 2014, including a requirement that insurers guarantee the issuance of coverage to all individuals regardless of health status, strict rules on how health insurance is rated, the assessment of new taxes and fees (including annual fees on health insurance companies), the creation of public exchanges for Individuals and Small Groups, the availability of premium subsidies for certain Individual products, and substantial expansions in eligibility for Medicaid.

Despite significant preparation for the advent of the public exchanges, there have been many technical difficulties in their implementation, which entail uncertainties associated with mix and volume of business. In November 2013, CMS notified the various state Insurance Commissioners that, under a transitional policy, health insurance coverage in the Individual or Small Group markets that is renewed for a policy year starting between January 1, 2014 and October 1, 2014 that would otherwise have been deemed non-compliant with certain market reforms under Health Care Reform will not be considered by CMS to be out of compliance with respect to such market reforms, provided certain conditions are met. CMS further encouraged state agencies responsible for enforcing the specified market reforms to adopt the same transitional policy with respect to this coverage. Some states have adopted the transitional policy, some have declined to adopt it and yet others have not taken a position.

Additionally, in March 2014 a second round of transition relief was issued by CMS, providing that health insurance coverage in the Individual or Small Group markets that is renewed for a policy year beginning on or before October 1, 2016, that would otherwise have been deemed non-compliant with certain market reforms under Health Care Reform, will not be considered by CMS to be out of compliance with respect to such market reforms, provided certain conditions are met. Again, some states have adopted this transitional policy, some have not and others have not taken a position.

Due to the impact of the transitional policies, insurers in the ACA compliant Individual market, including Anthem, may be adversely selected by individuals who will have a higher acuity level than the anticipated pool of participants in the public exchange markets. In addition, the risk adjustment, reinsurance, and risk corridor premium stabilization programs of Health Care Reform, or Health Care Reform Premium Stabilization Programs, established to apportion risk amongst insurers, may not be effective in appropriately mitigating the financial risks related to our public exchange products. These factors, along with the limited information about the individuals who have access to these newly established public exchanges that was available when we established premiums, may have a material adverse effect on our results of operations if premiums are not adequate or do not appropriately reflect the acuity of these individuals. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions utilized in setting adequate premium rates could have a material adverse effect on our results of operations, financial position, and cash flows.

In addition, there have been other material changes and delays in the implementation of the ACA that could have a material adverse effect on our results of operations, financial position, and cash flows. These include:

- Delay in the effective date of the employer mandate from 2014 to 2015;
- Delay of the commencement of the 2015 open enrollment period from October 15 to November 15, 2014 through February 15, 2015; and
- Other unanticipated regulatory changes and delays.

These delays and changes may have a material and significant impact on anticipated enrollment in public exchange and off-exchange products, thus affecting the risk pools and premium rates. The technical difficulties in implementing the public exchanges have impacted the sharing of enrollment information between the federal government and health insurers. Finally, implementation of the ACA brings with it significant oversight responsibilities by health insurers that may result in increased governmental audits, increased assertions of False Claims Act violations, and an increased risk of other litigation.

The ACA continues to require additional guidance and specificity to be provided by HHS, the Department of Labor, CMS and the Department of the Treasury. These regulatory agencies continue to consider recommendations from external groups, such as the NAIC. Many provisions have final rules available for review while some proposed regulations have been released for comment or have yet to be released and others are in-process. Of particular note is the yet to be issued regulation pertaining to administrative simplification to create uniformity in implementing electronic standards. We continue to carefully evaluate each rule as it is issued; and, therefore, it continues to be too early to fully understand the impacts of the legislation on our overall business. Some of the more significant considerations of the ACA are described below:

- MLR regulations were issued by HHS in December 2011; however, significant changes could still occur to the MLR requirements through additional regulatory guidance and/or modification of the regulation. The minimum MLR thresholds by line of business, as defined by HHS, are as follows:

Line of Business	%
Large Group	85
Small Group	80
Individual	80

New York state regulations require us to meet a more restrictive MLR threshold of 82% for both Small Group and Individual lines of business. The minimum MLR thresholds disclosed above are based on definitions of an MLR calculation provided by HHS, or specific states, as applicable, and differ from our calculation of "benefit expense ratio" based on premium revenue and benefit expense as reported in accordance with U.S. generally accepted accounting principles, or GAAP. Furthermore, the definitions of the lines of business differ under the various state and federal regulations and may not correspond to our lines of business. Definitions under the MLR regulation also impact insurers differently depending upon their organizational structure or tax status, which could result in a competitive advantage to some insurance providers that may not be available to us, resulting in an uneven playing field in the industry. Significant changes to the MLR requirements may occur through additional regulatory action by HHS.

Health Care Reform also imposed a separate minimum MLR threshold of 85% for Medicare Advantage plans beginning in 2014. Medicare Advantage plans that do not meet this threshold will have to pay a minimum MLR rebate. If a plan's MLR is below 85% for three consecutive years beginning with 2014, enrollment will be restricted. A Medicare Advantage plan contract will be terminated if the plan's MLR is below 85% for five consecutive years.

Approximately 67.0% and 32.2% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2014. Approximately 63.1% and 27.3% of our premium revenue and medical membership, respectively, were subject to the minimum MLR regulations as of and for the year ended December 31, 2013.

- The ACA required states to establish public exchanges by January 1, 2014 through which qualified individuals and qualified small employers may access coverage. If a state failed to establish a public exchange, the federal government established a public exchange in that state. To date sixteen states plus the District of Columbia have elected to operate state-based public exchanges. The remaining states have either a federal partnership public exchange (six states) or a federally operated public exchange (twenty-eight states). In the states in which we offer products on public exchanges, six states have passed legislation or executive orders establishing state-based public exchanges (California, Colorado, Connecticut, Kentucky, Nevada and New York).
- The ACA required the modification of existing products and development of new products to meet the requirements of the legislation, subject to certain transitional relief. Individual and Small Group products must cover essential health benefits as defined in the ACA along with many other requirements and cost sharing features. Individual and Small Group products must meet the definition of the "metal" product requirements (bronze, silver, gold and platinum). Each metal product must satisfy a specific actuarial value. Health insurers participating on public exchanges must offer at least one silver and one gold product. Additionally, effective January 1, 2014, health insurers were required to cancel or discontinue the sale of existing non-ACA-compliant Individual and Small Group products, subject to the conditions of the November 2013 and March 2014 CMS transitional policies discussed above.
- Regulations became effective in September 2011 that require filings for premium rate increases for Small Group and Individual products above specified thresholds, generally 10%, to be reviewed. The regulations provide for state insurance regulators to conduct the reviews, except for cases where a state does not have an "effective" rate review program or in federal enforcement states, in which cases HHS will conduct the reviews for any rate increase filed.
- The Health Care Reform Premium Stabilization Programs introduce new requirements to the MLR calculation, beginning with the 2014 benefit year for the Individual and Small Group markets. The risk adjustment program is a permanent program that transfers dollars from insurers who enroll individuals with lower relative health risk to insurers who enroll individuals with higher relative health risk. Risk adjustment payments/receipts will be determined separately for each state and for Individual and Small Group. The second premium stabilization program is the transitional reinsurance program, a temporary program that runs from 2014 through 2016. The transitional reinsurance program is intended to help stabilize premiums by reimbursing issuers of ACA-compliant non-grandfathered Individual market plans for eligible claims between a defined attachment point and ceiling, at a coinsurance rate defined by HHS. The program will be funded through assessments per covered enrollee upon the commercial health insurance market and sponsors of self-funded health benefit plans of approximately \$12.0 billion, \$8.0 billion and \$5.0 billion in 2014, 2015 and 2016, respectively. The final premium stabilization program is the temporary risk corridor program, also a three year program through 2016, that protects insurers from inaccurate pricing of Individual and Small Group qualified health plans and substantially similar off-exchange products. Beginning in 2014, MLR rebate calculations are adjusted to reflect the impact of the Health Care Reform Premium Stabilization Programs.
- Through December 31, 2013 and depending on the laws in each state, health insurers were allowed to consider factors such as health status, gender and age in determining the appropriate premium for products in the Individual and Small Group markets. Some states have adopted rules that limit the variation between the highest and lowest premium for the identical insurance policy. The differential in pricing is commonly referred to as "rating bands". The process of using these rating bands allowed health insurers to appropriately price for products and to spread the risk more broadly across all policyholders. Except for policies issued under the CMS transitional policies, beginning in 2014, the ACA precludes health insurers from using health status and gender in the determination of the appropriate insurance premium. In addition, rating bands for age cannot vary by more than 3 to 1 and the rating

bands for tobacco use cannot vary by more than 1.5 to 1. The ongoing use of the 3 to 1 rating bands may have a significant impact on the majority of Individual and Small Group customers and could lead to adverse selection in the market as well as increased variability in projecting future premiums for those customer markets.

- In 2014 significant new taxes and fees became effective for health insurers, some of which may or may not be passed through to customers. The most significant of the taxes and fees is the annual Health Insurance Provider Fee, or HIP Fee, on health insurers that write certain types of health insurance on U.S. risks. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to an adjusted amount of health insurance for all U.S. health risk for those certain lines of business written during the preceding calendar year. The HIP Fee is non-deductible for federal income tax purposes. The total amount to be collected from allocations to health insurers in 2014 was \$8.0 billion, and our portion of the HIP Fee for 2014 was \$893.3 million. The final calculation and payment of the HIP Fee occurred in the third quarter of 2014 and was recognized as a general and administrative expense. The annual HIP Fee to be allocated to all health insurers increases to \$11.3 billion for 2015 and 2016, \$13.9 billion for 2017 and \$14.3 billion for 2018. For 2019 and beyond, the annual HIP Fee will increase from the amount for the preceding year by the rate of premium growth for the preceding year.
- Medicare Advantage reimbursement rates will not increase as much as they would otherwise due to a new payment formula promulgated by the ACA that is expected to significantly reduce reimbursements in the future. We also expect further and ongoing regulatory guidance on a number of issues related to Medicare, evolving methodology for ratings and quality bonus payments, and potential action on an audit methodology to review data submitted under "risk adjuster" programs.

In June 2012, the U.S. Supreme Court issued a decision affirming that the majority of the provisions of the ACA were constitutional. However, the provision of the ACA related to the mandatory expansion of state Medicaid programs was declared unconstitutional. One case pertaining to the constitutionality of the contraceptive mandate was decided by the U.S. Supreme Court during the past year, in which the Supreme Court held that closely-held for-profit businesses are entitled to object to the contraceptive mandate. Another pending case pertains to challenges to the premium tax subsidies and whether the subsidies are available for eligible residents in all states or only those residents in states which have established state-based public exchanges.

Dodd-Frank Wall Street Reform and Consumer Protection Act

The Dodd-Frank Wall Street Reform and Consumer Protection Act, or the Dodd-Frank Act became law in 2010. The Dodd-Frank Act represents a far-reaching overhaul of the framework for the U.S. financial services industry. Even though we are primarily a health benefits company, our business has been impacted by the Dodd-Frank Act. Many of its provisions require the adoption of rules for implementation, including those that govern which non-bank financial companies may become subject to the oversight of the Federal Reserve. These non-bank financial companies are defined as those that could pose a threat to the economy's financial stability either due to the potential of material financial distress at the company or due to the company's ongoing activities. While we are not currently considered a non-bank financial company for purposes of Federal Reserve oversight, future regulations or interpretations could change that result. Further, our investments in derivative instruments became subject to rules regarding the reporting and clearing of transactions and new margin requirements.

In addition, the Dodd-Frank Act creates a Federal Insurance Office, with limited powers that include information-gathering and subpoena authority. Although the Federal Insurance Office does not have authority over health insurance, it may have authority over other parts of our business, such as life insurance.

HIPAA and Gramm-Leach-Bliley Act

The federal Health Insurance Portability and Accountability Act of 1996, or HIPAA, imposes obligations for issuers of health insurance coverage and health benefit plan sponsors. This law requires guaranteed renewability of health care coverage for most group health plans and certain individuals. Also, the law limited exclusions based on preexisting medical conditions.

The administrative simplification provisions of HIPAA imposed a number of requirements on covered entities (including insurers, HMOs, group health plans, providers and clearinghouses). These requirements include uniform standards of common electronic health care transactions; privacy and security regulations; and unique identifier rules for employers,

health plans and providers. Additional federal privacy and security requirements, including breach notification, improved enforcement and additional limitations on use and disclosure of protected health information were passed through the Health Information Technology for Economic and Clinical Health, or HITECH, Act provisions of the American Recovery and Reinvestment Act of 2009 and corresponding implementing regulations. CMS posted the Interim Final Rule with Comment, or IFC, adopting operating rules for two electronic transactions: eligibility for a health plan and health care claims status. Based on the comments received on the IFC, CMS has decided not to change any of the policies established in the rule. Thus, the interim final rule became the final rule. The rule had a January 1, 2013 compliance date and we believe we have effectively complied with the requirements of the rule.

The federal Gramm-Leach-Bliley Act generally places restrictions on the disclosure of non-public information to non-affiliated third parties, and requires financial institutions, including insurers, to provide customers with notice regarding how their non-public personal information is used, including an opportunity to “opt out” of certain disclosures. State departments of insurance and certain federal agencies adopted implementing regulations as required by federal law. In addition, a number of states have adopted data security laws and/or regulations, regulating data security and/or requiring security breach notification, which may apply to us in certain circumstances.

Employee Retirement Income Security Act of 1974

The provision of services to certain employee welfare benefit plans is subject to the Employee Retirement Income Security Act of 1974, as amended, or ERISA, a complex set of laws and regulations subject to interpretation and enforcement by the Internal Revenue Service and the Department of Labor. ERISA regulates certain aspects of the relationships between us, the employers that maintain employee welfare benefit plans subject to ERISA and participants in such plans. Some of our administrative services and other activities may also be subject to regulation under ERISA. In addition, certain states require licensure or registration of companies providing third party claims administration services for benefit plans. We provide a variety of products and services to employee welfare benefit plans that are covered by ERISA. Plans subject to ERISA can also be subject to state laws and the question of whether and to what extent ERISA preempts a state law has been, and will continue to be, interpreted by many courts.

HMO and Insurance Holding Company Laws, including Risk-Based Capital Requirements

We are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. These holding company laws and regulations generally require insurance companies and HMOs within an insurance holding company system to register with the insurance department of each state where they are domiciled and to file with those states’ insurance departments certain reports describing capital structure, ownership, financial condition, certain intercompany transactions and general business operations. In addition, various notice and reporting requirements generally apply to transactions between insurance companies and HMOs and their affiliates within an insurance holding company system, depending on the size and nature of the transactions. Some insurance holding company laws and regulations require prior regulatory approval or, in certain circumstances, prior notice of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other provisions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends.

Additionally, the holding company acts of the states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company, which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would “control” the insurance holding company. “Control” is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

The states of domicile of our regulated subsidiaries have statutory risk-based capital, or RBC, requirements for health and other insurance companies and HMOs based on the RBC Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company’s investments and products. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance department or insurance commissioner of its state of domicile for each calendar year. The law requires

increasing degrees of regulatory oversight and intervention as a company's RBC declines. As of December 31, 2014, the RBC levels of our insurance and HMO subsidiaries exceeded all RBC thresholds.

Guaranty Fund Assessments

Under insolvency or guaranty association laws in most states, insurance companies can be assessed for amounts paid by guaranty funds for policyholder losses incurred when an insurance company becomes insolvent. Most state insolvency or guaranty association laws currently provide for assessments based upon the amount of premiums received on insurance underwritten within such state (with a minimum amount payable even if no premium is received). Under many of these guaranty association laws, assessments against insurance companies that issue policies of accident or sickness insurance are made retrospectively. Some states permit insurers to recover assessments paid through full or partial premium tax offsets or through future policyholder assessments.

States' adoption of the revised NAIC Model Guaranty Fund Act will tend to decrease our liability for insolvent insurers. The revised act reduces the premium base on which assessments are calculated, by omitting Medicare Parts C and D premium from the assessment base.

While the amount and timing of any future assessments cannot be predicted with certainty, we believe that future guaranty association assessments for insurer insolvencies will not have a material adverse effect on our liquidity and capital resources with the exception of potential exposure related to the Penn Treaty Network America Insurance Company and its subsidiary American Network Insurance Company insolvency as discussed in Note 13, "Commitments and Contingencies", to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Employees

At December 31, 2014, we had approximately 51,500 employees. Our employees are an important asset, and we seek to develop them to their full potential. We believe that our relationship with our employees is good.

Available Information

We are a large accelerated filer (as defined in Rule 12b-2 of the Securities Exchange Act of 1934, as amended, or Exchange Act) and are required, pursuant to Item 101 of Regulation S-K, to provide certain information regarding our website and the availability of certain documents filed with or furnished to the U.S. Securities and Exchange Commission, or SEC. Our Internet website is www.antheminc.com. We have included our Internet website address throughout this Annual Report on Form 10-K as textual reference only. The information contained on our Internet website is not incorporated into this Annual Report on Form 10-K. We make available, free of charge, by mail or through our Internet website, our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act as soon as reasonably practicable after we electronically file such material with or furnish it to the SEC. We also include on our Internet website our Corporate Governance Guidelines, our Standards of Ethical Business Conduct and the charter of each standing committee of our Board of Directors. In addition, we intend to disclose on our Internet website any amendments to, or waivers from, our Standards of Ethical Business Conduct that are required to be publicly disclosed pursuant to rules of the SEC and the New York Stock Exchange, or NYSE. Anthem, Inc. is an Indiana corporation incorporated on July 17, 2001.

ITEM 1A. RISK FACTORS.

The following factors, among others, could cause actual results to differ materially from those contained in forward-looking statements made in this Annual Report on Form 10-K and presented elsewhere by management from time to time. Such factors, among others, may have a material adverse effect on our business, financial condition, and results of operations and you should carefully consider them. It is not possible to predict or identify all such factors. Consequently, you should not consider any such list to be a complete statement of all our potential risks or uncertainties. Because of these and other factors, past performance should not be considered an indication of future performance.

Federal Health Care Reform together with the changes in federal and state regulations that have been, and continue to be, enacted to implement it, could adversely affect our business, cash flows, financial condition and results of operations.

The passage of Health Care Reform during 2010 and subsequent regulations represent significant changes to the U.S. health care system. The legislation and regulations are far-reaching and are intended to expand access to health insurance coverage over time by increasing the eligibility thresholds for most state Medicaid programs and providing certain other individuals and small businesses with tax credits to subsidize a portion of the cost of health insurance coverage. The legislation includes a requirement that most individuals obtain health insurance coverage beginning in 2014. In addition, the new laws impose significant fees, assessments and taxes on us and other health insurers, health plans and other industry participants. Health Care Reform imposes an annual industry-wide health insurer fee which was \$8.0 billion beginning in 2014 and growing to \$14.3 billion by 2018 and increasing annually thereafter. This health insurance fee is not deductible for income tax purposes and will be allocated pro rata among us and other industry participants based on net premiums written. Health Care Reform also imposes industry-wide reinsurance assessments of \$12.0 billion in 2014, and \$8.0 billion and \$5.0 billion in 2015 and 2016, respectively. Insurance companies will pay the fees based upon insured members whereas self-insured entities will pay them directly to HHS. As we are one of the nation's largest health benefits companies, we expect our share of the Health Care Reform fees, assessments and taxes will continue to be significant. There is some uncertainty whether we will be able to include all or a portion of these fees, assessments and taxes in our premium rates.

Health Care Reform also imposes new regulations on the health insurance sector, including, but not limited to, guaranteed coverage and expanded benefit requirements; prohibitions on some annual and all lifetime limits on amounts paid on behalf of or to our members; increased restrictions on rescinding coverage; establishment of minimum MLR and customer rebate requirements; creation of a federal rate review process; a requirement to cover preventive services on a first dollar basis; the establishment of public exchanges and essential benefit packages and greater limitations on how we price certain of our products. The legislation also reduces the reimbursement levels for our health plans participating in the Medicare Advantage program over time. There are also limitations on the amount of executive compensation that is deductible for income tax purposes.

The legislation also contains risk adjustment provisions applicable to the Individual and Small Group markets that took effect in 2014. These risk adjustment provisions effectively transfer funds from health plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to help protect against adverse selection. Effectively adapting to these risk adjustment provisions has required us to modify our operational and strategic initiatives to focus on and manage different populations of potential members than we have in the past. If we are not able to successfully design and implement operational and strategic initiatives to adapt to these changes in certain of our markets, our financial condition and results of operations may be adversely affected.

Some of the provisions of Health Care Reform became effective immediately upon enactment, while most of the other provisions became effective in January 2014, with the remaining provisions to be phased in over the next several years. These changes could impact us through potential disruption to the employer-based market, potential cost shifting in the health care delivery system to insurance companies and limitations on the ability to increase premiums to meet costs. We have dedicated, and will continue to dedicate, material resources and incurred, and will continue to incur, material expenses to implement and comply with Health Care Reform at both the state and federal levels, including implementing and complying with future regulations that provide guidance on and clarification of significant portions of the legislation. The Health Care Reform law and regulations are likely to have significant effects on our future operations, which, in turn, could impact the value of our business model and results of operations, including potential impairments of our goodwill and other intangible assets. Difficulties and delays with regard to implementation of provisions of Health Care Reform in 2013 and 2014, including with regard to the functionality of the public exchanges and the lack of full cooperation and coordination between federal and state authorities as to implementation of Health Care Reform, have increased uncertainties and made our planning relating to Health Care Reform more difficult and unpredictable, which increases the risk that we will experience unanticipated adverse consequences arising out of Health Care Reform.

Finally, federal and state regulatory agencies may further restrict our ability to obtain new product approvals, implement changes in premium rates or impose additional restrictions, under new or existing laws that could adversely affect our business, cash flows, financial condition and results of operations.

Changes in the regulation of our business by state and federal regulators may adversely affect our business, cash flows, financial condition and results of operations.

Our insurance, managed health care and HMO subsidiaries are subject to extensive regulation and supervision by the insurance, managed health care or HMO regulatory authorities of each state in which they are licensed or authorized to do business, as well as to regulation by federal and local agencies. We cannot assure that future regulatory action by state insurance or HMO authorities or federal regulatory authorities will not have a material adverse effect on the profitability or marketability of our health benefits or managed care products or on our business, financial condition and results of operations. In addition, because of our participation in government-sponsored programs such as Medicare and Medicaid, a number of our subsidiaries are also subject to regulation by CMS and state Medicaid agencies, and to changes in government regulations or policy with respect to, among other things, reimbursement levels, eligibility requirements and additional governmental participation which could also adversely affect our business, financial condition and results of operations. In addition, we cannot ensure that application of the federal and/or state tax regulatory regime that currently applies to us will not, or future tax regulation by either federal and/or state governmental authorities concerning us could not, have a material adverse effect on our business, operations or financial condition.

State legislatures will continue to focus on health care delivery and financing issues. Most states are very focused on how to manage and reduce their budgets and are exploring ways to mitigate costs. As such, some states have acted to reduce or limit increases to premium payments. Others have enacted, or are contemplating enacting, significant reform of their health insurance markets to include provisions affecting both public programs and privately-financed health insurance arrangements. In addition, California has enacted legislation to establish minimum benefit expense ratio thresholds and continues to consider legislative proposals to require prior regulatory approval of premium rate increases. If enacted into law, these state proposals could have a material adverse impact on our business, cash flows, operations or financial condition.

The U.S. Supreme Court has determined that significant portions of the ACA, including the provisions regarding public exchanges, are constitutional. As a result, some states have developed their own public exchanges, while other states are relying on HHS to operate the public exchange in their states or are implementing partnership exchanges with the federal government. These multiple public exchange options have led to increased uncertainties and made our planning for these public exchanges more difficult. The Supreme Court decision also permitted states to opt out of the elements of Health Care Reform that require expansion of Medicaid coverage in January 2014 without losing their current federal Medicaid funding. A number of states in which we offer Medicaid products, including Florida, Georgia, Kansas, Louisiana, South Carolina, Tennessee, Texas, Virginia and Wisconsin, have indicated their current decision to opt out of Medicaid expansion, at least for the present time. If states allow certain programs to expire or choose to opt out of Medicaid expansion, we could experience reduced Medicaid enrollment and reduced growth opportunities.

The U.S. Supreme Court is now considering a case that challenges the premium tax subsidies and whether the subsidies are available for eligible residents in all states or only those residents in states which have established state-based public exchanges. In January 2014, the D.C. District Court upheld the subsidies for both state-based and federal public exchanges and in November 2014, the U.S. Supreme Court issued a writ of certiorari and is expected to decide the case during its current term, which ends in June 2015. If the decision alters the availability of the subsidies, it may have a material adverse effect on our enrollment, cash flows and results of operations.

Additionally, from time to time, Congress has considered, or may consider in the future, various forms of managed care reform legislation which, if adopted, could fundamentally alter the treatment of coverage decisions under ERISA. There have been legislative attempts to limit ERISA's preemptive effect on state laws and litigants' ability to seek damages beyond the benefits offered under their plans. If adopted, such limitations could increase our liability exposure, could permit greater state regulation of our operations, and could expand the scope of damages, including punitive damages, litigants could be awarded. While we cannot predict if any of these initiatives will ultimately become effective or, if enacted, what their terms will be, their enactment could increase our costs, expose us to expanded liability or require us to revise the ways in which we conduct business.

Our inability to contain health care costs, implement increases in premium rates on a timely basis, maintain adequate reserves for policy benefits or maintain our current provider agreements may adversely affect our business and profitability.

Our profitability depends in large part on accurately predicting health care costs and on our ability to manage future health care costs through underwriting criteria, medical management, product design and negotiation of favorable provider contracts. Last minute changes in the implementation of Health Care Reform at the end of 2013 and in the spring of 2014, in particular those relating to difficulties with the functionality of the public exchanges, may erode the Individual and Small Group pools so that our assumptions underlying the pricing and design of our public exchange products prove to be inaccurate in a way that materially adversely affects the expected profitability of those products. Government-imposed limitations on Medicare and Medicaid reimbursement have also caused the private sector to bear a greater share of increasing health care costs. Changes in health care practices, demographic characteristics, inflation, new technologies, the cost of prescription drugs, clusters of high cost cases, changes in the regulatory environment and numerous other factors affecting the cost of health care may adversely affect our ability to predict and manage health care costs, as well as our business, financial condition and results of operations. Relatively small differences between predicted and actual health care costs as a percentage of premium revenues can result in significant changes in our results of operations, particularly with respect to our products sold through the public exchanges, as we and our competitors have limited experience with pricing such products or the utilization rates for medical or other covered services by members who purchase our products through such exchanges. The public exchanges may increase the risk that our products will be selected by individuals who have a higher risk profile or utilization rate than the pool of participants we anticipated when we established the pricing for these public exchange products. Therefore, health care benefit costs in excess of our cost projections reflected in our public exchange product pricing cannot be recovered in the current premium period through higher premiums; however, in certain circumstances, Federal risk adjustment mechanisms, including risk adjustment payments, risk corridors and reinsurance, could help offset health care benefit costs in excess of our projections. If it is determined that our assumptions regarding cost trends, utilization, enrollment, adverse selection, acuity and other assumptions utilized in setting our premium rates are significantly different than actual results, even with these risk adjustment mechanisms, our income statement and financial position could be adversely affected.

In addition to the challenge of managing health care costs, we face pressure to contain premium rates. Our customers may renegotiate their contracts to seek to contain their costs or may move to a competitor to obtain more favorable premiums. Further, federal and state regulatory agencies may restrict our ability to implement changes in premium rates. For example, the ACA includes an annual rate review requirement to prohibit unreasonable rate increases, and our plans may be excluded from participating in the public exchanges if they are deemed to have a history of "unreasonable" rate increases. Fiscal concerns regarding the continued viability of programs such as Medicare and Medicaid may cause decreasing reimbursement rates, delays in premium payments or a lack of sufficient increase in reimbursement rates for government-sponsored programs in which we participate. A limitation on our ability to increase or maintain our premium or reimbursement levels or a significant loss of membership resulting from our need to increase or maintain premium or reimbursement levels could adversely affect our business, cash flows, financial condition and results of operations.

The reserves that we establish for health insurance policy benefits and other contractual rights and benefits are based upon assumptions concerning a number of factors, including trends in health care costs, expenses, general economic conditions and other factors. To the extent the actual claims experience is less favorable than estimated based on our underlying assumptions, our incurred losses would increase and future earnings could be adversely affected.

Our profitability is dependent in part upon our ability to contract on favorable terms with hospitals, physicians and other health care providers. The failure to maintain or to secure cost-effective health care provider contracts may result in a loss of membership or higher medical costs, which could adversely affect our business. In addition, ACO practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other care providers choose may change the way that these providers interact with us and may change the competitive landscape. Such organizations or groups of physicians may compete directly with us, which may impact our relationship with these providers or affect the way that we price our products and estimate our costs and may require us to incur costs to change our operations, and our results of operations, financial position and cash flow could be adversely affected. Further, our inability to contract with providers, or if providers attempt to use their market position to negotiate more favorable contracts or place us at a competitive disadvantage, or the inability of providers to provide adequate care, could adversely affect our business. In addition, we do not have contracts with all providers that

render services to our members and, as a result, do not have a pre-established agreement about the amount of compensation those out-of-network providers will accept for the services they render, which can result in significant litigation or arbitration proceedings.

A significant reduction in the enrollment in our health benefits programs could have an adverse effect on our business and profitability.

A significant reduction in the number of enrollees in our health benefits programs could adversely affect our business, financial condition and results of operations. Factors that could contribute to a reduction in enrollment include: reductions in workforce by existing customers; general economic downturn that results in business failures and high unemployment rates; employers no longer offering certain health care coverage as an employee benefit or electing to offer this coverage on a voluntary, employee-funded basis; state and federal regulatory changes; failure to obtain new customers or retain existing customers; premium increases and benefit changes; our exit from a specific market; negative publicity and news coverage; participation on public exchanges and related underwriting changes; and failure to attain or maintain nationally recognized accreditations.

There are various risks associated with participating in Medicaid and Medicare programs, including dependence upon government funding and the timing of payments, compliance with government contracts and increased regulatory oversight.

We contract with various state and federal agencies, including CMS, to provide managed health care services, including Medicare Advantage plans, Medicare Supplement plans, Medicare approved prescription drug plans, Medicaid, TANF, SPD, LTSS, CHIP and ACA-related Medicaid expansion programs. We also provide various administrative services for several other entities offering medical and/or prescription drug plans to their Medicare eligible members through our affiliated companies and we offer employer group waiver plans which provide medical and/or prescription drug coverage to retirees. We are also participating in Medicare and Medicaid dual eligible programs in several states. These programs in our Government Business segment have been the subject of recent regulatory reform initiatives, including Health Care Reform, which are still in the process of being implemented. It is difficult to predict the future impact of Health Care Reform on our Government Business segment due to Health Care Reform's complexity, gradual and delayed implementation, and possible amendment. Changes in Health Care Reform have required us to make investments in new products, services and technologies, which investments may not be realized due to possible delays and amendments that continue to occur. Health Care Reform, other regulatory reform initiatives or additional changes in existing laws or regulations, or their interpretations, could have a material adverse effect on our business, cash flow, financial condition and results of operations.

Revenues from the Medicare and Medicaid programs are dependent, in whole or in part, upon annual funding from the federal government and/or applicable state governments. The base premium rate paid by each state or federal agency differs depending upon a combination of various factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix, member eligibility category and risk scores. Future levels of Medicare and Medicaid rates may be affected by continued government efforts to contain costs and may be further affected by state and federal budgetary constraints. If the federal government or any state in which we operate were to decrease rates paid to us, or pay us less than the amount necessary to keep pace with our cost trends, it could have a material adverse effect on our business, financial condition and results of operations. Further, certain of our contracts with the states are subject to cancellation in the event of the unavailability of state funds. In addition, the various states' new Medicare and Medicaid dual eligible programs are still subject to uncertainty surrounding payment rates and other requirements, which could affect where we seek to participate in these new programs. An unexpected reduction, inadequate government funding or significantly delayed payments for these programs may adversely affect our revenues, cash flow and financial results.

A portion of our premium revenue comes from CMS through our Medicare Advantage and Medicare Part D contracts. As a consequence, our Medicare Advantage and Medicare Part D plans are dependent on federal government funding levels. The premium rates paid to Medicare plans are established based on benchmarks which are now tied to a percentage of Medicare fee for service, although the rates differ depending on a combination of factors, including upper payment limits established by CMS, a member's health profile and status, age, gender, county or region, benefit mix, member eligibility categories and risk scores. Beginning in 2014, Medicare Advantage and Medicare Part D plans became subject to MLR rules. Continuing government efforts to contain health care related expenditures, including prescription drug cost, and other federal budgetary constraints that result in changes in the Medicare program, including changes with respect to funding, could lead to

reductions in the amount of reimbursement, or other changes that could have a material adverse effect on our business, cash flow, financial condition and results of operations. Risks associated with the Medicare Advantage and Medicare Part D plans include potential uncollectability of receivables resulting from processing and/or verifying enrollment, inadequacy of underwriting assumptions, inability to receive and process correct information (including inability due to systems issues by the federal government, the applicable state government or us), uncollectability of premiums from members, increased medical or pharmaceutical costs, overpayments identified as a result of ongoing auditing and monitoring activities, and the limited enrollment periods in this business. While we believe we have adequately reviewed our assumptions and estimates regarding these complex and wide-ranging programs under Medicare Parts C and D, including those related to collectability of receivables and establishment of liabilities, the actual results may be materially different than our assumptions and estimates and could have a material adverse effect on our business, financial condition and results of operations. There is also the possibility that Medicare Advantage Special Needs plans will not be re-authorized by Congress. Without Congressional action, these plans will expire on December 31, 2016. If the Special Needs plans are not re-authorized, there could be a loss of revenue and it would become more difficult to coordinate Medicare benefits with other coverage.

Our contracts with the various state governmental agencies and CMS contain certain provisions regarding data submission, provider network maintenance, quality measures, claims payment, continuity of care, call center performance and other requirements specific to state and federal program regulations. If we fail to comply with these requirements, we may be subject to fines, penalties, liquidated damages and retrospective adjustments in payments made to our health plans, that could impact our profitability. Additionally, we could be required to file a corrective plan of action with additional penalties for noncompliance, including a negative impact on future membership enrollment levels. Further, certain of our CMS and state Medicaid contracts are subject to a competitive procurement process, and if our existing contracts are not renewed or if we are not awarded new contracts as a result of this competitive procurement process, this could have a material adverse effect on our business, cash flows, financial condition and results of operations.

In addition to the contractual requirements affecting our participation in Medicaid and Medicare programs, we are also subject to various state and federal health care laws and regulations, including those directed at preventing fraud and abuse in government funded programs. Failure to comply with these laws and regulations could result in investigations or litigation, with the imposition of fines, restrictions or exclusions from program participation or the imposition of corporate integrity agreements or other agreements with a federal or state governmental agency that could adversely impact our business, cash flows, financial condition and results of operations.

Further, CMS has been conducting audits of our Medicare Advantage health plans to validate the diagnostic data and patient claims that are submitted to CMS. These audits may result in retrospective adjustments in payments made to our health plans. In addition, if we fail to report and correct errors discovered through our own auditing procedures or during a CMS audit or otherwise fail to comply with the applicable laws and regulations, we could be subject to fines, civil penalties or other sanctions which could have a material adverse effect on our ability to participate in these programs, and on our financial condition, cash flows and results of operations. The ACA also established recovery audit programs for Medicare Parts C and D. The Medicare Part D Recovery Audit Contractor, or RAC, has been auditing Medicare Part D claims and recouping overpayments since 2012. A Medicare Part C RAC has not yet been named but CMS expects to award a Medicare Part C RAC contract in the near future, which could increase the amount of audits and subsequent recoupments by the federal government.

The ACA also authorized state Medicaid programs to implement RAC programs similar to Medicare RAC programs and a number of states have done so. This could increase the amount of audits and subsequent recoupment by the federal and state governments, which could adversely affect our financial condition and results of operations.

In addition, there are an increasing number of investigations regarding compliance with various provisions of the ACA. These investigations are being conducted by both CMS and state regulators. As a result, we could be subject to multiple investigations of the same issue. These investigations, and possible resulting enforcement actions, could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

Regional concentrations of our business may subject us to economic downturns in those regions.

Most of our revenues are generated in the states of California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Maryland, Missouri, Nevada, New Hampshire, New York, Ohio, Tennessee, Texas, Virginia and Wisconsin. Due to this concentration of business in these states, we are exposed to potential losses resulting from the risk of state specific or regional economic downturns impacting these states. If such negative economic conditions do not improve, we may experience a reduction in existing and new business, which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

The health benefits industry is subject to negative publicity, which could adversely affect our business and profitability.

The health benefits industry is subject to negative publicity, which can arise from, among other things, the ongoing debate over Health Care Reform. Negative publicity may result in increased regulation and legislative review of industry practices, which may further increase our costs of doing business and adversely affect our profitability by: adversely affecting our ability to market our products and services; requiring us to change our products and services; or increasing the regulatory burdens under which we operate.

In addition, as long as we use the Blue Cross and Blue Shield names and marks in marketing our health benefits products and services, any negative publicity concerning the BCBSA or other BCBSA licensees may adversely affect us and the sale of our health benefits products and services. Any such negative publicity could adversely affect our business, cash flows, financial condition and results of operations.

We face competition in many of our markets and customers and brokers have flexibility in moving between competitors.

As a health benefits company, we operate in a highly competitive environment and in an industry that is currently subject to significant changes from legislative reform, business consolidations, new strategic alliances, aggressive marketing practices by other health benefits organizations and market pressures brought about by an informed and organized customer base, particularly among large employers. For example, we began to compete for sales on public exchanges in 2014, which has required, and will continue to require, us to develop or acquire the tools (including social media tools) necessary to interact with the exchanges and with consumers using the exchanges, increase our focus on individual customers and improve our consumer-focused sales and marketing, customer interfaces and product offerings. These factors have produced and will likely continue to produce significant pressures on the profitability of health benefits companies.

We also will have to respond to pricing and other actions taken by existing competitors and potentially disruptive new entrants. Due to the price transparency provided by public exchanges, in the market for individual health insurance we face competitive pressures from existing and new competitors. These risks may be enhanced if employers shift to defined contribution health care benefits plans and make greater utilization of private insurance exchanges or encourage their employees to purchase health insurance on the public exchanges. We can provide no assurance that we will be able to compete successfully on these public exchanges or that we will be able to benefit from any opportunities presented by such exchanges. If we are not competitive on these public exchanges or are unsuccessful in reducing our cost structure, our future growth and profitability may be adversely impacted.

We are currently dependent on the non-exclusive services of independent agents and brokers in the marketing of our health care products, particularly with respect to individuals, seniors and small employer group customers. We face intense competition for the services and allegiance of these independent agents and brokers, who may also market the products of our competitors. Our relationship with our brokers and independent agents could be adversely impacted by changes in our business practices to address Health Care Reform legislation, including potential reductions in commissions and consulting fees paid to agents and brokers. We cannot ensure that we will be able to compete successfully against current and future competitors or that competitive pressures faced by us will not materially and adversely affect our business, cash flows, financial condition and results of operations.

We face intense competition to attract and retain employees. Further, managing key executive succession and retention is critical to our success.

We are dependent on retaining existing employees, attracting additional qualified employees to meet current and future needs and achieving productivity gains from our investment in technology. We face intense competition for qualified employees, and there can be no assurance that we will be able to attract and retain such employees or that such competition among potential employers will not result in increasing salaries. An inability to retain existing employees or attract additional employees could have a material adverse effect on our business, cash flows, financial condition and results of operations.

We would be adversely affected if we fail to adequately plan for succession of our President and Chief Executive Officer and other senior management and retention of key executives. While we have succession plans in place for members of our senior management, and continue to review and update those plans, and we have employment arrangements with certain key executives, these plans and arrangements do not guarantee that the services of our senior executives will continue to be available to us or that we will be able to attract and retain suitable successors.

A change in our health care product mix may impact our profitability.

Our health care products that involve greater potential risk generally tend to be more profitable than administrative services products and those health care products where the employer groups assume the underwriting risks. Individuals and small employer groups are more likely to purchase our higher-risk health care products because such purchasers are generally unable or unwilling to bear greater liability for health care expenditures. Typically, government-sponsored programs also involve our higher-risk health care products. It is not yet clear whether our products sold on the public exchanges will be more or less profitable products. A shift of enrollees from more profitable products to less profitable products could have a material adverse effect on our financial condition and results of operations.

As a holding company, we are dependent on dividends from our subsidiaries. These dividends are necessary to pay our outstanding indebtedness. Our regulated subsidiaries are subject to state regulations, including restrictions on the payment of dividends, maintenance of minimum levels of capital and restrictions on investment portfolios.

We are a holding company whose assets include all of the outstanding shares of common stock (or other ownership interest) of our subsidiaries including our intermediate holding companies and regulated insurance and HMO subsidiaries. Our subsidiaries are separate legal entities. As a holding company, we depend on dividends from our subsidiaries. Furthermore, our subsidiaries are not obligated to make funds available to us, and creditors of our subsidiaries will have a superior claim to certain of our subsidiaries' assets. Among other restrictions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends. In some states we have made special undertakings that may limit the ability of our regulated subsidiaries to pay dividends. In addition, our subsidiaries' ability to make any payments to us will also depend on their earnings, the terms of their indebtedness, business and tax considerations and other legal restrictions. Our ability to repurchase shares or pay dividends in the future to our shareholders and meet our obligations, including paying operating expenses and debt service on our outstanding and future indebtedness, will depend upon the receipt of dividends from our subsidiaries. An inability of our subsidiaries to pay dividends in the future in an amount sufficient for us to meet our financial obligations may materially adversely affect our business, cash flows, financial condition and results of operations.

Most of our regulated subsidiaries are subject to RBC standards, imposed by their states of domicile. These laws are based on the RBC Model Act adopted by the NAIC and require our regulated subsidiaries to report their results of risk-based capital calculations to the departments of insurance and the NAIC. Failure to maintain the minimum RBC standards could subject our regulated subsidiaries to corrective action, including state supervision or liquidation. Our regulated subsidiaries are currently in compliance with the risk-based capital or other similar requirements imposed by their respective states of domicile. As discussed in more detail below, we are a party to license agreements with the BCBSA which contain certain requirements and restrictions regarding our operations, including minimum capital and liquidity requirements, which could restrict the ability of our regulated subsidiaries to pay dividends.

Our regulated subsidiaries are subject to state laws and regulations that require diversification of our investment portfolios and limit the amount of investments in certain riskier investment categories, such as below-investment-grade fixed maturity securities, mortgage loans, real estate and equity investments, which could generate higher returns on our investments. Failure to comply with these laws and regulations might cause investments exceeding regulatory limitations to

be treated as non-admitted assets for purposes of measuring statutory surplus and risk-based capital, and, in some instances, require the sale of those investments.

We have substantial indebtedness outstanding and may incur additional indebtedness in the future. Such indebtedness could also adversely affect our ability to pursue desirable business opportunities.

Our debt service obligations require us to use a portion of our cash flow to pay interest and principal on debt instead of for other corporate purposes, including funding future expansion. If our cash flow and capital resources are insufficient to service our debt obligations, we may be forced to seek extraordinary dividends from our subsidiaries, sell assets, seek additional equity or debt capital or restructure our debt. However, these measures might be unsuccessful or inadequate in permitting us to meet scheduled debt service obligations.

We may also incur future debt obligations that might subject us to restrictive covenants that could affect our financial and operational flexibility. Our breach or failure to comply with any of these covenants could result in a default under our credit agreement. If we default under our credit agreement, the lenders could cease to make further extensions of credit or cause all of our outstanding debt obligations under our credit agreement to become immediately due and payable, together with accrued and unpaid interest. If the indebtedness under our notes or our credit agreement is accelerated, we may be unable to repay or finance the amounts due. Indebtedness could also limit our ability to pursue desirable business opportunities, and may affect our ability to maintain an investment grade rating for our indebtedness.

A downgrade in our credit ratings could have an adverse effect on our business, financial condition and results of operations.

Claims-paying ability and financial strength ratings by nationally recognized statistical rating organizations are an important factor in establishing the competitive position of insurance companies and health benefits companies. Each of the credit rating agencies reviews its ratings periodically and there can be no assurance that our current credit ratings will be maintained in the future. We believe our strong credit ratings are an important factor in marketing our products to customers, since credit ratings information is broadly disseminated and generally used throughout the industry. If our credit ratings are downgraded or placed under review, with possible negative implications, such actions could adversely affect our business, financial condition and results of operations. These credit ratings reflect each credit rating agency's opinion of our financial strength, operating performance and ability to meet our obligations to policyholders and creditors, and are not evaluations directed toward the protection of investors in our common stock.

We face risks related to litigation.

We are, or may in the future, be a party to a variety of legal actions that may affect any business, such as employment and employment discrimination-related suits and administrative charges before government agencies, employee benefit claims, breach of contract actions, tort claims and intellectual property-related litigation. In addition, because of the nature of our business, we are subject to a variety of legal actions relating to our business operations, including the design, administration and offering of our products and services. These could include claims relating to the denial of health care benefits; the rescission of health insurance policies; development or application of medical policy; medical malpractice actions; product liability claims; allegations of anti-competitive and unfair business activities; provider disputes over compensation; provider tiering programs; termination of provider contracts; the recovery of overpayments from providers; self-funded business; disputes over co-payment calculations; reimbursement of out-of-network claims; the failure to disclose certain business or corporate governance practices; the failure to comply with various state or federal laws, including but not limited to, ERISA and the Mental Health Parity Act; and customer audits and contract performance, including government contracts. These actions or proceedings could have a material adverse effect on our business, cash flows, financial condition and results of operations.

In addition, we are also involved in, or may in the future be party to, pending or threatened litigation of the character incidental to the business transacted, arising out of our operations or our 2001 demutualization, including, but not limited to, breaches of security and violations of privacy requirements (including as a result of the cyber attack reported by us in February 2015, as more fully described under Note 13, "Commitments and Contingencies - Data Breach," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K), shareholder actions, compliance with federal and state laws and regulations (including *qui tam* or "whistleblower" actions), or sales and

acquisitions of businesses or assets. We are from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings, including challenges to the award of government contracts by disappointed bidders. These investigations, audits and reviews include routine and special investigations by various state insurance departments, state attorneys general and the U.S. Attorney General. Such investigations could result in the imposition of civil or criminal fines, penalties and other sanctions. Liabilities that may result from these actions could have a material adverse effect on our cash flows, results of operations or financial position.

Recent court decisions and legislative activity may increase our exposure for any of these types of claims. In some cases, substantial non-economic (including injunctive relief), treble or punitive damages may be sought. We currently have insurance coverage for some of these potential liabilities. Other potential liabilities may not be covered by insurance, insurers may dispute coverage or the amount of insurance may not be enough to cover the damages awarded. In addition, certain types of damages may not be covered by insurance, and insurance coverage for all or certain forms of liability may become unavailable or prohibitively expensive in the future. Any adverse judgment against us resulting in such damage awards could have an adverse effect on our cash flows, results of operations and financial condition.

Further, litigation brought against the federal and some state governments over Health Care Reform could have a material adverse effect on our business, cash flows, financial condition and results of operations as changes to Health Care Reform resulting from this litigation create uncertainty over the applicability and enforceability of portions of the law and the various regulations, which impacts our strategy and could negatively impact our future growth opportunities.

Our future obligations for state guaranty association assessments could increase in the event that Health Care Reform and its implementation result in increased insolvencies of health plans.

Under insolvency or guaranty association laws in most states, insurance companies can be assessed for amounts paid by guaranty funds for policyholder losses incurred when an insurance company becomes insolvent. Most state insolvency or guaranty association laws provide for assessments based upon the amount of premiums received on insurance underwritten within such state. While in the past, health insurance company insolvencies have been infrequent, the changes to the U.S. health care system and markets and related uncertainties from implementation of Health Care Reform may result in increased insolvencies of health insurance companies covered by these state insolvency or guaranty association laws. In that event, we may experience increased guaranty association assessments for health insurer insolvencies, the amount and timing of which cannot be predicted with certainty.

There are various risks associated with providing health care services.

The direct provision of health care services by our CareMore subsidiary involves risks of additional litigation arising from medical malpractice actions based on our treatment decisions or brought against us or our physician associates for alleged malpractice or professional liability claims arising out of the delivery of health care and related services. In addition, liability may arise from maintaining health care premises that serve the public. If we fail to maintain adequate insurance coverage for these liabilities, or if such insurance is not available, the resulting costs could adversely affect our cash flows, financial condition or results of operations.

Additionally, many states in which we operate our CareMore subsidiary limit the practice of medicine to licensed individuals or professional organizations comprised of licensed individuals. Business corporations generally may not exercise control over the medical decisions of physicians ("corporate practice of medicine") and we are not licensed to practice medicine. Rules and regulations relating to the practice of medicine, fee-splitting between physicians and referral sources, and similar issues vary from state to state. Further, certain federal and state laws, including those covering our Medicare and Medicaid plans, prohibit the offer, payment, solicitation, or receipt of any form of remuneration to induce, or in return for, the referral of patient care opportunities, including, but not limited to, Medicare patients ("anti-kickback rules"), and also generally prohibit physicians from making referrals to any entity providing certain designated health services if the referring physician or related person has an ownership or financial interest in the entity ("self-referral rules").

We believe that our health care service operations comply with applicable rules and regulations regarding the corporate practice of medicine, fee-splitting, anti-kickback, self-referral and similar issues. However, any enforcement actions by governmental officials alleging non-compliance with these rules and regulations could adversely affect our business, cash flows, financial condition or results of operations.

We are a party to license agreements with the BCBSA that entitle us to the exclusive and in certain areas non-exclusive use of the Blue Cross and Blue Shield names and marks in our geographic territories. The termination of these license agreements or changes in the terms and conditions of these license agreements could adversely affect our business, financial condition and results of operations.

We use the Blue Cross and Blue Shield names and marks as identifiers for our products and services under licenses from the BCBSA. Our license agreements with the BCBSA contain certain requirements and restrictions regarding our operations and our use of the Blue Cross and Blue Shield names and marks, including: minimum capital and liquidity requirements imposed by the BCBSA; enrollment and customer service performance requirements; participation in programs that provide portability of membership between plans; disclosures to the BCBSA relating to enrollment and financial conditions; disclosures as to the structure of the Blue Cross and Blue Shield system in contracts with third parties and in public statements; plan governance requirements; a requirement that at least 80% (or, in the case of Blue Cross of California, substantially all) of a licensee's annual combined local net revenue, as defined by the BCBSA, attributable to health care plans and related services within its service areas must be sold, marketed, administered or underwritten under the Blue Cross and Blue Shield names and marks; a requirement that at least 66 2/3% of a licensee's annual combined national net revenue, as defined by the BCBSA, attributable to health care plans and related services must be sold, marketed, administered or underwritten under the Blue Cross and Blue Shield names and marks; a requirement that neither a plan nor any of its licensed affiliates may permit an entity other than a plan or a licensed affiliate to obtain control of the plan or the licensed affiliate or to acquire a substantial portion of its assets related to licensable services; a requirement that we divide our Board of Directors into three classes serving staggered three-year terms; a requirement that we guarantee certain contractual and financial obligations of our licensed affiliates; and a requirement that we indemnify the BCBSA against any claims asserted against it resulting from the contractual and financial obligations of any subsidiary that serves as a fiscal intermediary providing administrative services for Medicare Parts A and B. Failure to comply with the foregoing requirements could result in a termination of the license agreements.

The standards under the license agreements may be modified in certain instances by the BCBSA. For example, from time to time there have been proposals considered by the BCBSA to modify the terms of the license agreements to restrict various potential business activities of licensees. These proposals have included, among other things, a limitation on the ability of a licensee to make its provider networks available to insurance carriers or other entities not holding a Blue Cross or Blue Shield license. To the extent that such amendments to the license agreements are adopted in the future, they could have a material adverse effect on our future expansion plans or results of operations. Further, BCBS licensees have certain requirements to perform administrative services for members of other BCBS licensees. If we or another BCBS licensee is not in compliance with all legal requirements or are unable to perform administrative services as required, this could have an adverse effect on our members and our ability to maintain our licenses, which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

Upon the occurrence of an event causing termination of the license agreements, we would no longer have the right to use the Blue Cross and Blue Shield names and marks or to sell Blue Cross and Blue Shield health insurance products and services in one or more of our service areas. Furthermore, the BCBSA would be free to issue a license to use the Blue Cross and Blue Shield names and marks in these service areas to another entity. Our existing Blue Cross and Blue Shield members would be provided with instructions for obtaining alternative products and services licensed by the BCBSA. Events that could cause the termination of a license agreement with the BCBSA include failure to comply with minimum capital requirements imposed by the BCBSA, failure to comply with governance requirements such as maintaining a classified board structure, a change of control or violation of the BCBSA ownership limitations on our capital stock, impending financial insolvency and the appointment of a trustee or receiver or the commencement of any action against a licensee seeking its dissolution. We believe that the Blue Cross and Blue Shield names and marks are valuable identifiers of our products and services in the marketplace.

Upon termination of a license agreement, the BCBSA would have the right to impose a "Re-establishment Fee" upon us, which would be used in part to fund the establishment of a replacement Blue Cross and/or Blue Shield licensee in the vacated service area. The fee is set at \$98.33 per licensed enrollee. As of December 31, 2014 we reported 28.6 million Blue Cross and/or Blue Shield enrollees. If the Re-establishment Fee was applied to our total Blue Cross and/or Blue Shield enrollees, we would be assessed approximately \$2.8 billion by the BCBSA. Accordingly, termination of the license agreements would have a material adverse effect on our business, financial condition and results of operations.

Large-scale medical emergencies may have a material adverse effect on our business, cash flows, financial condition and results of operations.

Large-scale medical emergencies can take many forms and can cause widespread illness and death. For example, federal and state law enforcement officials have issued warnings about potential terrorist activity involving biological and other weapons. In addition, natural disasters such as hurricanes and the potential for a wide-spread pandemic of influenza coupled with the lack of availability of appropriate preventative medicines can have a significant impact on the health of the population of wide-spread areas. If the United States were to experience widespread bioterrorism or other attacks, large-scale natural disasters in our concentrated coverage areas or a large-scale pandemic or epidemic, our covered medical expenses could rise and we could experience a material adverse effect on our business, cash flows, financial condition and results of operations or, in the event of extreme circumstances, our viability could be threatened.

We have built a significant portion of our current business through mergers and acquisitions, joint ventures and strategic alliances and we expect to pursue such opportunities in the future.

The following are some of the risks associated with mergers and acquisitions, joint ventures and strategic alliances (collectively, "business combinations") that could have a material adverse effect on our business, financial condition and results of operations:

- some of the acquired businesses may not achieve anticipated revenues, earnings or cash flow, business opportunities, synergies, growth prospects and other anticipated benefits;
- the goodwill or other intangible assets established as a result of our business combinations may be incorrectly valued or become non-recoverable;
- we may assume liabilities that were not disclosed to us or which were under-estimated;
- we may experience difficulties in integrating acquired businesses, be unable to integrate acquired businesses successfully or as quickly as expected, and be unable to realize anticipated economic, operational and other benefits in a timely manner, which could result in substantial costs and delays or other operational, technical or financial problems;
- business combinations could disrupt our ongoing business, distract management, result in the loss of key employees, divert resources, result in tax costs or inefficiencies and make it difficult to maintain our current business standards, controls, information technology systems, policies and procedures;
- we may finance future business combinations by issuing common stock for some or all of the purchase price, which could dilute the ownership interests of our shareholders;
- we may also incur additional debt related to future business combinations; and
- we would be competing with other firms, some of which may have greater financial and other resources, to acquire attractive companies.

The value of our intangible assets may become impaired.

Due largely to our past mergers, acquisitions and divestitures, goodwill and other intangible assets represent a substantial portion of our assets. If we make additional acquisitions it is likely that we will record additional intangible assets on our consolidated balance sheets.

In accordance with applicable accounting standards, we periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may no longer be recoverable, in which case a charge to income may be necessary. This impairment testing requires us to make assumptions and judgments regarding the estimated fair value of our reporting units, including goodwill and other intangible assets (with indefinite lives). In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately. Estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used. If estimated fair values are less than the carrying values of goodwill and other intangible assets with indefinite lives in future impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

Any future evaluations requiring an impairment of our goodwill and other intangible assets could materially affect our results of operations and shareholders' equity in the period in which the impairment occurs. A material decrease in shareholders' equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

In addition, the estimated value of our reporting units may be impacted as a result of business decisions we make associated with the implementation of the various Health Care Reform regulations. Such decisions, which could unfavorably affect our ability to support the carrying value of certain goodwill and other intangible assets, could result in impairment charges in future periods.

Adverse securities and credit market conditions may significantly affect our ability to meet liquidity needs.

The securities and credit markets have in the past experienced higher than normal volatility, although current market conditions are more stable. In some cases, the markets have exerted downward pressure on availability of liquidity and credit capacity for certain issuers. We need liquidity to pay our operating expenses, make payments on our indebtedness and pay capital expenditures. The principal sources of our cash receipts are premiums, administrative fees, investment income, other revenue, proceeds from the sale or maturity of our investment securities, proceeds from borrowings and proceeds from the issuance of common stock under our employee stock plans.

Our access to additional financing will depend on a variety of factors such as market conditions, the general availability of credit, the volume of trading activities, the overall availability of credit to our industry, our credit ratings and credit capacity, as well as the possibility that customers or lenders could develop a negative perception of our long- or short-term financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If one or a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms. One of our sources of liquidity is our \$2,500.0 million commercial paper program. Should commercial paper issuance be unavailable, we have the ability to use a combination of cash on hand and/or our \$2,000.0 million senior revolving credit facility to redeem any outstanding commercial paper upon maturity. Additionally, we believe the lenders participating in our senior credit facility would be willing and able to provide financing in accordance with their legal obligations. We did not have any borrowings outstanding under our commercial paper program at December 31, 2014.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value may result in a loss charged to income.

The market values of our investments vary from time to time depending on economic and market conditions. For various reasons, we may sell certain of our investments at prices that are less than the carrying value of the investments. In addition, in periods of declining interest rates, bond calls and mortgage loan prepayments generally increase, resulting in the reinvestment of these funds at the then lower market rates. In periods of rising interest rates, the market values of our fixed maturity securities will generally decrease, which could result in material unrealized or realized losses on investments in future periods. In addition, defaults by issuers, primarily from investments in corporate and municipal bonds, who fail to pay or perform their obligations, could reduce net investment income, which would adversely affect our profitability. We cannot assure you that our investment portfolios will produce positive returns in future periods.

In accordance with FASB guidance for debt and equity investments, we classify fixed maturity and equity securities in our investment portfolio as "available-for-sale" or "trading" and report those securities at fair value. Current and long-term available-for-sale investment securities represented a significant percentage of our total consolidated assets at December 31, 2014. Also, in accordance with applicable FASB accounting guidance, we review our investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis analyzing both quantitative and qualitative factors. Such factors considered include the length of time and the extent to which market value has been less than cost, financial condition and near term prospects of the issuer, recommendations of investment advisors and forecasts of economic, market or industry trends.

Changes in the economic environment, including periods of increased volatility of the securities markets, can increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. We believe we have adequately reviewed our investment securities for impairment and we believe that we have

appropriately estimated the fair values of our investment securities. However, over time, the economic and market environment may provide additional insight, which could change our judgment regarding the fair value of certain securities and/or impairment. Given the sometimes rapidly changing market conditions and the significant judgments involved, there is continuing risk that further declines in fair value may occur and material other-than-temporary impairments may be charged to income in future periods, resulting in realized losses.

We may not be able to realize the value of our deferred tax assets.

In accordance with applicable accounting standards, we separately recognize deferred tax assets and deferred tax liabilities. Such deferred tax assets and deferred tax liabilities represent the tax effect of temporary differences between financial reporting and tax reporting measured at tax rates enacted at the time the deferred tax asset or liability is recorded.

At each financial reporting date, we evaluate our deferred tax assets to determine the likely realization of the benefit of the temporary differences. Our evaluation includes a review of the types of temporary differences that created the deferred tax asset; the amount of taxes paid on both capital gains and ordinary income in prior periods and available for a carry-back claim; the forecasted future taxable income, and therefore, the likely future deduction of the deferred tax item; and any other significant issues that might impact the realization of the deferred tax asset. If it is "more likely than not" that all or a portion of the deferred tax asset may not be realized, we establish a valuation allowance. Significant judgment is required in determining an appropriate valuation allowance.

Any future increase in the valuation allowance would result in additional income tax expense and a decrease in shareholders' equity, which could materially affect our financial position and results of operations in the period in which the increase occurs. A material decrease in shareholders' equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants.

An unauthorized disclosure of sensitive or confidential member or employee information, including by cyber attack or other security breach, could cause a loss of data, give rise to remediation or other expenses, expose us to liability under federal and state laws, and subject us to litigation and investigations, which could have an adverse effect on our business, cash flows, financial condition and results of operations.

As part of our normal operations, we collect, process and retain sensitive and confidential member and employee information. We are subject to various federal, state and international laws and rules regarding the use and disclosure of sensitive or confidential member and provider information, including HIPAA, the HITECH Act, the Gramm-Leach-Bliley Act, and numerous state laws governing personal information. Despite the security measures we have in place to help ensure compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, are vulnerable to cyber attacks, security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events.

In February 2015, we reported the discovery that certain of our information technology systems had been the target of an external cyber attack, as more fully described under Note 13, "Commitments and Contingencies - Data Breach," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K. We are in the process of determining the extent of this cyber attack; however, at this time we believe that personal information of many of our current and former members and employees was obtained in the cyber attack. We have incurred expenses to investigate and remediate this matter and expect to continue to incur expenses of this nature in the foreseeable future. Although we are unable to quantify the ultimate magnitude of such expenses at this time, they may be significant. In addition, we are currently responding to a number of governmental inquiries and are subject to purported class action lawsuits and other claims relating to the cyber attack, and in the future we may be subject to additional litigation and governmental investigations. These investigations and claims could divert the attention of management from the operation of our business, result in reputational damage and have a material adverse impact on our business, cash flows, financial condition and results of operations. While we have contingency plans and insurance coverage for potential liabilities of this nature, these may not be sufficient to cover all claims and liabilities.

In addition, we cannot ensure that we will be able to identify, prevent or contain the effects of additional cyber attacks or other cybersecurity risks in the future that bypass our security measures or disrupt our information technology systems or business. As a result, cybersecurity and the continued development and enhancement of our controls, processes and practices

designed to protect our systems, computers, software, data and networks from attack, damage and unauthorized access, remain a priority for us. Noncompliance with any privacy or security laws and regulations, or any security breach, cyber attack or cybersecurity breach, and any incident involving the misappropriation, loss or other unauthorized disclosure of, or access to, sensitive or confidential member information, whether by us or by one of our vendors, could require us to expend significant resources to continue to modify or enhance our protective measures and to remediate any damage. In addition, this could result in interruptions to our operations and damage our reputation, and could also result in regulatory enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, cash flows, financial condition and results of operations.

The failure to effectively maintain and upgrade our information systems could adversely affect our business.

Our business depends significantly on effective information systems, and we have many different information systems for our various businesses. As a result of our merger and acquisition activities, we have acquired additional systems. Our information systems require an ongoing commitment of significant resources to maintain and enhance existing systems and develop new systems in order to keep pace with continuing changes in information processing technology, emerging cybersecurity risks and threats, evolving industry and regulatory standards including the minimum MLR rebates, public exchanges and other aspects of Health Care Reform, compliance with legal requirements (such as a new set of standardized diagnostic codes, known as ICD-10), private insurance exchanges and changing customer preferences. In addition, we may from time to time obtain significant portions of our systems-related or other services or facilities from independent third parties, which may make our operations vulnerable to such third parties' failure to perform adequately.

Our failure to maintain effective and efficient information systems, or our failure to efficiently and effectively consolidate our information systems to eliminate redundant or obsolete applications, could have a material adverse effect on our business, financial condition and results of operations. If the information we rely upon to run our business were found to be inaccurate or unreliable or if we fail to maintain our information systems and data integrity effectively, we could have a decrease in membership, have problems in determining medical cost estimates and establishing appropriate pricing and reserves, have disputes with customers and providers, have regulatory problems, sanctions or penalties imposed, have increases in operating expenses or suffer other adverse consequences. In addition, federal regulations require that we begin using ICD-10 by October 2015, which has required and will continue to require significant information technology investment. If we fail to adequately implement ICD-10 or comply with the operating rules, we may incur losses with respect to the resources invested and have other material adverse effects on our business and results of operations. Also, as we convert or migrate members to our more efficient and effective systems, the risk of disruption in our customer service is increased during the migration or conversion process and such disruption could have a material adverse effect on our business, cash flow, financial condition and results of operations.

We continue to implement initiatives for more effective and efficient information technology systems by modernizing interactions with customers, brokers, agents, providers, employees and other stakeholders through web-enabling technology and redesigning internal operations. We cannot assure you that we will be able to fully implement all desired products or systems in a timely and effective manner. The failure to implement and maintain the most advanced technological capabilities could result in competitive and cost disadvantages to us as compared to our competitors.

We are dependent on the success of our relationships with third parties for various services and functions, including pharmacy benefit management services.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Certain of these third parties provide us with significant portions of our requirements, and we could become overly dependent on key vendors, which could cause us to lose core competencies. A termination of our agreements with, or disruption in the performance of, one or more of these service providers could result in service disruptions or unavailability, reduced service quality and effectiveness, increased or duplicative costs, an inability to meet our obligations to our customers or require us to seek alternative service providers on less favorable contract terms, any of which could adversely affect our business, reputation, cash flows, financial condition and operating results.

In particular, we are a party to an agreement with Express Scripts whereby Express Scripts is the exclusive provider of PBM services to our plans, excluding some Amerigroup subsidiaries and certain self-insured members, which have exclusive agreements with different PBM service providers. It is expected that those Amerigroup subsidiaries will complete their

transition to the Express Scripts agreement during 2015. The Express Scripts PBM services include, but are not limited to, pharmacy network management, home delivery, pharmacy customer service, claims processing, rebate management, drug utilization and specialty pharmaceutical management services. Accordingly, the agreement contains certain financial and operational requirements obligating both Express Scripts and us. The failure of either party to meet the respective requirements could potentially serve as a basis for early termination of the contract. If this relationship was terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms. As a result, we may not be able to meet the full demands of our customers, which could have a material adverse effect on our business, reputation and results of operations. In addition, our failure to meet certain minimum script volume requirements results in financial penalties that could have a material adverse effect on our results of operations.

Indiana law, other applicable laws, our articles of incorporation and bylaws, and provisions of our BCBSA license agreements may prevent or discourage takeovers and business combinations that our shareholders might consider in their best interest.

Indiana law and our articles of incorporation and bylaws may delay, defer, prevent or render more difficult a takeover attempt that our shareholders might consider in their best interests. For instance, they may prevent our shareholders from receiving the benefit from any premium to the market price of our common stock offered by a bidder in a takeover context. Even in the absence of a takeover attempt, the existence of these provisions may adversely affect the prevailing market price of our common stock if they are viewed as discouraging takeover attempts in the future.

We are regulated as an insurance holding company and subject to the insurance holding company acts of the states in which our insurance company subsidiaries are domiciled, as well as similar provisions included in the health statutes and regulations of certain states where these subsidiaries are regulated as managed care companies or HMOs. The insurance holding company acts and regulations and these similar health provisions restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes and regulations, without such approval (or an exemption), no person may acquire any voting security of a domestic insurance company or HMO, or an insurance holding company which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would "control" the insurance holding company, insurance company or HMO. "Control" is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person. Further, the Indiana business corporation law contains business combination provisions that, in general, prohibit for five years any business combination with a beneficial owner of 10% or more of our common stock unless the holder's acquisition of the stock was approved in advance by our Board of Directors.

Our articles of incorporation restrict the beneficial ownership of our capital stock in excess of specific ownership limits. The ownership limits restrict beneficial ownership of our voting capital stock to less than 10% for institutional investors and less than 5% for non-institutional investors, both as defined in our articles of incorporation. Additionally, no person may beneficially own shares of our common stock representing a 20% or more ownership interest in us. These restrictions are intended to ensure our compliance with the terms of our licenses with the BCBSA. Our articles of incorporation prohibit ownership of our capital stock beyond these ownership limits without prior approval of a majority of our continuing directors (as defined in our articles of incorporation). In addition, as discussed above in the risk factor describing our license agreements with the BCBSA, such license agreements are subject to termination upon a change of control and re-establishment fees would be imposed upon termination of the license agreements.

Certain other provisions included in our articles of incorporation and bylaws may also have anti-takeover effects and may delay, defer or prevent a takeover attempt that our shareholders might consider in their best interests. In particular, our articles of incorporation and bylaws: divide our Board of Directors into three classes serving staggered three-year terms (which is required by our license agreement with the BCBSA); permit our Board of Directors to determine the terms of and issue one or more series of preferred stock without further action by shareholders; restrict the maximum number of directors; limit the ability of shareholders to remove directors; impose restrictions on shareholders' ability to fill vacancies on our Board of Directors; prohibit shareholders from calling special meetings of shareholders; impose advance notice requirements for shareholder proposals and nominations of directors to be considered at meetings of shareholders; and prohibit shareholders from amending our bylaws.

We also face other risks that could adversely affect our business, financial condition or results of operations, which include:

- any requirement to restate financial results in the event of inappropriate application of accounting principles;
- a significant failure of our internal control over financial reporting;
- failure of our prevention and control systems related to employee compliance with internal policies, including data security;
- provider fraud that is not prevented or detected and impacts our medical costs or those of self-insured customers;
- failure to protect our proprietary information; and
- failure of our corporate governance policies or procedures.

ITEM 1B. UNRESOLVED SEC STAFF COMMENTS.

None.

ITEM 2. PROPERTIES.

Our principal executive offices are located at 120 Monument Circle, Indianapolis, Indiana. In addition to this location, we have other principal operating facilities located in each of the fourteen states where we operate as licensees of the BCBSA, in each of the nine additional states where Amerigroup conducts business and in the additional state of Arizona where CareMore maintains a branch office. A majority of these locations are leased properties. Our facilities support our various business segments. We believe that our properties are adequate and suitable for our business as presently conducted as well as for the foreseeable future.

ITEM 3. LEGAL PROCEEDINGS.

For information regarding our legal proceedings, see the "*Litigation*," "*Data Breach*" and "*Other Contingencies*" sections of Note 13, "Commitments and Contingencies" to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

ITEM 4. MINE SAFETY DISCLOSURES.

Not Applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES.

Market Prices

Our common stock, par value \$0.01 per share, is listed on the NYSE under the symbol "ANTM." On February 5, 2015, the closing price on the NYSE was \$137.23. As of February 5, 2015, there were 74,717 shareholders of record of our common stock. The following table presents high and low sales prices for our common stock on the NYSE for the periods indicated.

	High	Low
2014		
First Quarter	\$ 102.56	\$ 81.84
Second Quarter	110.03	90.75
Third Quarter	124.58	106.52
Fourth Quarter	129.96	108.92
2013		
First Quarter	\$ 66.62	\$ 58.75
Second Quarter	82.33	65.82
Third Quarter	90.00	80.75
Fourth Quarter	94.36	83.13

Dividends

The quarterly cash dividend declared by our Board of Directors was \$0.4375, \$0.3750 and \$0.2875 per share in 2014, 2013 and 2012, respectively. On January 27, 2015, our Board of Directors declared a quarterly cash dividend to shareholders of \$0.6250 per share.

We regularly review the appropriate use of capital, including common stock repurchases, repurchases of debt securities and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt securities is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors. Further, our ability to pay dividends to our shareholders, if authorized by our Board of Directors, is significantly dependent upon the receipt of dividends from our subsidiaries, including Anthem Insurance Companies, Inc., Anthem Southeast, Inc., Anthem Holding Corp., WellPoint Holding Corp., WellPoint Acquisition, LLC, WellPoint Insurance Services, Inc., ATH Holding Company, LLC and SellCore, Inc. The payment of dividends by our insurance subsidiaries without prior approval of the insurance department of each subsidiary's domiciliary jurisdiction is limited by formula. Dividends in excess of these amounts are subject to prior approval by the respective insurance departments.

Securities Authorized for Issuance under Equity Compensation Plans

The information required by this Item concerning securities authorized for issuance under our equity compensation plans is set forth in or incorporated by reference into Part III, Item 12 "Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters" in this Annual Report on Form 10-K.

Issuer Purchases of Equity Securities

The following table presents information related to our repurchases of common stock for the periods indicated:

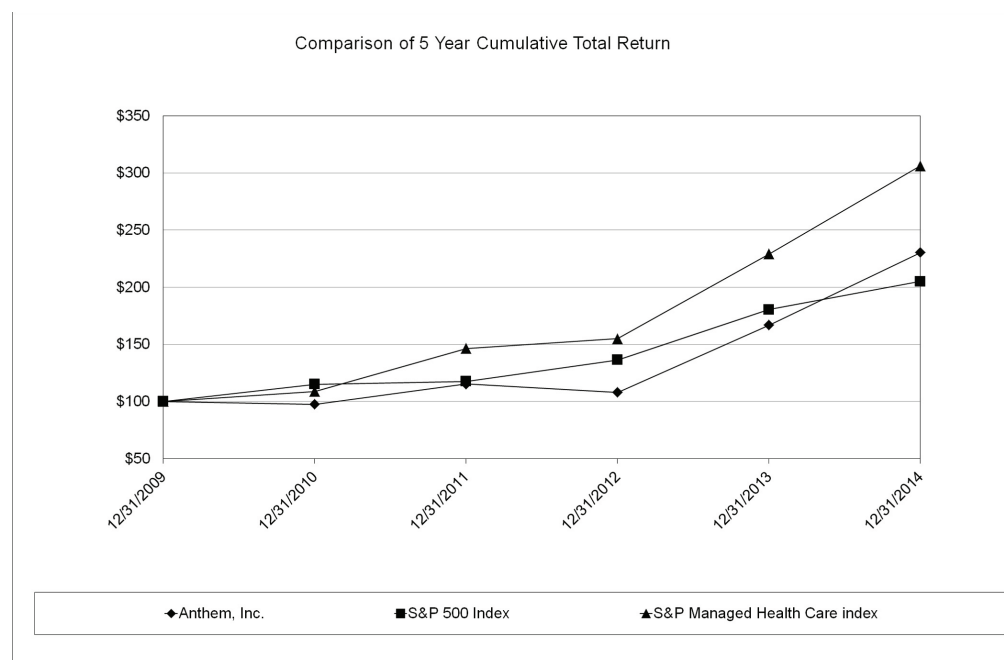
Period	Total Number of Shares Purchased ¹	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Programs ²	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Programs
<i>(In millions, except share and per share data)</i>				
October 1, 2014 to October 31, 2014	1,514,534	\$ 117.30	1,506,731	\$ 5,858.1
November 1, 2014 to November 30, 2014	507,812	125.99	507,196	5,794.2
December 1, 2014 to December 31, 2014	871,233	125.43	817,392	5,691.7
	<u>2,893,579</u>		<u>2,831,319</u>	

- ¹ Total number of shares purchased includes 62,260 shares delivered to or withheld by us in connection with employee payroll tax withholding upon exercise or vesting of stock awards. Stock grants to employees and directors and stock issued for stock option plans and stock purchase plans in the consolidated statements of shareholders' equity are shown net of these shares purchased.
- ² Represents the number of shares repurchased through the common stock repurchase program authorized by our Board of Directors, which the Board evaluates periodically. During the year ended December 31, 2014, we repurchased 30,439,237 shares at a cost of \$2,998.8 under the program, including the cost of options to purchase shares. The Board of Directors has authorized our common stock repurchase program since 2003. The Board's most recent authorized increase to the program was \$5,000.0 on October 2, 2014. Between January 1, 2015 and February 5, 2015, we repurchased 1.8 shares at a cost of \$229.9, bringing our current availability to \$5,461.8 at February 5, 2015. No duration has been placed on our common stock repurchase program and we reserve the right to discontinue the program at any time.

Performance Graph

The following Performance Graph and related information compares the cumulative total return to shareholders of our common stock for the period from December 31, 2009 through December 31, 2014, with the cumulative total return over such period of (i) the Standard & Poor's 500 Stock Index (the "S&P 500 Index") and (ii) the Standard & Poor's Managed Health Care Index (the "S&P Managed Health Care Index"). The graph assumes an investment of \$100 on December 31, 2009 in each of our common stock, the S&P 500 Index and the S&P Managed Health Care Index (and the reinvestment of all dividends).

The comparisons shown in the graph below are based on historical data and we caution that the stock price performance shown in the graph below is not indicative of, and is not intended to forecast, the potential future performance of our common stock. Information used in the graph was obtained from S&P Capital IQ, a source believed to be reliable, but we are not responsible for any errors or omissions in such information. The following graph and related information shall not be deemed "soliciting materials" or to be "filed" with the SEC, nor shall such information be incorporated by reference into any future filing under the Securities Act of 1933, as amended, or the Exchange Act, except to the extent that we specifically incorporate it by reference into such filing.



	December 31,					
	2009	2010	2011	2012	2013	2014
Anthem, Inc.	\$ 100	\$ 98	\$ 115	\$ 108	\$ 167	\$ 230
S&P 500 Index	100	115	117	136	180	205
S&P Managed Health Care Index	100	109	146	155	229	306

Based upon an initial investment of \$100 on December 31, 2009 with dividends reinvested.

ITEM 6. SELECTED FINANCIAL DATA.

The table below provides selected consolidated financial data of Anthem. The information has been derived from our consolidated financial statements for each of the years in the five year period ended December 31, 2014. You should read this selected consolidated financial data in conjunction with the audited consolidated financial statements and notes as of and for the year ended December 31, 2014 included in Part II, Item 8 "Financial Statements and Supplementary Data", and Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

	As of and for the Years Ended December 31				
	2014 ¹	2013 ¹	2012 ^{1,2}	2011 ²	2010
<i>(in millions, except where indicated and except per share data)</i>					
Income Statement Data					
Total operating revenue ³	\$ 73,021.7	\$ 70,191.4	\$ 60,514.0	\$ 59,865.2	\$ 57,740.5
Total revenues	73,874.1	71,023.5	61,497.2	60,710.7	58,698.5
Income from continuing operations	2,560.1	2,634.3	2,651.0	2,646.7	2,887.1
Net income	2,569.7	2,489.7	2,655.5	2,646.7	2,887.1
Per Share Data					
Basic net income per share - continuing operations	\$ 9.28	\$ 8.83	\$ 8.25	\$ 7.35	\$ 7.03
Diluted net income per share - continuing operations	8.96	8.67	8.17	7.25	6.94
Dividends per share	1.75	1.50	1.15	1.00	—
Other Data (unaudited)					
Benefit expense ratio ⁴	83.1%	85.1%	85.3%	85.1%	83.2%
Selling, general and administrative expense ratio ⁵	16.1%	14.2%	14.3%	14.1%	15.1%
Income from continuing operations before income taxes as a percentage of total revenues	5.9%	5.4%	6.3%	6.5%	7.4%
Net income as a percentage of total revenues	3.5%	3.5%	4.3%	4.4%	4.9%
Medical membership <i>(in thousands)</i>	37,499	35,653	36,130	34,251	33,323
Balance Sheet Data					
Cash and investments	\$ 23,777.7	\$ 22,395.9	\$ 22,464.6	\$ 20,696.5	\$ 20,311.8
Total assets	62,065.0	59,574.5	58,955.4	52,163.2	50,242.5
Long-term debt, less current portion	14,127.2	13,573.6	14,170.8	8,465.7	8,147.8
Total liabilities	37,813.7	34,809.3	35,152.7	28,875.0	26,429.9
Total shareholders' equity	24,251.3	24,765.2	23,802.7	23,288.2	23,812.6

- 1 The operating results of 1-800 CONTACTS, Inc. are reported as discontinued operations at December 31, 2014, 2013 and 2012 as a result of the divestiture completed on January 31, 2014. Included in net income for the year ended December 31, 2014 is income from discontinued operations, net of tax, of \$9.6. Included in net income for the year ended December 31, 2013 is a loss from discontinued operations, net of tax, of \$144.6. Included in net income for the year ended December 31, 2012 is income from discontinued operations, net of tax, of \$4.5.
- 2 The net assets of and results of operations for AMERIGROUP Corporation are included from its acquisition date of December 24, 2012. The net assets of and results of operations for CareMore Health Group, Inc. are included from its acquisition date of August 22, 2011.
- 3 Operating revenue is obtained by adding premiums, administrative fees and other revenue.
- 4 The benefit expense ratio represents benefit expenses as a percentage of premium revenue.
- 5 The selling, general and administrative expense ratio represents selling, general and administrative expenses as a percentage of total operating revenue.

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS.

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

On November 5, 2014, the shareholders of the Company approved a proposal to amend our articles of incorporation to change our name to Anthem, Inc. from WellPoint, Inc. The name change was effective December 2, 2014. References in this Annual Report on Form 10-K to the terms "we," "our," "us," "Anthem" or the "Company" refer to Anthem, Inc., an Indiana corporation, and, unless the context otherwise requires, its direct and indirect subsidiaries.

This Management's Discussion and Analysis, or MD&A, should be read in conjunction with our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Overview

We currently manage our operations through three reportable segments: Commercial and Specialty Business, Government Business and Other. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, merger and acquisition activity and changing laws and regulations. Therefore, these reportable segments may change in the future. Our Commercial and Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial and Specialty Business segment offer fully-insured health products; provide a broad array of managed care services to self-funded customers including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services; and provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal health care guidance.

Our Government Business segment includes Medicare and Medicaid businesses, National Government Services, or NGS, and services provided to the federal government in connection with the Federal Employee Program, or FEP. Medicare business includes services such as Medicare Advantage, Medicare Part D, and Medicare Supplement. Medicaid business includes our managed care alternatives through publicly funded health care programs, including Medicaid; Temporary Assistance for Needy Family, or TANF, programs; programs for seniors and people with disabilities, or SPD; programs for long-term services and support, or LTSS; Children's Health Insurance Programs, or CHIP, and Medicaid expansion programs. NGS acts as a Medicare contractor in several regions across the nation.

Our Other segment includes other businesses that do not meet the quantitative thresholds for an operating segment as defined by Financial Accounting Standards Board, or FASB, guidance, as well as corporate expenses not allocated to the other reportable segments.

Our operating revenue consists of premiums, administrative fees and other revenue. Premium revenue comes from fully-insured contracts where we indemnify our policyholders against costs for covered health and life benefits. Administrative fees come from contracts where our customers are self-insured, or where the fee is based on either processing of transactions or a percent of network discount savings realized. Additionally, we earn administrative fee revenues from our Medicare processing business and from other health-related businesses including disease management programs. Other revenue includes miscellaneous income other than premium revenue and administrative fees.

Our benefit expense primarily includes costs of care for health services consumed by our members, such as outpatient care, inpatient hospital care, professional services (primarily physician care) and pharmacy benefit costs. All four components are affected both by unit costs and utilization rates. Unit costs include the cost of outpatient medical procedures per visit, inpatient hospital care per admission, physician fees per office visit and prescription drug prices. Utilization rates represent the volume of consumption of health services and typically vary with the age and health status of our members and their social and lifestyle choices, along with clinical protocols and medical practice patterns in each of our markets. A portion of benefit expense recognized in each reporting period consists of actuarial estimates of claims incurred but not yet paid by us. Any changes in these estimates are recorded in the period the need for such an adjustment arises. While we offer a diversified mix of managed care products and services through our managed care plans, our aggregate cost of care can fluctuate based on a change in the overall mix of these products and services. Our managed care plans include: preferred provider organizations,

or PPOs; health maintenance organizations, or HMOs; point-of-service plans, or POS plans; traditional indemnity plans and other hybrid plans, including consumer-driven health plans, or CDHPs; and hospital only and limited benefit products.

We classify certain claims-related costs as benefit expense to reflect costs incurred for our members' traditional medical care, as well as those expenses which improve our members' health and medical outcomes. These claims-related costs may be comprised of expenses incurred for: (i) medical management, including case and utilization management; (ii) health and wellness, including disease management services for such conditions as diabetes, high-risk pregnancies, congestive heart failure and asthma management and wellness initiatives like weight-loss programs and smoking cessation treatments; and (iii) clinical health policy. These types of claims-related costs are designed to ultimately lower our members' cost of care.

Our selling expense consists of external broker commission expenses, and generally varies with premium or membership volume. Our general and administrative expense consists of fixed and variable costs. Examples of fixed costs are depreciation, amortization and certain facilities expenses. Certain variable costs, such as premium taxes, vary directly with premium volume. Other variable costs, such as salaries and benefits, do not vary directly with changes in premium, but are more aligned with changes in membership. The acquisition or loss of a significant block of business would likely impact staffing levels, and thus associated compensation expense. Other variable costs include professional and consulting expenses and advertising. Other factors can impact our administrative cost structure, including systems efficiencies, inflation and changes in productivity.

Our results of operations depend in large part on our ability to accurately predict and effectively manage health care costs through effective contracting with providers of care to our members and our medical management and health and wellness programs. Several economic factors related to health care costs, such as regulatory mandates of coverage as well as direct-to-consumer advertising by providers and pharmaceutical companies, have a direct impact on the volume of care consumed by our members. The potential effect of escalating health care costs, any changes in our ability to negotiate competitive rates with our providers and any regulatory or market driven restrictions on our ability to obtain adequate premium rates to offset overall inflation in health care costs, including increases in unit costs and utilization resulting from the aging of the population and other demographics, as well as advances in medical technology, may impose further risks to our ability to profitably underwrite our business, and may have a material impact on our results of operations.

Our future results of operations will also be impacted by certain external forces and resulting changes in our business model and strategy. In 2010, the Patient Protection and Affordable Care Act, or ACA, as well as the Health Care and Education Reconciliation Act of 2010, or collectively, Health Care Reform, became law, causing significant changes to the U.S. health care system. Since then, significant regulations have been enacted by the U.S. Department of Health and Human Services, or HHS, the Department of Labor and the Department of the Treasury. The legislation and regulations are far-reaching and are intended to expand access to health insurance coverage over time by increasing the eligibility thresholds for most state Medicaid programs and providing certain other individuals and small businesses with tax credits to subsidize a portion of the cost of health insurance coverage. As a result of the complexity of the law, its impact on health care in the United States and the continuing modification and interpretation of Health Care Reform rules, we continue to analyze and refine our estimates of the ultimate impact of Health Care Reform on our business, cash flows, financial condition and results of operations. Health Care Reform provides growth opportunities for health insurers, but also introduces new risks and uncertainties, and required changes in the way products are designed, underwritten, priced, distributed and administered. For additional discussion, see Part I, Item 1 "Business - Regulation," and Part I, Item 1A "Risk Factors" in this Annual Report on Form 10-K.

Pricing in our Commercial and Specialty Business segment, including our Individual and Small Group lines of business, remains competitive, but rational, and we strive to price our health care benefit products consistent with anticipated underlying medical trends. We believe our pricing strategy, based on predictive modeling, proprietary research and data-driven processes, as well as our overall investments for Health Care Reform, have positioned us to benefit from the potential growth opportunities available in fully-insured commercial products as a result of Health Care Reform. In the Individual and Small Group markets, we offer on-exchange products through state or federally facilitated marketplaces, referred to as public exchanges; and off-exchange products. Federal premium subsidies are available only for certain members who purchase certain public exchange products. While the ultimate level of public exchange enrollment cannot be predicted, we have experienced a greater number of policy applications for new members through the public exchanges than expected, including geographical regions with lower price competition. The public exchanges may increase the risk that our products will be selected by individuals who have a higher risk profile or utilization rate than the pool of participants we anticipated when we

established the pricing for these public exchange products. However, the risk characteristics of new applicants in 2014 tracked closely to the risk levels utilized in the development of our pricing assumptions. Although it is not yet clear whether our products sold on the public exchanges will be more or less profitable products, we believe that our pricing strategy, brand name and network quality will provide a strong foundation for commercial risk membership growth opportunities in the future.

In our Individual markets we offer bronze, silver and gold products, both on and off the public exchanges, in the states of California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. Additionally, we offer platinum products, both on and off the public exchanges, in the states of California and New York.

In our Small Group markets, we offer bronze, silver and gold products, both on and off the public exchanges, in the states of Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, New Hampshire, Ohio and Virginia and we offer bronze, silver and gold products, off the public exchanges, in the states of California, New York and Wisconsin. Additionally, we offer platinum products, off the public exchanges, in the states of California, Colorado, Connecticut, Georgia, Maine, New Hampshire, Missouri and Virginia.

Private exchanges have recently gained significant visibility in the marketplace based on the promise of helping employers reduce costs, increase consumer engagement and manage the complexities created by the ACA and other market forces. While private exchanges have been a distribution channel in the Medicare and Individual markets for some time, the heightened level of activity and investment among the consulting and broker communities and other health insurance carriers has generated an increasing level of interest among employers in the Commercial market. To date, adoption levels have been lower than analyst predictions, but expectations for significant longer term growth remain. While the ultimate volume, pace of growth and winning business models remain highly uncertain, we believe private exchanges will provide opportunities for growth and will serve a significant role in our future strategy.

Health Care Reform also imposes new regulations on the health insurance sector, including, but not limited to, guaranteed coverage and expanded benefit requirements; prohibitions on some annual and all lifetime limits on amounts paid on behalf of or to our members; increased restrictions on rescinding coverage; establishment of minimum medical loss ratio, or MLR, and customer rebate requirements; establishment of a mandatory annual Health Insurance Provider Fee, or HIP Fee; creation of a federal rate review process; a requirement to cover preventive services on a first dollar basis; the establishment of public exchanges and essential benefit packages and greater limitations on how we price certain of our products. The legislation also reduces the reimbursement levels for our health plans participating in the Medicare Advantage program over time. There are also limitations on the amount of executive compensation that is deductible for income tax purposes.

As a result of Health Care Reform, HHS issued MLR regulations that require us to meet minimum MLR thresholds for Large Group, Small Group and Individual lines of business. For purposes of determining MLR rebates, HHS has defined the types of costs that should be included in the MLR rebate calculation. However, certain components of the MLR calculation as defined by HHS cannot be classified consistently under U.S. generally accepted accounting principles, or GAAP. While considered benefit expense or a reduction of premium revenue by HHS, certain of these costs are classified as other types of expense, such as income tax expense or selling, general and administrative expense, in our GAAP basis financial statements. Accordingly, the benefit expense ratio determined using our consolidated GAAP operating results is not comparable to the MLR calculated under HHS regulations.

Health Care Reform also imposed a separate minimum MLR threshold of 85% for Medicare Advantage plans beginning in 2014. Medicare Advantage plans that do not meet this threshold will have to pay a minimum MLR rebate. If a plan's MLR is below 85% for three consecutive years beginning with 2014, enrollment will be restricted. A Medicare Advantage plan contract will be terminated if the plan's MLR is below 85% for five consecutive years.

Beginning in 2014, Health Care Reform imposes an annual HIP Fee on health insurers that write certain types of health insurance on U.S. risks. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to an adjusted amount of health insurance for all U.S. health risk for those certain lines of business written during the preceding calendar year. The HIP Fee is non-deductible for federal income tax purposes. The total amount to be collected from allocations to health insurers in 2014 was \$8,000.0, and our portion of the HIP Fee for 2014 was \$893.3. The final calculation and payment of the HIP Fee occurred in the third quarter of 2014 and was recognized as a general and administrative expense. The annual HIP Fee to be allocated to all health insurers

increases to \$11,300.0 for 2015 and 2016, \$13,900.0 for 2017 and \$14,300.0 for 2018. For 2019 and beyond, the annual HIP Fee will increase from the amount for the preceding year by the rate of premium growth for the preceding year.

These and other provisions of Health Care Reform are likely to have significant effects on our future operations, which, in turn, could impact the value of our business model and results of operations, including potential impairments of our goodwill and other intangible assets. We will continue to evaluate the impact of Health Care Reform as key aspects go into effect and additional guidance is made available. For additional discussion regarding Health Care Reform, see Part I, Item 1 “Business—Regulation” and Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K.

Finally, federal and state regulatory agencies may further restrict our ability to obtain new product approvals, implement changes in premium rates or impose additional restrictions, under new or existing laws that could adversely affect our business, cash flows, financial condition and results of operations.

We are also subject to regulations that may result in assessments under state insurance guaranty association laws. The National Organization of Life & Health Insurance Guaranty Associations, or NOLHGA, is a voluntary organization consisting of the state life and health insurance guaranty associations located throughout the U.S. Such associations, working together with NOLHGA, provide a safety net for their state’s policyholders, ensuring that they continue to receive coverage, subject to state maximum limits, even if their insurer is declared insolvent. We are aware that the Pennsylvania Insurance Commissioner, or Insurance Commissioner, has placed Penn Treaty Network America Insurance Company and its subsidiary American Network Insurance Company, or collectively Penn Treaty, in rehabilitation, an intermediate action before insolvency. The state court denied the Insurance Commissioner’s petition for the liquidation of Penn Treaty and ordered the Insurance Commissioner to file an updated plan of rehabilitation. An initial plan was filed on April 30, 2013. The Insurance Commissioner filed an amended plan on August 8, 2014 and a second amended plan on October 8, 2014. The state court set a schedule for a notice and comment period and ordered a hearing on the second amended plan, with public comments due by February 13, 2015. The Insurance Commissioner has filed a Notice of Appeal asking the Pennsylvania Supreme Court to reverse the order denying the liquidation petition. The Supreme Court held oral argument on the appeal in September 2014. In the event rehabilitation of Penn Treaty is unsuccessful and Penn Treaty is declared insolvent and placed in liquidation, we and other insurers may be required to pay a portion of their policyholder claims through state guaranty association assessments in future periods. Given the uncertainty around whether Penn Treaty will ultimately be declared insolvent and, if so, the amount of the insolvency, the amount and timing of any associated future guaranty fund assessments, and the availability and amount of any potential premium tax and other offsets, we currently cannot estimate our net exposure, if any, to this potential insolvency. We will continue to monitor the situation and may record a liability and expense in future reporting periods, which could be material to our cash flows and results of operations.

In addition to the external forces discussed in the preceding paragraphs, our results of operations are impacted by levels and mix of membership. In recent history, we experienced membership declines due to unfavorable economic conditions driving increased unemployment. In addition, we believe the self-insured portion of our group membership base will continue to increase as a percentage of total group membership. Further, our mix of membership may include more individuals with a higher acuity level obtaining coverage through our products available on the public exchanges, which may not be appropriately adjusted for in our premium rates. These membership trends could have a material adverse effect on our future results of operations.

In February 2015, we reported that we were the target of a sophisticated external cyber attack. The attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many of our current and former members and employees. We are in the process of determining the extent of this cyber attack and are supporting federal law enforcement efforts to identify the responsible parties. For additional information about the cyber attack, see Note 13, “Commitments and Contingencies - *Data Breach*,” to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Also see Part I, Item 1A “Risk Factors” in this Annual Report on Form 10-K, for a discussion of the factors identified above and other risk factors that could cause actual results to differ materially from those contained in forward-looking statements made in this Annual Report on Form 10-K and presented elsewhere by management from time to time.

Executive Summary

We are one of the largest health benefits companies in terms of medical membership in the United States, serving 37.5 medical members through our affiliated health plans as of December 31, 2014. We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as BCBS in 10 New York City metropolitan and surrounding counties, and as Blue Cross or BCBS in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield, or Empire Blue Cross (in our New York service areas). We also conduct business through arrangements with other BCBS licensees in the states of South Carolina and Texas. We conduct business through our AMERIGROUP Corporation, or Amerigroup, subsidiary, in Florida, Georgia, Kansas, Louisiana, Maryland, Nevada, New Jersey, New Mexico, New York, Tennessee, Texas and Washington. We also serve customers throughout the country as HealthLink, UniCare (including a non-risk arrangement with the state of Massachusetts), and in certain Arizona, California, Nevada, New York and Virginia markets through our CareMore Health Group, Inc., or CareMore, subsidiary. We are licensed to conduct insurance operations in all 50 states through our subsidiaries.

On February 17, 2015, we completed our acquisition of Simply Healthcare Holdings, Inc., or Simply Healthcare, a leading managed care company for people enrolled in Medicaid and Medicare programs in the state of Florida. This acquisition, which was originally announced on December 22, 2014, aligns with our strategy for continued growth in our Government Business segment. As a result, we will, through our affiliated Medicaid and Medicare plans, serve more than half a million members in the state of Florida.

In preparation for the recent and ongoing changes to the U.S. health care system and to focus on our core growth opportunities across our Commercial and Specialty Business and Government Business segments, we entered into a definitive agreement in December 2013 to sell our 1-800 CONTACTS, Inc., or 1-800 CONTACTS, business to the private equity firm Thomas H. Lee Partners, L.P. Concurrently, we entered into an asset purchase agreement with Luxottica Group to sell our glasses.com related assets. The divestitures were completed on January 31, 2014. The operating results for 1-800 CONTACTS are reported as discontinued operations within the consolidated statements of income included in Part II, Item 8 of this Annual Report on Form 10-K. These results were previously reported in the Commercial and Specialty Business segment. Additionally, the assets and liabilities of 1-800 CONTACTS are reported as held for sale for the year ended December 31, 2013 in the consolidated balance sheets included in Part II, Item 8 of this Annual Report on Form 10-K. Unless otherwise specified, all financial information disclosed in this MD&A is from continuing operations, other than net income, diluted earnings per share and cash flows. In accordance with FASB guidance, we have elected to not separately disclose net cash provided by or used in operating, investing, and financing activities and the net effect of those cash flows on cash and cash equivalents for discontinued operations during the periods presented. For additional information regarding these transactions, see Note 3, "Business Acquisitions and Divestitures," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Operating revenue for the year ended December 31, 2014 was \$73,021.7, an increase of \$2,830.3, or 4.0%, from the year ended December 31, 2013. The increase in operating revenue was primarily a result of higher premium revenue in our Government Business segment, and, to a lesser extent, increased administrative fees in our Commercial and Specialty Business segment. These increases were partially offset by lower premium revenue in our Commercial and Specialty Business segment.

Net income for the year ended December 31, 2014 was \$2,569.7, an increase of \$80.0, or 3.2%, from the year ended December 31, 2013. The increase in net income was primarily due to higher operating results in both our Government Business segment and our Commercial and Specialty Business segment. In addition, net income for the year ended December 31, 2013 was impacted by a loss from discontinued operations recorded in relation to the sale of our 1-800 CONTACTS business. The increase in net income for the year ended December 31, 2014 was further attributable to a decrease in realized losses on the early extinguishment of debt, a decrease in amortization of intangible assets and an increase in net earnings from investment activities. These increases were partially offset by an increase in income tax expense primarily due to the non-tax deductible portion of new fees associated with Health Care Reform that became effective January 1, 2014.

Our diluted earnings per share, or EPS, for the year ended December 31, 2014 was \$8.99, an increase of \$0.79, or 9.6%, from the year ended December 31, 2013. Our diluted EPS from continuing operations for the year ended December 31, 2014 was \$8.96, an increase of \$0.29, or 3.3%, from the year ended December 31, 2013. Our diluted shares for the year ended December 31, 2014 were 285.9, a decrease of 17.9, or 5.9%, compared to the year ended December 31, 2013. The increase in diluted EPS resulted primarily from the lower number of shares outstanding in 2014 due to share buyback activity under our share repurchase program and the increase in net income.

Operating cash flow for the year ended December 31, 2014 was \$3,369.3, or 1.3 times net income. Operating cash flow for the year ended December 31, 2013 was \$3,052.3, or 1.2 times net income. The increase in operating cash flow from 2013 of \$317.0 was primarily attributable to an increase in premium receipts primarily as a result of rate increases across our businesses designed to cover overall cost trends and new fees associated with Health Care Reform and an increase in administrative fee receipts primarily as a result of growth in membership. The increase in cash provided by operating activities was offset, in part, by payments for new fees associated with Health Care Reform, including the HIP Fee and assessments related to the Health Care Reform reinsurance premium stabilization program. The increase was further offset by an increase in claims payments primarily as a result of membership growth, an increase in personnel service costs and an increase in income taxes paid.

Our results of operations discussed throughout this MD&A are determined in accordance with GAAP. We also calculate operating gain, which is a non-GAAP measure, to further aid investors in understanding and analyzing our core operating results and comparing them among periods. Operating gain is calculated as total operating revenue less benefit expense, and selling, general and administrative expense. We use this measure as a basis for evaluating segment performance, allocating resources, setting incentive compensation targets and forecasting future operating periods. This information is not intended to be considered in isolation or as a substitute for income before income tax expense, net income or EPS prepared in accordance with GAAP, and may not be comparable to similarly titled measures reported by other companies. For additional details on operating gain, see our "Reportable Segments Results of Operations" discussion included in this MD&A. For a reconciliation of reportable segment operating gain to income from continuing operations before income tax expense, see Note 19, "Segment Information," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We intend to expand through a combination of organic growth, strategic acquisitions and efficient use of capital in both existing and new markets. Our growth strategy is designed to enable us to take advantage of additional economies of scale as well as providing us access to new and evolving technologies and products. In addition, we believe geographic and product diversity reduces our exposure to local or regional regulatory, economic and competitive pressures and provides us with increased opportunities for growth. While we have achieved strong growth as a result of strategic mergers and acquisitions, we have also achieved organic growth in our existing markets over time by delivering excellent service, offering competitively priced products, providing access to high quality provider networks and effectively capitalizing on the brand strength of the Blue Cross and Blue Shield names and marks.

Significant Transactions

While Health Care Reform has caused significant changes to the U.S. health care system in recent years, the more significant transactions that have occurred over the last three years that have impacted or will impact our capital structure or that have or will influence how we conduct our business operations include:

- Acquisition of Simply Healthcare (2015);
- Use of Capital—Board of Directors declaration of dividends on common stock (2014 and prior) and a 42.9% increase in the quarterly dividend to \$0.6250 per share (2015); authorization for repurchases of our common stock (2014 and prior); and debt repurchases and new debt issuance (2014 and prior);
- Acquisition of Amerigroup and the related debt issuance (2012); and
- Acquisition of 1-800 CONTACTS (2012) and subsequent divestiture (2014).

For additional information regarding these transactions, see Note 3, "Business Acquisitions and Divestitures," Note 12, "Debt" and Note 14, "Capital Stock," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Membership

Our medical membership includes seven different customer types: Local Group, Individual, National Accounts, BlueCard®, Medicare, Medicaid and FEP. BCBS-branded business generally refers to members in our service areas licensed by the BCBSA. Non-BCBS-branded business refers to Amerigroup and CareMore members as well as Healthlink and UniCare members predominantly outside of our BCBSA service areas.

- Local Group consists of those employer customers with less than 5% of eligible employees located outside of the headquarter state, as well as customers with more than 5% of eligible employees located outside of the headquarter state with up to 5,000 eligible employees. In addition, Local Group includes UniCare members and, effective January 1, 2014, the Employer Group Medicare Advantage members related to Local Group are reported as part of Local Group membership. These are retired members of Local Group accounts who have selected a Medicare Advantage product and were previously reported with our Medicare membership within our Government Business Segment. The Employer Group Medicare Advantage members represent less than 1.0% of Local Group membership. Local Group accounts are generally sold through brokers or consultants working with industry specialists from our in-house sales force and are offered both on and off the public exchanges. Local Group insurance premiums may be based on claims incurred by the group or sold on a self-insured basis. The customer's buying decision is typically based upon the size and breadth of our networks, customer service, the quality of our medical management services, the administrative cost included in our quoted price, our financial stability, reputation and our ability to effectively service large complex accounts. Local Group accounted for 40.4%, 41.3% and 40.6% of our medical members at December 31, 2014, 2013 and 2012, respectively.
- Individual consists of individual customers under age 65 and their covered dependents. Individual policies are generally sold through independent agents and brokers, retail partnerships, our in-house sales force or via the Internet. Individual business is sold on a fully-insured basis. We offer on-exchange products through public exchanges and off-exchange products. Federal premium subsidies are available only for certain public exchange Individual products. Individual customers are generally more sensitive to product pricing and, to a lesser extent, the configuration of the network, and the efficiency of administration. Account turnover is generally higher with Individual as compared to Local Group. Individual business accounted for 4.8%, 4.9% and 5.1% of our medical members at December 31, 2014, 2013 and 2012, respectively.
- National Accounts generally consist of multi-state employer groups primarily headquartered in an Anthem service area with at least 5% of the eligible employees located outside of the headquarter state and with more than 5,000 eligible employees. Some exceptions are allowed based on broker relationships. Service area is defined as the geographic area in which we are licensed to sell BCBS products. National Accounts are generally sold through independent brokers or consultants retained by the customer working with our in-house sales force. We have an advantage when competing for very large National Accounts due to the size and breadth of our networks and our ability to access the national provider networks of BCBS companies at their competitive local market rates. Additionally, effective January 1, 2014, the Employer Group Medicare Advantage members related to National Accounts groups are reported as part of National Accounts membership. These are retired members of a National Accounts group who have selected a Medicare Advantage product and were previously reported with our Medicare membership within our Government Business segment. The Employer Group Medicare Advantage members represent less than 1.0% of National Accounts membership. National Accounts represented 19.1%, 19.0% and 19.4% of our medical members at December 31, 2014, 2013 and 2012, respectively.
- BlueCard® host customers represent enrollees of Blue Cross and/or Blue Shield plans not owned by Anthem who receive health care services in our BCBSA licensed markets. BlueCard® membership consists of estimated host members using the national BlueCard® program. Host members are generally members who reside in or travel to a state in which an Anthem subsidiary is the Blue Cross and/or Blue Shield licensee and who are covered under an employer-sponsored health plan issued by a non-Anthem controlled BCBSA licensee (i.e., the "home plan"). We perform certain administrative functions for BlueCard® members, for which we receive administrative fees from the BlueCard® members' home plans. Other administrative functions, including maintenance of enrollment information and customer service, are performed by the home plan. Host members are computed using, among other things, the average number of BlueCard® claims received per month. BlueCard® host membership accounted for 14.1%, 14.2% and 13.9% of our medical members at December 31, 2014, 2013 and 2012, respectively.

- Medicare customers are Medicare-eligible individual members age 65 and over who have enrolled in Medicare Advantage, a managed care alternative for the Medicare program, who have purchased Medicare Supplement benefit coverage, some disabled under age 65, or all ages with End Stage Renal Disease. Medicare Supplement policies are sold to Medicare recipients as supplements to the benefits they receive from the Medicare program. Rates are filed with and in some cases approved by state insurance departments. Most of the premium for Medicare Advantage is paid directly by the federal government on behalf of the participant who may also be charged a small premium. Medicare Supplement and Medicare Advantage products are marketed in the same manner, primarily through independent agents and brokers. Medicare business accounted for 3.7%, 4.0% and 4.3% of our medical members at December 31, 2014, 2013 and 2012, respectively.
- Medicaid membership represents eligible members who receive health care benefits through publicly funded health care programs, including Medicaid, TANF, SPD, LTSS, CHIP and Medicaid expansion programs. Total Medicaid program business accounted for 13.8%, 12.3% and 12.5% of our medical members at December 31, 2014, 2013 and 2012, respectively.
- FEP members consist of United States government employees and their dependents within our geographic markets through our participation in the national contract between the BCBSA and the U.S. Office of Personnel Management. FEP business accounted for 4.1%, 4.3% and 4.2% of our medical members at December 31, 2014, 2013 and 2012, respectively.

In addition to reporting our medical membership by customer type, we report by funding arrangement according to the level of risk that we assume in the product contract. Our two principal funding arrangement categories are fully-insured and self-funded. Fully-insured products are products in which we indemnify our policyholders against costs for health benefits. Self-funded products are offered to customers, generally larger employers, who elect to retain most or all of the financial risk associated with their employees' health care costs. Some self-funded customers choose to purchase stop-loss coverage to limit their retained risk.

The following table presents our medical membership by customer type, funding arrangement and reportable segment as of December 31, 2014, 2013 and 2012. Also included below is other membership by product. The medical membership and other membership presented are unaudited and in certain instances include estimates of the number of members represented by each contract at the end of the period.

(In thousands)	December 31			2014 vs. 2013		2013 vs. 2012	
	2014	2013	2012	Change	% Change	Change	% Change
Medical Membership							
Customer Type							
Local Group	15,137	14,725	14,681	412	2.8 %	44	0.3 %
Individual	1,793	1,755	1,855	38	2.2 %	(100)	(5.4)%
National:							
National Accounts	7,155	6,777	7,000	378	5.6 %	(223)	(3.2)%
BlueCard®	5,279	5,050	5,016	229	4.5 %	34	0.7 %
Total National	12,434	11,827	12,016	607	5.1 %	(189)	(1.6)%
Medicare	1,404	1,441	1,538	(37)	(2.6)%	(97)	(6.3)%
Medicaid	5,193	4,378	4,520	815	18.6 %	(142)	(3.1)%
FEP	1,538	1,527	1,520	11	0.7 %	7	0.5 %
Total Medical Membership by Customer Type	37,499	35,653	36,130	1,846	5.2 %	(477)	(1.3)%
Funding Arrangement							
Self-Funded	22,800	20,294	20,176	2,506	12.3 %	118	0.6 %
Fully-Insured	14,699	15,359	15,954	(660)	(4.3)%	(595)	(3.7)%
Total Medical Membership by Funding Arrangement	37,499	35,653	36,130	1,846	5.2 %	(477)	(1.3)%
Reportable Segment							
Commercial and Specialty Business	29,364	28,307	28,552	1,057	3.7 %	(245)	(0.9)%
Government Business	8,135	7,346	7,578	789	10.7 %	(232)	(3.1)%
Total Medical Membership by Reportable Segment	37,499	35,653	36,130	1,846	5.2 %	(477)	(1.3)%
Other Membership							
Life and Disability Members	4,762	4,819	4,838	(57)	(1.2)%	(19)	(0.4)%
Dental Members	4,995	4,895	4,863	100	2.0 %	32	0.7 %
Dental Administration Members	4,918	4,886	4,103	32	0.7 %	783	19.1 %
Vision Members	5,096	4,743	4,519	353	7.4 %	224	5.0 %
Medicare Advantage Part D Members	690	628	734	62	9.9 %	(106)	(14.4)%
Medicare Part D Standalone Members	467	474	574	(7)	(1.5)%	(100)	(17.4)%

December 31, 2014 Compared to December 31, 2013

Medical Membership (in thousands)

During the year ended December 31, 2014, total medical membership increased 1,846, or 5.2%, primarily due to increases in our Medicaid, Local Group, National Accounts and BlueCard® membership.

Self-funded medical membership increased 2,506, or 12.3%, primarily due to increases in our Local Group self-funded accounts including the New York State contract conversion from a fully-insured contract to a self-funded administrative services only, or ASO, contract and the acquisition of a large state ASO contract, which both occurred in the first quarter of 2014. The increase was further attributable to growth in our National Accounts and BlueCard® membership.

Fully-insured membership decreased 660, or 4.3%, primarily due to the New York State contract conversion and Local Group membership losses as a result of affordability challenges affecting healthcare consumers. The decrease was partially offset by growth in our Medicaid business.

Local Group membership increased 412, or 2.8%, primarily due to the acquisition of a large ASO state contract. This increase was partially offset by fully-insured membership declines resulting from affordability challenges affecting healthcare consumers.

Individual membership increased 38, or 2.2%, primarily due to public exchange sales in the majority of our markets, partially offset by off-exchange lapses.

National Accounts membership increased 378, or 5.6%, primarily due to new sales and in-group change partially offset by lapses.

BlueCard® membership increased 229, or 4.5%, primarily due to favorable membership activity at other BCBSA plans whose members reside in or travel to our licensed areas.

Medicare membership decreased 37, or 2.6%, primarily due to our product repositioning strategy toward HMO product offerings and select service area reductions.

Medicaid membership increased 815, or 18.6%, primarily due to market expansions and commencement of operations in new markets.

FEP membership increased 11, or 0.7%, primarily due to favorable open enrollment.

Other Membership (in thousands)

Our Other products are often ancillary to our health business and can therefore be impacted by corresponding changes in our medical membership.

Life and disability membership decreased 57, or 1.2%, primarily due to higher lapses and in-group change in our Local Group and Individual businesses.

Dental membership increased 100, or 2.0%, primarily due to new sales and growth in our Local Group and National Accounts businesses.

Dental administration membership increased 32, or 0.7%, primarily due to membership expansion under current contracts.

Vision membership increased 353, or 7.4%, primarily due to strong sales and in-group change in our Local Group and National Accounts businesses.

Medicare Advantage Part D membership increased 62, or 9.9%, primarily due to the addition of a new state contract, partially offset by decreases in various markets due to our product repositioning strategy toward HMO product offerings and select service area reductions.

Medicare Part D standalone membership decreased 7, or 1.5%, primarily due to competitive pressure in certain markets.

December 31, 2013 Compared to December 31, 2012

Medical Membership (in thousands)

During the year ended December 31, 2013, total medical membership decreased 477, or 1.3%, primarily due to decreases in our National Accounts, Medicaid, Medicare and Individual membership.

Self-funded medical membership increased 118, or 0.6%, primarily due to increases in our Local Group self-funded accounts, partially offset by lapses in our National Accounts and BlueCard® business.

Fully-insured membership decreased 595, or 3.7%, primarily due to membership losses in certain Local Group and Individual markets, as well as membership losses in our Medicaid and Medicare business, described below.

Local Group membership increased 44, or 0.3%, primarily due to new sales in several markets, partially offset by insured membership losses from strategic product portfolio changes in certain states, competitive pressure in certain markets and, we believe, affordability challenges affecting healthcare consumers in general.

Individual membership decreased 100, or 5.4%, primarily due to a heightened competitive environment in certain markets.

National Accounts membership decreased 223, or 3.2%, primarily due to lapses in our self-funded business.

BlueCard® membership increased 34, or 0.7%, primarily due to favorable membership activity at other BCBSA plans whose members reside in or travel to our licensed areas.

Medicare membership decreased 97, or 6.3%, primarily due to our product repositioning strategy toward HMO product offerings.

Medicaid membership decreased 142, or 3.1%, primarily due to membership losses in our California and New York plans and termination of the Ohio contract on June 30, 2013, partially offset by an increase in membership in various other states.

FEP membership increased 7, or 0.5%, primarily due to favorable in-group change.

Other Membership (in thousands)

Our Other products are often ancillary to our health business and can therefore be impacted by corresponding changes in our medical membership.

Life and disability membership decreased 19, or 0.4%, primarily due to the overall declines in our Commercial and Specialty Business medical membership. Life and disability products are generally offered as part of Commercial and Specialty Business medical membership sales.

Dental membership increased 32, or 0.7%, primarily due to growth from the launch of new product offerings, partially offset by declines in our Commercial and Specialty Business membership.

Dental administration membership increased 783, or 19.1%, primarily due to the acquisition of a large managed dental contract pursuant to which we provide dental administrative services.

Vision membership increased 224, or 5.0%, primarily due to strong sales and in-group change in our Local Group business.

Medicare Advantage Part D membership decreased 106, or 14.4%, primarily due to our product repositioning strategy toward HMO product offerings.

Medicare Part D standalone membership decreased 100, or 17.4%, primarily due to competitive pressure in certain markets.

Cost of Care

The following discussion summarizes our aggregate underlying cost of care trends for the year ended December 31, 2014 for our Local Group fully-insured business only.

Our cost of care trends are calculated by comparing the year-over-year change in average per member per month claim costs, excluding member co-payments and deductibles. While our cost of care trend varies by geographic location, based on underlying medical cost trends, we estimate that our aggregate cost of care trend was approximately 6.5% for the full year of 2014. We anticipate that medical cost trends will increase by approximately 50 basis points in 2015.

Provider rate increases were a primary driver of medical cost trends in 2014, consistent with 2013, and we continually negotiate with hospitals and physicians to manage these cost trends. We remain committed to optimizing our reimbursement rates and strategies to help address the cost pressures faced by employers and consumers. Unit cost increases were also a driver of pharmacy cost. In recent years many large volume brand drugs have launched generic alternatives, which have helped to mitigate pharmacy cost trend, but in 2014 we experienced a return to more normal historical average trends. New high cost Hepatitis C drug therapies also have put upward pressure on pharmacy trend.

Medical utilization, including pharmacy utilization, has been lower than in previous years and was not a primary driver of increased costs for the year ended December 31, 2014.

In response to cost trends, we continue to pursue contracting and plan design changes, promote and implement performance-based contracts that reward clinical outcomes and quality, and expand our disease management and advanced care management programs. We are taking a leadership role in the area of payment reform as evidenced by our Enhanced Personal Health Care program. By establishing the primary care doctor as central to the coordination of a patient's health care needs, the initiative builds on the success of current patient-centered medical home programs in helping to improve patient care while lowering costs.

A number of clinical management initiatives are in place to help mitigate inpatient trend. Focused review efforts continue in key areas, including targeting outlier facilities for length of stay and readmission, and high risk maternity and neonatal intensive care unit cases, among others. Additionally, we continue to refine our programs related to readmission management, focused behavioral health readmission reduction and post-discharge follow-up care.

Outpatient costs are a collection of different types of expenses, such as outpatient facilities, labs, x-rays, emergency room, occupational and physical therapy and many others. Two key examples developed to mitigate outpatient costs are as follows:

- *Cancer Care Quality Program:* This program, developed in collaboration with our subsidiary, AIM Specialty Health, or AIM, identifies certain cancer treatment pathways selected based upon current medical evidence, peer-reviewed published literature, consensus guidelines and our clinical policies to support oncologists in identifying cancer treatment therapies that are highly effective and provide greater value.
- *Expanded Cost and Quality Surgery Program:* This program, developed in collaboration with AIM, proactively contacts members who have elected to have an endoscopy, colonoscopy, or knee or shoulder arthroscopy to inform them about alternative sites of care, with the goal of offering information about providers who may be more cost effective.

Consolidated Results of Operations

Our consolidated summarized results of operations for the years ended December 31, 2014, 2013 and 2012 are discussed in the following section.

	Years Ended December 31			Change			
				2014 vs. 2013		2013 vs. 2012	
	2014	2013	2012	\$	%	\$	%
Total operating revenue	\$ 73,021.7	\$ 70,191.4	\$ 60,514.0	\$ 2,830.3	4.0 %	\$ 9,677.4	16.0 %
Net investment income	724.4	659.1	686.1	65.3	9.9 %	(27.0)	(3.9)%
Net realized gains on investments	177.0	271.9	334.9	(94.9)	(34.9)%	(63.0)	(18.8)%
Other-than-temporary impairment losses on investments	(49.0)	(98.9)	(37.8)	49.9	50.5 %	(61.1)	(161.6)%
Total revenues	73,874.1	71,023.5	61,497.2	2,850.6	4.0 %	9,526.3	15.5 %
Benefit expense	56,854.9	56,237.1	48,213.6	617.8	1.1 %	8,023.5	16.6 %
Selling, general and administrative expense	11,748.4	9,952.9	8,680.5	1,795.5	18.0 %	1,272.4	14.7 %
Other expense ¹	902.7	993.3	744.8	(90.6)	(9.1)%	248.5	33.4 %
Total expenses	69,506.0	67,183.3	57,638.9	2,322.7	3.5 %	9,544.4	16.6 %
Income from continuing operations before income tax expense	4,368.1	3,840.2	3,858.3	527.9	13.7 %	(18.1)	(0.5)%
Income tax expense	1,808.0	1,205.9	1,207.3	602.1	49.9 %	(1.4)	(0.1)%
Income from continuing operations	2,560.1	2,634.3	2,651.0	(74.2)	(2.8)%	(16.7)	(0.6)%
Income (loss) from discontinued operations, net of tax²	9.6	(144.6)	4.5	154.2	NM³	(149.1)	NM³
Net income	\$ 2,569.7	\$ 2,489.7	\$ 2,655.5	\$ 80.0	3.2 %	\$ (165.8)	(6.2)%
Average diluted shares outstanding	285.9	303.8	324.8	(17.9)	(5.9)%	(21.0)	(6.5)%
Diluted net income (loss) per share:							
Diluted - continuing operations	\$ 8.96	\$ 8.67	\$ 8.17	\$ 0.29	3.3 %	\$ 0.50	6.1 %
Diluted - discontinued operations ²	0.03	(0.47)	0.01	0.50	NM ³	(0.48)	NM ³
Diluted net income per share	\$ 8.99	\$ 8.20	\$ 8.18	\$ 0.79	9.6 %	\$ 0.02	0.2 %
Benefit expense ratio ⁴	83.1%	85.1%	85.3%		(200)bp ⁵		(20)bp ⁵
Selling, general and administrative expense ratio ⁶	16.1%	14.2%	14.3%		190bp ⁵		(10)bp ⁵
Income from continuing operations before income taxes as a percentage of total revenue	5.9%	5.4%	6.3%		50bp ⁵		(90)bp ⁵
Net income as a percentage of total revenue	3.5%	3.5%	4.3%		0bp ⁵		(80)bp ⁵

Certain of the following definitions are also applicable to all other results of operations tables in this discussion:

- Includes interest expense, amortization of other intangible assets and loss on extinguishment of debt.
- The operating results of 1-800 CONTACTS are reported as discontinued operations as a result of the sale of the business completed on January 31, 2014.
- Calculation not meaningful.
- Benefit expense ratio represents benefit expense as a percentage of premium revenue. Premiums for the years ended December 31, 2014, 2013 and 2012 were \$68,389.8, \$66,119.1 and \$56,496.7, respectively. Premiums are included in total operating revenue presented above.
- bp = basis point; one hundred basis points = 1%.
- Selling, general and administrative expense ratio represents selling, general and administrative expense as a percentage of total operating revenue.

Year Ended December 31, 2014 Compared to the Year Ended December 31, 2013

Total operating revenue increased \$2,830.3, or 4.0%, to \$73,021.7 in 2014, resulting primarily from higher premiums and, to a lesser extent, increased administrative fees. Higher premiums were mainly due to rate increases across our businesses designed to cover overall cost trends and new fees associated with Health Care Reform, including HIP Fees reimbursed by Medicaid state plans. The increase in premiums was further attributable to membership increases in our Medicaid and Individual businesses. The increase in premiums was offset, in part, by fully-insured membership declines in our Local Group business as a result of the New York State contract conversion and affordability challenges affecting healthcare consumers. The increase was further offset by higher experience rated refunds in our Medicaid business, and lower premiums in our Medicare Advantage business primarily due to membership declines and a refinement of estimates associated with Medicare risk score revenue for prior years. The increase in administrative fees primarily resulted from membership growth in our Local Group business, including the New York State contract conversion and the acquisition of a large state ASO contract, which both occurred in the first quarter of 2014. The increase in administrative fees was further attributable to growth in our National Accounts business.

Net investment income increased \$65.3, or 9.9%, to \$724.4 in 2014, primarily due to higher income from alternative investments and higher investment yields.

Net realized gains on investments decreased \$94.9, or 34.9%, to \$177.0 in 2014, primarily due to a decrease in net realized gains on sales of equity securities, partially offset by an increase in net realized gains on sales of fixed maturity securities.

Other-than-temporary impairment losses on investments decreased \$49.9, or 50.5%, to \$49.0 in 2014, primarily due to a decrease in impairment losses on certain joint venture investments and fixed maturity securities.

Benefit expense increased \$617.8, or 1.1%, to \$56,854.9 in 2014, primarily due to benefit cost trends across our businesses and membership growth in our Medicaid and Individual businesses. The increase in benefit expense was further a result of higher pharmacy costs primarily attributable to new high cost Hepatitis C drug therapies. These increases were partially offset by the fully-insured membership declines in our Local Group and Medicare Advantage businesses, as described above. In addition, the increase in benefit expense was offset, in part, by our estimate of reinsurance recoveries relating to the Health Care Reform reinsurance premium stabilization program of \$753.4 for 2014.

Our benefit expense ratio decreased 200 basis points to 83.1% in 2014, primarily due to rate increases across our businesses designed to cover overall cost trends and new fees associated with Health Care Reform, including additional premiums collected to help cover the non-tax deductible impact of the HIP Fee. The decrease was further attributable to better than expected medical cost trends in our Medicaid business. These improvements were partially offset by higher pharmacy costs primarily attributable to new high cost Hepatitis C drug therapies.

Selling, general and administrative expense increased \$1,795.5, or 18.0%, to \$11,748.4 in 2014. Our selling, general and administrative expense ratio increased 190 basis points to 16.1% in 2014. The increases in the expense and ratio were both primarily due to new fees related to Health Care Reform that were effective January 1, 2014, including \$893.3 for the HIP Fee and \$447.7 of assessments related to the Health Care Reform reinsurance premium stabilization program.

Other expenses decreased \$90.6, or 9.1%, to \$902.7 in 2014, primarily due to lower losses recognized on debt extinguishment associated with the early redemption and repurchase of outstanding senior unsecured notes. During the years ended December 31, 2014 and 2013, we recognized losses on extinguishment of debt of \$81.1 and \$145.3, respectively. The decrease in other expense was further attributable to reduced amortization of certain other intangible assets acquired in prior years. For additional information related to our borrowings, see "Liquidity and Capital Resources - *Future Sources and Uses of Liquidity*," below.

Income tax expense increased \$602.1, or 49.9%, to \$1,808.0 in 2014. The effective tax rates in 2014 and 2013 were 41.4% and 31.4%, respectively. The increase in income tax expense was primarily due to the non-tax deductible HIP Fee effective for 2014 and increased income before income taxes. The 2013 expense and effective tax rate were lower because they include benefits resulting from a favorable tax election made subsequent to the Amerigroup acquisition and from inclusion of Amerigroup in our state apportionment factors calculation, which produces a lower state tax expense. The increase in the effective tax rate for 2014 was primarily due to the non-tax deductible HIP fee.

Our net income as a percentage of total revenue was 3.5% in 2014 and 2013 as a result of all factors discussed above.

Year Ended December 31, 2013 Compared to the Year Ended December 31, 2012

Total operating revenue increased \$9,677.4, or 16.0% to \$70,191.4 in 2013, resulting primarily from higher premiums and, to a lesser extent, increased administrative fees. The higher premiums were mainly due to increases in our Medicaid business primarily as a result of our acquisition of Amerigroup in December 2012. Rate increases in our Local Group, FEP, Individual and National businesses designed to cover overall cost trends as well as premium rate and membership increases in our Specialty businesses and increased administrative fees resulting from pricing increases for self-funded members in our Commercial businesses also contributed to the increased operating revenue. These increases were partially offset by fully-insured membership declines in our Local Group business due to strategic portfolio changes in certain states, competitive pressure in certain markets and, we believe, affordability challenges affecting healthcare consumers in general. Additionally, lower revenues in our Medicare Advantage and Medicare Part D businesses, primarily due to membership declines as a result of our product repositioning strategy toward HMO product offerings, partially offset the increased operating revenues.

Net investment income decreased \$27.0, or 3.9%, to \$659.1 in 2013, primarily due to lower investment yields.

Net realized gains on investments decreased \$63.0, or 18.8%, to \$271.9 in 2013, primarily due to lower net realized gains on sales of fixed maturity securities partially offset by an increase in net realized gains on sales of equity securities, a realized gain on the partial divestiture of an equity method investment and an increase in net realized gains on sales and settlements of derivative financial instruments.

Other-than-temporary impairment losses on investments increased \$61.1, or 161.6%, to \$98.9 in 2013, primarily due to the impairment of certain joint venture investments and fixed maturity securities.

Benefit expense increased \$8,023.5, or 16.6%, to \$56,237.1 in 2013, primarily from our acquisition of Amerigroup and increased benefit costs in our Local Group, Individual and FEP businesses. These increases were partially offset by the fully-insured membership declines in our Local Group and Medicare Advantage businesses as described above.

Our benefit expense ratio decreased 20 basis points to 85.1% in 2013, due, in part, to our product repositioning strategy in certain Medicare Advantage plans toward HMO product offerings with lower benefit costs. The decrease was further attributable to the favorable impact of declines in membership in our Local Group business in products with higher benefit costs and lower than expected medical cost trends. These improvements were partially offset by the acquisition of Amerigroup, which carries higher average benefit expense ratios than our consolidated average as well as higher than expected medical cost trends in our Individual business.

Selling, general and administrative expense increased \$1,272.4, or 14.7%, to \$9,952.9 in 2013, primarily due to the inclusion of selling, general and administrative expense related to our Amerigroup subsidiary in 2013. The increase was further attributable to costs incurred in preparation for the implementation of Health Care Reform effective in 2014 as well as increases in incentive compensation as a result of our operating performance.

Our selling, general and administrative expense ratio decreased 10 basis points to 14.2% in 2013, primarily due to the effect of the increase in operating revenue from Amerigroup partially offset by the increased selling general and administrative expense discussed in the preceding paragraph.

Other expense increased \$248.5, or 33.4%, to \$993.3 in 2013, primarily due to losses recognized on debt extinguishment associated with our early redemption and repurchases of \$1,100.0 aggregate principal amount of outstanding senior unsecured notes. The increase in other expense was further attributable to increased interest expense resulting from higher outstanding debt balances associated with our acquisition of Amerigroup and the issuance on July 30, 2013 of \$650.0 of 2.300% notes due 2018 and \$600.0 of 5.100% notes due 2044 to fund, in part, the early redemption and repurchases discussed above. For additional information related to our borrowings, see "Liquidity and Capital Resources - *Future Sources and Uses of Liquidity*," below.

Income tax expense decreased \$1.4, or 0.1%, to \$1,205.9 in 2013. The effective tax rates in 2013 and 2012 were 31.4% and 31.3%, respectively. The effective tax rate in 2013 included benefits resulting from a favorable tax election made subsequent to the Amerigroup acquisition and inclusion of Amerigroup in our state apportionment factors calculation, which

produced a lower effective state tax rate. The effective tax rate in 2012 included benefits resulting from settlement with the IRS of items related to not-for-profit conversions and corporate reorganizations prior to 2012, as well as issues related to certain of our acquired companies incurred prior to our acquisition of those companies. These favorable items in the 2012 effective tax rate were partially offset by increases due to the impact of non-tax deductible litigation settlement expenses and an increase in our state deferred tax asset valuation allowance attributable to uncertainty associated with certain state net operating loss carryforwards.

In December 2013, we entered into a definitive agreement to sell our 1-800 CONTACTS business and an asset purchase agreement to sell our glasses.com related assets (collectively, 1-800 CONTACTS). The operating results for 1-800 CONTACTS are reported as discontinued operations. For the year ended December 31, 2013, we recorded a loss from discontinued operations, net of tax, of \$144.6 compared to income from discontinued operations, net of tax, of \$4.5 for the year ended December 31, 2012. Included in the loss from discontinued operations for the year ended December 31, 2013, is a loss on disposal of held for sale assets, net of tax, of \$164.5. The loss on disposal was calculated as the difference between the fair value, as determined by the sales agreements less costs to sell, and the carrying value of the held for sale assets at December 31, 2013. The divestitures were completed on January 31, 2014 and did not result in any material difference to the loss on disposal recognized during the year ended December 31, 2013.

Our net income as a percentage of total revenue decreased 80 basis points to 3.5% in 2013 as compared to 2012 as a result of all factors discussed above.

Reportable Segments Results of Operations

We use operating gain to evaluate the performance of our reportable segments, which are Commercial and Specialty Business; Government Business; and Other. Operating gain, which is a non-GAAP measure, is calculated as total operating revenue less benefit expense and selling, general and administrative expense. It does not include net investment income, net realized gains/losses on investments, other-than-temporary impairment losses recognized in income, interest expense, amortization of other intangible assets, loss on extinguishment of debt or income taxes, as these items are managed in a corporate shared service environment and are not the responsibility of operating segment management. Effective January 1, 2014, our Employer Group Medicare Advantage members are being reported within Local Group and National Accounts in our Commercial and Specialty Business segment and prior period segment amounts have been reclassified to conform to the new presentation. These members were previously reported with our Medicare membership within our Government Business segment. The Employer Group Medicare Advantage members are retired members who have selected a Medicare Advantage product through our Local Group and National Accounts.

The discussion of segment results for the years ended December 31, 2014, 2013 and 2012 presented below are based on operating gain, as described above, and operating margin, which is calculated as operating gain divided by operating revenue. Our definitions of operating gain and operating margin may not be comparable to similarly titled measures reported by other companies. For additional information, including a reconciliation of non-GAAP financial measures, see Note 19, "Segment Information," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Our Commercial and Specialty Business, Government Business, and Other segments' summarized results of operations for the years ended December 31, 2014, 2013 and 2012 are as follows:

	Years Ended December 31			Change			
				2014 vs. 2013		2013 vs. 2012	
	2014	2013	2012	\$	%	\$	%
Commercial and Specialty Business							
Operating revenue	\$ 39,199.6	\$ 39,404.2	\$ 39,639.9	\$ (204.6)	(0.5)%	\$ (235.7)	(0.6)%
Operating gain	\$ 3,260.9	\$ 3,176.4	\$ 3,396.3	\$ 84.5	2.7 %	\$ (219.9)	(6.5)%
Operating margin	8.3%	8.1%	8.6%		20bp		(50)bp
Government Business							
Operating revenue	\$ 33,796.4	\$ 30,752.6	\$ 20,838.9	\$ 3,043.8	9.9 %	\$ 9,913.7	47.6 %
Operating gain	\$ 1,191.9	\$ 844.0	\$ 285.4	\$ 347.9	41.2 %	\$ 558.6	195.7 %
Operating margin	3.5%	2.7%	1.4%		80bp		130bp
Other							
Operating revenue ¹	\$ 25.7	\$ 34.6	\$ 35.2	\$ (8.9)	(25.7)%	\$ (0.6)	(1.7)%
Operating loss ²	\$ (34.4)	\$ (19.0)	\$ (61.8)	\$ (15.4)	81.1 %	\$ 42.8	(69.3)%

¹ Fluctuations not material.

² Fluctuations primarily a result of changes in unallocated corporate expenses.

Year Ended December 31, 2014 Compared to the Year Ended December 31, 2013

Commercial and Specialty Business

Operating revenue decreased \$204.6, or 0.5%, to \$39,199.6 in 2014, primarily due to fully-insured membership declines in our Local Group business resulting from the impact of the New York State contract conversion and affordability challenges affecting healthcare consumers. These decreases were partially offset by premium rate increases in our Local Group and Individual businesses designed to cover overall cost trends and new fees associated with Health Care Reform, and membership growth in our Individual business. The decrease in operating revenue was further offset by increased administrative fees primarily resulting from membership growth in our Local Group business, including the acquisition of a large state ASO contract in the first quarter of 2014. The increase in administrative fees was further attributable to growth in our National Accounts business.

Operating gain increased \$84.5, or 2.7%, to \$3,260.9 in 2014, primarily as a result of improved performance in our Individual business reflecting our public exchange strategy implemented during the year, along with membership growth in self-funded products. The increase in operating gain was further attributable to additional premiums collected to help cover the non-tax deductible impact of the HIP Fee. These increases were partially offset by insured membership declines in our Local Group business, continued costs incurred associated with Health Care Reform market changes and higher pharmacy costs primarily attributable to new high cost Hepatitis C drug therapies.

The operating margin in 2014 was 8.3%, a 20 basis point increase over 2013, primarily due to the factors discussed in the preceding two paragraphs.

Government Business

Operating revenue increased \$3,043.8, or 9.9%, to \$33,796.4 in 2014, primarily due to increased premiums in our Medicaid and FEP businesses as a result of premium rate increases designed to cover overall cost trends and new fees associated with Health Care Reform. The increase in operating revenue was further attributable to membership growth in our Medicaid business and additional premiums collected to help cover the non-tax deductible impact of the HIP Fee. These increases were partially offset by higher experience rated refunds in our Medicaid business, lower premiums in our Medicare

businesses, primarily due to membership declines in our Medicare Advantage business, and a refinement of estimates associated with Medicare risk score revenue for prior years.

Operating gain increased \$347.9, or 41.2%, to \$1,191.9 in 2014, primarily due to better than expected medical cost trends and membership growth in our Medicaid business. These increases were partially offset by higher pharmacy costs primarily attributable to new high cost Hepatitis C drug therapies, and a refinement of estimates associated with Medicare risk score revenue for prior years.

The operating margin in 2014 was 3.5%, a 80 basis point increase over 2013, primarily due to the factors discussed in the preceding two paragraphs.

Year Ended December 31, 2013 Compared to the Year Ended December 31, 2012

Commercial and Specialty Business

Operating revenue decreased \$235.7, or 0.6%, to \$39,404.2 in 2013, primarily due to fully-insured membership declines in our Local Group business resulting from strategic product portfolio changes in certain states, competitive pressure in certain markets and, we believe, affordability challenges affecting healthcare consumers in general. This decrease was partially offset by premium rate increases in our Local Group, Individual and National businesses designed to cover overall cost trends, premium rate and membership increases in our Specialty businesses, primarily related to our dental and vision products, as well as increased administrative fees resulting from pricing increases for self-funded members in our Commercial businesses.

Operating gain decreased \$219.9, or 6.5%, to \$3,176.4 in 2013, primarily as a result of higher selling, general and administrative expenses driven by costs incurred in preparation for the implementation of Health Care Reform provisions that become effective in 2014 as well as increases in allocated incentive compensation as a result of consolidated operating performance. The decrease was further attributable to increased benefit costs in our Individual business. These decreases were partially offset by improved results in our Local Group business resulting from lower than anticipated medical cost trends.

The operating margin in 2013 was 8.1%, a 50 basis point decrease from 2012, primarily due to the factors discussed in the preceding two paragraphs.

Government Business

Operating revenue increased \$9,913.7, or 47.6%, to \$30,752.6 in 2013, primarily due to the acquisition of Amerigroup, growth in our FEP business due to premium rate increases designed to cover overall cost trends, and increases in membership in our CareMore and FEP businesses. These increases were partially offset by membership declines in our non-CareMore Medicare Advantage and Medicare Part D businesses related to our product repositioning strategy toward HMO product offerings.

Operating gain increased \$558.6, or 195.7%, to \$844.0 in 2013, primarily due to the acquisition of Amerigroup and improved operating results in the majority of our other government lines of business.

The operating margin in 2013 was 2.7%, a 130 basis point increase over 2012, primarily due to the factors discussed in the preceding two paragraphs.

Critical Accounting Policies and Estimates

We prepare our consolidated financial statements in conformity with GAAP. Application of GAAP requires management to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes and within this MD&A. We consider our most important accounting policies that require significant estimates and management judgment to be those policies with respect to liabilities for medical claims payable, income taxes, goodwill and other intangible assets, investments and retirement benefits, which are discussed below. Our other significant accounting policies are summarized in Note 2, "Basis of Presentation and Significant Accounting Policies," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

We continually evaluate the accounting policies and estimates used to prepare the consolidated financial statements. In general, our estimates are based on historical experience, evaluation of current trends, information from third party professionals and various other assumptions that we believe to be reasonable under the known facts and circumstances.

Medical Claims Payable

The most subjective accounting estimate in our consolidated financial statements is our liability for medical claims payable. At December 31, 2014, this liability was \$6,861.2 and represented 18.1% of our total consolidated liabilities. We record this liability and the corresponding benefit expense for incurred but not paid claims, including the estimated costs of processing such claims. Incurred but not paid claims include (1) an estimate for claims that are incurred but not reported, as well as claims reported to us but not yet processed through our systems, which approximated 95.8%, or \$6,572.4, of our total medical claims liability as of December 31, 2014; and (2) claims reported to us and processed through our systems but not yet paid, which approximated 4.2%, or \$288.8, of the total medical claims payable as of December 31, 2014. The level of claims payable processed through our systems but not yet paid may fluctuate from one period end to the next, from approximately 1% to 5% of our total medical claims liability, due to timing of when claim payments are made.

Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be appropriate under moderately adverse circumstances. We determine the amount of the liability for incurred but not paid claims by following a detailed actuarial process that entails using both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this process, historical paid claims data is formatted into "claim triangles," which compare claim incurred dates to the dates of claim payments. This information is analyzed to create "completion factors" that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims.

For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather they are projected by estimating the claims expense for those months based on recent claims expense levels and health care trend levels, or "trend factors."

Because the reserve methodology is based upon historical information, it must be adjusted for known or suspected operational and environmental changes. These adjustments are made by our actuaries based on their knowledge and their estimate of emerging impacts to benefit costs and payment speed. Circumstances to be considered in developing our best estimate of reserves include changes in utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations. A comparison of prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In our comparison of prior year, the methods and assumptions are not changed as reserves are recalculated; rather the availability of additional paid claims information drives our changes in the re-estimate of the unpaid claim liability. To the extent appropriate, changes in such development are recorded as a change to current period benefit expense.

We regularly review and set assumptions regarding cost trends and utilization when initially establishing claim liabilities. We continually monitor and adjust the claims liability and benefit expense based on subsequent paid claims activity. If it is determined that our assumptions regarding cost trends and utilization are significantly different than actual results, our income statement and financial position could be impacted in future periods. Adjustments of prior year estimates may result in additional benefit expense or a reduction of benefit expense in the period an adjustment is made. Further, due to the considerable variability of health care costs, adjustments to claim liabilities occur each period and are sometimes significant as compared to the net income recorded in that period. Prior period development is recognized immediately upon the actuary's judgment that a portion of the prior period liability is no longer needed or that an additional liability should have been accrued. That determination is made when sufficient information is available to ascertain that the re-estimate of the liability is reasonable.

While there are many factors that are used as a part of the estimation of our medical claims payable liability, the two key assumptions having the most significant impact on our incurred but not paid claims liability as of December 31, 2014 were the completion and trend factors. As discussed above, these two key assumptions can be influenced by other operational variables including system changes, provider submission patterns and business combinations.

There is variation in the reasonable choice of completion factors by duration for durations of three months through twelve months where the completion factors have the most significant impact. As previously discussed, completion factors tend to be less reliable for the most recent months and therefore are not specifically utilized for months one and two. In our analysis for the claim liabilities at December 31, 2014, the variability in months three to five was estimated to be between 40 and 90 basis points, while months six through twelve have much lower variability ranging from 0 to 30 basis points.

The difference in completion factor assumptions, assuming moderately adverse experience, results in variability of 2%, or approximately \$155.0, in the December 31, 2014 incurred but not paid claims liability, depending on the completion factors chosen. It is important to note that the completion factor methodology inherently assumes that historical completion rates will be reflective of the current period. However, it is possible that the actual completion rates for the current period will develop differently from historical patterns and therefore could fall outside the possible variations described herein.

The other major assumption used in the establishment of the December 31, 2014 incurred but not paid claim liability was the trend factors. In our analysis for the period ended December 31, 2014, there was a 330 basis point differential in the high and low trend factors assuming moderately adverse experience. This range of trend factors would imply variability of 4%, or approximately \$303.0, in the incurred but not paid claims liability, depending upon the trend factors used. Because historical trend factors are often not representative of current claim trends, the trend experience for the most recent six to nine months, plus knowledge of recent events likely affecting current trends, have been taken into consideration in establishing the incurred but not paid claims liability at December 31, 2014.

See Note 11, "Medical Claims Payable," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K, for a reconciliation of the beginning and ending balance for medical claims payable for the years ended December 31, 2014, 2013 and 2012. Components of the total incurred claims for each year include amounts accrued for current year estimated claims expense as well as adjustments to prior year estimated accruals. In Note 11, "Medical Claims Payable," the line labeled "Net incurred medical claims: Prior years redundancies" accounts for those adjustments made to prior year estimates. The impact of any reduction of "Net incurred medical claims: Prior years redundancies" may be offset as we establish the estimate of "Net incurred medical claims: Current year." Our reserving practice is to consistently recognize the actuarial best estimate of our ultimate liability for our claims. When we recognize a release of the redundancy, we disclose the amount that is not in the ordinary course of business, if material.

The ratio of current year medical claims paid as a percent of current year net medical claims incurred was 89.4% for 2014, 89.3% for 2013 and 89.1% for 2012. The increase in these ratios reflects acceleration in processing claims that occurred over the course of the past three years.

We calculate the percentage of prior years' redundancies in the current year as a percent of prior years' net incurred claims payable less prior years' redundancies in the current year in order to demonstrate the development of the prior years' reserves. This metric was 9.7% for the year ended December 31, 2014, 10.8% for the year ended December 31, 2013 and 10.4% for the year ended December 31, 2012. The year ended December 31, 2014 metric reflects a slightly higher level of accuracy compared to the targeted prior year reserve for adverse deviation and a resultant lower level of prior years' redundancies than the years ended December 31, 2013 and 2012.

We calculate the percentage of prior years' redundancies in the current period as a percent of prior years' net incurred medical claims to indicate the percentage of redundancy included in the preceding year calculation of current year net incurred medical claims. We believe this calculation supports the reasonableness of our prior year estimate of incurred medical claims and the consistency in our methodology. For the year ended December 31, 2014, this metric was 1.0%, which was calculated using the redundancy of \$541.9. This metric was 1.3% for 2013 and 1.1% for 2012.

The following table shows the variance between total net incurred medical claims as reported in Note 11, "Medical Claims Payable," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K, for each of 2013 and 2012 and the incurred claims for such years had it been determined retrospectively (computed as the difference between "net incurred medical claims – current year" for the year shown and "net incurred medical claims – prior years redundancies" for the immediately following year):

	Years Ended December 31	
	2013	2012
Total net incurred medical claims, as reported	\$ 55,295.2	\$ 47,566.5
Retrospective basis, as described above	55,352.4	47,481.0
Variance	\$ (57.2)	\$ 85.5
Variance to total net incurred medical claims, as reported	(0.1)%	0.2%

Given that our business is primarily short tailed (which means that medical claims are generally paid within twelve months of the member receiving service from the provider), the variance to total net incurred medical claims, as reported above, is used to assess the reasonableness of our estimate of ultimate incurred medical claims for a given calendar year with the benefit of one year of experience. We expect that substantially all of the development of the 2014 estimate of medical claims payable will be known during 2015.

The 2013 variance to total net incurred medical claims, as reported of (0.1)% was smaller in absolute value than the 2012 percentage of 0.2%. The lower 2013 variance was driven by a more consistent level of prior year redundancies in 2014 and 2013 associated with 2013 and 2012 claim payments, respectively. Prior year redundancies in 2012 associated with 2011 claim payments were slightly lower by comparison, thus creating a higher 2012 variance.

Income Taxes

We account for income taxes in accordance with FASB guidance, which requires, among other things, the separate recognition of deferred tax assets and deferred tax liabilities. Such deferred tax assets and deferred tax liabilities represent the tax effect of temporary differences between financial reporting and tax reporting measured at tax rates enacted at the time the deferred tax asset or liability is recorded. A valuation allowance must be established for deferred tax assets if it is "more likely than not" that all or a portion may be unrealized. Our judgment is required in determining an appropriate valuation allowance.

At each financial reporting date, we assess the adequacy of the valuation allowance by evaluating each of our deferred tax assets based on the following:

- the types of temporary differences that created the deferred tax asset;
- the amount of taxes paid in prior periods and available for a carry-back claim;
- the forecasted future taxable income, and therefore, likely future deduction of the deferred tax item; and
- any significant other issues impacting the likely realization of the benefit of the temporary differences.

We, like other companies, frequently face challenges from tax authorities regarding the amount of taxes due. These challenges include questions regarding the timing and amount of deductions that we have taken on our tax returns. In evaluating any additional tax liability associated with various positions taken in our tax return filings, we record additional liabilities for potential adverse tax outcomes. Based on our evaluation of our tax positions, we believe we have appropriately accrued for uncertain tax benefits, as required by the guidance. To the extent we prevail in matters we have accrued for, our future effective tax rate would be reduced and net income would increase. If we are required to pay more than accrued, our future effective tax rate would increase and net income would decrease. Our effective tax rate and net income in any given future period could be materially impacted.

In the ordinary course of business, we are regularly audited by federal and other tax authorities, and from time to time, these audits result in proposed assessments. We believe our tax positions comply with applicable tax law and we intend to defend our positions vigorously through the federal, state and local appeals processes. We believe we have adequately

provided for any reasonable foreseeable outcome related to these matters. Accordingly, although their ultimate resolution may require additional tax payments, we do not anticipate any material impact on our results of operations from these matters.

For additional information, see Note 7, "Income Taxes," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Goodwill and Other Intangible Assets

Our consolidated goodwill at December 31, 2014 was \$17,082.0 and other intangible assets were \$7,958.1. The sum of goodwill and other intangible assets represented 40.3% of our total consolidated assets and 103.3% of our consolidated shareholders' equity at December 31, 2014.

We follow FASB guidance for business combinations and goodwill and other intangible assets, which specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Under the guidance, goodwill and other intangible assets (with indefinite lives) are not amortized but are tested for impairment at least annually. Furthermore, goodwill and other intangible assets are allocated to reporting units for purposes of the annual impairment test. Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units, which include goodwill and other intangible assets. In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately.

We complete our annual impairment tests of existing goodwill and other intangible assets with indefinite lives during the fourth quarter of each year. These tests involve the use of estimates related to the fair value of goodwill at the reporting unit level and other intangible assets with indefinite lives, and require a significant degree of management judgment and the use of subjective assumptions. Certain interim impairment tests are also performed when potential impairment indicators exist or changes in our business or other triggering events occur.

Fair value is estimated using the income and market approaches for goodwill at the reporting unit level and the income approach for our indefinite lived intangible assets. Use of the income and market approaches for our goodwill impairment test reflects our view that both valuation methodologies provide a reasonable estimate of fair value. The income approach is developed using assumptions about future revenue, expenses and net income derived from our internal planning process. These estimated future cash flows are then discounted. Our assumed discount rate is based on our industry's weighted-average cost of capital. Market valuations are based on observed multiples of certain measures including membership, revenue and EBITDA (earnings before interest, taxes, depreciation and amortization) and include market comparisons to publicly traded companies in our industry.

We did not incur any impairment losses as a result of our 2014 annual impairment tests as the estimated fair values of our reporting units were substantially in excess of the carrying values as of December 31, 2014. Additionally, we do not believe that the estimated fair values of our reporting units are at risk of becoming impaired in the next twelve months. However, as a result of certain provisions of Health Care Reform, along with current economic conditions, we have experienced lower operating margins in certain lines of business. Those margins could become further compressed if results from implementation of Health Care Reform are significantly different than anticipated. As a result, the estimated fair values of certain of our reporting units with goodwill could fall below their carrying values in future periods and if that were to occur, we would be required to record impairment losses at that time.

While we believe we have appropriately allocated the purchase price of our acquisitions, this allocation requires many assumptions to be made regarding the fair value of assets and liabilities acquired. In addition, estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used. If estimated fair values are less than the carrying values of goodwill and other intangibles with indefinite lives in future annual impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

For additional information, see Note 3, "Business Acquisitions and Divestitures" and Note 9, "Goodwill and Other Intangible Assets," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Investments

Current and long-term available-for-sale investment securities were \$19,909.9 at December 31, 2014 and represented 32.1% of our total consolidated assets at December 31, 2014. We classify fixed maturity and equity securities in our investment portfolio as “available-for-sale” or “trading” and report those securities at fair value. Certain fixed maturity securities are available to support current operations and, accordingly, we classify such investments as current assets without regard to their contractual maturity. Investments used to satisfy contractual, regulatory or other requirements are classified as long-term, without regard to contractual maturity.

We review investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We conduct this review on a quarterly basis, using both qualitative and quantitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the length of time and the extent to which a security’s market value has been less than its cost, the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors), financial condition and near term prospects of the issuer, including the credit ratings and changes in the credit ratings of the issuer, recommendations of investment advisors, and forecasts of economic, market or industry trends. In addition, for equity securities, we determine whether we have the intent and ability to hold the security for a period of time to allow for a recovery of its fair value above its carrying amount. If any declines of equity securities are determined to be other-than-temporary, we charge the losses to income when that determination is made.

Certain FASB other-than-temporary impairment, or OTTI, guidance applies to fixed maturity securities and provides guidance on the recognition, presentation of, and disclosures for OTTIs. If a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, the decline in value is deemed to be other-than-temporary and is presented within the Other-than-temporary impairment losses recognized in income line item on our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, the credit component of the OTTI is presented within the Other-than-temporary impairment losses recognized in income line item on our consolidated statements of income and the non-credit component of the OTTI is recognized in other comprehensive income. Furthermore, unrealized losses entirely caused by non-credit related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive income.

The credit component of an OTTI is determined by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting our best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of acquisition. For mortgage-backed and asset-backed securities, cash flow estimates are based on assumptions regarding the underlying collateral including prepayment speeds, vintage, type of underlying asset, geographic concentrations, default rates, recoveries and changes in value. For all other debt securities, cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings, and estimates regarding timing and amount of recoveries associated with a default.

We have a committee of accounting and investment associates and management that is responsible for managing the impairment review process. The current economic environment and volatility of securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets.

We believe we have adequately reviewed our investment securities for impairment and that our investment securities are carried at fair value. However, over time, the economic and market environment may provide additional insight regarding the fair value of certain securities, which could change our judgment regarding impairment. This could result in other-than-temporary impairment losses on investments being charged against future income. Given the current market conditions and the significant judgments involved, there is continuing risk that further declines in fair value may occur and additional, material other-than-temporary impairment losses on investments may be recorded in future periods.

In addition to available-for-sale investment securities, we held additional long-term investments of \$1,695.9, or 2.7% of total consolidated assets, at December 31, 2014. These long-term investments consisted primarily of certain other equity

investments, cash surrender value of corporate-owned life insurance policies and real estate. Due to their less liquid nature, these investments are classified as long-term.

Through our investing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in equity market valuations. We manage the market risks through our investment policy, which establishes credit quality limits and limits on investments in individual issuers. Ineffective management of these risks could have an impact on our future earnings and financial position. Our investment portfolio includes fixed maturity securities with a fair value of \$17,971.8 at December 31, 2014. The weighted-average credit rating of these securities was "A" as of December 31, 2014. Included in this balance are investments in fixed maturity securities of states, municipalities and political subdivisions and mortgage-backed securities of \$1,403.7 and \$7.4, respectively, that are guaranteed by third parties. With the exception of twelve securities with a fair value of \$7.7, these securities are all investment-grade and carry a weighted-average credit rating of "AA" as of December 31, 2014. The securities are guaranteed by a number of different guarantors and we do not have any significant exposure to any single guarantor (neither indirect through the guarantees, nor direct through investment in the guarantor). Further, due to the high underlying credit rating of the issuers, the weighted-average credit rating of these securities without a guarantee was "A" as of December 31, 2014 for the securities for which such information is available.

Fair values of available-for-sale fixed maturity and equity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level I or Level II inputs for the determination of fair value in accordance with FASB guidance for fair value measurements and disclosures. We have controls in place to review the pricing services' qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable.

We obtain only one quoted price for each security from the pricing services, which are derived through recently reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. As we are responsible for the determination of fair value, we perform monthly analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. Our analysis includes a review of month-to-month price fluctuations. If unusual fluctuations are noted in this review, we may obtain additional information from other pricing services to validate the quoted price. There were no adjustments to quoted market prices obtained from the pricing services during the years ended December 31, 2014 and 2013.

In certain circumstances, it may not be possible to derive pricing model inputs from observable market activity, and therefore, such inputs are estimated internally. Such securities are designated Level III in accordance with FASB guidance. Securities designated Level III at December 31, 2014 totaled \$202.8 and represented less than 1% of our total assets measured at fair value on a recurring basis. Our Level III securities primarily consisted of certain corporate securities, equity securities and structured securities for which observable inputs were not always available and the fair values of these securities were estimated using internal estimates for inputs including, but not limited to, prepayment speeds, credit spreads, default rates and benchmark yields.

For additional information, see Part II, Item 7A "Quantitative and Qualitative Disclosures about Market Risk", and Part II, Item 8, Note 2, "Basis of Presentation and Significant Accounting Policies," Note 4, "Investments," and Note 6, "Fair Value," to our audited consolidated financial statements included in this Annual Report on Form 10-K.

Retirement Benefits

Pension Benefits

We sponsor defined benefit pension plans for some of our employees. These plans are accounted for in accordance with FASB guidance for retirement benefits, which requires that amounts recognized in financial statements be determined on an actuarial basis. As permitted by the guidance, we calculate the value of plan assets as described below. Further, the difference between our expected rate of return and the actual performance of plan assets, as well as certain changes in pension liabilities, are amortized over future periods.

An important factor in determining our pension expense is the assumption for expected long-term return on plan assets. As of our December 31, 2014 measurement date, we selected a weighted-average long-term rate of return on plan assets of 7.62%. We use a total portfolio return analysis in the development of our assumption. Factors such as past market performance, the long-term relationship between fixed maturity and equity securities, interest rates, inflation and asset allocations are considered in the assumption. The assumption includes an estimate of the additional return expected from active management of the investment portfolio. Peer data and an average of historical returns are also reviewed for appropriateness of the selected assumption. We believe our assumption of future returns is reasonable. However, if we lower our expected long-term return on plan assets, future contributions to the pension plan and pension expense would likely increase.

This assumed long-term rate of return on assets is applied to a calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over three years, producing the expected return on plan assets that is included in the determination of pension expense. We apply a corridor approach to amortize unrecognized actuarial gains or losses. Under this approach, only accumulated net actuarial gains or losses in excess of 10% of the greater of the projected benefit obligation or the fair value of plan assets are amortized over the average remaining service or lifetime of the workforce as a component of pension expense. The net deferral of past asset gains or losses affects the calculated value of plan assets and, ultimately, future pension expense.

The discount rate reflects the current rate at which the pension liabilities could be effectively settled at the end of the year based on our most recent measurement date. At the December 31, 2014 measurement date, the selected weighted-average discount rate was 3.66%, compared to 4.39% at the December 31, 2013 measurement date. We developed this rate using a yield curve approach. Using yields available on high-quality fixed maturity securities with various maturity dates, the yield curve approach provides a "customized" rate, which is meant to match the expected cash flows of our specific benefit plans. The net effect of changes in the discount rate, as well as the net effect of other changes in actuarial assumptions and experience, have been deferred and amortized as a component of pension expense in accordance with FASB guidance.

In managing the plan assets, our objective is to be a responsible fiduciary while minimizing financial risk. Plan assets include a diversified mix of investment grade fixed maturity securities, equity securities and alternative investments across a range of sectors and levels of capitalization to maximize the long-term return for a prudent level of risk. In addition to producing a reasonable return, the investment strategy seeks to minimize the volatility in our expense and cash flow.

Other Postretirement Benefits

We provide most associates with certain medical, vision and dental benefits upon retirement. We use various actuarial assumptions, including a discount rate and the expected trend in health care costs, to estimate the costs and benefit obligations for our retiree benefits.

At our December 31, 2014 measurement date, the selected discount rate for all plans was 3.74%, compared to a discount rate of 4.48% at the December 31, 2013 measurement date. We developed this rate using a yield curve approach as described above.

The assumed health care cost trend rates used to measure the expected cost of pre-Medicare (those who are not currently eligible for Medicare benefits) other benefits at our December 31, 2014 measurement date was 8.00% for 2015 with a gradual decline to 4.50% by the year 2025. The assumed health care cost trend rates used to measure the expected cost of post-Medicare (those who are currently eligible for Medicare benefits) other benefits at our December 31, 2014 measurement date was 6.00% for 2015 with a gradual decline to 4.50% by the year 2021. These estimated trend rates are subject to change in the future. The health care cost trend rate assumption has a significant effect on the amounts reported. For example, an increase in the assumed health care cost trend rate of one percentage point would increase the postretirement benefit obligation as of December 31, 2014 by \$56.7 and would increase service and interest costs by \$2.0. Conversely, a decrease in the assumed health care cost trend rate of one percentage point would decrease the postretirement benefit obligation by \$47.6 as of December 31, 2014 and would decrease service and interest costs by \$1.8.

For additional information regarding our retirement benefits, see Note 10, "Retirement Benefits," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

New Accounting Pronouncements

For information regarding new accounting pronouncements that were issued or became effective during the year ended December 31, 2014 that had, or are expected to have a material impact on our financial position, results of operations or financial statement disclosures, see the "*Recently Adopted Accounting Guidance*" and "*Recent Accounting Guidance Not Yet Adopted*" sections of Note 2, "Basis of Presentation and Significant Accounting Policies" to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Liquidity and Capital Resources

Introduction

Our cash receipts result primarily from premiums, administrative fees, investment income, other revenue, proceeds from the sale or maturity of our investment securities, proceeds from borrowings, and proceeds from the issuance of common stock under our employee stock plans. Cash disbursements result mainly from claims payments, administrative expenses, taxes, purchases of investment securities, interest expense, payments on borrowings, acquisitions, capital expenditures, repurchases of our debt securities and common stock and the payment of cash dividends. Cash outflows fluctuate with the amount and timing of settlement of these transactions. Any future decline in our profitability would likely have an unfavorable impact on our liquidity.

We manage our cash, investments and capital structure so we are able to meet the short and long-term obligations of our business while maintaining financial flexibility and liquidity. We forecast, analyze and monitor our cash flows to enable investment and financing within the overall constraints of our financial strategy.

A substantial portion of the assets held by our regulated subsidiaries are in the form of cash and cash equivalents and investments. After considering expected cash flows from operating activities, we generally invest cash that exceeds our near term obligations in longer term marketable fixed maturity securities to improve our overall investment income returns. Our investment strategy is to make investments consistent with insurance statutes and other regulatory requirements, while preserving our asset base. Our investments are generally available-for-sale to meet liquidity and other needs. Our subsidiaries pay out excess capital annually in the form of dividends to their respective parent companies for general corporate use, as permitted by applicable regulations.

The availability of financing in the form of debt or equity is influenced by many factors including our profitability, operating cash flows, debt levels, debt ratings, contractual restrictions, regulatory requirements and market conditions. The securities and credit markets have in the past experienced higher than normal volatility, although current market conditions are more stable. During recent years, the federal government and various governmental agencies have taken a number of steps to restore liquidity in the financial markets and to help relieve the credit crisis and strengthen the regulation of the financial services market. In addition, governments around the world have developed their own plans to provide liquidity and security in the credit markets and to ensure adequate capital in certain financial institutions.

We have a \$2,500.0 commercial paper program. Should commercial paper issuance be unavailable, we have the ability to use a combination of cash on hand and/or our \$2,000.0 senior revolving credit facility to redeem any outstanding commercial paper upon maturity. Additionally, we believe the lenders participating in our credit facility would be willing and able to provide financing in accordance with their legal obligations. In addition to the \$2,000.0 senior revolving credit facility, we estimate that we will receive approximately \$2,100.0 of dividends from our subsidiaries during 2015, which also provides further operating and financial flexibility.

The table below outlines the cash flows provided by or used in operating, investing and financing activities for the years ended December 31, 2014, 2013 and 2012:

	Years Ended December 31		
	2014	2013	2012
Cash flows provided by (used in):			
Operating activities	\$ 3,369.3	\$ 3,052.3	\$ 2,744.6
Investing activities	(974.9)	(2,234.4)	(4,551.6)
Financing activities	(1,822.5)	(1,717.8)	2,088.9
Effect of foreign exchange rates on cash and cash equivalents	(7.1)	2.2	1.1
Increase (decrease) in cash and cash equivalents	\$ 564.8	\$ (897.7)	\$ 283.0

Liquidity—Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

During the year ended December 31, 2014, net cash flow provided by operating activities was \$3,369.3, compared to \$3,052.3 for the year ended December 31, 2013, an increase of \$317.0. This increase was primarily attributable to an increase in premium receipts as a result of rate increases across our businesses designed to cover overall cost trends and new fees associated with Health Care Reform and an increase in administrative fee receipts primarily as a result of growth in membership. The increase in cash provided by operating activities was offset, in part, by payments for new fees associated with Health Care Reform, including the HIP Fee and assessments related to the Health Care Reform reinsurance premium stabilization program. The increase was further offset by an increase in claims payments primarily as a result of membership growth, an increase in personnel service costs and an increase in income taxes paid.

Net cash flow used in investing activities was \$974.9 during the year ended December 31, 2014, compared to \$2,234.4 for the year ended December 31, 2013. The decrease in cash flow used in investing activities of \$1,259.5 primarily resulted from cash provided by the sale of our 1-800 CONTACTS business and glasses.com related assets on January 31, 2014 and a decrease in net purchases of investments, partially offset by changes in securities lending collateral.

Net cash flow used in financing activities was \$1,822.5 during the year ended December 31, 2014, compared to \$1,717.8 for the year ended December 31, 2013. The increase in cash flow used in financing activities of \$104.7 primarily resulted from an increase in common stock repurchases, a decrease in proceeds from the issuance of common stock under our employee stock plans and an increase in net repayments of commercial paper borrowings. These increases in net cash used in financing activities were partially offset by changes in short- and long-term borrowings as a result of net proceeds received from long-term borrowings during 2014 compared to net repayments of short- and long-term borrowings during 2013. In addition, the increase in net cash flow used in financing activities was partially offset by changes in bank overdrafts and changes in securities lending payable.

Liquidity—Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

During the year ended December 31, 2013, net cash flow provided by operating activities was \$3,052.3, compared to \$2,744.6 for the year ended December 31, 2012, an increase of \$307.7. This increase was driven primarily by an increase in net income adjusted for non-cash items, primarily due to the loss on disposal of discontinued operations, changes in amortization expense and realized losses on extinguishment of debt. The increase was further attributable to an increase in net cash flow provided by Amerigroup as 2012 included post-acquisition change-in-control payments and transaction costs that did not recur in 2013. Additionally, the increase was due to a net increase in the collection of income tax refunds in 2013.

Net cash flow used in investing activities was \$2,234.4 during the year ended December 31, 2013, compared to \$4,551.6 for the year ended December 31, 2012. The decrease in cash flow used in investing activities of \$2,317.2 primarily resulted from a decrease in cash used for the purchase of subsidiaries, as net cash used in investing activities for 2012 included the acquisitions of Amerigroup and 1-800 CONTACTS, while there were no purchases of subsidiaries in 2013. This decrease was partially offset by the net change in investment activity and changes in securities lending collateral.

Net cash flow used in financing activities was \$1,717.8 during the year ended December 31, 2013, compared to net cash flow provided by financing activities of \$2,088.9 for the year ended December 31, 2012. The change in cash flow from

financing activities of \$3,806.7 primarily resulted from an increase in long-term borrowings in 2012 primarily used to fund the acquisition of Amerigroup compared to an increase in net repayments of long-term borrowings in 2013. The change in cash flow from financing activity was further attributable to a decrease in common stock repurchases, changes in securities lending payable, and an increase in proceeds from the issuance of common stock under our employee stock plans.

Financial Condition

We maintained a strong financial condition and liquidity position, with consolidated cash, cash equivalents and investments, including long-term investments, of \$23,777.7 at December 31, 2014. Since December 31, 2013, total cash, cash equivalents and investments, including long-term investments, increased by \$1,381.8 primarily due to cash generated from operations, net proceeds received from long-term borrowings, proceeds from the sale of our 1-800-CONTACTS business, changes in securities lending payable and proceeds from issuance of common stock under employee stock plans. These increases were partially offset by common stock repurchases, purchases of property and equipment, changes in securities lending collateral, cash dividends paid to shareholders and net repayments of commercial paper borrowings.

Many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid to their respective parent companies. Certain accounting practices prescribed by insurance regulatory authorities, or statutory accounting practices, differ from GAAP. Changes that occur in statutory accounting practices, if any, could impact our subsidiaries' future dividend capacity. In addition, we have agreed to certain undertakings to regulatory authorities, including the requirement to maintain certain capital levels in certain of our subsidiaries.

At December 31, 2014, we held \$2,699.9 of cash, cash equivalents and investments at the parent company, which are available for general corporate use, including investment in our businesses, acquisitions, potential future common stock repurchases and dividends to shareholders, repurchases of debt securities and debt and interest payments.

We calculate our consolidated debt-to-capital ratio, a non-GAAP measure, which we believe assists investors and rating agencies in measuring our overall leverage and additional borrowing capacity. In addition, our bank covenants include a maximum debt-to-capital ratio that we cannot and did not exceed. Our debt-to-capital ratio is calculated as the sum of debt divided by the sum of debt plus shareholders' equity. Our debt-to-capital ratio may not be comparable to similarly titled measures reported by other companies. Our consolidated debt-to-capital ratio was 38.5% and 36.9% as of December 31, 2014 and 2013, respectively.

Our senior debt is rated "A-" by Standard & Poor's, "BBB+" by Fitch, Inc., "Baa2" by Moody's Investor Service, Inc. and "bbb+" by AM Best Company, Inc. We intend to maintain our senior debt investment grade ratings. A significant downgrade in our debt ratings could adversely affect our borrowing capacity and costs.

Future Sources and Uses of Liquidity

On February 17, 2015, we completed our acquisition of Simply Healthcare using a combination of cash and commercial paper borrowings.

We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansion.

We have a senior credit facility, or the facility, with certain lenders for general corporate purposes. The facility, as amended, provides credit up to \$2,000.0 and matures on September 29, 2016. The interest rate on the facility is based on either (i) the LIBOR rate plus a predetermined percentage rate based on our credit rating at the date of utilization, or (ii) a base rate as defined in the facility agreement plus a predetermined percentage rate based on our credit rating at the date of utilization. Our ability to borrow under the facility is subject to compliance with certain covenants. There were no amounts outstanding under the facility as of December 31, 2014.

We have an authorized commercial paper program of up to \$2,500.0, the proceeds of which may be used for general corporate purposes. We did not have any borrowings outstanding under our commercial paper program at December 31, 2014. At December 31, 2013, we had \$379.2 outstanding under our commercial paper program. Commercial paper borrowings have been classified as long-term debt at December 31, 2013 as our general practice and intent is to replace short-term commercial paper outstanding at expiration with additional short-term commercial paper for an uninterrupted period extending for more than one year and we have the ability to redeem our commercial paper with borrowings under the senior credit facility described above. We resumed borrowing under our commercial paper program in the first quarter of 2015.

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati and the Federal Home Loan Bank of Atlanta, collectively, the FHLBs, and as a member we have the ability to obtain short-term cash advances subject to certain minimum collateral requirements. At December 31, 2014 and 2013, \$400.0 was outstanding under our short-term FHLBs borrowings.

On September 15, 2014, we redeemed the \$500.0 outstanding principal balance of our 5.000% senior unsecured notes due 2014, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling \$512.3. We recognized a loss on extinguishment of debt of \$2.3 for the redemption of these notes.

On September 11, 2014, we redeemed the \$1,097.9 outstanding principal balance of our 5.250% senior unsecured notes due 2016, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling \$1,178.2. We recognized a loss on extinguishment of debt of \$67.6 for the redemption of these notes.

Additionally, during the year ended December 31, 2014, we repurchased \$52.0 of outstanding principal amount of certain other senior unsecured notes, plus applicable premium for early redemption plus accrued and unpaid interest, for cash totaling \$61.0. We recognized a loss on extinguishment of debt of \$11.2 for the year ended December 31, 2014 for the repurchase of these notes.

On August 12, 2014, we issued \$850.0 of 2.250% notes due 2019, \$800.0 of 3.500% notes due 2024, \$800.0 of 4.650% notes due 2044, and \$250.0 of 4.850% notes due 2054 under our shelf registration statement. We used the proceeds from this offering in part to fund the purchase price of the 5.000% and 5.250% senior unsecured notes discussed above, and the remaining net proceeds are being used for general corporate purposes. Interest on the notes is payable semi-annually in arrears on February 15 and August 15 of each year, commencing on February 15, 2015. The notes have a call feature that allows us to repurchase the notes at any time at our option and a put feature that allows a note holder to require us to repurchase the notes upon the occurrence of both a change in control event and a downgrade of the notes below an investment grade rating.

On September 5, 2013, we redeemed the \$400.0 outstanding principal balance of our 6.000% senior unsecured notes due 2014, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling \$411.0. We recognized a loss on extinguishment of debt of \$10.0 for the redemption of these notes.

On July 30, 2013, we initiated a cash tender offer and consent solicitation to purchase up to \$300.0 aggregate principal amount of our outstanding 5.875% notes due 2017 and 7.000% notes due 2019 (the "First Tranche Offer") and to purchase up to \$300.0 aggregate principal amount of our outstanding 5.950% notes due 2034, 5.850% notes due 2036, 6.375% notes due 2037 and 5.800% notes due 2040 (the "Second Tranche Offer"), collectively, the "Tender Offers". The Tender Offers were each subject to increase up to an additional \$100.0 at our election. On August 12, 2013, we increased the Second Tranche Offer to \$400.0 and on August 13, 2013 we repurchased \$300.0 of the First Tranche Offer notes and \$400.0 of the Second Tranche Offer notes for cash totaling \$837.7. Holders who tendered their notes prior to the early tender date received the principal amounts, applicable premium for early redemption and accrued and unpaid interest to the early tender offer settlement date. We recognized a loss on extinguishment of debt of \$135.3 for the repurchase of these notes.

On July 30, 2013, we issued \$650.0 of 2.300% notes due 2018 and \$600.0 of 5.100% notes due 2044 under our shelf registration statement. We used the proceeds from this offering in part to fund the purchase price of the 6.000% senior unsecured notes and the Tender Offers discussed above, and the balance for general corporate purposes. Interest on the notes is payable semi-annually in arrears on January 15 and July 15 of each year, commencing on January 15, 2014. The notes have a call feature that allows us to repurchase the notes at any time at our option and a put feature that allows a note holder to require us to repurchase the notes upon the occurrence of both a change in control event and a downgrade of the notes below an investment grade rating.

On January 25, 2013, we redeemed the outstanding principal balance of \$475.0 of 7.500% senior unsecured notes due 2019, plus applicable premium for early redemption, for cash totaling \$555.6. The weighted-average redemption price of the notes was approximately 117% of the principal amount outstanding.

While we generally issue senior unsecured notes for long-term borrowing purposes, on October 9, 2012, we issued \$1,500.0 of senior convertible debentures, or the Debentures. The Debentures are governed by an indenture, or the Indenture, dated as of October 9, 2012 between us and The Bank of New York Mellon Trust Company, N.A., as trustee. The Debentures bear interest at a rate of 2.750% per year, payable semi-annually in arrears in cash on April 15 and October 15 of each year, and mature on October 15, 2042, unless earlier redeemed, repurchased or converted into shares of common stock at the applicable conversion rate. We used approximately \$371.0 of the net proceeds from the issuance to repurchase shares of our common stock concurrently with the offering of the Debentures, and the balance was used for general corporate purposes, including but not limited to additional purchases of shares of our common stock pursuant to our share repurchase program and the repayment of debt. For additional information related to our borrowing activities and the Debentures, including the circumstances under which holders may convert the Debentures into common stock, see Note 12, "Debt" to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

As discussed in "Financial Condition" above, many of our subsidiaries are subject to various government regulations that restrict the timing and amount of dividends and other distributions that may be paid. Based upon these requirements, we are currently estimating approximately \$2,100.0 of dividends to be paid to the parent company during 2015. During 2014, we received \$3,234.5 of dividends from our subsidiaries.

We regularly review the appropriate use of capital, including common stock repurchases, repurchases of debt securities and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt securities is at the discretion of our Board of Directors and depends upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors.

A summary of the cash dividend activity for the year ended December 31, 2014 is as follows:

Declaration Date	Record Date	Payment Date	Cash Dividend per Share	Total
January 28, 2014	March 10, 2014	March 25, 2014	\$ 0.4375	\$ 123.4
April 29, 2014	June 10, 2014	June 25, 2014	0.4375	120.5
July 29, 2014	September 10, 2014	September 25, 2014	0.4375	119.2
October 28, 2014	December 5, 2014	December 22, 2014	0.4375	117.6

On January 27, 2015, our Board of Directors declared a quarterly cash dividend of \$0.6250 per share on the outstanding shares of our common stock. This quarterly dividend is payable on March 25, 2015 to shareholders of record as of March 10, 2015.

A summary of common stock repurchases for the period January 1, 2015 through February 5, 2015 (subsequent to December 31, 2014) and for the year ended December 31, 2014 is as follows:

	January 1, 2015 Through February 5, 2015	Year Ended December 31, 2014
Shares repurchased	1.8	30.4
Average price per share	\$ 131.16	\$ 98.52
Aggregate cost	\$ 229.9	\$ 2,998.8
Authorization remaining at the end of each period	\$ 5,461.8	\$ 5,691.7

Under the common stock repurchase program authorized by our Board of Directors, on February 4, 2014, we entered into an accelerated share repurchase agreement with a counterparty. The agreement provided for the repurchase of a number of shares, equal to \$600.0, as determined by the volume weighted-average price of our shares during the term of the agreement. In March 2014, we repurchased 6.6 shares under the agreement. The shares repurchased under the agreement are included in the amount disclosed above as shares repurchased during the year ended December 31, 2014.

On October 2, 2014, the Board of Directors authorized a \$5,000.0 increase to the common stock repurchase program. Repurchases may be made from time to time at prevailing market prices, subject to certain restrictions on volume, pricing and timing. The repurchases are effected from time to time in the open market, through negotiated transactions, including accelerated share repurchase agreements, and through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. We expect to utilize the unused authorization remaining at December 31, 2014 over a multi-year period, subject to market and industry conditions. Our stock repurchase program is discretionary as we are under no obligation to repurchase shares. We repurchase shares under the program when we believe it is a prudent use of capital.

Our current retirement benefits funding strategy is to fund an amount at least equal to the minimum required funding as determined under ERISA with consideration of maximum tax deductible amounts. We may elect to make discretionary contributions up to the maximum amount deductible for income tax purposes. For the year ended December 31, 2014, no material contributions were necessary to meet ERISA required funding levels. However, during the year ended December 31, 2014, we made tax deductible discretionary contributions to the pension benefit plans of \$3.6.

Contractual Obligations and Commitments

Our estimated contractual obligations and commitments as of December 31, 2014 are as follows:

	Total	Payments Due by Period			
		Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
Debt ¹	\$ 25,235.8	\$ 1,231.7	\$ 2,104.2	\$ 3,622.8	\$ 18,277.1
Operating lease commitments	896.1	148.7	257.1	215.4	274.9
Projected other postretirement benefits	478.3	63.3	128.7	132.0	154.3
Purchase obligations:					
IBM outsourcing agreements ²	475.3	103.3	194.1	177.9	—
Other purchase obligations ³	2,763.5	1,703.8	915.3	138.2	6.2
Other long-term liabilities ⁴	1,036.4	—	469.7	384.7	182.0
Investment commitments	555.1	213.0	188.8	125.4	27.9
Total contractual obligations and commitments	\$ 31,440.5	\$ 3,463.8	\$ 4,257.9	\$ 4,796.4	\$ 18,922.4

¹ Includes estimated interest expense.

² Relates to agreements with International Business Machines Corporation, or IBM, to provide information technology infrastructure services. For further information, see Note 13, "Commitments and Contingencies," to the audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

³ Includes obligations related to non-IBM information technology service agreements and telecommunication contracts.

⁴ Estimated future payments for funded pension benefits have been excluded from this table as we had no funding requirements under ERISA at December 31, 2014 as a result of the value of the assets in the plans. In addition, amounts include other obligations resulting from third-party service contracts.

The above table does not contain \$129.9 of gross liabilities for uncertain tax positions and interest for which we cannot reasonably estimate the timing of the resolutions with the respective taxing authorities. For further information, see Note 7, "Income Taxes," to the audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

In addition to the contractual obligations and commitments discussed above, we have a variety of other contractual agreements related to acquiring materials and services used in our operations. However, we do not believe these other agreements contain material noncancelable commitments.

We believe that funds from future operating cash flows, cash and investments and funds available under our senior credit facility or from public or private financing sources will be sufficient for future operations and commitments, and for capital acquisitions and other strategic transactions.

Off-Balance Sheet Arrangements

We do not have any off-balance sheet arrangements that will require funding in future periods.

Risk-Based Capital

Our regulated subsidiaries' states of domicile have statutory risk-based capital, or RBC, requirements for health and other insurance companies and health maintenance organizations largely based on the National Association of Insurance Commissioners, or NAIC, RBC Model Act. These RBC requirements are intended to measure capital adequacy, taking into account the risk characteristics of an insurer's investments and products. The NAIC sets forth the formula for calculating the RBC requirements, which are designed to take into account asset risks, insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company's business. In general, under the RBC Model Act, an insurance company must submit a report of its RBC level to the state insurance department or insurance commissioner, as appropriate, at the end of each calendar year. Our regulated subsidiaries' respective RBC levels as of December 31, 2014, which was the most recent date for which reporting was required, were in excess of all mandatory RBC thresholds. In addition to exceeding the RBC requirements, we are in compliance with the liquidity and capital requirements for a licensee of the BCBSA and with the tangible net worth requirements applicable to certain of our California subsidiaries.

For additional information, see Note 21, "Statutory Information," to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995

This document contains certain forward-looking information about us that is intended to be covered by the safe harbor for "forward-looking statements" provided by the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that are not generally historical facts. Words such as "expect(s)," "feel(s)," "believe(s)," "will," "may," "anticipate(s)," "intend," "estimate," "project" and similar expressions are intended to identify forward-looking statements, which generally are not historical in nature. These statements include, but are not limited to, financial projections and estimates and their underlying assumptions; statements regarding plans, objectives and expectations with respect to future operations, products and services; and statements regarding future performance. Such statements are subject to certain risks and uncertainties, many of which are difficult to predict and generally beyond our control, that could cause actual results to differ materially from those expressed in, or implied or projected by, the forward-looking information and statements. These risks and uncertainties include: those discussed and identified in our public filings with the U.S. Securities and Exchange Commission, or SEC; increased government participation in, or regulation or taxation of health benefits and managed care operations, including, but not limited to, the impact of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, or Health Care Reform; trends in health care costs and utilization rates; our ability to secure sufficient premium rates including regulatory approval for and implementation of such rates; our participation in the federal and state health insurance exchanges under Health Care Reform, which have experienced technical difficulties in implementation and which entail uncertainties associated with the mix and volume of business, particularly in our Individual and Small Group markets, that could negatively impact the adequacy of our premium rates and which may not be sufficiently offset by the risk apportionment provisions of Health Care Reform; our ability to contract with providers consistent with past practice; competitor pricing below market trends of increasing costs; reduced enrollment, as well as a negative change in our health care product mix; risks and uncertainties regarding Medicare and Medicaid programs, including those related to non-compliance with the complex regulations imposed thereon and funding risks with respect to revenue received from participation therein; a downgrade in our financial strength ratings; litigation and investigations targeted at our industry and our ability to resolve litigation and investigations within estimates; medical malpractice or professional liability claims or other risks related to health care services provided by our subsidiaries; our ability to repurchase shares of our common stock and pay dividends on our common stock due to the adequacy of our cash flow and earnings and other considerations; non-compliance by any party with the Express Scripts, Inc. pharmacy benefit management services agreement, which could result in financial penalties, our inability to meet customer demands, and sanctions imposed by governmental entities, including the Centers for Medicare and Medicaid Services; events that result in negative publicity for us or the health benefits industry;

failure to effectively maintain and modernize our information systems and e-business organization and to maintain good relationships with third party vendors for information system resources; events that may negatively affect our licenses with the Blue Cross and Blue Shield Association; possible impairment of the value of our intangible assets if future results do not adequately support goodwill and other intangible assets; intense competition to attract and retain employees; unauthorized disclosure of member or employee sensitive or confidential information, including the impact and outcome of investigations, inquiries, claims and litigation related to the cyber attack we reported in February 2015; changes in the economic and market conditions, as well as regulations that may negatively affect our investment portfolios and liquidity; possible restrictions in the payment of dividends by our subsidiaries and increases in required minimum levels of capital and the potential negative effect from our substantial amount of outstanding indebtedness; general risks associated with mergers and acquisitions; various laws and provisions in our governing documents that may prevent or discourage takeovers and business combinations; future public health epidemics and catastrophes; and general economic downturns. Readers are cautioned not to place undue reliance on these forward-looking statements that speak only as of the date hereof. Except to the extent otherwise required by federal securities law, we do not undertake any obligation to republish revised forward-looking statements to reflect events or circumstances after the date hereof or to reflect the occurrence of unanticipated events. Readers are also urged to carefully review and consider the various disclosures in our SEC reports.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK.

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

As a result of our investing and borrowing activities, we are exposed to financial market risks, including those resulting from changes in interest rates and changes in equity market valuations. Potential impacts discussed below are based upon sensitivity analyses performed on our financial position as of December 31, 2014. Actual results could vary from these estimates. Our primary objectives with our investment portfolio are to provide safety and preservation of capital, sufficient liquidity to meet cash flow requirements, the integration of investment strategy with the business operations and an attainment of a competitive after-tax total return.

Investments

Our investment portfolio is exposed to three primary sources of risk: credit quality risk, interest rate risk and market valuation risk.

The primary risks associated with our fixed maturity securities are credit quality risk and interest rate risk. Credit quality risk is defined as the risk of a credit event, such as a ratings downgrade or default, to an individual fixed maturity security and the potential loss attributable to that event. Credit quality risk is managed through our investment policy, which establishes credit quality limitations on the overall portfolio as well as diversification and percentage limits on securities of individual issuers. The result is a well-diversified portfolio of fixed maturity securities, with an average credit rating of approximately "A." Interest rate risk is defined as the potential for economic losses on fixed maturity securities due to a change in market interest rates. Our fixed maturity portfolio is invested primarily in U.S. government securities, corporate bonds, asset-backed bonds, mortgage-related securities and municipal bonds, all of which have exposure to changes in the level of market interest rates. Interest rate risk is managed by maintaining asset duration within a band based upon our liabilities, operating performance and liquidity needs. Additionally, we have the capability of holding any security to maturity, which would allow us to realize full par value.

Our available-for-sale investment portfolio includes corporate securities which account for 41.9% of the total portfolio at December 31, 2014 and are subject to credit/default risk. In a declining economic environment, corporate yields will usually increase prompted by concern over the ability of corporations to make interest payments, thus causing a decrease in the price of corporate securities, and the decline in value of the corporate fixed maturity portfolio. We manage this risk through fundamental credit analysis, diversification of issuers and industries and an average credit rating of our corporate fixed maturity portfolio of approximately "BBB."

Our equity portfolio is comprised of large capitalization and small capitalization domestic equities, foreign equities and index mutual funds. Our equity portfolio is subject to the volatility inherent in the stock market, driven by concerns over economic conditions, earnings and sales growth, inflation, and consumer confidence. These systemic risks cannot be managed through diversification alone. However, more routine risks, such as stock/industry specific risks, are managed by investing in a diversified equity portfolio.

As of December 31, 2014, 90.3% of our available-for-sale investments were fixed maturity securities. Market risk is addressed by actively managing the duration, allocation and diversification of our investment portfolio. We have evaluated the impact on the fixed maturity portfolio's fair value considering an immediate 100 basis point change in interest rates. A 100 basis point increase in interest rates would result in an approximate \$777.5 decrease in fair value, whereas a 100 basis point decrease in interest rates would result in an approximate \$607.8 increase in fair value. While we classify our fixed maturity securities as "available-for-sale" for accounting purposes, we believe our cash flows and duration of our portfolio should allow us to hold securities to maturity, thereby avoiding the recognition of losses should interest rates rise significantly.

As of December 31, 2014, 9.7% of our available-for-sale investments were equity securities. An immediate 10% decrease in each equity investment's value, arising from market movement, would result in a fair value decrease of \$193.8. Alternatively, an immediate 10% increase in each equity investment's value, attributable to the same factor, would result in a fair value increase of \$193.8.

For additional information regarding our investments, see Part II, Item 8, Note 4, "Investments", to our audited consolidated financial statements and "Critical Accounting Policies and Estimates - Investments" within Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

Long-Term Debt

Our total long-term debt at December 31, 2014 was \$14,752.2 and includes senior unsecured notes, convertible debentures and subordinated surplus notes by one of our insurance subsidiaries. This debt is subject to interest rate risk as these instruments have fixed interest rates and the fair value is affected by changes in market interest rates. The senior unsecured notes had combined carrying and estimated fair value of \$13,752.9 and \$14,764.6, respectively, at December 31, 2014. The carrying value and estimated fair value of the convertible debentures were \$974.4 and \$2,581.9, respectively, at December 31, 2014. The carrying value and estimated fair value of the surplus notes were \$24.9 and \$30.2, respectively, at December 31, 2014.

Should interest rates increase or decrease in the future, the estimated fair value of our fixed rate debt would decrease or increase accordingly. For additional information regarding our long-term debt, see Note 6, "Fair Value" and Note 12, "Debt" to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K.

Derivatives

We have exposure to economic losses due to interest rate risk arising from changes in the level or volatility of interest rates. We attempt to mitigate our exposure to interest rate risk through the use of derivative financial instruments. These strategies include the use of interest rate swaps and forward contracts, which are used to lock-in interest rates or to hedge (on an economic basis) interest rate risks associated with variable rate debt. We have used these types of instruments as designated hedges against specific liabilities.

Changes in interest rates will affect the estimated fair value of these derivatives. As of December 31, 2014, we recorded a net liability of \$5.2, the estimated fair value of the swaps at that date. We have evaluated the impact on the interest rate swaps' fair value considering an immediate 100 basis point change in interest rates. A 100 basis point increase in interest rates would result in an approximate \$43.7 decrease in fair value, whereas a 100 basis point decrease in interest rates would result in an approximate \$43.7 increase in fair value.

We also utilize put and call options on the S&P 500 index to hedge, on an economic basis, the exposure of our equity security portfolio to fluctuations in the equity markets. While the impact of fluctuations in the equity markets on these derivatives are largely offset by changes in the fair values of our equity security portfolio, the change in fair value of the derivatives is recognized immediately in our income statement, whereas the change in fair value of our equity securities is recognized in accumulated other comprehensive income. Accordingly, a decrease in the S&P 500 index of 10% would result in an approximate increase of \$27.9 in the fair value of these derivatives. An increase in the S&P 500 index of 10% would result in an approximate decrease of \$17.4 in the fair value of these derivatives.

For additional information regarding our derivatives, see Note 5, "Derivative Financial Instruments" to our audited consolidated financial statements included in Part II, Item 8 of this Annual Report on Form 10-K. Also for accounting related to securities in our equity portfolio, see "Critical Accounting Policies and Estimates - Investments" within Part II, Item 7 "Management Discussion and Analysis of Financial Condition and Results of Operations" included in this Annual Report on Form 10-K.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA.

ANTHEM, INC.

CONSOLIDATED FINANCIAL STATEMENTS

Years ended December 31, 2014, 2013 and 2012

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**Report of Independent Registered
Public Accounting Firm**

The Board of Directors and Shareholders of Anthem, Inc.

We have audited the accompanying consolidated balance sheets of Anthem, Inc. (the “Company”) as of December 31, 2014 and 2013, and the related consolidated statements of income, comprehensive income, shareholders’ equity, and cash flows for each of the three years in the period ended December 31, 2014. Our audits also included the financial statement schedule listed in the Index at Item 15(a). These financial statements and schedule are the responsibility of the Company’s management. Our responsibility is to express an opinion on these financial statements and schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Anthem, Inc. at December 31, 2014 and 2013, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2014, in conformity with U.S. generally accepted accounting principles. Also, in our opinion, the related financial statement schedule, when considered in relation to the basic financial statements taken as a whole, presents fairly in all material respects the information set forth therein.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Anthem, Inc.’s internal control over financial reporting as of December 31, 2014, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 24, 2015 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Indianapolis, Indiana
February 24, 2015

Anthem, Inc.
Consolidated Balance Sheets

	December 31, 2014	December 31, 2013
<i>(In millions, except share data)</i>		
Assets		
Current assets:		
Cash and cash equivalents	\$ 2,151.7	\$ 1,582.1
Investments available-for-sale, at fair value:		
Fixed maturity securities (amortized cost of \$17,120.4 and \$16,826.7)	17,467.4	17,038.2
Equity securities (cost of \$1,303.7 and \$1,168.5)	1,906.6	1,735.5
Other invested assets, current	20.2	16.3
Accrued investment income	161.4	168.8
Premium and self-funded receivables	4,825.5	3,968.7
Other receivables	2,117.0	1,063.3
Income taxes receivable	308.9	235.7
Securities lending collateral	1,515.2	969.8
Deferred tax assets, net	280.4	383.0
Other current assets	1,474.6	1,677.5
Assets held for sale	—	906.9
Total current assets	32,228.9	29,745.8
Long-term investments available-for-sale, at fair value:		
Fixed maturity securities (amortized cost of \$500.7 and \$455.9)	504.4	449.9
Equity securities (cost of \$27.0 and \$27.4)	31.5	31.3
Other invested assets, long-term	1,695.9	1,542.6
Property and equipment, net	1,944.3	1,801.5
Goodwill	17,082.0	16,917.2
Other intangible assets	7,958.1	8,441.0
Other noncurrent assets	619.9	645.2
Total assets	\$ 62,065.0	\$ 59,574.5
Liabilities and shareholders' equity		
Liabilities		
Current liabilities:		
Policy liabilities:		
Medical claims payable	\$ 6,861.2	\$ 6,127.2
Reserves for future policy benefits	68.1	63.1
Other policyholder liabilities	2,626.5	2,073.2
Total policy liabilities	9,555.8	8,263.5
Unearned income	1,078.1	822.7
Accounts payable and accrued expenses	3,651.8	3,426.3
Security trades pending payable	66.2	95.2
Securities lending payable	1,515.3	969.7
Short-term borrowings	400.0	400.0
Current portion of long-term debt	625.0	518.0
Other current liabilities	1,861.2	1,674.7
Liabilities held for sale	—	181.4
Total current liabilities	18,753.4	16,351.5
Long-term debt, less current portion	14,127.2	13,573.6
Reserves for future policy benefits, noncurrent	671.3	723.0
Deferred tax liabilities, net	3,226.0	3,325.2
Other noncurrent liabilities	1,035.8	836.0
Total liabilities	37,813.7	34,809.3
Commitments and contingencies—Note 13		
Shareholders' equity		
Preferred stock, without par value, shares authorized - 100,000,000; shares issued and outstanding - none	—	—
Common stock, par value \$0.01, shares authorized - 900,000,000; shares issued and outstanding - 268,109,932 and 293,273,830	2.7	2.9
Additional paid-in capital	10,062.3	10,765.2

Retained earnings	14,014.4	13,813.9
Accumulated other comprehensive income	171.9	183.2
Total shareholders' equity	<u>24,251.3</u>	<u>24,765.2</u>
Total liabilities and shareholders' equity	<u><u>\$ 62,065.0</u></u>	<u><u>\$ 59,574.5</u></u>

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Income

	Years Ended December 31		
	2014	2013	2012
<i>(In millions, except per share data)</i>			
Revenues			
Premiums	\$ 68,389.8	\$ 66,119.1	\$ 56,496.7
Administrative fees	4,590.6	4,031.9	3,934.1
Other revenue	41.3	40.4	83.2
Total operating revenue	73,021.7	70,191.4	60,514.0
Net investment income	724.4	659.1	686.1
Net realized gains on investments	177.0	271.9	334.9
Other-than-temporary impairment losses on investments:			
Total other-than-temporary impairment losses on investments	(56.2)	(100.6)	(41.2)
Portion of other-than-temporary impairment losses recognized in other comprehensive income	7.2	1.7	3.4
Other-than-temporary impairment losses recognized in income	(49.0)	(98.9)	(37.8)
Total revenues	73,874.1	71,023.5	61,497.2
Expenses			
Benefit expense	56,854.9	56,237.1	48,213.6
Selling, general and administrative expense:			
Selling expense	1,490.1	1,526.9	1,586.9
General and administrative expense	10,258.3	8,426.0	7,093.6
Total selling, general and administrative expense	11,748.4	9,952.9	8,680.5
Interest expense	600.7	602.7	511.8
Amortization of other intangible assets	220.9	245.3	233.0
Loss on extinguishment of debt	81.1	145.3	—
Total expenses	69,506.0	67,183.3	57,638.9
Income from continuing operations before income tax expense	4,368.1	3,840.2	3,858.3
Income tax expense	1,808.0	1,205.9	1,207.3
Income from continuing operations	2,560.1	2,634.3	2,651.0
Income (loss) from discontinued operations, net of tax	9.6	(144.6)	4.5
Net income	\$ 2,569.7	\$ 2,489.7	\$ 2,655.5
Basic net income (loss) per share:			
Basic - continuing operations	\$ 9.28	\$ 8.83	\$ 8.25
Basic - discontinued operations	0.03	(0.49)	0.01
Basic net income per share	\$ 9.31	\$ 8.34	\$ 8.26
Diluted net income (loss) per share:			
Diluted - continuing operations	\$ 8.96	\$ 8.67	\$ 8.17
Diluted - discontinued operations	0.03	(0.47)	0.01
Diluted net income per share	\$ 8.99	\$ 8.20	\$ 8.18
Dividends per share	\$ 1.75	\$ 1.50	\$ 1.15

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Comprehensive Income

	Years Ended December 31		
	2014	2013	2012
<i>(In millions)</i>			
Net income	\$ 2,569.7	\$ 2,489.7	\$ 2,655.5
Other comprehensive (loss) income, net of tax:			
Change in net unrealized gains/losses on investments	118.6	(294.7)	189.9
Change in non-credit component of other-than-temporary impairment losses on investments	(3.9)	1.7	4.5
Change in net unrealized gains/losses on cash flow hedges	(3.6)	3.0	0.1
Change in net periodic pension and postretirement costs	(118.1)	172.7	(10.9)
Foreign currency translation adjustments	(4.3)	1.4	0.6
Other comprehensive (loss) income	<u>(11.3)</u>	<u>(115.9)</u>	<u>184.2</u>
Total comprehensive income	<u>\$ 2,558.4</u>	<u>\$ 2,373.8</u>	<u>\$ 2,839.7</u>

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Cash Flows

	Years Ended December 31		
	2014	2013	2012
<i>(In millions)</i>			
Operating activities			
Net income	\$ 2,569.7	\$ 2,489.7	\$ 2,655.5
Adjustments to reconcile net income to net cash provided by operating activities:			
Net realized gains on investments	(177.0)	(271.9)	(334.9)
Other-than-temporary impairment losses recognized in income	49.0	98.9	37.8
Loss on extinguishment of debt	81.1	145.3	—
(Gain) loss on disposal from discontinued operations	(3.2)	221.8	—
(Gain) loss on disposal of assets	(1.7)	3.9	4.7
Deferred income taxes	30.7	59.1	127.5
Amortization, net of accretion	744.5	800.9	633.6
Depreciation expense	106.5	107.9	107.1
Impairment of property and equipment	7.9	47.7	66.8
Share-based compensation	168.9	146.0	146.5
Excess tax benefits from share-based compensation	(46.4)	(30.1)	(28.8)
Changes in operating assets and liabilities:			
Receivables, net	(1,899.7)	(418.3)	189.9
Other invested assets	(21.7)	(15.1)	(38.9)
Other assets	405.5	(33.6)	79.2
Policy liabilities	1,240.6	(345.8)	(53.7)
Unearned income	255.1	(73.8)	(193.7)
Accounts payable and accrued expenses	(14.4)	303.6	(406.5)
Other liabilities	(7.9)	(154.6)	(132.8)
Income taxes	(34.0)	9.3	(73.9)
Other, net	(84.2)	(38.6)	(40.8)
Net cash provided by operating activities	3,369.3	3,052.3	2,744.6
Investing activities			
Purchases of fixed maturity securities	(9,613.4)	(13,704.5)	(15,040.4)
Proceeds from fixed maturity securities:			
Sales	8,066.0	10,977.9	13,675.9
Maturities, calls and redemptions	1,318.7	1,836.8	1,781.5
Purchases of equity securities	(912.0)	(820.3)	(232.8)
Proceeds from sales of equity securities	746.5	721.0	422.7
Purchases of other invested assets	(205.7)	(251.5)	(303.7)
Proceeds from sales of other invested assets	124.7	127.1	35.5
Settlement of non-hedging derivatives	(67.4)	(109.8)	(59.8)
Changes in securities lending collateral	(545.6)	(405.1)	307.9
Purchases of subsidiaries, net of cash acquired	—	—	(4,597.0)
Proceeds from sale of subsidiary, net of cash sold	740.0	—	—
Purchases of property and equipment	(714.6)	(646.5)	(544.9)
Proceeds from sales of property and equipment	88.0	39.2	0.4
Other, net	(0.1)	1.3	3.1
Net cash used in investing activities	(974.9)	(2,234.4)	(4,551.6)
Financing activities			
Net repayments of commercial paper borrowings	(379.2)	(191.7)	(229.0)
Proceeds from long-term borrowings	2,700.0	1,250.0	6,468.9
Repayments of long-term borrowings	(1,730.1)	(1,801.9)	(1,251.3)
Proceeds from short-term borrowings	2,050.0	1,100.0	642.0
Repayments of short-term borrowings	(2,050.0)	(950.0)	(492.0)
Changes in securities lending payable	545.6	405.0	(307.8)
Changes in bank overdrafts	173.0	9.9	(17.6)
Premiums paid on equity options	—	(25.8)	—
Repurchase and retirement of common stock	(2,998.8)	(1,620.1)	(2,496.8)
Cash dividends	(480.7)	(448.0)	(367.1)

Proceeds from issuance of common stock under employee stock plans	301.3	524.7	110.8
Excess tax benefits from share-based compensation	46.4	30.1	28.8
Net cash (used in) provided by financing activities	(1,822.5)	(1,717.8)	2,088.9
Effect of foreign exchange rates on cash and cash equivalents	(7.1)	2.2	1.1
Change in cash and cash equivalents	564.8	(897.7)	283.0
Cash and cash equivalents at beginning of year	1,586.9	2,484.6	2,201.6
Cash and cash equivalents at end of year	2,151.7	1,586.9	2,484.6
Less cash and cash equivalents of discontinued operations at end of year	—	(4.8)	(9.3)
Cash and cash equivalents of continuing operations at end of year	\$ 2,151.7	\$ 1,582.1	\$ 2,475.3

See accompanying notes.

Anthem, Inc.
Consolidated Statements of Shareholders' Equity

	Common Stock		Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive Income	Total Shareholders' Equity
	Number of Shares	Par Value				
<i>(In millions)</i>						
January 1, 2012	339.4	\$ 3.4	\$ 11,679.2	\$ 11,490.7	\$ 114.9	\$ 23,288.2
Net income	—	—	—	2,655.5	—	2,655.5
Other comprehensive income	—	—	—	—	184.2	184.2
Repurchase and retirement of common stock	(39.7)	(0.4)	(1,368.5)	(1,127.9)	—	(2,496.8)
Dividends and dividend equivalents	—	—	—	(371.2)	—	(371.2)
Issuance of convertible debentures	—	—	331.5	—	—	331.5
Conversion of stock awards in connection with AMERIGROUP Corporation acquisition	—	—	19.7	—	—	19.7
Issuance of common stock under employee stock plans, net of related tax benefits	5.0	—	191.6	—	—	191.6
December 31, 2012	304.7	\$ 3.0	\$ 10,853.5	\$ 12,647.1	\$ 299.1	\$ 23,802.7
Net income	—	—	—	2,489.7	—	2,489.7
Other comprehensive loss	—	—	—	—	(115.9)	(115.9)
Premiums paid on equity options	—	—	(7.9)	—	—	(7.9)
Repurchase and retirement of common stock	(20.7)	(0.1)	(749.5)	(870.5)	—	(1,620.1)
Convertible debentures tax adjustment	—	—	(3.3)	—	—	(3.3)
Dividends and dividend equivalents	—	—	—	(452.4)	—	(452.4)
Issuance of common stock under employee stock plans, net of related tax benefits	9.3	—	672.4	—	—	672.4
December 31, 2013	293.3	\$ 2.9	\$ 10,765.2	\$ 13,813.9	\$ 183.2	\$ 24,765.2
Net income	—	—	—	2,569.7	—	2,569.7
Other comprehensive loss	—	—	—	—	(11.3)	(11.3)
Settlement of equity options	—	—	(31.4)	—	—	(31.4)
Repurchase and retirement of common stock	(30.4)	(0.2)	(1,115.5)	(1,883.1)	—	(2,998.8)
Dividends and dividend equivalents	—	—	—	(486.1)	—	(486.1)
Issuance of common stock under employee stock plans, net of related tax benefits	5.2	—	444.0	—	—	444.0
December 31, 2014	268.1	\$ 2.7	\$ 10,062.3	\$ 14,014.4	\$ 171.9	\$ 24,251.3

See accompanying notes.

Anthem, Inc.

Notes to Consolidated Financial Statements

December 31, 2014

(In Millions, Except Per Share Data or As Otherwise Stated Herein)

1. Organization

On November 5, 2014, the shareholders of the Company approved a proposal to amend our articles of incorporation to change our name to Anthem, Inc. from WellPoint, Inc. The name change was effective December 2, 2014. References to the terms “we”, “our”, “us”, “Anthem” or the “Company” used throughout these Notes to Consolidated Financial Statements refer to Anthem, Inc., an Indiana corporation, and unless the context otherwise requires, its direct and indirect subsidiaries.

We are one of the largest health benefits companies in terms of medical membership in the United States, serving 37.5 medical members through our affiliated health plans as of December 31, 2014. We offer a broad spectrum of network-based managed care plans to large and small employer, individual, Medicaid and Medicare markets. Our managed care plans include: preferred provider organizations, or PPOs; health maintenance organizations, or HMOs; point-of-service, or POS, plans; traditional indemnity plans and other hybrid plans, including consumer-driven health plans, or CDHPs; and hospital only and limited benefit products. In addition, we provide a broad array of managed care services to self-funded customers, including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services. We provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal health care. We also provide services to the federal government in connection with the Federal Employee Program, or FEP. We also sold contact lenses, eyeglasses and other ocular products through our 1-800 CONTACTS, Inc., or 1-800 CONTACTS, business which was divested on January 31, 2014.

We are an independent licensee of the Blue Cross and Blue Shield Association, or BCBSA, an association of independent health benefit plans. We serve our members as the Blue Cross licensee for California and as the Blue Cross and Blue Shield, or BCBS, licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, New York (as BCBS in 10 New York City metropolitan and surrounding counties, and as Blue Cross or BCBS in selected upstate counties only), Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D.C.) and Wisconsin. In a majority of these service areas we do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross and Blue Shield of Georgia, and Empire Blue Cross Blue Shield, or Empire Blue Cross (in our New York service areas). We also conduct business through arrangements with other BCBS licensees in the states of South Carolina and Texas. We conduct business through our AMERIGROUP Corporation, or Amerigroup, subsidiary, in Florida, Georgia, Kansas, Louisiana, Maryland, Nevada, New Jersey, New Mexico, New York, Tennessee, Texas and Washington. We also serve customers throughout the country as HealthLink, UniCare (including a non-risk arrangement with the state of Massachusetts), and in certain Arizona, California, Nevada, New York and Virginia markets through our CareMore Health Group, Inc., or CareMore, subsidiary. We are licensed to conduct insurance operations in all 50 states through our subsidiaries.

2. Basis of Presentation and Significant Accounting Policies

Basis of Presentation: The accompanying consolidated financial statements include the accounts of Anthem and its subsidiaries and have been prepared in conformity with U.S. generally accepted accounting principles, or GAAP. All significant intercompany accounts and transactions have been eliminated in consolidation.

Certain of our subsidiaries operate outside of the United States and have functional currencies other than the U.S. dollar, or USD. We translate the assets and liabilities of those subsidiaries to USD using the exchange rate in effect at the end of the period. We translate the revenues and expenses of those subsidiaries to USD using the average exchange rates in effect during the period. The net effect of these translation adjustments is included in “Foreign currency translation adjustments” in our consolidated statements of shareholders’ equity.

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

Reclassifications: Certain prior year amounts have been reclassified to conform to the current year presentation. In addition, certain other immaterial reclassifications have been made in the current year.

Use of Estimates: The preparation of consolidated financial statements in conformity with GAAP requires us to make estimates and assumptions that affect the amounts reported in our consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash Equivalents: All highly liquid investments with maturities of three months or less when purchased are classified as cash equivalents.

Investments: Certain Financial Accounting Standards Board, or FASB, other-than-temporary impairment, or OTTI, guidance applies to fixed maturity securities and provides guidance on the recognition, presentation of, and disclosures for OTTIs. If a fixed maturity security is in an unrealized loss position and we have the intent to sell the fixed maturity security, or it is more likely than not that we will have to sell the fixed maturity security before recovery of its amortized cost basis, the decline in value is deemed to be other-than-temporary and is presented within the Other-than-temporary impairment losses recognized in income line item on our consolidated statements of income. For impaired fixed maturity securities that we do not intend to sell or it is more likely than not that we will not have to sell such securities, but we expect that we will not fully recover the amortized cost basis, the credit component of the OTTI is presented within the Other-than-temporary impairment losses recognized in income line item on our consolidated statements of income and the non-credit component of the OTTI is recognized in other comprehensive income. Furthermore, unrealized losses entirely caused by non-credit related factors related to fixed maturity securities for which we expect to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive income, or AOCI.

The credit component of an OTTI is determined by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting our best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of acquisition. For mortgage-backed and asset-backed securities, cash flow estimates are based on assumptions regarding the underlying collateral including prepayment speeds, vintage, type of underlying asset, geographic concentrations, default rates, recoveries and changes in value. For all other debt securities, cash flow estimates are driven by assumptions regarding probability of default, including changes in credit ratings, and estimates regarding timing and amount of recoveries associated with a default.

The unrealized gains or losses on our current and long-term equity securities classified as available-for-sale are included in accumulated other comprehensive income as a separate component of shareholders' equity, unless the decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such equity securities until their full cost can be recovered, in which case such equity securities are written down to fair value and the loss is charged to other-than-temporary impairment losses recognized in income.

We maintain various rabbi trusts to account for the assets and liabilities under certain deferred compensation plans. Under these plans, the participants can defer certain types of compensation and elect to receive a return on the deferred amounts based on the changes in fair value of various investment options, primarily a variety of mutual funds. We have corporate-owned life insurance policies on certain participants in the deferred compensation plans. The cash surrender value of the corporate-owned life insurance policies is reported in other invested assets, long-term, in the consolidated balance sheets. The remaining rabbi trust assets are generally invested according to the participant's investment election, and are classified as trading, which are reported in other invested assets, current, in the consolidated balance sheets.

We use the equity method of accounting for investments in companies in which our ownership interest enables us to influence the operating or financial decisions of the investee company. Our proportionate share of equity in net income of these unconsolidated affiliates is reported with net investment income.

For asset-backed securities included in fixed maturity securities, we recognize income using an effective yield based on anticipated prepayments and the estimated economic life of the securities. When estimates of prepayments change, the effective yield is recalculated to reflect actual payments to date and anticipated future payments. The net investment in the securities is adjusted to the amount that would have existed had the new effective yield been applied since the acquisition of the securities. Such adjustments are reported with net investment income.

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

Investment income is recorded when earned. All securities sold resulting in investment gains and losses are recorded on the trade date. Realized gains and losses are determined on the basis of the cost or amortized cost of the specific securities sold.

We participate in securities lending programs whereby marketable securities in our investment portfolio are transferred to independent brokers or dealers based on, among other things, their creditworthiness in exchange for cash and securities collateral initially equal to at least 102% of the market value of the securities on loan and is thereafter maintained at a minimum of 100% of the market value of the securities loaned (calculated as the ratio of the market value of collateral to the market value of the securities on loan). Accordingly, the market value of the securities on loan to each borrower is monitored daily and the borrower is required to deliver additional collateral if the market value of the securities on loan exceeds the market value of collateral delivered. The fair value of the collateral received at the time of the transactions amounted to \$1,515.3 and \$969.7 at December 31, 2014 and 2013, respectively. The value of the collateral represented 103% and 102% of the market value of the securities on loan at December 31, 2014 and 2013, respectively. Under FASB guidance related to accounting for transfers and servicing of financial assets and extinguishments of liabilities, we recognize the collateral as an asset, which is reported as "securities lending collateral" on our consolidated balance sheets and we record a corresponding liability for the obligation to return the collateral to the borrower, which is reported as "securities lending payable." The securities on loan are reported in the applicable investment category on the consolidated balance sheets. Unrealized gains or losses on securities lending collateral are included in accumulated other comprehensive income as a separate component of shareholders' equity.

Premium and Self-Funded Receivables: Premium and self-funded receivables include the uncollected amounts from fully-insured and self-funded groups, and are reported net of an allowance for doubtful accounts of \$213.6 and \$223.6 at December 31, 2014 and 2013, respectively. The allowance for doubtful accounts is based on historical collection trends and our judgment regarding the ability to collect specific accounts.

Other Receivables: Other receivables include pharmacy rebates, provider advances, claims recoveries, reinsurance, government programs, proceeds due from brokers on investment trades and other miscellaneous amounts due to us. These receivables are reported net of an allowance for doubtful accounts of \$142.2 and \$115.0 at December 31, 2014 and 2013, respectively, which is based on historical collection trends and our judgment regarding the ability to collect specific amounts.

Income Taxes: We file a consolidated income tax return. Deferred income tax assets and liabilities are recognized for temporary differences between the financial statement and tax return bases of assets and liabilities based on enacted tax rates and laws. The deferred tax benefits of the deferred tax assets are recognized to the extent realization of such benefits is more likely than not. Deferred income tax expense or benefit generally represents the net change in deferred income tax assets and liabilities during the year, excluding the impact from amounts initially recorded for business combinations, if any. Current income tax expense represents the tax consequences of revenues and expenses currently taxable or deductible on various income tax returns for the year reported.

We account for income tax contingencies in accordance with FASB guidance that contains a model to address uncertainty in tax positions and clarifies the accounting for income taxes by prescribing a minimum recognition threshold, which all income tax positions must achieve before being recognized in the financial statements.

Property and Equipment: Property and equipment is recorded at cost, net of accumulated depreciation. Depreciation is computed principally by the straight-line method over estimated useful lives ranging from fifteen to thirty-nine years for buildings and improvements, three to seven years for data processing equipment, furniture and other equipment, and three to five years for computer software. Leasehold improvements are depreciated over the term of the related lease. Certain costs related to the development or purchase of internal-use software are capitalized and amortized.

Goodwill and Other Intangible Assets: FASB guidance requires business combinations to be accounted for using the acquisition method of accounting and it also specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Goodwill represents the excess of cost of acquisition over the fair value of net assets acquired. Other intangible assets represent the values assigned to subscriber bases, provider and hospital networks, Blue Cross and Blue Shield and other trademarks, licenses, non-compete and other agreements. Goodwill and other intangible assets are allocated to reportable segments based on the relative fair value of the components of the businesses acquired.

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Notes to Consolidated Financial Statements (continued)

Goodwill and other intangible assets with indefinite lives are not amortized but are tested for impairment at least annually. We complete our annual impairment tests of existing goodwill and other intangible assets with indefinite lives during the fourth quarter of each year. Certain interim impairment tests are also performed when potential impairment indicators exist or changes in our business or other triggering events occur. Goodwill and other intangible assets are allocated to reporting units for purposes of the annual goodwill impairment test. In addition, certain other intangible assets with indefinite lives, such as trademarks, are also tested separately.

FASB guidance allows for qualitative assessments of whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount for purposes of a goodwill impairment analysis and whether it is more likely than not that an indefinite-lived intangible asset is impaired for purposes of an indefinite-lived intangible asset impairment analysis. Quantitative analysis must be performed if qualitative analyses are not conclusive. Entities also have the option to bypass the assessment of qualitative factors and proceed directly to performing quantitative analyses. We begin our annual tests with quantitative analyses. Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units, including goodwill and other intangible assets with indefinite lives. Estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used.

Fair value for purposes of the goodwill impairment test is calculated using a blend of a projected income and market valuation approach. The projected income approach is developed using assumptions about future revenue, expenses and net income derived from our internal planning process. Our assumed discount rate is based on our industry's weighted-average cost of capital and reflects volatility associated with the cost of equity capital. Market valuations are based on observed multiples of certain measures including membership, revenue, EBITDA (earnings before interest, taxes, depreciation and amortization) and net income as well as market capitalization analyses of Anthem and other comparable companies. A goodwill impairment loss is recognized to the extent that the carrying amount exceeds the asset's fair value. This determination is made at the reporting unit level and consists of two steps. First, the fair value of a reporting unit is determined and compared to its carrying amount. Second, if the carrying amount of a reporting unit exceeds its fair value, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation on a business acquisition, at the impairment test date.

The fair value of indefinite-lived intangible assets is estimated and compared to the carrying value. We estimate the fair value of indefinite-lived intangible assets using a projected income approach. We recognize an impairment loss when the estimated fair value of indefinite-lived intangible assets is less than the carrying value. If significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

Derivative Financial Instruments: We primarily invest in the following types of derivative financial instruments: interest rate swaps, forward contracts, put and call options, credit default swaps, embedded derivatives, warrants and swaptions. Derivatives embedded within non-derivative instruments, such as options embedded in convertible fixed maturity securities, are bifurcated from the host instrument when the embedded derivative is not clearly and closely related to the host instrument. Our use of derivatives is limited by statutes and regulations promulgated by the various regulatory bodies to which we are subject, and by our own derivative policy. Our derivative use is generally limited to hedging purposes, on an economic basis, and we generally do not use derivative instruments for speculative purposes.

We have exposure to economic losses due to interest rate risk arising from changes in the level or volatility of interest rates. We attempt to mitigate our exposure to interest rate risk through active portfolio management, including rebalancing our existing portfolios of assets and liabilities, as well as changing the characteristics of investments to be purchased or sold in the future. In addition, derivative financial instruments are used to modify the interest rate exposure of certain liabilities or forecasted transactions. These strategies include the use of interest rate swaps and forward contracts, which are used to lock-in interest rates or to hedge, on an economic basis, interest rate risks associated with variable rate debt. We have used these types of instruments as designated hedges against specific liabilities.

All investments in derivatives are recorded as assets or liabilities at fair value. If certain correlation, hedge effectiveness and risk reduction criteria are met, a derivative may be specifically designated as a hedge of exposure to changes in fair value or cash flow. The accounting for changes in the fair value of a derivative depends on the intended use of the derivative and

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

the nature of any hedge designation thereon. Amounts excluded from the assessment of hedge effectiveness, if any, as well as the ineffective portion of the gain or loss, are reported in results of operations immediately. If the derivative is not designated as a hedge, the gain or loss resulting from the change in the fair value of the derivative is recognized in results of operations in the period of change. Cash flows associated with the settlement of non-designated derivatives are shown on a net basis in investing activity in our consolidated statements of cash flow.

From time to time, we may also purchase derivatives to hedge, on an economic basis, our exposure to foreign currency exchange fluctuations associated with the operations of certain of our subsidiaries. We generally use futures or forward contracts for these transactions. We generally do not designate these contracts as hedges and, accordingly, the changes in fair value of these derivatives are recognized in income immediately.

Credit exposure associated with non-performance by the counterparties to derivative instruments is generally limited to the uncollateralized fair value of the asset related to instruments recognized in the consolidated balance sheets. We attempt to mitigate the risk of non-performance by selecting counterparties with high credit ratings and monitoring their creditworthiness and by diversifying derivatives among multiple counterparties. At December 31, 2014, we believe there were no material concentrations of credit risk with any individual counterparty.

We generally enter into master netting agreements, which reduce credit risk by permitting net settlement of transactions with the same counterparty. Certain of our derivative agreements also contain credit support provisions that require us or the counterparty to post collateral if there are declines in the derivative fair value or our credit rating. The derivative assets and derivative liabilities are reported at their fair values net of collateral and netting by counterparty. At December 31, 2014 we had posted collateral of \$127.8 and received collateral of \$105.0 related to our derivative financial instruments.

Retirement Benefits: We recognize the funded status of pension and other postretirement benefit plans on the consolidated balance sheets based on fiscal-year-end measurements of plan assets and benefit obligations. Prepaid pension benefits represent prepaid costs related to defined benefit pension plans and are reported with other noncurrent assets. Postretirement benefits represent outstanding obligations for retiree medical, life, vision and dental benefits. Liabilities for pension and other postretirement benefits are reported with current and noncurrent liabilities based on the amount by which the actuarial present value of benefits payable in the next twelve months included in the benefit obligation exceeds the fair value of plan assets.

We determine the expected return on plan assets using the calculated value of plan assets, which recognizes changes in the fair value of plan assets in a systematic manner over three years. We apply a corridor approach to amortize unrecognized actuarial gains or losses. Under this approach, only accumulated net actuarial gains or losses in excess of 10% of the greater of the projected benefit obligation or the fair value of plan assets are amortized over the average remaining service or lifetime of the workforce as a component of net periodic benefit cost.

Medical Claims Payable: Liabilities for medical claims payable include estimated provisions for incurred but not paid claims on an undiscounted basis, as well as estimated provisions for expenses related to the processing of claims. Incurred but not paid claims include (1) an estimate for claims that are incurred but not reported, as well as claims reported to us but not yet processed through our systems; and (2) claims reported to us and processed through our systems but not yet paid.

Liabilities for both claims incurred but not reported and reported but not yet processed through our systems are determined in aggregate by employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be appropriate under moderately adverse circumstances. We determine the amount of the liability for incurred but not paid claims by following a detailed actuarial process that entails using both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities.

We regularly review and set assumptions regarding cost trends and utilization when initially establishing claim liabilities. We continually monitor and adjust the claims liability and benefit expense based on subsequent paid claims activity. If our assumptions regarding cost trends and utilization are significantly different than actual results, our income statement and financial position could be impacted in future periods.

Premium deficiencies are recognized when it is probable that expected claims and administrative expenses will exceed future premiums on existing medical insurance contracts without consideration of investment income. Determination of

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

premium deficiencies for longer duration life and disability contracts includes consideration of investment income. For purposes of premium deficiencies, contracts are deemed to be either short or long duration and are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts. Once established, premium deficiencies are released commensurate with actual claims experience over the remaining life of the contract. No premium deficiencies were established at December 31, 2014 or 2013.

Reserves for Future Policy Benefits: Reserves for future policy benefits include liabilities for life and long-term disability insurance policy benefits based upon interest, mortality and morbidity assumptions from published actuarial tables, modified based upon our experience. Future policy benefits also include liabilities for insurance policies for which some of the premiums received in earlier years are intended to pay anticipated benefits to be incurred in future years. Future policy benefits are continually monitored and reviewed, and when reserves are adjusted, differences are reflected in benefit expense.

The current portion of reserves for future policy benefits relates to the portion of such reserves that we expect to pay within one year. We believe that our liabilities for future policy benefits, along with future premiums received are adequate to satisfy our ultimate benefit liability; however, these estimates are inherently subject to a number of variable circumstances. Consequently, the actual results could differ materially from the amounts recorded in our consolidated financial statements.

Other Policyholder Liabilities: Other policyholder liabilities include rate stabilization reserves associated with retrospectively rated insurance contracts and certain case-specific reserves. Other policyholder liabilities also includes liabilities for premium refunds based upon the minimum medical loss ratio, or MLR, the relative health risk of members, or other contractual or regulatory requirements. Rate stabilization reserves represent accumulated premiums that exceed what customers owe us based on actual claim experience. The timing of payment of these retrospectively rated refunds is based on the contractual terms with the customers and can vary from period to period based on the specific contractual requirements.

We are required to meet certain minimum MLR thresholds prescribed by the Patient Protection and Affordable Care Act, or ACA, and related Health Care and Education Reconciliation Act of 2010, or collectively, Health Care Reform. If we do not meet or exceed the minimum MLR thresholds specified by Health Care Reform, we are required to pay rebates to certain customers. Minimum MLR rebates are calculated by applicable line of business (Large Group, Small Group and Individual) and legal entity in accordance with regulations issued by the Department of Health and Human Services, or HHS. Such calculations are made using estimated calendar year medical loss expense and premiums, as defined by HHS.

We follow HHS guidelines for determining the types of expenses that may be included in our minimum MLR rebate calculations, which differ from benefit expense and premiums as reported in our consolidated financial statements prepared in conformity with GAAP. Certain amounts reported as expense in our GAAP basis consolidated financial statements may be reported as a reduction of premiums in accordance with HHS regulations. In addition, profit amounts included in our payments to third party administrative service providers are recorded as benefit expense in our consolidated GAAP financial statements while HHS does not allow for the inclusion of these expenses within the medical loss expense for purposes of calculating minimum MLR.

Revenue Recognition: Premiums for fully-insured contracts are recognized as revenue over the period insurance coverage is provided, and, if applicable, net of amounts recognized for minimum MLR rebates and the Health Care Reform risk adjustment, reinsurance and risk corridor premium stabilization programs. Premiums related to the unexpired contractual coverage periods are reflected in the accompanying consolidated balance sheets as unearned income. Premiums include revenue from retrospectively rated contracts where revenue is based on the estimated ultimate loss experience of the contract. Premium revenue includes an adjustment for retrospectively rated refunds based on an estimate of incurred claims. Premium rates for certain lines of business are subject to approval by the Department of Insurance of each respective state.

Administrative fees include revenue from certain group contracts that provide for the group to be at risk for all, or with supplemental insurance arrangements, a portion of their claims experience. We charge these self-funded groups an administrative fee, which is based on the number of members in a group or the group's claim experience. In addition, administrative fees include amounts received for the administration of Medicare or certain other government programs. Under our self-funded arrangements, revenue is recognized as administrative services are performed. All benefit payments under these programs are excluded from benefit expense.

Share-Based Compensation: Our current compensation philosophy provides for share-based compensation, including stock options, restricted stock awards and an employee stock purchase plan. Stock options are granted for a fixed number of

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

shares with an exercise price at least equal to the fair value of the shares at the date of the grant. Restricted stock awards are issued at the fair value of the stock on the grant date. Effective January 1, 2014, the employee stock purchase plan allows for a purchase price per share which is 95% of the fair value of a share of common stock on the last trading day of the plan quarter. The employee stock purchase plan discount is not recognized as compensation expense based on GAAP guidance. All other share-based payments to employees are recognized as compensation expense in the income statement based on their fair values. Additionally, excess tax benefits, which result from actual tax benefits exceeding deferred tax benefits previously recognized based on grant date fair value, are recognized as additional paid-in-capital and are reclassified from operating cash flows to financing cash flows in the consolidated statements of cash flows. Our share-based employee compensation plans and assumptions are described in Note 14, "Capital Stock."

Advertising and Marketing Costs: We use print, broadcast and other advertising to promote our products and to develop our corporate image. We market our products through direct marketing activities and an extensive network of independent agents, brokers and retail partnerships for Individual and Medicare customers, and for certain Local Group customers with a smaller employee base. Products for National Accounts and Local Group customers with a larger employee base are generally sold through independent brokers or consultants retained by the customer and working with industry specialists from our in-house sales force. In the Individual and Small Group markets we offer products through state or federally facilitated marketplaces, or public exchanges, and off-exchange products. Federal premium subsidies are available only for certain public exchange products. The cost of advertising and marketing for product promotion is expensed as incurred while advertising and marketing costs associated with corporate image is expensed when first aired. Total advertising and marketing expense was \$337.0, \$350.9 and \$285.4 for the years ended December 31, 2014, 2013 and 2012, respectively.

Earnings per Share: Earnings per share amounts, on a basic and diluted basis, have been calculated based upon the weighted-average common shares outstanding for the period.

Basic earnings per share excludes dilution and is computed by dividing income available to common shareholders by the weighted-average number of common shares outstanding for the period. Diluted earnings per share includes the dilutive effect of stock options, restricted stock and convertible debentures, using the treasury stock method. The treasury stock method assumes exercise of stock options and vesting of restricted stock, with the assumed proceeds used to purchase common stock at the average market price for the period. The difference between the number of shares assumed issued and number of shares assumed purchased represents the dilutive shares.

Recently Adopted Accounting Guidance: In November 2014, the FASB issued Accounting Standards Update, or ASU, No. 2014-17, *Business Combinations (Topic 805): Pushdown Accounting (a consensus of the FASB Emerging Issues Task Force)*. This ASU provides an acquired entity, or any subsidiaries of the acquired entity, with the option to apply pushdown accounting in its separate financial statements upon occurrence of an event in which an acquirer obtains control of the acquired entity. The election to apply pushdown accounting can be made either in the period in which the change-in-control event occurs, or in a subsequent period. An election to apply pushdown accounting in a reporting period after the reporting period in which the change-in-control event occurred would be considered a change in accounting principle. If pushdown accounting is applied to an individual change-in-control event, that election is irrevocable. The adoption of the provisions of this ASU upon its effective date of November 18, 2014 did not have a material impact on our consolidated financial position, results of operations, cash flows or financial statement disclosures.

Effective January 1, 2014, we adopted the provisions of ASU No. 2011-06, Other Expenses (Topic 720): *Fees Paid to the Federal Government by Health Insurers (a consensus of the FASB Emerging Issues Task Force)*, or ASU 2011-06. Health Care Reform imposes a mandatory annual Health Insurance Provider Fee, or HIP Fee, on health insurers that write certain types of health insurance on U.S. risks. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to an adjusted amount of health insurance for all U.S. health risk for those certain lines of business written during the preceding calendar year. The HIP Fee is non-deductible for federal income tax purposes. The total amount to be collected from allocations to health insurers in 2014 was \$8,000.0, and our portion of the HIP Fee for 2014 was \$893.3. The final calculation and payment of the HIP Fee occurred in the third quarter of 2014. ASU 2011-06 addresses how the HIP Fee should be recognized and classified in the financial statements of health insurers. In accordance with ASU 2011-06, we recorded our estimated liability for the HIP Fee in full at the beginning of the year with a corresponding deferred asset that was amortized to expense on a straight-line basis throughout the year.

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

Recent Accounting Guidance Not Yet Adopted: In May 2014, the FASB issued Accounting Standards Update, or ASU, No. 2014-09, *Revenue from Contracts with Customers (Topic 606)*, or ASU 2014-09. Upon the effective date, ASU 2014-09 will supersede almost all existing revenue recognition guidance under GAAP, with certain exceptions, including an exception for revenue accounted for in accordance with the provisions of Accounting Standards Codification Topic 944, *Financial Services - Insurance*, or Topic 944. ASU 2014-09 will require a company to recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the company expects to be entitled in exchange for those goods or services. ASU 2014-09 is effective for interim and annual reporting periods beginning after December 15, 2016 and early adoption is not permitted. An entity has the option to apply the provisions of ASU 2014-09 either retrospectively to each prior reporting period presented or retrospectively with the cumulative effect of initially applying the new guidance recognized at the date of initial application. We are currently evaluating the effects the adoption of ASU 2014-09 will have on our financial statements and related disclosures for revenue transactions outside the scope of Topic 944.

In April 2014, the FASB issued ASU No. 2014-08, *Presentation of Financial Statements (Topic 205) and Property, Plant and Equipment (Topic 360): Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity*, or ASU 2014-08. ASU 2014-08 changes the criteria for determining which disposals can be presented as discontinued operations and modifies related disclosure requirements. Under the new guidance, a discontinued operation is defined as a disposal of a component of an entity or a group of components of an entity that is disposed of or is classified as held for sale and represents a strategic shift that has (or will have) a major effect on an entity's operations and financial results. ASU 2014-08 is effective prospectively to new disposals and new classifications of disposal groups as held for sale in interim and annual periods beginning on or after December 15, 2014, with early adoption permitted. The adoption of ASU 2014-08 is not expected to have a material impact on our consolidated financial position, results of operations or cash flows.

There were no other new accounting pronouncements that were issued or became effective during the year ended December 31, 2014 that had, or are expected to have, a material impact on our financial position, results of operations, cash flows or financial statement disclosures.

3. Business Acquisitions and Divestitures

Amerigroup

In December 2012, we completed our acquisition of Amerigroup, one of the nation's leading managed care companies focused on meeting the health care needs of financially vulnerable Americans. This acquisition furthers our goal of creating better health care quality at more affordable prices for our customers. Amerigroup also advances our capabilities in effectively and efficiently serving the growing Medicaid population, including the expanding dual eligible population, seniors, persons with disabilities and long-term services and support markets.

We paid \$92.00 per share in cash to acquire all of the outstanding shares of Amerigroup for total cash consideration of \$4,755.8. In addition, 0.5 shares of Amerigroup restricted stock converted to 0.7 shares of Anthem restricted stock, valued at \$17.1, and 0.1 shares underlying Amerigroup stock options converted to 0.2 shares underlying Anthem stock options, valued at \$2.6. We also incurred \$24.0 of transaction costs, which were recorded to general and administrative expense during the year ended December 31, 2012.

In accordance with FASB accounting guidance for business combinations, the consideration transferred was allocated to the fair value of Amerigroup's assets acquired and liabilities assumed, including identifiable intangible assets. In 2013, we finalized our purchase accounting and made a measurement period adjustment to the fair value of certain assets acquired and liabilities assumed at the date of acquisition. The effect of these adjustments on the preliminary purchase price allocation recorded at December 31, 2012 was an increase to goodwill of \$28.9, an increase in other intangible assets of \$20.0, a decrease in current liabilities of \$1.6, and an increase in noncurrent liabilities of \$50.5. The below table and the accompanying consolidated balance sheets reflect the impact of these adjustments.

The excess of the consideration transferred over the estimated fair value of net assets acquired resulted in non-tax-deductible goodwill of \$3,062.0, all of which was allocated to our Government Business segment. Goodwill recognized from the acquisition of Amerigroup primarily relates to the future economic benefits arising from expected synergies and is consistent with our stated intentions to strengthen our position and expand operations in the government sector to serve Medicaid and Medicare enrollees.

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

The following table summarizes the estimated fair values of Amerigroup assets acquired and liabilities assumed as of the date of acquisition:

Current assets	\$	2,716.5
Goodwill		3,062.0
Other intangible assets		975.0
Other noncurrent assets		406.1
Total assets acquired		7,159.6
Current liabilities		1,416.6
Noncurrent liabilities		967.5
Total liabilities assumed		2,384.1
Net assets acquired	\$	4,775.5

Of the \$975.0 of total other intangible assets acquired, \$65.0 represents finite-lived customer relationships with an amortization period of three years, \$30.0 represents provider and hospital networks with an amortization period of twenty years and \$880.0 represents indefinite-lived state Medicaid licenses and trade names.

The results of operations of Amerigroup for the period following December 24, 2012 are included in our consolidated financial statements within our Government Business segment and represented \$219.0 of our operating revenue and an offset to net income of \$6.1 for the year ended December 31, 2012. The pro-forma effects of this acquisition for periods prior to acquisition were not considered material to our consolidated results of operations.

1-800 CONTACTS

In December 2013, we entered into a definitive agreement to sell our 1-800 CONTACTS business to the private equity firm Thomas H. Lee Partners, L.P. Additionally, we entered into an asset purchase agreement with Luxottica Group to sell our glasses.com related assets (collectively, 1-800 CONTACTS). The operating results for 1-800 CONTACTS are reported as discontinued operations in the accompanying consolidated statements of income. These results were previously reported in the Commercial and Specialty Business segment. Additionally, the assets and liabilities of 1-800 CONTACTS are reported as held for sale in the accompanying consolidated balance sheets as of December 31, 2013.

The sales were completed on January 31, 2014 and did not result in any material difference to the loss on disposal from discontinued operations recorded during the year ended December 31, 2013. Prior to the sales, 2014 income from discontinued operations, net of tax, was \$9.6. Summarized financial information for the 1-800 CONTACTS discontinued operations for the years ended December 31, 2013 and 2012 is as follows:

	2013	2012
Revenues	\$ 434.7	\$ 214.5
Income from discontinued operations before tax	\$ 17.3	\$ 7.2
Income tax (benefit) expense	(2.6)	2.7
Income from discontinued operations	19.9	4.5
Loss on disposal from discontinued operations, net of tax	(164.5)	—
(Loss) income from discontinued operations, net of tax	\$ (144.6)	\$ 4.5

In connection with the sale of 1-800 CONTACTS, we recognized a loss on disposal of \$221.8, net of an income tax benefit of \$57.3 for the year ended December 31, 2013. The loss on disposal was calculated as the difference between the fair value, as determined by the sales agreements less costs to sell, and the carrying value of the held for sale assets at December 31, 2013.

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Notes to Consolidated Financial Statements (continued)

The assets and liabilities of 1-800 CONTACTS are reported as held for sale in the accompanying consolidated balance sheets at December 31, 2013 and consist of the following:

Assets	
Cash and cash equivalents	\$ 4.8
Property and equipment	27.6
Goodwill	409.9
Other intangibles	415.4
Other assets	49.2
Total assets	<u>\$ 906.9</u>
Liabilities	
Accounts payable and other accrued expenses	\$ 34.2
Deferred income taxes	142.5
Other liabilities	4.7
Total liabilities	<u>\$ 181.4</u>

Acquisition of Simply Healthcare Holdings, Inc.

On February 17, 2015, we completed our acquisition of Simply Healthcare Holdings, Inc., a leading managed care company for people enrolled in Medicaid and Medicare programs in the state of Florida. This acquisition, which was originally announced on December 22, 2014, aligns with our strategy for continued growth in our Government Business segment. As a result, we will, through our affiliated Medicaid and Medicare plans, serve more than half a million members in the state of Florida.

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

4. Investments

A summary of current and long-term investments, available-for-sale, at December 31, 2014 and 2013 is as follows:

	Cost or Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses		Estimated Fair Value	Non-Credit Component of Other-Than- Temporary Impairments Recognized in AOCI
			Less than 12 Months	12 Months or Greater		
December 31, 2014						
Fixed maturity securities:						
United States Government securities	\$ 315.7	\$ 4.6	\$ (0.3)	\$ —	\$ 320.0	\$ —
Government sponsored securities	94.6	0.8	—	(0.4)	95.0	—
States, municipalities and political subdivisions, tax-exempt	5,451.4	287.0	(1.8)	(3.0)	5,733.6	—
Corporate securities	8,335.9	162.9	(123.1)	(43.2)	8,332.5	(6.8)
Options embedded in convertible securities	98.7	—	—	—	98.7	—
Residential mortgage-backed securities	2,099.7	68.9	(1.0)	(8.6)	2,159.0	—
Commercial mortgage-backed securities	504.8	6.1	(0.6)	(0.4)	509.9	—
Other debt securities	720.3	6.1	(1.7)	(1.6)	723.1	—
Total fixed maturity securities	17,621.1	536.4	(128.5)	(57.2)	17,971.8	\$ (6.8)
Equity securities	1,330.7	618.5	(11.1)	—	1,938.1	—
Total investments, available-for-sale	\$ 18,951.8	\$ 1,154.9	\$ (139.6)	\$ (57.2)	\$ 19,909.9	—
December 31, 2013						
Fixed maturity securities:						
United States Government securities	\$ 300.8	\$ 2.5	\$ (3.4)	\$ —	\$ 299.9	\$ —
Government sponsored securities	174.4	0.4	(1.3)	—	173.5	—
States, municipalities and political subdivisions, tax-exempt	5,899.5	202.9	(90.1)	(9.6)	6,002.7	(0.6)
Corporate securities	7,614.1	205.2	(95.2)	(15.5)	7,708.6	(0.1)
Options embedded in convertible securities	89.2	—	—	—	89.2	—
Residential mortgage-backed securities	2,269.4	48.0	(41.4)	(7.1)	2,268.9	—
Commercial mortgage-backed securities	479.0	10.5	(2.6)	(0.3)	486.6	—
Other debt securities	456.2	5.8	(2.5)	(0.8)	458.7	(0.1)
Total fixed maturity securities	17,282.6	475.3	(236.5)	(33.3)	17,488.1	\$ (0.8)
Equity securities	1,195.9	578.9	(8.0)	—	1,766.8	—
Total investments, available-for-sale	\$ 18,478.5	\$ 1,054.2	\$ (244.5)	\$ (33.3)	\$ 19,254.9	—

At December 31, 2014, we owned \$2,668.9 of mortgage-backed securities and \$633.8 of asset-backed securities out of a total available-for-sale investment portfolio of \$19,909.9. These securities included sub-prime and Alt-A securities with fair values of \$37.5 and \$81.0, respectively. These sub-prime and Alt-A securities had accumulated net unrealized gains of \$1.5 and \$5.3, respectively. The average credit rating of the sub-prime and Alt-A securities was “CCC” and “CC”, respectively.

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

The following tables summarize for available-for-sale fixed maturity securities and available-for-sale equity securities in an unrealized loss position at December 31, 2014 and 2013, the aggregate fair value and gross unrealized loss by length of time those securities have been continuously in an unrealized loss position.

	Less than 12 Months			12 Months or Greater		
	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss
<i>(Securities are whole amounts)</i>						
December 31, 2014						
Fixed maturity securities:						
United States Government securities	17	\$ 145.3	\$ (0.3)	2	\$ 0.9	\$ —
Government sponsored securities	2	0.3	—	16	29.3	(0.4)
States, municipalities and political subdivisions, tax-exempt	136	315.6	(1.8)	80	174.3	(3.0)
Corporate securities	1,802	3,213.3	(123.1)	314	514.6	(43.2)
Residential mortgage-backed securities	78	155.0	(1.0)	186	398.3	(8.6)
Commercial mortgage-backed securities	43	156.2	(0.6)	10	33.2	(0.4)
Other debt securities	79	270.6	(1.7)	21	65.0	(1.6)
Total fixed maturity securities	2,157	4,256.3	(128.5)	629	1,215.6	(57.2)
Equity securities	407	125.4	(11.1)	—	—	—
Total fixed maturity and equity securities	2,564	\$ 4,381.7	\$ (139.6)	629	\$ 1,215.6	\$ (57.2)
December 31, 2013						
Fixed maturity securities:						
United States Government securities	27	\$ 179.2	\$ (3.4)	—	\$ —	\$ —
Government sponsored securities	22	73.4	(1.3)	—	—	—
States, municipalities and political subdivisions, tax-exempt	806	2,070.9	(90.1)	42	82.4	(9.6)
Corporate securities	1,448	2,586.6	(95.2)	107	81.3	(15.5)
Residential mortgage-backed securities	605	1,243.0	(41.4)	80	116.2	(7.1)
Commercial mortgage-backed securities	52	177.7	(2.6)	4	5.6	(0.3)
Other debt securities	65	185.3	(2.5)	17	16.2	(0.8)
Total fixed maturity securities	3,025	6,516.1	(236.5)	250	301.7	(33.3)
Equity securities	426	120.8	(8.0)	—	—	—
Total fixed maturity and equity securities	3,451	\$ 6,636.9	\$ (244.5)	250	\$ 301.7	\$ (33.3)

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

The amortized cost and fair value of available-for-sale fixed maturity securities at December 31, 2014, by contractual maturity, are shown below. Expected maturities may differ from contractual maturities because the issuers of the securities may have the right to prepay obligations.

	Amortized Cost	Estimated Fair Value
Due in one year or less	\$ 507.3	\$ 510.8
Due after one year through five years	4,649.6	4,702.9
Due after five years through ten years	5,227.9	5,360.8
Due after ten years	4,631.8	4,728.4
Mortgage-backed securities	2,604.5	2,668.9
Total available-for-sale fixed maturity securities	<u>\$ 17,621.1</u>	<u>\$ 17,971.8</u>

The major categories of net investment income for the years ended December 31 are as follows:

	2014	2013	2012
Fixed maturity securities	\$ 644.1	\$ 638.9	\$ 671.2
Equity securities	57.7	45.9	38.4
Cash and cash equivalents	0.8	1.0	2.5
Other	66.3	19.8	16.2
Investment income	<u>768.9</u>	<u>705.6</u>	<u>728.3</u>
Investment expense	<u>(44.5)</u>	<u>(46.5)</u>	<u>(42.2)</u>
Net investment income	<u>\$ 724.4</u>	<u>\$ 659.1</u>	<u>\$ 686.1</u>

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

Net realized investment gains/losses and net change in unrealized appreciation/depreciation in investments for the years ended December 31 are as follows:

	2014	2013	2012
Net realized gains (losses) on investments:			
Fixed maturity securities:			
Gross realized gains from sales	\$ 198.2	\$ 225.9	\$ 401.0
Gross realized losses from sales	(50.6)	(125.7)	(54.8)
Net realized gains from sales of fixed maturity securities	147.6	100.2	346.2
Equity securities:			
Gross realized gains from sales	106.5	224.1	82.0
Gross realized losses from sales	(90.2)	(100.5)	(93.8)
Net realized gains (losses) from sales of equity securities	16.3	123.6	(11.8)
Other realized gains on investments	13.1	48.1	0.5
Net realized gains on investments	177.0	271.9	334.9
Other-than-temporary impairment losses recognized in income:			
Fixed maturity securities	(22.3)	(42.5)	(11.8)
Equity securities	(13.5)	(13.9)	(17.5)
Other invested assets, long-term	(13.2)	(42.5)	(8.5)
Other-than-temporary impairment losses recognized in income	(49.0)	(98.9)	(37.8)
Change in net unrealized gains (losses) on investments:			
Fixed maturity securities	145.2	(679.8)	199.8
Equity securities	36.5	225.4	94.7
Total change in net unrealized gains (losses) on investments	181.7	(454.4)	294.5
Deferred income tax (expense) benefit	(63.1)	159.7	(104.6)
Net change in net unrealized gains (losses) on investments	118.6	(294.7)	189.9
Net realized gains on investments, other-than-temporary impairment losses recognized in income and net change in net unrealized gains (losses) on investments	\$ 246.6	\$ (121.7)	\$ 487.0

A primary objective in the management of our fixed maturity and equity portfolios is to maximize total return relative to underlying liabilities and respective liquidity needs. In achieving this goal, assets may be sold to take advantage of market conditions or other investment opportunities as well as tax considerations. Sales will generally produce realized gains and losses. In the ordinary course of business, we may sell securities at a loss for a number of reasons, including, but not limited to: (i) changes in the investment environment; (ii) expectations that the fair value could deteriorate further; (iii) desire to reduce exposure to an issuer or an industry; (iv) changes in credit quality; or (v) changes in expected cash flow.

Proceeds from fixed maturity securities, equity securities and other invested assets and the related gross realized gains and gross realized losses for the years ended December 31 are as follows:

	2014	2013	2012
Proceeds	\$ 10,255.9	\$ 13,662.8	\$ 15,915.6
Gross realized gains	317.8	498.1	483.5
Gross realized losses	(140.8)	(226.2)	(148.6)

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

A significant judgment in the valuation of investments is the determination of when an other-than-temporary decline in value has occurred. We follow a consistent and systematic process for recognizing impairments on securities that sustain other-than-temporary declines in value. We have established a committee responsible for the impairment review process. The decision to impair a security incorporates both quantitative criteria and qualitative information. The impairment review process considers a number of factors including, but not limited to: (i) the length of time and the extent to which the fair value has been less than book value, (ii) the financial condition and near term prospects of the issuer, (iii) our intent and ability to retain impaired equity security investments for a period of time sufficient to allow for any anticipated recovery in fair value, (iv) our intent to sell or the likelihood that we will need to sell a fixed maturity security before recovery of its amortized cost basis, (v) whether the debtor is current on interest and principal payments, (vi) the reasons for the decline in value (i.e., credit event compared to liquidity, general credit spread widening, currency exchange rate or interest rate factors) and (vii) general market conditions and industry or sector specific factors. For securities that are deemed to be other-than-temporarily impaired, the security is adjusted to fair value and the resulting losses are recognized in the consolidated statements of income. The new cost basis of the impaired securities is not increased for future recoveries in fair value.

Other-than-temporary impairments recorded in 2014, 2013 and 2012 were primarily the result of the continued credit deterioration on specific issuers in the bond markets and the fair values of certain equity securities remaining below cost for an extended period of time. There were no individually significant OTTI losses on investments by issuer during 2014, 2013 or 2012.

Investment securities are exposed to various risks, such as interest rate, market and credit. Due to the level of risk associated with certain investment securities and the level of uncertainty related to changes in the value of investment securities, it is possible that changes in these risk factors in the near term could have an adverse material impact on our results of operations or shareholders' equity.

The changes in the amount of the credit component of OTTI losses on fixed maturity securities recognized in income, for which a portion of the OTTI losses was recognized in other comprehensive income, was not material for the years ended December 31, 2014, 2013 or 2012.

At December 31, 2014 and 2013, no investments exceeded 10% of shareholders' equity.

At December 31, 2014, the carrying value of fixed maturity investments that did not produce income during 2014 was \$9.2. At December 31, 2013, we did not hold any fixed maturity investments that did not produce income during 2013.

As of December 31, 2014 we had committed approximately \$555.0 to future capital calls from various third-party investments in exchange for an ownership interest in the related entities.

At December 31, 2014 and 2013, securities with carrying values of approximately \$504.4 and \$449.9, respectively, were deposited by our insurance subsidiaries under requirements of regulatory authorities.

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

5. Derivative Financial Instruments

A summary of the aggregate contractual or notional amounts and estimated fair values related to derivative financial instruments at December 31, 2014 and 2013 is as follows:

	Contractual/ Notional Amount	Balance Sheet Location	Estimated Fair Value	
			Asset	(Liability)
December 31, 2014				
Hedging instruments				
Interest rate swaps	\$ 1,185.0	Other assets/other liabilities	\$ 2.6	\$ (7.8)
Non-hedging instruments				
Derivatives embedded in convertible fixed maturity securities	287.0	Fixed maturity securities	98.7	—
Interest rate swaps	97.9	Equity securities	—	(9.4)
Options	12,208.5	Other assets/other liabilities	428.0	(458.4)
Futures	—	Equity securities	0.5	(1.5)
Subtotal non-hedging	12,593.4	Subtotal non-hedging	527.2	(469.3)
Total derivatives	\$ 13,778.4	Total derivatives	529.8	(477.1)
		Amounts netted	(216.7)	216.7
		Net derivatives	\$ 313.1	\$ (260.4)
December 31, 2013				
Hedging instruments				
Interest rate swaps	\$ 1,660.0	Other assets/other liabilities	\$ 30.9	\$ (20.7)
Non-hedging instruments				
Derivatives embedded in convertible fixed maturity securities	295.0	Fixed maturity securities	89.2	—
Credit default and interest rate swaps	72.6	Equity securities	1.8	(2.5)
Options	14,912.4	Equity securities/other assets	776.5	(787.7)
Futures	—	Equity securities	3.5	(1.6)
Subtotal non-hedging	15,280.0	Subtotal non-hedging	871.0	(791.8)
Total derivatives	\$ 16,940.0	Total derivatives	901.9	(812.5)
		Amounts netted	(791.8)	791.8
		Net derivatives	\$ 110.1	\$ (20.7)

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

Fair Value Hedges

We have entered into various interest rate swap contracts to convert a portion of our interest rate exposure on our long-term debt from fixed rates to floating rates. The floating rates payable on all of our fair value hedges are benchmarked to LIBOR. A summary of our outstanding fair value hedges at December 31, 2014 and 2013 is as follows:

Type of Fair Value Hedges	Year Entered Into	Outstanding Notional Amount		Interest Rate Received	Expiration Date
		2014	2013		
Interest rate swap	2014	\$ 150.0	\$ —	4.350 %	August 15, 2020
Interest rate swap	2013	10.0	10.0	4.350	August 15, 2020
Interest rate swap	2012	200.0	200.0	4.350	August 15, 2020
Interest rate swap	2012	625.0	625.0	1.875	January 15, 2018
Interest rate swap	2012	200.0	200.0	2.375	February 15, 2017
Interest rate swap	2011	—	200.0	5.250	—
Interest rate swap	2010	—	25.0	5.250	—
Interest rate swap	2006	—	200.0	5.000	—
Interest rate swap	2005	—	200.0	5.000	—
Total notional amount outstanding		<u>\$ 1,185.0</u>	<u>\$ 1,660.0</u>		

A summary of the effect of fair value hedges on our income statement for the years ended December 31, 2014, 2013 and 2012 is as follows:

Type of Fair Value Hedges	Income Statement Location of Hedge Gain	Hedge Gain Recognized	Hedged Item	Income Statement Location of Hedged Item Loss	Hedged Item Loss Recognized
Year ended December 31, 2014					
Interest rate swaps	Interest expense	<u>\$ 25.5</u>	Fixed rate debt	Interest expense	<u>\$ (25.5)</u>
Year ended December 31, 2013					
Interest rate swaps	Interest expense	<u>\$ 31.5</u>	Fixed rate debt	Interest expense	<u>\$ (31.5)</u>
Year ended December 31, 2012					
Interest rate swaps	Interest expense	<u>\$ 38.2</u>	Fixed rate debt	Interest expense	<u>\$ (38.2)</u>

Cash Flow Hedges

We have historically entered into forward starting pay fixed interest rate swaps, with the objective of eliminating the variability of cash flows in the interest payments on various debt issuances. These swaps have all terminated and no amounts were outstanding at December 31, 2014 or 2013. The unrecognized loss for all terminated cash flow hedges included in accumulated other comprehensive income was \$35.9 and \$32.3 at December 31, 2014 and 2013. As of December 31, 2014, the total amount of amortization over the next twelve months for all cash flow hedges will increase interest expense by approximately \$5.5.

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

A summary of the effect of cash flow hedges on our financial statements for the years ended December 31, 2014, 2013 and 2012 is as follows:

Type of Cash Flow Hedge	Effective Portion			Ineffective Portion	
	Pretax Hedge Loss Recognized in Other Comprehensive (Loss) Income	Income Statement Location of Loss Reclassification from Accumulated Other Comprehensive Income	Hedge Loss Reclassified from Accumulated Other Comprehensive Income	Income Statement Location of Loss Recognized	Hedge Loss Recognized
Year ended December 31, 2014					
Forward starting pay fixed swaps	\$ —	Interest expense	\$ (5.0)	None	\$ —
Year ended December 31, 2013					
Forward starting pay fixed swaps	\$ —	Interest expense	\$ (4.6)	None	\$ —
Year ended December 31, 2012					
Forward starting pay fixed swaps	\$ (4.0)	Interest expense	\$ (4.2)	Interest expense	\$ (0.1)

We test for cash flow hedge effectiveness at hedge inception and re-assess at the end of each reporting period. No amounts were excluded from the assessment of hedge effectiveness.

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

Non-Hedging Derivatives

A summary of the effect of non-hedging derivatives on our income statement for the years ended December 31, 2014, 2013 and 2012 is as follows:

Type of Non-hedging Derivatives	Income Statement Location of Gain (Loss) Recognized	Derivative Gain (Loss) Recognized
Year ended December 31, 2014		
Derivatives embedded in convertible fixed maturity securities	Net realized gains on investments	\$ 11.6
Interest rate swaps	Net realized gains on investments	(11.6)
Options	Net realized gains on investments	(54.6)
Futures	Net realized gains on investments	(10.0)
Swaptions	Net realized gains on investments	1.3
Total		<u>\$ (63.3)</u>
Year ended December 31, 2013		
Derivatives embedded in convertible fixed maturity securities	Net realized gains on investments	\$ 31.5
Interest rate swaps	Net realized gains on investments	2.2
Options	Net realized gains on investments	(111.7)
Futures	Net realized gains on investments	22.3
Swaptions	Net realized gains on investments	3.0
Total		<u>\$ (52.7)</u>
Year ended December 31, 2012		
Derivatives embedded in convertible fixed maturity securities	Net realized gains on investments	\$ (2.4)
Credit default and interest rate swaps	Net realized gains on investments	(3.9)
Options	Net realized gains on investments	(66.0)
Futures	Net realized gains on investments	(6.7)
Total		<u>\$ (79.0)</u>

6. Fair Value

Assets and liabilities recorded at fair value in the consolidated balance sheets are categorized based upon the level of judgment associated with the inputs used to measure their fair value. Level inputs, as defined by FASB guidance for fair value measurements and disclosures, are as follows:

Level Input:	Input Definition:
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The following methods, assumptions and inputs were used to determine the fair value of each class of the following assets and liabilities recorded at fair value in the consolidated balance sheets:

Cash equivalents: Cash equivalents primarily consist of highly rated money market funds with maturities of three months or less, and are purchased daily at par value with specified yield rates. Due to the high ratings and short-term nature of the funds, we designate all cash equivalents as Level I.

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

Fixed maturity securities, available-for-sale: Fair values of available-for-sale fixed maturity securities are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level I or Level II inputs for the determination of fair value to facilitate fair value measurements and disclosures. United States Government securities represent Level I securities, while Level II securities primarily include corporate securities, securities from states, municipalities and political subdivisions and mortgage-backed securities. For securities not actively traded, the pricing services may use quoted market prices of comparable instruments or discounted cash flow analyses, incorporating inputs that are currently observable in the markets for similar securities. We have controls in place to review the pricing services' qualifications and procedures used to determine fair values. In addition, we periodically review the pricing services' pricing methodologies, data sources and pricing inputs to ensure the fair values obtained are reasonable. Inputs that are often used in the valuation methodologies include, but are not limited to, broker quotes, benchmark yields, credit spreads, default rates and prepayment speeds. We also have certain fixed maturity securities, primarily corporate debt securities, that are designated Level III securities. For these securities, the valuation methodologies may incorporate broker quotes or discounted cash flow analyses using assumptions for inputs such as expected cash flows, benchmark yields, credit spreads, default rates and prepayment speeds that are not observable in the markets.

Equity securities, available-for-sale: Fair values of equity securities are generally designated as Level I and are based on quoted market prices. For certain equity securities, quoted market prices for the identical security are not always available and the fair value is estimated by reference to similar securities for which quoted prices are available. These securities are designated Level II. We also have certain equity securities, including private equity securities, for which the fair value is estimated based on each security's current condition and future cash flow projections. Such securities are designated Level III. The fair values of these private equity securities are generally based on either broker quotes or discounted cash flow projections using assumptions for inputs such as the weighted-average cost of capital, long-term revenue growth rates and earnings before interest, taxes, depreciation and amortization, or EBITDA, and/or revenue multiples that are not observable in the markets.

Other invested assets, current: Other invested assets, current include securities held in rabbi trusts that are classified as trading. Fair values are based on quoted market prices.

Securities lending collateral: Fair values of securities lending collateral are based on quoted market prices, where available. These fair values are obtained primarily from third party pricing services, which generally use Level I or Level II inputs for the determination of fair value, to facilitate fair value measurements and disclosures.

Derivatives: Fair values are based on the quoted market prices by the financial institution that is the counterparty to the derivative transaction. We independently verify prices provided by the counterparties using valuation models that incorporate market observable inputs for similar derivative transactions.

In addition, the following methods and assumptions were used to determine the fair value of each class of pension benefit plan assets and other benefit plan assets not defined above (see Note 10, "Retirement Benefits," for fair values of benefit plan assets):

Mutual funds: Fair values are based on quoted market prices, which represent the net asset value, or NAV, of shares held.

Common and collective trusts: Fair values of common/collective trusts that replicate traded money market funds are based on cost, which approximates fair value. Fair values of common/collective trusts that invest in securities are valued at the NAV of the shares held, where the trust applies fair value measurements to the underlying investments to determine the NAV.

Partnership interests: Fair values are estimated based on the plan's proportionate share of the undistributed partners' capital as reported in audited financial statements of the partnership.

Contract with insurance company: Fair value of the contract in the insurance company general investment account is determined by the insurance company based on the fair value of the underlying investments of the account.

Investment in DOL 103-12 trust: Fair value is based on the plan's proportionate share of the fair value of investments held by the trust, qualified as a Department of Labor Regulation 2520.103-12 entity, or DOL 103-12 trust, as reported in

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

audited financial statements of the trust, where the trustee applies fair value measurements to the underlying investments of the trust.

Life insurance contracts: Fair value is based on the cash surrender value of the policies as reported by the insurer.

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Notes to Consolidated Financial Statements (continued)

A summary of fair value measurements by level for assets and liabilities measured at fair value on a recurring basis at December 31, 2014 and 2013 is as follows:

	Level I	Level II	Level III	Total
December 31, 2014				
Assets:				
Cash equivalents	\$ 573.2	\$ —	\$ —	\$ 573.2
Investments available-for-sale:				
Fixed maturity securities:				
United States Government securities	320.0	—	—	320.0
Government sponsored securities	—	95.0	—	95.0
States, municipalities and political subdivisions, tax-exempt	—	5,733.6	—	5,733.6
Corporate securities	7.1	8,180.8	144.6	8,332.5
Options embedded in convertible securities	—	98.7	—	98.7
Residential mortgage-backed securities	—	2,159.0	—	2,159.0
Commercial mortgage-backed securities	—	506.6	3.3	509.9
Other debt securities	89.2	627.3	6.6	723.1
Total fixed maturity securities	416.3	17,401.0	154.5	17,971.8
Equity securities	1,696.9	192.9	48.3	1,938.1
Other invested assets, current	20.2	—	—	20.2
Securities lending collateral	808.3	706.9	—	1,515.2
Derivatives excluding embedded options (reported with other assets)	—	224.8	—	224.8
Total assets	\$ 3,514.9	\$ 18,525.6	\$ 202.8	\$ 22,243.3
Liabilities:				
Derivatives excluding embedded options (reported with other liabilities)	\$ —	\$ (260.4)	\$ —	\$ (260.4)
Total liabilities	\$ —	\$ (260.4)	\$ —	\$ (260.4)
December 31, 2013				
Assets:				
Cash equivalents	\$ 632.3	\$ —	\$ —	\$ 632.3
Investments available-for-sale:				
Fixed maturity securities:				
United States Government securities	299.9	—	—	299.9
Government sponsored securities	—	173.5	—	173.5
States, municipalities and political subdivisions, tax-exempt	—	6,002.7	—	6,002.7
Corporate securities	—	7,593.4	115.2	7,708.6
Options embedded in convertible securities	—	89.2	—	89.2
Residential mortgage-backed securities	—	2,268.9	—	2,268.9
Commercial mortgage-backed securities	—	480.1	6.5	486.6
Other debt securities	35.6	408.3	14.8	458.7
Total fixed maturity securities	335.5	17,016.1	136.5	17,488.1
Equity securities	1,475.7	249.7	41.4	1,766.8
Other invested assets, current	16.3	—	—	16.3
Securities lending collateral	408.5	561.3	—	969.8
Derivatives excluding embedded options (reported with other assets)	—	58.4	—	58.4
Total assets	\$ 2,868.3	\$ 17,885.5	\$ 177.9	\$ 20,931.7
Liabilities:				
Derivatives excluding embedded options (reported with other liabilities)	\$ —	\$ (20.7)	\$ —	\$ (20.7)
Total liabilities	\$ —	\$ (20.7)	\$ —	\$ (20.7)

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

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using Level III inputs for the years ended December 31, 2014, 2013 and 2012 is as follows:

	Corporate Securities	Residential Mortgage- backed Securities	Commercial Mortgage- backed Securities	Other Debt Securities	Equity Securities	Total
Year ended December 31, 2014						
Beginning balance at January 1, 2014	\$ 115.2	\$ —	\$ 6.5	\$ 14.8	\$ 41.4	\$ 177.9
Total (losses) gains:						
Recognized in net income	(4.4)	—	—	—	(0.7)	(5.1)
Recognized in accumulated other comprehensive income	8.5	—	—	0.4	2.8	11.7
Purchases	68.9	—	3.6	6.5	15.9	94.9
Sales	(48.0)	—	—	(3.6)	(10.6)	(62.2)
Settlements	(11.0)	—	(3.7)	(0.4)	—	(15.1)
Transfers into Level III	24.8	—	—	—	—	24.8
Transfers out of Level III	(9.4)	—	(3.1)	(11.1)	(0.5)	(24.1)
Ending balance at December 31, 2014	\$ 144.6	\$ —	\$ 3.3	\$ 6.6	\$ 48.3	\$ 202.8
Change in unrealized losses included in net income related to assets still held for the year ended December 31, 2014	\$ (11.1)	\$ —	\$ —	\$ —	\$ (0.7)	\$ (11.8)
Year ended December 31, 2013						
Beginning balance at January 1, 2013	\$ 121.1	\$ 4.3	\$ —	\$ 3.9	\$ 26.2	\$ 155.5
Total (losses) gains:						
Recognized in net income	(30.3)	—	—	(0.1)	(4.8)	(35.2)
Recognized in accumulated other comprehensive income	(3.5)	—	—	0.6	9.5	6.6
Purchases	51.9	—	—	1.6	17.6	71.1
Sales	(4.8)	—	—	—	(7.1)	(11.9)
Settlements	(15.5)	(1.9)	(6.1)	(0.7)	—	(24.2)
Transfers into Level III	3.0	13.1	12.6	9.8	—	38.5
Transfers out of Level III	(6.7)	(15.5)	—	(0.3)	—	(22.5)
Ending balance at December 31, 2013	\$ 115.2	\$ —	\$ 6.5	\$ 14.8	\$ 41.4	\$ 177.9
Change in unrealized losses included in net income related to assets still held for the year ended December 31, 2013	\$ (30.8)	\$ —	\$ —	\$ (0.1)	\$ (6.5)	\$ (37.4)
Year Ended December 31, 2012						
Beginning balance at January 1, 2012	\$ 195.1	\$ —	\$ 6.3	\$ 59.0	\$ 24.4	\$ 284.8
Total gains (losses):						
Recognized in net income	15.2	—	—	0.1	(0.9)	14.4
Recognized in accumulated other comprehensive income	(19.7)	—	0.1	0.7	(14.2)	(33.1)
Purchases	77.8	3.0	3.4	—	4.9	89.1
Business combinations	2.6	—	—	—	—	2.6
Sales	(29.8)	—	—	(16.6)	(0.5)	(46.9)
Settlements	(67.8)	(0.1)	(0.1)	(1.3)	—	(69.3)
Transfers into Level III	2.9	1.4	1.9	12.0	12.5	30.7
Transfers out of Level III	(55.2)	—	(11.6)	(50.0)	—	(116.8)
Ending balance at December 31, 2012	\$ 121.1	\$ 4.3	\$ —	\$ 3.9	\$ 26.2	\$ 155.5
Change in unrealized losses included in net income related to assets still held for the year ended December 31, 2012	\$ —	\$ —	\$ —	\$ —	\$ (0.7)	\$ (0.7)

Transfers between levels, if any, are recorded as of the beginning of the reporting period. There were no material transfers into or out of Level III during the years ended December 31, 2014 or 2013 and no material transfers into Level III

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Notes to Consolidated Financial Statements (continued)

during the year ended December 31, 2012. During the year ended December 31, 2012, the transfers out of Level III of corporate securities were for certain sub-prime securities transferred from Level III to Level II as a result of inputs that were previously unobservable becoming observable due to increased volume and level of trading in active markets. In addition, the transfers out of Level III of other debt securities were for certain inverse floating rate securities transferred from Level III to Level II as a result of those securities' impending maturity and settlement and recent trading activity of similar securities in observable markets.

During the years ended December 31, 2014, 2013 or 2012, there were no material transfers from Level I to Level II or from Level II to Level I.

Certain assets and liabilities are measured at fair value on a nonrecurring basis; that is, the instruments are not measured at fair value on an ongoing basis but are subject to fair value adjustments only in certain circumstances. There were no material assets or liabilities measured at fair value on a nonrecurring basis during the years ended December 31, 2014 or 2013.

Our valuation policy is determined by members of our treasury and accounting departments. Whenever possible, our policy is to obtain quoted market prices in active markets to estimate fair values for recognition and disclosure purposes. Where quoted market prices in active markets are not available, fair values are estimated using discounted cash flow analyses, broker quotes or other valuation techniques. These techniques are significantly affected by our assumptions, including discount rates and estimates of future cash flows. Potential taxes and other transaction costs are not considered in estimating fair values. Our valuation policy is generally to obtain only one quoted price for each security from third party pricing services, which are derived through recently reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information. When broker quotes are used, we generally obtain only one broker quote per security. As we are responsible for the determination of fair value, we perform monthly analysis on the prices received from the pricing services to determine whether the prices are reasonable estimates of fair value. This analysis is performed by our internal treasury personnel who are familiar with our investment portfolios, the pricing services engaged and the valuation techniques and inputs used. Our analysis includes a review of month-to-month price fluctuations. If unusual fluctuations are noted in this review, we may obtain additional information from other pricing services to validate the quoted price. There were no adjustments to quoted market prices obtained from the pricing services during the years ended December 31, 2014, 2013 or 2012.

In addition to the preceding disclosures on assets recorded at fair value in the consolidated balance sheets, FASB guidance also requires the disclosure of fair values for certain other financial instruments for which it is practicable to estimate fair value, whether or not such values are recognized in the consolidated balance sheets.

Non-financial instruments such as real estate, property and equipment, other current assets, deferred income taxes, intangible assets and certain financial instruments, such as policy liabilities, are excluded from the fair value disclosures. Therefore, the fair value amounts cannot be aggregated to determine our underlying economic value.

The carrying amounts reported in the consolidated balance sheets for cash, accrued investment income, premium and self-funded receivables, other receivables, income taxes receivable, unearned income, accounts payable and accrued expenses, security trades pending payable, securities lending payable and certain other current liabilities approximate fair value because of the short term nature of these items. These assets and liabilities are not listed in the table below.

The following methods and assumptions were used to estimate the fair value of each class of financial instrument:

Other invested assets, long-term: Other invested assets, long-term include primarily our investments in limited partnerships, joint ventures and other non-controlled corporations, as well as the cash surrender value of corporate-owned life insurance policies. Investments in limited partnerships, joint ventures and other non-controlled corporations are carried at our share in the entities' undistributed earnings, which approximates fair value. The carrying value of corporate-owned life insurance policies represents the cash surrender value as reported by the respective insurer, which approximates fair value.

Short-term borrowings: The fair value of our short-term borrowings is based on quoted market prices for the same or similar debt, or, if no quoted market prices were available, on the current market interest rates estimated to be available to us for debt of similar terms and remaining maturities.

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

Long-term debt - commercial paper: The carrying amount for commercial paper approximates fair value as the underlying instruments have variable interest rates at market value.

Long-term debt - notes: The fair values of our notes are based on quoted market prices in active markets for the same or similar debt, or, if no quoted market prices are available, on the current market observable rates estimated to be available to us for debt of similar terms and remaining maturities.

Long-term debt—convertible debentures: The fair value of our convertible debentures is based on the quoted market price in the active private market in which the convertible debentures trade.

A summary of the carrying value and fair value by level of financial instruments not recorded at fair value on our consolidated balance sheets at December 31, 2014 and 2013 are as follows:

	Carrying Value	Fair Value			
		Level I	Level II	Level III	Total
December 31, 2014					
Assets:					
Other invested assets, long-term	\$ 1,695.9	\$ —	\$ —	\$ 1,695.9	\$ 1,695.9
Liabilities:					
Debt:					
Short-term borrowings	400.0	—	400.0	—	400.0
Notes	13,777.8	—	14,794.8	—	14,794.8
Convertible debentures	974.4	—	2,581.9	—	2,581.9
December 31, 2013					
Assets:					
Other invested assets, long-term	\$ 1,542.6	\$ —	\$ —	\$ 1,542.6	\$ 1,542.6
Liabilities:					
Debt:					
Short-term borrowings	400.0	—	400.0	—	400.0
Commercial paper	379.2	—	379.2	—	379.2
Notes	12,746.4	—	13,014.3	—	13,014.3
Convertible debentures	966.0	—	2,030.6	—	2,030.6

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

7. Income Taxes

The components of deferred income taxes at December 31 are as follows:

	2014	2013
Deferred tax assets relating to:		
Retirement benefits	\$ 357.7	\$ 287.8
Accrued expenses	329.9	342.8
Insurance reserves	209.7	213.1
Net operating loss carryforwards	14.8	17.2
Bad debt reserves	132.9	124.8
State income tax	40.6	32.9
Deferred compensation	46.6	52.0
Investment basis difference	88.2	166.3
Other	34.2	84.0
Total deferred tax assets	1,254.6	1,320.9
Valuation allowance	(2.6)	(24.1)
Total deferred tax assets, net of valuation allowance	1,252.0	1,296.8
Deferred tax liabilities relating to:		
Unrealized gains on securities	331.4	266.5
Acquisition related:		
Trademarks and other non-amortizable intangible assets	2,200.5	2,200.5
Subscriber base, provider and hospital networks	301.1	370.9
Internally developed software and other amortization differences	654.9	703.9
Retirement benefits	241.1	231.5
Debt discount	184.0	186.9
State deferred tax	49.1	55.3
Depreciation and amortization	29.6	33.1
Other	205.9	190.4
Total deferred tax liabilities	4,197.6	4,239.0
Net deferred tax liability	\$ (2,945.6)	\$ (2,942.2)
Deferred tax asset-current	\$ 280.4	\$ 383.0
Deferred tax liability-noncurrent	(3,226.0)	(3,325.2)
Net deferred tax liability	\$ (2,945.6)	\$ (2,942.2)

Changes in the valuation allowance during 2014 included a decrease of \$9.8 related to reduction in statutory state income tax rates, a decrease of \$16.2 related to utilization of state net operating losses, and an increase of \$4.5 related to the sale of 1-800 CONTACTS, for a net decrease of \$21.5.

Changes in the valuation allowance during 2013 included an increase of \$12.1 impacting tax expense related to additional state operating losses and a reduction of \$6.1 impacting goodwill related to acquisition goodwill adjustments for a net increase of \$6.0.

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

Significant components of the provision for income taxes for the years ended December 31 consist of the following:

	2014	2013	2012
Current tax expense (benefit):			
Federal	\$ 1,629.4	\$ 1,226.4	\$ 1,060.2
State and local	65.8	(42.6)	95.7
Total current tax expense	1,695.2	1,183.8	1,155.9
Deferred tax expense	112.8	22.1	51.4
Total income tax expense	<u>\$ 1,808.0</u>	<u>\$ 1,205.9</u>	<u>\$ 1,207.3</u>

State and local current tax expense is reported gross of federal benefit, and includes amounts related to true up of prior years' tax, audit settlements, uncertain tax positions and state tax credits. Such items are included in multiple lines in the following rate reconciliation table on a net of federal tax basis.

A reconciliation of income tax expense recorded in the consolidated statements of income and amounts computed at the statutory federal income tax rate for the years ended December 31 is as follows:

	2014		2013		2012	
	Amount	Percent	Amount	Percent	Amount	Percent
Amount at statutory rate	\$ 1,528.8	35.0 %	\$ 1,344.1	35.0 %	\$ 1,350.4	35.0 %
State and local income taxes net of federal tax benefit	49.0	1.1	24.4	0.6	25.5	0.6
Tax exempt interest and dividends received deduction	(65.9)	(1.5)	(64.9)	(1.7)	(59.3)	(1.5)
Health Insurance Provider fee	312.6	7.2	—	—	—	—
Audit settlements	—	—	—	—	(200.5)	(5.2)
Other, net	(16.5)	(0.4)	(97.7)	(2.5)	91.2	2.4
Total income tax expense	<u>\$ 1,808.0</u>	<u>41.4 %</u>	<u>\$ 1,205.9</u>	<u>31.4 %</u>	<u>\$ 1,207.3</u>	<u>31.3 %</u>

During the year ended December 31, 2014, we recognized income tax expense of \$312.6, or \$1.09 per diluted share, as a result of the non-tax deductibility of the Health Insurance Provider fee payments.

During the year ended December 31, 2013, we recognized income tax benefits of \$65.0, or \$0.21 per diluted share, resulting from a favorable tax election made subsequent to the Amerigroup acquisition. This benefit is included in Other, net above.

During the year ended December 31, 2012, we recognized income tax benefits of \$200.5, or \$0.62 per diluted share, for settlement of certain of our open tax issues with the Internal Revenue Service, or IRS, following approval by the Joint Committee on Taxation. This included amounts related to not-for-profit conversion and corporate reorganizations in prior years, as well as amounts associated with issues related to certain of our acquired companies. This income tax benefit includes the release of gross unrecognized tax benefits from uncertain tax positions, release of a valuation allowance and recognition of interest income. This income tax benefit, and resulting decrease in the effective tax rate, was partially offset due to the non-tax deductibility of litigation settlement expenses associated with the settlement of a class action lawsuit in June 2012 and an increase in our state deferred tax asset valuation allowance attributable to the uncertainty associated with some of our state net operating loss carryforwards.

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

The change in the carrying amount of gross unrecognized tax benefits from uncertain tax positions for the years ended December 31 is as follows:

	2014	2013
Balance at January 1	\$ 103.2	\$ 143.5
Additions for tax positions related to:		
Current year	10.9	5.0
Prior years	31.3	—
Reductions related to:		
Tax positions of prior years	(24.5)	(45.3)
Settlements with taxing authorities	(5.1)	—
Balance at December 31	<u>\$ 115.8</u>	<u>\$ 103.2</u>

The table above excludes interest, net of related tax benefits, which is treated as income tax expense (benefit) under our accounting policy. The interest is included in the amounts described in the following paragraph.

As of December 31, 2014, \$68.3 of unrecognized tax benefits would impact our effective tax rate in future periods, if recognized. Also included in the table above is \$10.9 that would be recognized as an adjustment to additional paid-in capital and \$8.7 that would be recognized as an adjustment to goodwill, neither of which would affect our effective tax rate. The December 31, 2014 balance also includes \$0.3 of tax positions for which ultimate deductibility is highly certain but for which there is uncertainty about the timing of such deductibility. Excluding the impact of interest and penalties, the disallowance of the shorter deductibility period would not affect our effective tax rate, but would accelerate the payment of cash to the taxing authority to an earlier period.

For the years ended December 31, 2014, 2013 and 2012, we recognized approximately \$(4.2), \$2.6 and \$(9.0) in interest, respectively. We had accrued approximately \$14.1 and \$18.3 for the payment of interest at December 31, 2014 and 2013, respectively.

As of December 31, 2014, as further described below, certain tax years remain open to examination by the IRS and various state and local authorities. In addition, we continue to discuss certain industry issues with the IRS. As a result of these examinations and discussions, we have recorded amounts for uncertain tax positions. It is anticipated that the amount of unrecognized tax benefits will change in the next twelve months due to possible settlements of audits and changes in temporary items. However, the ultimate resolution of these items is dependent on the completion of negotiations with various taxing authorities. While it is difficult to determine when other tax settlements will actually occur, it is reasonably possible that one could occur in the next twelve months and our unrecognized tax benefits could change within a range of approximately \$9.4 to \$(92.0).

We are a member of the IRS Compliance Assurance Process, or CAP. The objective of CAP is to reduce taxpayer burden and uncertainty while assuring the IRS of the accuracy of tax returns prior to filing, thereby reducing or eliminating the need for post-filing examinations.

As of December 31, 2014, the examinations of our 2014 and 2013 tax years continue to be in process. During 2014, the Joint Committee on Taxation approved our 2010 settlement. Also during 2014, a hearing with IRS Appeals was held and settlement was reached on our 2011 and 2012 tax years.

In certain states, we pay premium taxes in lieu of state income taxes. Premium taxes are reported with general and administrative expense.

At December 31, 2014, we had unused federal tax net operating loss carryforwards of approximately \$35.1 to offset future taxable income. The loss carryforwards expire in the years 2017 through 2024. During 2014, 2013 and 2012 federal income taxes paid totaled \$1,659.0, \$1,172.0 and \$1,188.2, respectively.

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

8. Property and Equipment

A summary of property and equipment at December 31 is as follows:

	2014	2013
Land and improvements	\$ 25.8	\$ 35.4
Building and components	279.9	384.0
Data processing equipment, furniture and other equipment	940.3	861.5
Computer software, purchased and internally developed	2,162.4	1,879.0
Leasehold improvements	356.4	325.1
Property and equipment, gross	3,764.8	3,485.0
Accumulated depreciation and amortization	(1,820.5)	(1,683.5)
Property and equipment, net	\$ 1,944.3	\$ 1,801.5

Depreciation expense for 2014, 2013 and 2012 was \$106.5, \$105.3 and \$102.9, respectively. Amortization expense on computer software and leasehold improvements for 2014, 2013 and 2012 was \$367.8, \$351.8 and \$260.6, respectively, which includes amortization expense on computer software, both purchased and internally developed, for 2014, 2013 and 2012 of \$329.2, \$313.6 and \$239.5, respectively. Capitalized costs related to the internal development of software of \$1,844.2 and \$1,561.0 at December 31, 2014 and 2013, respectively, are reported with computer software.

During the years ended December 31, 2014, 2013 and 2012, we recognized \$7.9, \$47.7 and \$66.8, respectively, of impairments related to computer software (primarily internally developed) due to project cancellation or asset replacement, some of which resulted from a change in strategic focus needed to effectively manage business operations in a post-Health Care Reform environment.

9. Goodwill and Other Intangible Assets

No goodwill is allocated to our Other segment. A summary of the change in the carrying amount of goodwill for our Commercial and Specialty Business segment and Government Business segment (see Note 19, "Segment Information") for 2014 and 2013 is as follows:

	Commercial and Specialty Business	Government Business	Total
Balance as of January 1, 2013	\$ 11,555.3	\$ 5,334.5	\$ 16,889.8
Measurement period adjustments	(1.3)	28.7	27.4
Balance as of December 31, 2013	\$ 11,554.0	\$ 5,363.2	\$ 16,917.2
Measurement period adjustments	(1.6)	(0.2)	(1.8)
Other adjustments	266.5	(99.9)	166.6
Balance as of December 31, 2014	\$ 11,818.9	\$ 5,263.1	\$ 17,082.0
Accumulated impairment as of December 31, 2014	\$ (41.0)	\$ —	\$ (41.0)

Measurement period adjustments incurred during 2014 included a reduction of \$1.8 related to the tax benefit on the exercise of stock options issued as part of various acquisitions. Other adjustments incurred during 2014 included transfers between business segments and reclassification to goodwill of the indefinite-lived provider network intangible asset, net of deferred taxes, presented in the other intangible asset table below. Measurement period adjustments incurred during 2013 included a reduction of \$1.5 related to the tax benefit on the exercise of stock options issued as part of various acquisitions and an increase of \$28.9 related to other measurement period adjustments.

As required by FASB guidance, we completed annual impairment tests of existing goodwill and other intangible assets with indefinite lives during 2014, 2013 and 2012. We perform these annual impairment tests during the fourth quarter. FASB guidance also requires interim impairment testing to be performed when potential impairment indicators exist. These tests

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

involve the use of estimates related to the fair value of goodwill and intangible assets with indefinite lives and require a significant degree of management judgment and the use of subjective assumptions. The fair values were estimated using the income and market value valuation methods, incorporating Level III internal estimates for inputs, including, but not limited to, revenue projections, income projections, cash flows and discount rates. We did not incur any impairment losses in 2014, 2013 or 2012 as the estimated fair values of our reporting units were substantially in excess of their carrying values.

The components of other intangible assets as of December 31 are as follows:

	2014			2013		
	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount
Intangible assets with finite lives:						
Customer relationships	\$ 3,318.4	\$ (2,473.4)	\$ 845.0	\$ 3,308.9	\$ (2,264.2)	\$ 1,044.7
Provider and hospital relationships	140.9	(51.4)	89.5	140.5	(44.7)	95.8
Other	61.6	(33.3)	28.3	61.7	(28.3)	33.4
Total	3,520.9	(2,558.1)	962.8	3,511.1	(2,337.2)	1,173.9
Intangible assets with indefinite lives:						
Blue Cross and Blue Shield and other trademarks	6,298.7	—	6,298.7	6,298.7	—	6,298.7
Provider network	—	—	—	271.8	—	271.8
State Medicaid licenses	696.6	—	696.6	696.6	—	696.6
Total	6,995.3	—	6,995.3	7,267.1	—	7,267.1
Other intangible assets	\$ 10,516.2	\$ (2,558.1)	\$ 7,958.1	\$ 10,778.2	\$ (2,337.2)	\$ 8,441.0

As of December 31, 2014, the estimated amortization expense for each of the five succeeding years is as follows: 2015, \$184.2; 2016, \$153.5; 2017, \$133.5; 2018, \$113.8; and 2019, \$94.1.

10. Retirement Benefits

We sponsor various non-contributory employee defined benefit plans through certain subsidiaries.

The Anthem Cash Balance Plan A and the Anthem Cash Balance Plan B are cash balance pension plans covering certain eligible employees of the affiliated companies that participate in these plans. Effective January 1, 2006, benefits were curtailed, with the result that most participants stopped accruing benefits but continue to earn interest on benefits accrued prior to the curtailment. Certain participants subject to collective bargaining and certain other participants who met grandfathering rules continue to accrue benefits. Participants that do not receive credits and/or benefit accruals are included in the Anthem Cash Balance Plan A, while current employees who are still receiving credits and/or benefits participate in the Anthem Cash Balance Plan B. Several pension plans acquired through various corporate mergers and acquisitions have been merged into these plans in prior years.

The UGS Pension Plan is a defined benefit pension plan with a cash balance component. The UGS Pension Plan covers eligible employees of the affiliated companies that participate in the UGS Pension Plan. Effective January 1, 2004, benefits were curtailed, with the result that most participants stopped accruing benefits but continue to earn interest on benefits previously accrued. Certain employees subject to collective bargaining and certain other employees who met grandfathering rules continue to accrue benefits.

The Employees' Retirement Plan of Blue Cross of California, or the BCC Plan, is a defined benefit pension plan that covers eligible employees of Blue Cross of California who are covered by a collective bargaining agreement. Effective January 1, 2007, benefits were curtailed under the BCC Plan with the result that no Blue Cross of California employees hired or rehired after December 31, 2006 are eligible to participate in the BCC Plan.

All of the plans' assets consist primarily of common stocks, fixed maturity securities, investment funds and short-term investments. The funding policies for all plans are to contribute amounts at least sufficient to meet the minimum funding

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

requirements set forth in the Employee Retirement Income Security Act of 1974, as amended, or ERISA, including amendment by the Pension Protection Act of 2006, and in accordance with income tax regulations, plus such additional amounts as are necessary to provide assets sufficient to meet the benefits to be paid to plan participants.

We use a December 31 measurement date for determining benefit obligations and fair value of plan assets.

The following tables disclose consolidated "pension benefits," which include the defined benefit pension plans described above, and consolidated "other benefits," which include postretirement health and welfare benefits including medical, vision and dental benefits offered to certain employees. Calculations were computed using assumptions at the December 31 measurement dates.

The reconciliation of the benefit obligation is as follows:

	Pension Benefits		Other Benefits	
	2014	2013	2014	2013
Benefit obligation at beginning of year	\$ 1,764.7	\$ 1,948.5	\$ 607.5	\$ 623.0
Service cost	13.0	14.2	3.2	6.7
Interest cost	74.1	67.8	26.3	22.4
Actuarial loss (gain)	185.4	(129.9)	45.3	4.8
Benefits paid	(122.8)	(135.9)	(35.7)	(49.4)
Benefit obligation at end of year	<u>\$ 1,914.4</u>	<u>\$ 1,764.7</u>	<u>\$ 646.6</u>	<u>\$ 607.5</u>

The changes in the fair value of plan assets are as follows:

	Pension Benefits		Other Benefits	
	2014	2013	2014	2013
Fair value of plan assets at beginning of year	\$ 1,944.0	\$ 1,817.9	\$ 349.8	\$ 320.3
Actual return on plan assets	160.2	223.4	17.7	37.0
Employer contributions	3.6	38.6	16.1	31.3
Benefits paid	(122.8)	(135.9)	(35.7)	(38.8)
Fair value of plan assets at end of year	<u>\$ 1,985.0</u>	<u>\$ 1,944.0</u>	<u>\$ 347.9</u>	<u>\$ 349.8</u>

The net amount included in the consolidated balance sheets is as follows:

	Pension Benefits		Other Benefits	
	2014	2013	2014	2013
Noncurrent assets	\$ 146.3	\$ 240.8	\$ —	\$ —
Current liabilities	(4.3)	(3.5)	—	—
Noncurrent liabilities	(71.4)	(58.0)	(298.7)	(257.7)
Net amount at December 31	<u>\$ 70.6</u>	<u>\$ 179.3</u>	<u>\$ (298.7)</u>	<u>\$ (257.7)</u>

The net amounts included in accumulated other comprehensive loss (income) that have not been recognized as components of net periodic benefit costs are as follows:

	Pension Benefits		Other Benefits	
	2014	2013	2014	2013
Net actuarial loss	\$ 563.7	\$ 427.2	\$ 211.2	\$ 169.6
Prior service credit	(2.2)	(3.0)	(88.0)	(102.4)
Net amount before tax at December 31	<u>\$ 561.5</u>	<u>\$ 424.2</u>	<u>\$ 123.2</u>	<u>\$ 67.2</u>

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

The estimated net actuarial loss and prior service credit for the defined benefit pension plans that will be reclassified from accumulated other comprehensive loss into net periodic benefit costs over the next year are \$23.8 and \$0.8, respectively. The estimated net actuarial loss and prior service credit for postretirement benefit plans that will be reclassified from accumulated other comprehensive loss into net periodic benefit costs over the next year are \$15.3 and \$14.4, respectively.

The accumulated benefit obligation for the defined benefit pension plans was \$1,908.1 and \$1,758.2 at December 31, 2014 and 2013, respectively.

As of December 31, 2014, certain pension plans had accumulated benefit obligations in excess of plan assets. For those same plans, the projected benefit obligation was also in excess of plan assets. Such plans had a combined projected benefit obligation, accumulated benefit obligation and fair value of plan assets of \$111.9, \$109.4 and \$36.9, respectively.

The weighted-average assumptions used in calculating the benefit obligations for all plans are as follows:

	Pension Benefits		Other Benefits	
	2014	2013	2014	2013
Discount rate	3.66%	4.39%	3.74%	4.48%
Rate of compensation increase	3.00%	3.00%	3.00%	3.00%
Expected rate of return on plan assets	7.62%	7.66%	7.00%	7.00%

The components of net periodic (credit) benefit cost included in the consolidated statements of income are as follows:

	2014	2013	2012
Pension Benefits			
Service cost	\$ 13.0	\$ 14.2	\$ 16.4
Interest cost	74.1	67.8	76.4
Expected return on assets	(137.5)	(133.1)	(134.7)
Recognized actuarial loss	21.0	28.3	30.5
Amortization of prior service credit	(0.8)	(0.8)	(0.8)
Settlement loss	5.2	11.0	13.8
Net periodic (credit) benefit cost	<u>\$ (25.0)</u>	<u>\$ (12.6)</u>	<u>\$ 1.6</u>
Other Benefits			
Service cost	\$ 3.2	\$ 6.7	\$ 6.8
Interest cost	26.3	22.4	27.5
Expected return on assets	(23.4)	(22.1)	(21.0)
Recognized actuarial loss	9.4	11.2	14.1
Amortization of prior service credit	(14.4)	(13.3)	(13.3)
Net periodic benefit cost	<u>\$ 1.1</u>	<u>\$ 4.9</u>	<u>\$ 14.1</u>

During the years ended December 31, 2014, 2013 and 2012 we incurred total settlement losses of \$5.2, \$11.0 and \$13.8, respectively, as lump-sum payments exceeded the service cost and interest cost components of net periodic benefit cost for certain of our plans.

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Notes to Consolidated Financial Statements (continued)

The weighted-average assumptions used in calculating the net periodic benefit cost for all plans are as follows:

	2014	2013	2012
Pension Benefits			
Discount rate	4.39%	3.60%	4.29%
Rate of compensation increase	3.00%	3.50%	3.50%
Expected rate of return on plan assets	7.66%	7.91%	8.00%
Other Benefits			
Discount rate	4.48%	3.71%	4.36%
Rate of compensation increase	3.00%	3.50%	3.50%
Expected rate of return on plan assets	7.00%	7.00%	7.00%

The assumed health care cost trend rates used to measure the expected cost of pre-Medicare (those who are not currently eligible for Medicare benefits) other benefits at our December 31, 2014 measurement date was 8.00% for 2015 with a gradual decline to 4.50% by the year 2025. The assumed health care cost trend rates used to measure the expected cost of post-Medicare (those who are currently eligible for Medicare benefits) other benefits at our December 31, 2014 measurement date was 6.00% for 2015 with a gradual decline to 4.50% by the year 2021. These estimated trend rates are subject to change in the future. The health care cost trend rate assumption has a significant effect on the amounts reported. For example, an increase in the assumed health care cost trend rate of one percentage point would increase the postretirement benefit obligation as of December 31, 2014 by \$56.7 and would increase service and interest costs by \$2.0. Conversely, a decrease in the assumed health care cost trend rate of one percentage point would decrease the postretirement benefit obligation by \$47.6 as of December 31, 2014 and would decrease service and interest costs by \$1.8.

Plan assets include a diversified mix of investment grade fixed maturity securities, equity securities and alternative investments across a range of sectors and levels of capitalization to maximize the long-term return for a prudent level of risk. The weighted-average target allocation for pension benefit plan assets is 45% equity securities, 46% fixed maturity securities, and 9% to all other types of investments. Equity securities primarily include a mix of domestic securities, foreign securities and mutual funds invested in equities. Fixed maturity securities primarily include treasury securities, corporate bonds, and asset-backed investments issued by corporations and the U.S. government. Other types of investments include partnership interests, collective trusts that replicate money market funds and insurance contracts designed specifically for employee benefit plans. As of December 31, 2014, there were no significant concentrations of investments in the pension benefit assets or other benefit assets. No plan assets were invested in Anthem common stock.

Pension benefit assets and other benefit assets recorded at fair value are categorized based upon the level of judgment associated with the inputs used to measure their fair value.

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Notes to Consolidated Financial Statements (continued)

The fair values of our pension benefit assets and other benefit assets by asset category and level inputs at December 31, 2014, excluding cash, investment income receivable and amounts due to/from brokers, resulting in a net liability of \$0.2, are as follows (see Note 6, "Fair Value," for additional information regarding the definition of level inputs):

	Level I	Level II	Level III	Total
December 31, 2014				
Pension Benefit Assets:				
Equity securities:				
U.S. securities	\$ 591.2	\$ 4.5	\$ —	\$ 595.7
Foreign securities	246.2	—	—	246.2
Mutual funds	36.8	—	—	36.8
Fixed maturity securities:				
Government securities	206.5	11.5	—	218.0
Corporate securities	—	373.6	—	373.6
Asset-backed securities	—	170.0	—	170.0
Other types of investments:				
Common and collective trusts	—	37.1	—	37.1
Partnership interests	—	—	120.7	120.7
Insurance company contracts	—	—	187.7	187.7
Treasury futures contracts	(0.9)	—	—	(0.9)
Total pension benefit assets	<u>\$ 1,079.8</u>	<u>\$ 596.7</u>	<u>\$ 308.4</u>	<u>\$ 1,984.9</u>
Other Benefit Assets:				
Equity securities:				
U.S. securities	\$ 22.0	\$ 0.3	\$ —	\$ 22.3
Foreign securities	9.5	—	—	9.5
Mutual funds	33.6	—	—	33.6
Fixed maturity securities:				
Government securities	6.2	—	—	6.2
Corporate securities	—	10.0	—	10.0
Asset-backed securities	—	10.5	—	10.5
Other types of investments:				
Common and collective trusts	—	1.4	—	1.4
Partnership interests	—	—	1.5	1.5
Life insurance contracts	—	—	238.4	238.4
Investment in DOL 103-12 trust	—	14.8	—	14.8
Total other benefit assets	<u>\$ 71.3</u>	<u>\$ 37.0</u>	<u>\$ 239.9</u>	<u>\$ 348.2</u>

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

The fair values of our pension benefit assets and other benefit assets by asset category and level inputs at December 31, 2013, excluding cash, investment income receivable and amounts due to/from brokers, resulting in a net asset of \$3.9, are as follows (see Note 6, "Fair Value," for additional information regarding the definition of level inputs):

	Level I	Level II	Level III	Total
December 31, 2013				
Pension Benefit Assets:				
Equity securities:				
U.S. securities	\$ 613.8	\$ —	\$ —	\$ 613.8
Foreign securities	296.8	—	—	296.8
Mutual funds	37.4	—	—	37.4
Fixed maturity securities:				
Government securities	177.9	11.5	—	189.4
Corporate securities	—	272.1	—	272.1
Asset-backed securities	—	127.0	—	127.0
Other types of investments:				
Common and collective trusts	—	46.6	—	46.6
Partnership interests	—	—	159.1	159.1
Insurance company contracts	—	—	197.4	197.4
Treasury futures contracts	0.7	—	—	0.7
Total pension benefit assets	<u>\$ 1,126.6</u>	<u>\$ 457.2</u>	<u>\$ 356.5</u>	<u>\$ 1,940.3</u>
Other Benefit Assets:				
Equity securities:				
U.S. securities	\$ 39.0	\$ —	\$ —	\$ 39.0
Foreign securities	18.6	—	—	18.6
Mutual funds	4.7	—	—	4.7
Fixed maturity securities:				
Government securities	14.3	—	—	14.3
Corporate securities	4.3	9.9	—	14.2
Asset-backed securities	—	11.2	—	11.2
Other types of investments:				
Common and collective trusts	—	2.2	—	2.2
Partnership interests	—	—	1.2	1.2
Life insurance contracts	—	—	230.0	230.0
Investment in DOL 103-12 trust	—	14.2	—	14.2
Total other benefit assets	<u>\$ 80.9</u>	<u>\$ 37.5</u>	<u>\$ 231.2</u>	<u>\$ 349.6</u>

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

A reconciliation of the beginning and ending balances of plan assets measured at fair value using Level III inputs for the years ended December 31, 2014, 2013 and 2012 is as follows:

	U.S. Equity Securities	Partnership Interests	Insurance Company Contracts	Life Insurance Contracts	Total
Year ended December 31, 2014					
Beginning balance at January 1, 2014	\$ —	\$ 160.3	\$ 197.4	\$ 230.0	\$ 587.7
Actual return on plan assets:					
Relating to assets still held at the reporting date	—	(5.4)	1.4	8.4	4.4
Purchases	—	8.4	11.6	—	20.0
Sales	—	(41.1)	(22.7)	—	(63.8)
Ending balance at December 31, 2014	<u>\$ —</u>	<u>\$ 122.2</u>	<u>\$ 187.7</u>	<u>\$ 238.4</u>	<u>\$ 548.3</u>
Year ended December 31, 2013					
Beginning balance at January 1, 2013	\$ —	\$ 177.7	\$ 202.5	\$ 203.7	\$ 583.9
Actual return on plan assets:					
Relating to assets still held at the reporting date	—	2.2	(5.6)	26.3	22.9
Purchases	—	15.6	9.5	—	25.1
Sales	—	(35.2)	(9.0)	—	(44.2)
Ending balance at December 31, 2013	<u>\$ —</u>	<u>\$ 160.3</u>	<u>\$ 197.4</u>	<u>\$ 230.0</u>	<u>\$ 587.7</u>
Year ended December 31, 2012					
Beginning balance at January 1, 2012	\$ 317.6	\$ 166.1	\$ 195.5	\$ 95.7	\$ 774.9
Actual return on plan assets:					
Relating to assets still held at the reporting date	—	4.5	5.5	13.2	23.2
Purchases	—	14.1	8.8	94.8	117.7
Sales	(317.6)	(7.0)	(7.3)	—	(331.9)
Ending balance at December 31, 2012	<u>\$ —</u>	<u>\$ 177.7</u>	<u>\$ 202.5</u>	<u>\$ 203.7</u>	<u>\$ 583.9</u>

There were no transfers between Levels I, II and III during the years ended December 31, 2014, 2013 and 2012. The significant decline in plan assets measured using Level III inputs as of December 31, 2012 was primarily due to the sale of an equity partnership.

Our current funding strategy is to fund an amount at least equal to the minimum required funding as determined under ERISA with consideration of maximum tax deductible amounts. We may elect to make discretionary contributions up to the maximum amount deductible for income tax purposes. For the years ended December 31, 2014, 2013 and 2012, no material contributions were necessary to meet ERISA required funding levels. However, during the years ended December 31, 2014, 2013 and 2012, we made tax deductible discretionary contributions to the pension benefit plans of \$3.6, \$38.6 and \$34.5, respectively. Employer contributions to other benefit plans represent discretionary contributions and do not include payments to retirees for current benefits.

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

Our estimated future payments for pension benefits and postretirement benefits, which reflect expected future service, as appropriate, are as follows:

	Pension Benefits	Other Benefits
2015	\$ 148.8	\$ 40.8
2016	152.6	41.4
2017	146.7	42.4
2018	143.4	43.3
2019	142.8	43.8
2020 – 2024	619.3	213.5

In addition to the defined benefit plans, we maintain the Anthem 401(k) Plan and CareMore 401(k) Pension Plan which are qualified defined contribution plans covering substantially all employees. Voluntary employee contributions are matched by us subject to certain limitations. Contributions made by us totaled \$111.1, \$102.5 and \$91.0 during 2014, 2013 and 2012, respectively.

11. Medical Claims Payable

A reconciliation of the beginning and ending balances for medical claims payable for the years ended December 31 is as follows:

	Years Ended December 31		
	2014	2013	2012
Gross medical claims payable, beginning of year	\$ 6,127.2	\$ 6,174.5	\$ 5,489.0
Ceded medical claims payable, beginning of year	(23.4)	(27.2)	(16.4)
Net medical claims payable, beginning of year	6,103.8	6,147.3	5,472.6
Business combinations and purchase adjustments	—	—	804.4
Net incurred medical claims:			
Current year	56,305.8	55,894.3	48,080.1
Prior years redundancies	(541.9)	(599.1)	(513.6)
Total net incurred medical claims	55,763.9	55,295.2	47,566.5
Net payments attributable to:			
Current year medical claims	50,353.9	49,887.2	42,832.4
Prior years medical claims	5,420.0	5,451.5	4,863.8
Total net payments	55,773.9	55,338.7	47,696.2
Net medical claims payable, end of year	6,093.8	6,103.8	6,147.3
Ceded medical claims payable, end of year	767.4	23.4	27.2
Gross medical claims payable, end of year	\$ 6,861.2	\$ 6,127.2	\$ 6,174.5

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any period end are continually reviewed and re-estimated as information regarding actual claims payments, or runout, becomes known. This information is compared to the originally established year end liability. Negative amounts reported for incurred medical claims related to prior years result from claims being settled for amounts less than originally estimated. The prior year redundancy of \$541.9 shown above for the year ended December 31, 2014 represents an estimate based on paid claim activity from January 1, 2014 to December 31, 2014. Medical claim liabilities are usually described as having a "short tail," which means that they are generally paid within twelve months of the member receiving service from the provider. Accordingly, the majority of the \$541.9 redundancy relates to claims incurred in calendar year 2013.

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

The following table provides a summary of the two key assumptions having the most significant impact on our incurred but not paid liability estimates for the years ended December 31, 2014, 2013 and 2012, which are the completion and trend factors. These two key assumptions can be influenced by utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, claim submission patterns and operational changes resulting from business combinations.

	Favorable Developments by Changes in Key Assumptions		
	2014	2013	2012
Assumed trend factors	\$ (399.5)	\$ (428.4)	\$ (394.4)
Assumed completion factors	(142.4)	(170.7)	(119.2)
Total	<u>\$ (541.9)</u>	<u>\$ (599.1)</u>	<u>\$ (513.6)</u>

The favorable development recognized in 2014 and 2013 resulted primarily from trend factors in late 2013 and late 2012, respectively, developing more favorably than originally expected as well as a smaller but significant contribution from completion factor development. The favorable development recognized in 2012 was driven by trend factors in late 2011 developing more favorably than originally expected.

12. Debt

Short-term Borrowings

We are a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati and the Federal Home Loan Bank of Atlanta, collectively, the FHLBs, and as a member we have the ability to obtain short-term cash advances subject to certain minimum collateral requirements. At December 31, 2014 and 2013, \$400.0 was outstanding under our short-term FHLBs borrowings. These outstanding short-term FHLBs borrowings at December 31, 2014 and 2013 had fixed interest rates of 0.195% and 0.170%, respectively.

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

Long-term Debt

The carrying value of long-term debt at December 31 consists of the following:

	2014	2013
Senior unsecured notes:		
5.000%, due 2014	\$ —	\$ 518.0
1.250%, due 2015	625.0	624.9
5.250%, due 2016	—	1,109.6
2.375%, due 2017	400.1	399.6
5.875%, due 2017	527.7	545.1
1.875%, due 2018	619.0	614.5
2.300%, due 2018	648.0	647.5
2.250%, due 2019	848.2	—
7.000%, due 2019	440.0	452.9
4.350%, due 2020	698.6	688.9
3.700%, due 2021	699.4	699.4
3.125%, due 2022	846.7	846.3
3.300%, due 2023	997.2	996.9
3.500%, due 2024	796.1	—
5.950%, due 2034	447.3	447.3
5.850%, due 2036	772.0	775.6
6.375%, due 2037	644.1	651.4
5.800%, due 2040	208.3	216.2
4.625%, due 2042	893.9	893.9
4.650%, due 2043	994.4	994.4
4.650%, due 2044	798.3	—
5.100%, due 2044	599.2	599.1
4.850%, due 2054	249.4	—
Senior convertible debentures:		
2.750%, due 2042	974.4	966.0
Surplus notes:		
9.000%, due 2027	24.9	24.9
Variable rate debt:		
Commercial paper program	—	379.2
Total long-term debt	14,752.2	14,091.6
Current portion of long-term debt	(625.0)	(518.0)
Long-term debt, less current portion	\$ 14,127.2	\$ 13,573.6

All long-term debt shown above is a direct obligation of Anthem, Inc., except for the surplus notes.

On September 15, 2014, we redeemed the \$500.0 outstanding principal balance of our 5.000% senior unsecured notes due 2014, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling \$512.3. We recognized a loss on extinguishment of debt of \$2.3 for the redemption of these notes.

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

On September 11, 2014, we redeemed the \$1,097.9 outstanding principal balance of our 5.250% senior unsecured notes due 2016, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling \$1,178.2. We recognized a loss on extinguishment of debt of \$67.6 for the redemption of these notes.

Additionally, during the year ended December 31, 2014, we repurchased \$52.0 of outstanding principal amount of certain other senior unsecured notes, plus applicable premium for early redemption plus accrued and unpaid interest, for cash totaling \$61.0. We recognized a loss on extinguishment of debt of \$11.2 for the repurchase of these notes.

On August 12, 2014, we issued \$850.0 of 2.250% notes due 2019, \$800.0 of 3.500% notes due 2024, \$800.0 of 4.650% notes due 2044, and \$250.0 of 4.850% notes due 2054 under our shelf registration statement. We used the proceeds from this offering in part to fund the purchase price of the 5.000% and 5.250% senior unsecured notes discussed above, and the remaining net proceeds are being used for general corporate purposes. Interest on the notes is payable semi-annually in arrears on February 15 and August 15 of each year, commencing on February 15, 2015. The notes have a call feature that allows us to repurchase the notes at any time at our option and a put feature that allows a note holder to require us to repurchase the notes upon the occurrence of both a change in control event and a downgrade of the notes below an investment grade rating.

On September 5, 2013, we redeemed the \$400.0 outstanding principal balance of our 6.000% senior unsecured notes due 2014, plus applicable premium for early redemption and accrued and unpaid interest to the redemption date, for cash totaling \$411.0. We recognized a loss on extinguishment of debt of \$10.0 for the redemption of these notes.

On July 30, 2013, we initiated a cash tender offer and consent solicitation to purchase up to \$300.0 aggregate principal amount of our outstanding 5.875% notes due 2017 and 7.000% notes due 2019 (the "First Tranche Offer") and to purchase up to \$300.0 aggregate principal amount of our outstanding 5.950% notes due 2034, 5.850% notes due 2036, 6.375% notes due 2037 and 5.800% notes due 2040 (the "Second Tranche Offer"), collectively, the "Tender Offers". The Tender Offers were each subject to increase up to an additional \$100.0 at our election. On August 12, 2013, we increased the Second Tranche Offer to \$400.0 and on August 13, 2013 we repurchased \$300.0 of the First Tranche Offer notes and 400.0 of the Second Tranche Offer notes for cash totaling \$837.7. Holders who tendered their notes prior to the early tender date received the principal amounts, applicable premium for early redemption and accrued and unpaid interest to the early tender offer settlement date. We recognized a loss on extinguishment of debt of \$135.3 for the repurchase of these notes.

On July 30, 2013, we issued \$650.0 of 2.300% notes due 2018 and \$600.0 of 5.100% notes due 2044 under our shelf registration statement. We used the proceeds from this offering in part to fund the purchase price of the 6.000% senior unsecured notes and the Tender Offers, discussed above, and the balance for general corporate purposes. Interest on the notes is payable semi-annually in arrears on January 15 and July 15 of each year, commencing on January 15, 2014. The notes have a call feature that allows us to repurchase the notes at any time at our option and a put feature that allows a note holder to require us to repurchase the notes upon the occurrence of both a change in control event and a downgrade of the notes below an investment grade rating.

On January 25, 2013, we redeemed the outstanding principal balance of \$475.0 of 7.500% senior unsecured notes due 2019, plus applicable premium for early redemption, for cash totaling \$555.6. The weighted-average redemption price of the notes was approximately 117% of the principal amount outstanding.

Surplus notes are unsecured obligations of Anthem Insurance Companies, Inc., or Anthem Insurance, a wholly owned subsidiary, and are subordinate in right of payment to all of Anthem Insurance's existing and future indebtedness. Any payment of interest or principal on the surplus notes may be made only with the prior approval of the Indiana Department of Insurance, or IDOI, and only out of capital and surplus funds of Anthem Insurance that the IDOI determines to be available for the payment under Indiana insurance laws.

We have a senior credit facility, or the facility, with certain lenders for general corporate purposes. The facility, as amended, provides credit up to \$2,000.0 and matures on September 29, 2016. The interest rate on the facility is based on either, (i) the LIBOR rate plus a predetermined percentage rate based on our credit rating at the date of utilization, or (ii) a base rate as defined in the facility agreement plus a predetermined percentage rate based on our credit rating at the date of utilization. Our ability to borrow under the facility is subject to compliance with certain covenants. There were no amounts outstanding under the facility at December 31, 2014 or 2013.

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

We have an authorized commercial paper program of up to \$2,500.0, the proceeds of which may be used for general corporate purposes. We did not have any borrowings outstanding under our commercial paper program at December 31, 2014. At December 31, 2013, we had \$379.2 outstanding under our commercial paper program with a weighted-average interest rate of 0.420%. Commercial paper borrowings have been classified as long-term debt at December 31, 2013 as our general practice and intent is to replace short-term commercial paper outstanding at expiration with additional short-term commercial paper for an uninterrupted period extending for more than one year and we have the ability to redeem our commercial paper with borrowings under the senior credit facility described above. We resumed borrowing under our commercial paper program in the first quarter of 2015.

Convertible Debentures

On October 9, 2012, we issued \$1,500.0 of senior convertible debentures, or the Debentures. The Debentures are governed by an indenture, or the Indenture, dated as of October 9, 2012 between us and The Bank of New York Mellon Trust Company, N.A., as trustee. The Debentures bear interest at a rate of 2.750% per year, payable semi-annually in arrears in cash on April 15 and October 15 of each year, and mature on October 15, 2042, unless earlier redeemed, repurchased or converted into shares of common stock at the applicable conversion rate. The Debentures also have a contingent interest feature that will require us to pay additional interest based on certain thresholds and for certain events, as defined in the Indenture, beginning on October 15, 2022.

Holders may convert their Debentures at their option prior to the close of business on the business day immediately preceding April 15, 2042, only under the following circumstances: (1) during any fiscal quarter commencing after the fiscal quarter ended December 31, 2012, if the last reported sale price of our common stock for at least 20 trading days during a period of 30 consecutive trading days ending on the last trading day of the preceding fiscal quarter is greater than or equal to 130% of the applicable conversion price on each applicable trading day; (2) during the five business day period after any 10 consecutive trading day period, or the measurement period, in which the trading price per \$1,000 (whole dollars) principal amount of Debentures for each trading day of that measurement period was less than 98% of the product of the last reported sale price of our common stock and the applicable conversion rate on each such day; (3) if we call any or all of the Debentures for redemption, at any time prior to the close of business on the third scheduled trading day prior to the redemption date; or (4) upon the occurrence of specified corporate events, as defined in the Indenture. On and after April 15, 2042 and until the close of business on the third scheduled trading day immediately preceding the Debentures' maturity date of October 15, 2042, holders may convert their Debentures into common stock at any time irrespective of the preceding circumstances. The Debentures are redeemable at our option at any time on or after October 20, 2022, upon the occurrence of certain events, as defined in the Indenture.

Upon conversion of the Debentures, we will deliver cash up to the aggregate principal amount of the Debentures converted. With respect to any conversion obligation in excess of the aggregate principal amount of the Debentures converted, we have the option to settle the excess with cash, shares of our common stock or a combination of cash and shares of common stock based on a daily conversion value, determined in accordance with the Indenture. The initial conversion rate for the Debentures will be 13.2319 shares of our common stock per \$1,000 (whole dollars) of principal amount of Debentures, which represents a 25% conversion premium based on the closing price of \$60.46 per share of our common stock on October 2, 2012 (the date the Debentures' terms were finalized) and is equivalent to an initial conversion price of \$75.575 per share of our common stock. As of December 31, 2014, our common stock was last traded at a price of \$125.67 per share. If the Debentures had been converted or matured at December 31, 2014, we would be obligated to pay the principal of the Debentures plus an amount in cash or shares equal to \$1,019.3. The Debentures and underlying shares of our common stock have not been and will not be registered under the Securities Act of 1933, as amended, or the Securities Act, or any state securities laws and may not be offered or sold in the United States absent registration or an applicable exemption from registration requirements. The Debentures were offered and sold to qualified institutional buyers pursuant to Rule 144A under the Securities Act, the restrictions for which expired in October 2013. We used approximately \$371.0 of the net proceeds from the issuance to repurchase shares of our common stock concurrently with the offering of the Debentures, and the remaining balance was used for general corporate purposes, including but not limited to additional purchases of shares of our common stock pursuant to our share repurchase program and the repayment of short-term and/or long-term debt.

We have accounted for the Debentures in accordance with the cash conversion guidance in FASB guidance for debt with conversion and other options. As a result, the value of the embedded conversion option has been bifurcated from its debt host

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

and recorded as a component of "additional paid-in capital" (net of deferred taxes and equity issuance costs) in our consolidated balance sheet.

The following table summarizes at December 31, 2014 the related balances, conversion rate and conversion price of the Debentures:

Outstanding principal amount	\$	1,500.0
Unamortized debt discount	\$	525.6
Net debt carrying amount	\$	974.4
Equity component carrying amount	\$	543.6
Conversion rate (shares of common stock per \$1,000 of principal amount)		13.3645
Effective conversion price (per \$1,000 of principal amount)	\$	74.8244

The remaining amortization period of the unamortized debt discount as of December 31, 2014 is approximately 28 years. The unamortized discount will be amortized into interest expense using the effective interest method based on an effective interest rate of 5.130%, which represents the market interest rate for a comparable debt instrument that does not have a conversion feature. During the year ended December 31, 2014, we recognized \$49.6 of interest expense related to the Debentures, of which \$41.2 represented interest expense recognized at the stated interest rate of 2.750% and \$8.4 represented interest expense resulting from amortization of the debt discount.

Total interest paid during 2014, 2013 and 2012 was \$575.9, \$597.2, and \$479.1, respectively.

We were in compliance with all applicable covenants under all of our outstanding debt agreements at December 31, 2014.

Future maturities of all long-term debt outstanding at December 31, 2014 are as follows: 2015, \$625.0; 2016, \$0.0; 2017, \$927.8; 2018, \$1,267.0; 2019, \$1,288.2 and thereafter, \$10,644.2.

13. Commitments and Contingencies

Litigation

In the ordinary course of business, we are defendants in, or parties to, a number of pending or threatened legal actions or proceedings. To the extent a plaintiff or plaintiffs in the following cases have specified in their complaint or in other court filings the amount of damages being sought, we have noted those alleged damages in the descriptions below. With respect to the cases described below, we contest liability and/or the amount of damages in each matter and believe we have meritorious defenses.

We are defending a certified class action filed as a result of the 2001 demutualization of Anthem Insurance. The lawsuit names Anthem Insurance as well as Anthem, Inc. and is captioned *Ronald Gold, et al. v. Anthem, Inc. et al.* Anthem Insurance's 2001 Plan of Conversion, or the Plan, provided for the conversion of Anthem Insurance from a mutual insurance company into a stock insurance company pursuant to Indiana law. Under the Plan, Anthem Insurance distributed the fair value of the company at the time of conversion to its Eligible Statutory Members, or ESMs, in the form of cash or Anthem common stock in exchange for their membership interests in the mutual company. Plaintiffs in *Gold* allege that Anthem Insurance distributed value to the wrong ESMs. Cross motions for summary judgment were granted in part and denied in part on July 26, 2006 with regard to the issue of sovereign immunity asserted by co-defendant, the state of Connecticut, or the State. The trial court also denied our motion for summary judgment as to plaintiffs' claims on January 10, 2005. The State appealed the denial of its motion to the Connecticut Supreme Court. We filed a cross-appeal on the sovereign immunity issue. On May 11, 2010, the Supreme Court reversed the judgment of the trial court denying the State's motion to dismiss the plaintiff's claims under sovereign immunity and dismissed our cross-appeal. The case was remanded to the trial court for further proceedings. Plaintiffs' motion for class certification was granted on December 15, 2011. We and the plaintiffs filed renewed cross-motions for summary judgment on January 24, 2013. On August 19, 2013, the trial court denied plaintiffs' motion for summary judgment. The trial court deferred a final ruling on our motion for summary judgment. On March 6, 2014, the trial court denied our motion for summary judgment finding that an issue of material fact

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

existed. A trial on liability commenced on October 14, 2014 and concluded on October 16, 2014. The matter was taken under advisement by the trial court, which has requested post-trial briefing. We expect the trial court to issue its decision on liability sometime in 2015. We intend to vigorously defend the *Gold* lawsuit; however, its ultimate outcome cannot be presently determined.

We are currently a defendant in eleven putative class actions relating to out-of-network, or OON, reimbursement that were consolidated into a single multi-district lawsuit called *In re WellPoint, Inc. (n/k/a Anthem, Inc.) Out-of-Network "UCR" Rates Litigation* that is pending in the United States District Court for the Central District of California. The lawsuits were filed in 2009. The plaintiffs include current and former members on behalf of a putative class of members who received OON services for which the defendants paid less than billed charges, the American Medical Association, four state medical associations, OON physicians, OON non-physician providers, the American Podiatric Medical Association, California Chiropractic Association and the California Psychological Association on behalf of putative classes of OON physicians and all OON non-physician health care providers. The plaintiffs have filed several amended complaints alleging that the defendants violated the Racketeer Influenced and Corrupt Organizations Act, or RICO, the Sherman Antitrust Act, ERISA, federal regulations, and state law by using an OON reimbursement database called Ingenix and by using non-Ingenix OON reimbursement methodologies. We have filed motions to dismiss in response to each of those amended complaints. Our motions to dismiss have been granted in part and denied in part by the court. The most recent pleading filed by the plaintiffs is a Fourth Amended Complaint to which we filed a motion to dismiss most, but not all, of the claims. In July 2013 the court issued an order granting in part and denying in part our motion. The court held that the state and federal anti-trust claims along with the RICO claims should be dismissed in their entirety with prejudice. The court further found that the ERISA claims, to the extent they involved non-Ingenix methodologies, along with those that involved our alleged non-disclosures should be dismissed with prejudice. The court also dismissed most of the plaintiffs' state law claims with prejudice. The only claims that remain after the court's decision are an ERISA benefits claim relating to claims priced based on Ingenix, a breach of contract claim on behalf of one subscriber plaintiff, a breach of implied covenant claim on behalf of one subscriber plaintiff, and one subscriber plaintiff's claim under the California Unfair Competition Law. The plaintiffs filed a motion for reconsideration of the motion to dismiss order, which the court granted in part and denied in part. The court ruled that the plaintiffs adequately allege that one Georgia provider plaintiff is deemed to have exhausted administrative remedies regarding non-Ingenix methodologies based on the facts alleged regarding that plaintiff so those claims are back in the case. Fact discovery is complete. The plaintiffs filed a motion for class certification in November 2013 seeking the following classes: (1) a subscriber ERISA class as to OON claims processed using the Ingenix database as the pricing methodology; (2) a physician provider class as to OON claims processed using Ingenix; (3) a non-physician provider class as to OON claims processed using Ingenix; (4) a provider ERISA class as to OON claims processed using non-Ingenix pricing methodologies; (5) a California subscriber breach of contract/unfair competition class; and (6) a subscriber breach of implied covenant class for all Anthem states except California. Following expert discovery and briefing, oral argument was held on the motion. In late 2014, the court denied the plaintiffs' motion for class certification in its entirety. The California subscriber plaintiffs are seeking leave to file a renewed motion for class certification with more narrowly defined proposed classes. We will oppose their request. Earlier in the case, in 2009, we filed a motion in the United States District Court for the Southern District of Florida, or the Florida Court, to enjoin the claims brought by the physician plaintiffs and certain medical association plaintiffs based on prior litigation releases, which was granted in 2011. The Florida Court ordered those plaintiffs to dismiss their claims that are barred by the release. The plaintiffs then filed a petition for declaratory judgment asking the court to find that these claims are not barred by the releases from the prior litigation. We filed a motion to dismiss the declaratory judgment action, which was granted. The plaintiffs appealed the dismissal of the declaratory judgment to the United States Court of Appeals for the Eleventh Circuit, but the dismissal was upheld. The enjoined physicians and some the medical associations did not dismiss their barred claims. The Florida Court found those enjoined plaintiffs in contempt and sanctioned them in July 2012. Those plaintiffs appealed the Florida Court's sanctions order to the United States Court of Appeals for the Eleventh Circuit. The Eleventh Circuit upheld the Florida court's enforcement of the injunction as it relates to the plaintiffs' RICO and antitrust claims, but vacated it as it relates to certain ERISA claims. The plaintiffs filed a petition for rehearing en banc as to the antitrust claims only, which was denied. The plaintiffs then filed a petition for writ of certiorari with the U.S. Supreme Court. The American Medical Association filed an amicus brief in support of the petition. We filed a response in opposition to the petition and the plaintiffs filed a reply. The petition is now full briefed and we are awaiting a ruling from the U.S. Supreme Court. We intend to vigorously defend these suits; however, their ultimate outcome cannot be presently determined.

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

We are a defendant in multiple lawsuits that were initially filed in 2012 against the BCBSA as well as Blue Cross and/or Blue Shield licensees across the country. The cases were consolidated into a single multi-district lawsuit called *In re Blue Cross Blue Shield Antitrust Litigation* that is pending in the United States District Court for the Northern District of Alabama. Generally, the suits allege that the BCBSA and the Blue plans have engaged in a conspiracy to horizontally allocate geographic markets through license agreements and other arrangements in violation of the Sherman Antitrust Act and related state laws. The cases were brought by two putative nationwide classes of plaintiffs, health plan subscribers and providers. Subscriber and provider plaintiffs each filed consolidated amended complaints on July 1, 2013. The consolidated amended subscriber complaint was also brought on behalf of putative state classes of health plan subscribers in Alabama, Arkansas, California, Florida, Hawaii, Illinois, Louisiana, Michigan, Mississippi, Missouri, New Hampshire, North Carolina, Pennsylvania, Rhode Island, South Carolina, Tennessee, and Texas. Defendants filed motions to dismiss in September 2013, which were argued in April 2014. In June 2014, the court denied the majority of the motions, ruling that plaintiffs had alleged sufficient facts at this stage of the litigation to avoid dismissal of their claims. Following the subsequent filing of amended complaints by each of the subscriber and provider plaintiffs, we filed our answer and asserted our affirmative defenses in December 2014. Discovery has commenced. We intend to vigorously defend these suits; however, their ultimate outcome cannot be presently determined.

Where available information indicates that it is probable that a loss has been incurred as of the date of the consolidated financial statements and we can reasonably estimate the amount of that loss, we accrue the estimated loss by a charge to income. In many proceedings, however, it is difficult to determine whether any loss is probable or reasonably possible. In addition, even where loss is possible or an exposure to loss exists in excess of the liability already accrued with respect to a previously identified loss contingency, it is not always possible to reasonably estimate the amount of the possible loss or range of loss.

With respect to many of the proceedings to which we are a party, we cannot provide an estimate of the possible losses, or the range of possible losses in excess of the amount, if any, accrued, for various reasons, including but not limited to some or all of the following: (i) there are novel or unsettled legal issues presented, (ii) the proceedings are in early stages, (iii) there is uncertainty as to the likelihood of a class being certified or decertified or the ultimate size and scope of the class, (iv) there is uncertainty as to the outcome of pending appeals or motions, (v) there are significant factual issues to be resolved, and/or (vi) in many cases, the plaintiffs have not specified damages in their complaint or in court filings. For those legal proceedings where a loss is probable, or reasonably possible, and for which it is possible to reasonably estimate the amount of the possible loss or range of losses, we currently believe that the range of possible losses, in excess of established reserves, for all of those proceedings is from \$0 to approximately \$250.0 at December 31, 2014. This estimated aggregate range of reasonably possible losses is based upon currently available information taking into account our best estimate of such losses for which such an estimate can be made.

Data Breach

In February 2015, we reported that we were the target of a sophisticated external cyber attack. The attackers gained unauthorized access to certain of our information technology systems and obtained personal information related to many of our current and former members and employees, such as names, birthdays, health care identification/social security numbers, street addresses, email addresses and employment information, including income data. To date, there is no evidence that credit card or medical information, such as claims, test results or diagnostic codes, were targeted, accessed or obtained, although no assurance can be given that we will not identify additional information that was accessed or obtained.

Currently, we are in the process of determining the extent of this cyber attack and supporting federal law enforcement efforts to identify the responsible parties. Upon discovery of the cyber attack, we took immediate action to remediate the security vulnerability and retained a cybersecurity firm to evaluate our systems and identify solutions based on the evolving landscape. We will provide credit monitoring and identity protection services to those who have been affected by this cyber attack. While the cyber attack did not have an impact on our business, cash flows, financial condition and results of operations for the year ended December 31, 2014, we have incurred expenses subsequent to the cyber attack to investigate and remediate this matter and expect to continue to incur expenses of this nature in the foreseeable future. Although we are unable to quantify the ultimate magnitude of such expenses at this time, they may be significant. We will recognize these expenses in the periods in which they are incurred.

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Notes to Consolidated Financial Statements (continued)

Actions have been filed in courts in many states and other claims have been or may be asserted against us on behalf of current or former members, current or former employees, shareholders or others seeking damages or other related relief, allegedly arising out of the cyber attack. State and federal agencies, including state insurance regulators, state attorneys general, and the Federal Bureau of Investigations, are investigating events related to the cyber attack, including how it occurred, its consequences and our responses. Although we are cooperating in these investigations, we may be subject to fines or other obligations, which may have an adverse effect on how we operate our business and our results of operations.

We have contingency plans and insurance coverage for potential liabilities of this nature, however, the coverage may not be sufficient to cover all claims and liabilities. While a loss from these matters is reasonably possible, we cannot reasonably estimate a range of possible losses because our investigation into the matter is ongoing, the proceedings remain in the early stages, alleged damages have not been specified, there is uncertainty as to the likelihood of a class or classes being certified or the ultimate size of any class if certified, and there are significant factual and legal issues to be resolved.

Other Contingencies

From time to time, we and certain of our subsidiaries are parties to various legal proceedings, many of which involve claims for coverage encountered in the ordinary course of business. We, like HMOs and health insurers generally, exclude certain health care and other services from coverage under our HMO, PPO and other plans. We are, in the ordinary course of business, subject to the claims of our enrollees arising out of decisions to restrict or deny reimbursement for uncovered services. The loss of even one such claim, if it results in a significant punitive damage award, could have a material adverse effect on us. In addition, the risk of potential liability under punitive damage theories may increase significantly the difficulty of obtaining reasonable settlements of coverage claims.

In addition to the lawsuits described above, we are also involved in other pending and threatened litigation of the character incidental to our business, and are from time to time involved as a party in various governmental investigations, audits, reviews and administrative proceedings. These investigations, audits, reviews and administrative proceedings include routine and special inquiries by state insurance departments, state attorneys general, the U.S. Attorney General and subcommittees of the U.S. Congress. Such investigations, audits, reviews and administrative proceedings could result in the imposition of civil or criminal fines, penalties, other sanctions and additional rules, regulations or other restrictions on our business operations. Any liability that may result from any one of these actions, or in the aggregate, could have a material adverse effect on our consolidated financial position or results of operations.

The National Organization of Life & Health Insurance Guaranty Associations, or NOLHGA, is a voluntary organization consisting of the state life and health insurance guaranty associations located throughout the U.S. Such associations, working together with NOLHGA, provide a safety net for their state's policyholders, ensuring that they continue to receive coverage, subject to state maximum limits, even if their insurer is declared insolvent. We are aware that the Pennsylvania Insurance Commissioner, or Insurance Commissioner, has placed Penn Treaty Network America Insurance Company and its subsidiary American Network Insurance Company, or collectively Penn Treaty, in rehabilitation, an intermediate action before insolvency. The state court denied the Insurance Commissioner's petition for the liquidation of Penn Treaty and ordered the Insurance Commissioner to file an updated plan of rehabilitation. An initial plan was filed on April 30, 2013. The Insurance Commissioner filed an amended plan on August 8, 2014 and a second amended plan on October 8, 2014. The state court set a schedule for a notice and comment period and ordered a hearing on the second amended plan, with public comments due by February 13, 2015. The Insurance Commissioner has filed a Notice of Appeal asking the Pennsylvania Supreme Court to reverse the order denying the liquidation petition. The Supreme Court held oral argument on the appeal in September 2014. In the event rehabilitation of Penn Treaty is unsuccessful and Penn Treaty is declared insolvent and placed in liquidation, we and other insurers may be required to pay a portion of their policyholder claims through state guaranty association assessments in future periods. Given the uncertainty around whether Penn Treaty will ultimately be declared insolvent and, if so, the amount of the insolvency, the amount and timing of any associated future guaranty fund assessments, and the availability and amount of any potential premium tax and other offsets, we currently cannot estimate our net exposure, if any, to this potential insolvency. We will continue to monitor the situation and may record a liability and expense in future reporting periods, which could be material to our cash flows and results of operations.

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

Contractual Obligations and Commitments

We are a party to an agreement with Express Scripts, Inc., or Express Scripts, whereby Express Scripts is the exclusive provider of pharmacy benefit management, or PBM, services to our plans, excluding some Amerigroup subsidiaries and certain self-insured members, which have exclusive agreements with different PBM service providers. It is expected that those Amerigroup subsidiaries will complete their transition to the Express Scripts agreement during 2015. The initial term of this agreement expires on December 31, 2019. Under this agreement, Express Scripts is the exclusive provider of certain specified PBM services, such as pharmacy network management, home delivery, pharmacy customer service, claims processing, rebate management, drug utilization and specialty pharmaceutical management services. Accordingly, the agreement contains certain financial and operational requirements obligating both Express Scripts and us. Express Scripts' primary obligations relate to the performance of such services and meeting certain pricing guarantees and performance standards. Our primary obligations relate to oversight, provision of data, payment for services and certain minimum volume requirements. The failure by either party to meet the respective requirements could potentially serve as a basis for financial penalties or early termination of the contract. We believe we have appropriately recognized all rights and obligations under this contract at December 31, 2014.

During December 2014, we entered into a new agreement with International Business Machines Corporation to provide information technology infrastructure services. This new agreement supersedes certain prior agreements and also includes provisions for additional services. Our remaining commitment under this agreement at December 31, 2014 was \$475.3 through March 31, 2020. We have the ability to terminate this agreement upon the occurrence of certain events, subject to early termination fees.

On March 31, 2009, we entered into an agreement with Affiliated Computer Services, Inc. to provide certain print and mailroom services that were previously performed in-house. Our remaining commitment under this agreement at December 31, 2014 was \$78.6 through March 31, 2016. We have the ability to terminate this agreement upon the occurrence of certain events, subject to early termination fees.

Vulnerability from Concentrations

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash equivalents, investment securities, premium receivables and instruments held through hedging activities. All investment securities are managed by professional investment managers within policies authorized by our Board of Directors. Such policies limit the amounts that may be invested in any one issuer and prescribe certain investee company criteria. Concentrations of credit risk with respect to premium receivables are limited due to the large number of employer groups that constitute our customer base in the states in which we conduct business. As of December 31, 2014, there were no significant concentrations of financial instruments in a single investee, industry or geographic location.

14. Capital Stock

Stock Incentive Plans

Our Board of Directors has adopted the Anthem Incentive Compensation Plan, or Incentive Compensation Plan, which has been approved by our shareholders. The term of the Incentive Compensation Plan is such that no awards may be granted on or after May 20, 2019. The Incentive Compensation Plan gives authority to the Compensation Committee of the Board of Directors to make incentive awards to our non-employee directors, employees and consultants, consisting of stock options, stock, restricted stock, restricted stock units, cash-based awards, stock appreciation rights, performance shares and performance units. The Incentive Compensation Plan, as amended and restated, limits the number of available shares for issuance to 60.1 shares, subject to adjustment as set forth in the Incentive Compensation Plan.

Stock options are granted for a fixed number of shares with an exercise price at least equal to the fair value of the shares at the grant date. Stock options vest over three years in equal semi-annual installments and generally have a term of seven years from the grant date.

Certain option grants contain provisions whereby the employee continues to vest in the award subsequent to termination due to retirement. Our attribution method for newly granted awards considers all vesting and other provisions, including retirement eligibility, in determining the requisite service period over which the fair value of the awards will be recognized.

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

Restricted stock awards are issued at the fair value of the stock on the grant date and may also include one or more performance measures that must be met for the restricted stock award to vest. The restrictions lapse in three equal annual installments.

For the years ended December 31, 2014, 2013 and 2012, we recognized share-based compensation expense of \$168.9, \$146.0 and \$146.5, respectively, as well as related tax benefits of \$60.7, \$52.6 and \$52.0, respectively.

A summary of stock option activity for the year ended December 31, 2014 is as follows:

	Number of Shares	Weighted-Average Option Price per Share	Weighted-Average Remaining Contractual Life (Years)	Aggregate Intrinsic Value
Outstanding at January 1, 2014	10.0	\$ 65.38		
Granted	1.8	90.32		
Exercised	(4.2)	67.26		
Forfeited or expired	(0.3)	69.30		
Outstanding at December 31, 2014	7.3	70.30	3.54	\$ 402.0
Exercisable at December 31, 2014	4.8	65.94	2.46	\$ 286.8

The intrinsic value of options exercised during the years ended December 31, 2014, 2013 and 2012 amounted to \$156.7, \$176.0 and \$65.4, respectively. We recognized tax benefits of \$53.2, \$56.8 and \$22.9 in 2014, 2013 and 2012, respectively, from option exercises and disqualifying dispositions. During the years ended December 31, 2014, 2013 and 2012 we received cash of \$283.6, \$524.7 and \$110.8, respectively, from exercises of stock options.

The total fair value of restricted stock awards that vested during the years ended December 31, 2014, 2013 and 2012 was \$174.0, \$46.7 and \$222.3, respectively.

A summary of the status of nonvested restricted stock activity, including restricted stock units, for the year ended December 31, 2014 is as follows:

	Restricted Stock Shares and Units	Weighted-Average Grant Date Fair Value per Share
Nonvested at January 1, 2014	4.2	\$ 63.83
Granted	1.7	90.53
Vested	(1.9)	64.10
Forfeited	(0.4)	68.71
Nonvested at December 31, 2014	3.6	75.63

During the year ended December 31, 2014, we granted approximately 0.7 restricted stock units under the Incentive Compensation Plan that were contingent upon us achieving specified operating gain targets for 2014. We expect to issue approximately 1.0 restricted stock units under this performance plan as certain performance targets were exceeded. These restricted stock units have been included in the activity shown above.

As of December 31, 2014, the total remaining unrecognized compensation expense related to nonvested stock options and restricted stock amounted to \$14.0 and \$76.9, respectively, which will be amortized over the weighted-average remaining requisite service periods of 11 months and 10 months, respectively.

As of December 31, 2014, there were approximately 21.2 shares of common stock available for future grants under the Incentive Compensation Plan.

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

Fair Value

We use a binomial lattice valuation model to estimate the fair value of all stock options granted. Expected volatility assumptions used in the binomial lattice model are based on an analysis of implied volatilities of publicly traded options on our stock and historical volatility of our stock price. The risk-free interest rate is derived from the U.S. Treasury strip rates at the time of the grant. The expected term of the options was derived from the outputs of the binomial lattice model, which incorporates post-vesting forfeiture assumptions based on an analysis of historical data. The dividend yield was based on our estimate of future dividend yields. Similar groups of employees that have dissimilar exercise behavior are considered separately for valuation purposes. We utilize the "multiple-grant" approach for recognizing compensation expense associated with each separately vesting portion of the share-based award.

The following weighted-average assumptions were used to estimate the fair values of options granted during the years ended December 31:

	2014	2013	2012
Risk-free interest rate	2.16%	1.25%	1.41%
Volatility factor	35.00%	35.00%	34.00%
Dividend yield (annual)	2.00%	2.40%	1.60%
Weighted-average expected life (years)	3.75	4.00	4.10

The following weighted-average fair values were determined for the years ending December 31:

	2014	2013	2012
Options granted during the year	\$ 22.41	\$ 14.64	\$ 16.50
Restricted stock and stock awards granted during the year	90.53	63.06	65.91

The binomial lattice option-pricing model requires the input of highly subjective assumptions including the expected stock price volatility. Because our stock option grants have characteristics significantly different from those of traded options, and because changes in the subjective input assumptions can materially affect the fair value estimate, in our opinion, existing models do not necessarily provide a reliable single measure of the fair value of our stock option grants.

Employee Stock Purchase Plan

We have registered 14.0 shares of common stock for the Employee Stock Purchase Plan, or the Stock Purchase Plan, which is intended to provide a means to encourage and assist employees in acquiring a stock ownership interest in Anthem. The Stock Purchase Plan was suspended during 2012 and 2013 and no shares were issued during those years. Effective January 1, 2014, the Stock Purchase Plan was reinstated. Pursuant to terms of the Stock Purchase Plan, an employee is permitted to purchase no more than \$25,000 (actual dollars) worth of stock in any calendar year, based on the fair value of the stock at the end of each plan quarter. Employees become participants by electing payroll deductions from 1% to 15% of gross compensation. Once purchased, the stock is accumulated in the employee's investment account. The Stock Purchase Plan allows participants to purchase shares of our common stock at a price per share of 95% of the fair value of a share of common stock on the last trading day of the plan quarter. The employee stock purchase plan discount is not recognized as compensation expense based on GAAP guidance. There were 0.2 shares issued during the year ended December 31, 2014. As of December 31, 2014, 5.9 shares were available for issuance under the Stock Purchase Plan.

Use of Capital and Stock Repurchase Program

We regularly review the appropriate use of capital, including common stock and debt security repurchases and dividends to shareholders. The declaration and payment of any dividends or repurchases of our common stock or debt are at the discretion of our Board of Directors and depend upon our financial condition, results of operations, future liquidity needs, regulatory and capital requirements and other factors deemed relevant by our Board of Directors. Historically our common stock repurchase program, discussed below, has been our primary use of capital. Beginning in 2011, our Board of Directors established a quarterly dividend to shareholders.

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

A summary of the cash dividend activity for the years ended December 31, 2014 and 2013 is as follows:

Declaration Date	Record Date	Payment Date	Cash Dividend per Share	Total
Year ended December 31, 2014				
January 28, 2014	March 10, 2014	March 25, 2014	\$ 0.4375	\$ 123.4
April 29, 2014	June 10, 2014	June 25, 2014	0.4375	120.5
July 29, 2014	September 10, 2014	September 25, 2014	0.4375	119.2
October 28, 2014	December 5, 2014	December 22, 2014	0.4375	117.6
Year ended December 31, 2013				
February 20, 2013	March 8, 2013	March 25, 2013	\$ 0.3750	\$ 113.4
May 15, 2013	June 10, 2013	June 25, 2013	0.3750	112.7
July 23, 2013	September 10, 2013	September 25, 2013	0.3750	111.4
October 22, 2013	December 9, 2013	December 23, 2013	0.3750	110.5

On January 27, 2015, the Board of Directors declared a quarterly cash dividend to shareholders of \$0.6250 per share on the outstanding shares of our common stock. This quarterly dividend will be paid on March 25, 2015 to the shareholders of record as of March 10, 2015.

Under our Board of Directors' authorization, we maintain a common stock repurchase program. On October 2, 2014, the Board of Directors authorized a \$5,000.0 increase to the common stock repurchase program. Repurchases may be made from time to time at prevailing market prices, subject to certain restrictions on volume, pricing and timing. The repurchases are effected from time to time in the open market, through negotiated transactions, including accelerated share repurchase agreements, and through plans designed to comply with Rule 10b5-1 under the Securities Exchange Act of 1934, as amended. Our stock repurchase program is discretionary as we are under no obligation to repurchase shares. We repurchase shares under the program when we believe it is a prudent use of capital. The excess cost of the repurchased shares over par value is charged on a pro rata basis to additional paid-in capital and retained earnings.

A summary of common stock repurchases for the period January 1, 2015 through February 5, 2015 (subsequent to December 31, 2014) and for the years ended December 31, 2014 and 2013 is as follows:

	January 1, 2015 through February 5, 2015	Years Ended December 31	
		2014	2013
Shares repurchased	1.8	30.4	20.7
Average price per share	\$ 131.16	\$ 98.52	\$ 78.08
Aggregate cost	\$ 229.9	\$ 2,998.8	\$ 1,620.1
Authorization remaining at the end of each period	\$ 5,461.8	\$ 5,691.7	\$ 3,691.0

During 2013, we purchased call options on 3.0 shares of our common stock. The call options allow us to repurchase shares at a predetermined strike price up through the expiration dates. The purpose of the call options is to reduce share price volatility on potential future common stock repurchases. The aggregate premium paid was \$25.8, of which \$7.9 was recorded as a reduction of shareholders' equity and the remaining \$17.9 was recorded as a derivative asset based on FASB guidance. The aggregate premium is reported in financing activities in our consolidated statements of cash flow. The call options had strike prices ranging from \$77.50 to \$83.10 per share. The aggregate fair value of the call options reported as a derivative asset was \$27.5 at December 31, 2013. The call options were exercised on various dates throughout January and February 2014.

Under the common stock repurchase program authorized by our Board of Directors, on February 4, 2014, we entered into an accelerated share repurchase agreement with a counterparty. The agreement provided for the repurchase of a number

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

of our shares, equal to \$600.0, as determined by the dollar volume weighted-average share price during the term of the agreement. In March 2014, we repurchased 6.6 shares under the agreement.

For additional information regarding the use of capital for debt security repurchases, see Note 12, "Debt."

15. Accumulated Other Comprehensive Income

A reconciliation of the components of accumulated other comprehensive income at December 31 is as follows:

	2014	2013
Investments:		
Gross unrealized gains	\$ 1,154.9	\$ 1,054.2
Gross unrealized losses	(196.8)	(277.8)
Net pretax unrealized gains	958.1	776.4
Deferred tax liability	(330.5)	(267.4)
Net unrealized gains on investments	627.6	509.0
Non-credit components of OTTI on investments:		
Gross unrealized losses	(6.8)	(0.8)
Deferred tax asset	2.4	0.3
Net unrealized non-credit component of OTTI on investments	(4.4)	(0.5)
Cash flow hedges:		
Gross unrealized losses	(55.2)	(49.7)
Deferred tax asset	19.3	17.4
Net unrealized losses on cash flow hedges	(35.9)	(32.3)
Defined benefit pension plans:		
Deferred net actuarial loss	(563.7)	(427.2)
Deferred prior service credits	2.2	3.0
Deferred tax asset	223.2	169.9
Net unrecognized periodic benefit costs for defined benefit pension plans	(338.3)	(254.3)
Postretirement benefit plans:		
Deferred net actuarial loss	(211.2)	(169.6)
Deferred prior service credits	88.0	102.4
Deferred tax asset	48.9	27.0
Net unrecognized periodic benefit costs for postretirement benefit plans	(74.3)	(40.2)
Foreign currency translation adjustments:		
Gross unrealized (losses) gains	(4.3)	2.2
Deferred tax asset (liability)	1.5	(0.7)
Net unrealized (losses) gains on foreign currency translation adjustments	(2.8)	1.5
Accumulated other comprehensive income	\$ 171.9	\$ 183.2

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

Other comprehensive income (loss) reclassification adjustments for the years ended December 31 are as follows:

	2014	2013	2012
Investments:			
Net holding gain (loss) on investment securities arising during the period, net of tax (expense) benefit of (\$18.3), \$223.6 and \$5.4, respectively	\$ 35.4	\$ (407.2)	\$ (3.2)
Reclassification adjustment for net realized gain on investment securities, net of tax expense of (\$44.8), (\$60.6) and (\$104.0), respectively	83.2	112.5	193.1
Total reclassification adjustment on investments	118.6	(294.7)	189.9
Non-credit component of OTTI on investments:			
Non-credit component of OTTI on investments, net of tax benefit (expense) of \$2.1, (\$0.9) and (\$2.4), respectively	(3.9)	1.7	4.5
Cash flow hedges:			
Holding (loss) gain, net of tax benefit (expense) of \$1.9, (\$1.6) and (\$0.1), respectively	(3.6)	3.0	0.1
Other:			
Net change in unrecognized periodic benefit costs for defined benefit pension and postretirement benefit plans, net of tax benefit (expense) of \$75.2, (\$106.8) and (\$7.1), respectively	(118.1)	172.7	(10.9)
Foreign currency translation adjustment, net of tax benefit (expense) of \$2.2, (\$0.6) and (\$0.3), respectively	(4.3)	1.4	0.6
Net (loss) gain recognized in other comprehensive (loss) income, net of tax benefit (expense) of \$18.3, \$53.1 and (\$108.5), respectively	<u>\$ (11.3)</u>	<u>\$ (115.9)</u>	<u>\$ 184.2</u>

16. Reinsurance

We reinsure certain risks with other companies and assume risk from other companies. We remain primarily liable to policyholders under ceded insurance contracts and are contingently liable for amounts recoverable from reinsurers in the event that such reinsurers do not meet their contractual obligations. We evaluate the financial condition of our reinsurers and monitor concentrations of credit risk arising from similar geographic regions, activities, or economic characteristics of the reinsurers to minimize our exposure to significant losses from reinsurer insolvencies. In conjunction with the Health Care Reform temporary reinsurance premium stabilization program, we recognize assessments upon our fully-insured non-grandfathered individual market plans that are eligible for reinsurance recoveries as ceded premiums and estimated reinsurance recoveries as a reduction to benefit expense. Assessments upon all other lines of business not eligible for reinsurance recoveries are recognized in general and administrative expense.

A summary of direct, assumed and ceded premiums written and earned for the years ended December 31 is as follows:

	2014		2013		2012	
	Written	Earned	Written	Earned	Written	Earned
Direct	\$ 68,628.6	\$ 68,304.3	\$ 65,939.1	\$ 66,038.9	\$ 56,443.6	\$ 56,373.6
Assumed	192.3	194.0	174.3	174.0	197.0	196.4
Ceded	(108.5)	(108.5)	(92.6)	(93.8)	(73.2)	(73.3)
Net premiums	<u>\$ 68,712.4</u>	<u>\$ 68,389.8</u>	<u>\$ 66,020.8</u>	<u>\$ 66,119.1</u>	<u>\$ 56,567.4</u>	<u>\$ 56,496.7</u>
Percentage—assumed to net premiums	<u>0.3%</u>	<u>0.3%</u>	<u>0.3%</u>	<u>0.3%</u>	<u>0.3%</u>	<u>0.3%</u>

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Notes to Consolidated Financial Statements (continued)

A summary of net premiums written and earned by segment (see Note 19, "Segment Information") for the years ended December 31 is as follows:

	2014		2013		2012	
	Written	Earned	Written	Earned	Written	Earned
Reportable segments:						
Commercial and Specialty Business	\$ 35,084.7	\$ 35,045.2	\$ 35,733.9	\$ 35,772.0	\$ 35,358.1	\$ 36,036.7
Government Business	33,627.7	33,344.6	30,286.9	30,347.1	21,209.3	20,460.0
Other	—	—	—	—	—	—
Net premiums	<u>\$ 68,712.4</u>	<u>\$ 68,389.8</u>	<u>\$ 66,020.8</u>	<u>\$ 66,119.1</u>	<u>\$ 56,567.4</u>	<u>\$ 56,496.7</u>

The effect of reinsurance on benefit expense for the years ended December 31 is as follows:

	2014	2013	2012
Direct	\$ 57,496.6	\$ 56,185.2	\$ 48,135.1
Assumed	182.4	155.6	173.0
Ceded	(824.1)	(103.7)	(94.5)
Net benefit expense	<u>\$ 56,854.9</u>	<u>\$ 56,237.1</u>	<u>\$ 48,213.6</u>

The effect of reinsurance on certain assets and liabilities at December 31 is as follows:

	2014	2013
Policy liabilities, assumed	\$ 57.4	\$ 55.4
Unearned income, assumed	0.4	0.4
Premiums payable, ceded	7.7	17.1
Premiums receivable, assumed	5.4	14.1

17. Leases

We lease office space and certain computer and related equipment using noncancelable operating leases. At December 31, 2014, future lease payments for operating leases with initial or remaining noncancelable terms of one year or more consist of the following:

2015	\$ 148.7
2016	132.1
2017	125.0
2018	115.8
2019	99.6
Thereafter	274.9
Total minimum payments required	<u>\$ 896.1</u>

We have certain lease agreements that contain contingent payment provisions. Under these provisions, we pay contingent amounts in addition to base rent, primarily based upon annual changes in the consumer price index. The schedule above contains estimated amounts for potential future increases in lease payments based on the contingent payment provisions.

Lease expense for 2014, 2013 and 2012 was \$192.5, \$185.9 and \$153.3, respectively.

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

18. Earnings per Share

The denominator for basic and diluted earnings per share at December 31 is as follows:

	2014	2013	2012
Denominator for basic earnings per share—weighted-average shares	275.9	298.5	321.5
Effect of dilutive securities—employee stock options, non-vested restricted stock awards and convertible debentures	10.0	5.3	3.3
Denominator for diluted earnings per share	285.9	303.8	324.8

During the years ended December 31, 2014, 2013 and 2012, weighted-average shares related to certain stock options of 0.5, 4.2 and 12.6, respectively, were excluded from the denominator for diluted earnings per share because the stock options were anti-dilutive.

19. Segment Information

On May 20, 2013, we announced certain organizational and executive leadership changes to align with how our Chief Executive Officer is managing our operations. Beginning with the three months ended June 30, 2013, our organizational structure is comprised of three reportable segments: Commercial and Specialty Business; Government Business; and Other.

Our Commercial and Specialty Business segment includes our Local Group, National Accounts, Individual and Specialty businesses. Business units in the Commercial and Specialty Business segment offer fully-insured health products; provide a broad array of managed care services to self-funded customers including claims processing, underwriting, stop loss insurance, actuarial services, provider network access, medical cost management, disease management, wellness programs and other administrative services; and provide an array of specialty and other insurance products and services such as dental, vision, life and disability insurance benefits, radiology benefit management and analytics-driven personal health care guidance.

Our Government Business segment includes Medicare and Medicaid businesses, National Government Services, or NGS, and services provided to the federal government in connection with FEP. Medicare business includes services such as Medicare Advantage, Medicare Part D, and Medicare Supplement. Medicaid business includes our managed care alternatives through publicly funded health care programs, including Medicaid, Temporary Assistance for Needy Family programs, programs for seniors and people with disabilities, programs for long-term services and support, Children's Health Insurance Programs and ACA-related Medicaid expansion programs. NGS acts as a Medicare contractor in several regions across the nation.

Our Other segment includes other businesses that do not meet the quantitative thresholds for an operating segment as defined by FASB guidance, as well as corporate expenses not allocated to the other reportable segments.

We define operating revenues, a non-GAAP measure, to include premium income, administrative fees and other revenues. Operating revenues are derived from premiums and fees received primarily from the sale and administration of health benefit products. Operating gain, a non-GAAP measure, is calculated as total operating revenue less benefit expense and selling, general and administrative expense.

Through our participation in various federal government programs, we generated approximately 21.0%, 20.3% and 23.7% of our total consolidated revenues from agencies of the U.S. government for the years ended December 31, 2014, 2013, and 2012, respectively. These revenues are contained in the Government Business segment.

The accounting policies of the segments are consistent with those described in the summary of significant accounting policies in Note 2, "Basis of Presentation and Significant Accounting Policies," except that certain shared administrative expenses for each segment are recognized on a pro rata allocated basis, which in aggregate approximates the consolidated expense. Any difference between the allocated expenses and actual consolidated expense is included in other expenses not allocated to reportable segments. Intersegment sales and expenses are recorded at cost and eliminated in the consolidated financial statements. We evaluate performance of the reportable segments based on operating gain or loss as defined above. We evaluate investment income, net realized gains on investments, OTTI losses recognized in income, interest expense, amortization expense, loss on extinguishment of debt and income taxes, and asset and liability details on a consolidated basis.

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

as these items are managed in a corporate shared service environment and are not the responsibility of segment operating management.

Financial data by reportable segment for the years ended December 31 is as follows:

	Commercial and Specialty Business	Government Business	Other	Total
Year ended December 31, 2014				
Operating revenue	\$ 39,199.6	\$ 33,796.4	\$ 25.7	\$ 73,021.7
Operating gain (loss)	3,260.9	1,191.9	(34.4)	4,418.4
Depreciation and amortization of property and equipment	—	—	474.3	474.3
Year ended December 31, 2013				
Operating revenue	\$ 39,404.2	\$ 30,752.6	\$ 34.6	\$ 70,191.4
Operating gain (loss)	3,176.4	844.0	(19.0)	4,001.4
Depreciation and amortization of property and equipment	—	—	457.1	457.1
Year ended December 31, 2012				
Operating revenue	\$ 39,639.9	\$ 20,838.9	\$ 35.2	\$ 60,514.0
Operating gain (loss)	3,396.3	285.4	(61.8)	3,619.9
Depreciation and amortization of property and equipment	—	—	363.5	363.5

The major product revenues for each of the reportable segments for the years ended December 31 are as follows:

	2014	2013	2012
Commercial and Specialty Business			
Managed care products	\$ 33,755.6	\$ 34,516.9	\$ 34,875.4
Managed care services	3,997.8	3,474.0	3,446.9
Dental/Vision products and services	1,037.3	952.5	903.9
Other	408.9	460.8	413.7
Total Commercial and Specialty Business	39,199.6	39,404.2	39,639.9
Government Business			
Managed care products	33,344.6	30,347.1	20,460.0
Managed care services	451.8	405.5	378.9
Total Government Business	33,796.4	30,752.6	20,838.9
Other			
Other	25.7	34.6	35.2
Total product revenues	\$ 73,021.7	\$ 70,191.4	\$ 60,514.0

The classification between managed care products and managed care services in the above table primarily distinguishes between the level of risk assumed. Managed care products represent insurance products where we bear the insurance risk, whereas managed care services represent product offerings where we provide claims adjudication and other administrative services to the customer, but the customer principally bears the insurance risk.

Asset and equity details by reportable segment have not been disclosed, as we do not internally report such information.

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

A reconciliation of reportable segment operating revenues to the amounts of total revenues included in the consolidated statements of income for the years ended December 31 is as follows:

	2014	2013	2012
Reportable segments operating revenues	\$ 73,021.7	\$ 70,191.4	\$ 60,514.0
Net investment income	724.4	659.1	686.1
Net realized gains on investments	177.0	271.9	334.9
Other-than-temporary impairment losses recognized in income	(49.0)	(98.9)	(37.8)
Total revenues	<u>\$ 73,874.1</u>	<u>\$ 71,023.5</u>	<u>\$ 61,497.2</u>

A reconciliation of reportable segment operating gain to income from continuing operations before income taxes included in the consolidated statements of income for the years ended December 31 is as follows:

	2014	2013	2012
Reportable segments operating gain	\$ 4,418.4	\$ 4,001.4	\$ 3,619.9
Net investment income	724.4	659.1	686.1
Net realized gains on investments	177.0	271.9	334.9
Other-than-temporary impairment losses recognized in income	(49.0)	(98.9)	(37.8)
Interest expense	(600.7)	(602.7)	(511.8)
Amortization of other intangible assets	(220.9)	(245.3)	(233.0)
Loss on extinguishment of debt	(81.1)	(145.3)	—
Income from continuing operations before income tax expense	<u>\$ 4,368.1</u>	<u>\$ 3,840.2</u>	<u>\$ 3,858.3</u>

20. Related Party Transactions

Anthem Foundation, Inc., or the Foundation, is an Indiana non-profit organization exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code. The Foundation was formed to conduct, support and assist charitable, health-related, educational, and other community-based programs and projects. The officers and directors of the Foundation are also our officers. These officers and directors receive no compensation from the Foundation for the management services performed for the Foundation but may be reimbursed by the Foundation for any cash expenditures incurred on behalf of the Foundation. During the years ended December 31, 2014, 2013 and 2012, we received \$0.8, \$0.7 and \$0.6, respectively, from the Foundation for administrative services provided by our associates. We contributed \$10.0 to the Foundation during the year ended December 31, 2013. We did not make any contributions to the Foundation during the years ended December 31, 2014 and 2012. The Foundation is not a subsidiary of ours and the financial results of the Foundation are not consolidated with our financial statements. We have no current legal obligations for future commitments to the Foundation.

21. Statutory Information

The majority of our insurance and HMO subsidiaries report their accounts in conformity with accounting practices prescribed or permitted by state insurance regulatory authorities, or statutory, which vary in certain respects from GAAP. However, certain of our insurance and HMO subsidiaries, including BCC, Blue Cross of California Partnership Plan, Inc., Golden West Health Plan, Inc. and CareMore Health Plan are regulated by the California Department of Managed Health Care, or DMHC, and report their accounts in conformity with GAAP (these entities are collectively referred to as the "DMHC regulated entities"). Typical differences of GAAP reporting as compared to statutory reporting are the inclusion of unrealized gains or losses relating to fixed maturity securities in shareholders' equity, recognition of all assets including those that are non-admitted for statutory purposes and recognition of all deferred tax assets without regard to statutory limits. The National Association of Insurance Commissioners, or NAIC, developed a codified version of the statutory accounting principles, designed to foster more consistency among the states for accounting guidelines and reporting. Prescribed statutory accounting practices are set forth in a variety of publications of the NAIC as well as state laws, regulations and general administrative rules.

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

Our ability to pay dividends and credit obligations is significantly dependent on receipt of dividends from our subsidiaries. The payment of dividends to us by our insurance and HMO subsidiaries without prior approval of the insurance departments of each subsidiary's domiciliary jurisdiction is limited by formula. Dividends in excess of these amounts are subject to prior approval by the respective state insurance departments or the DMHC.

Our statutory basis insurance and HMO subsidiaries are subject to risk-based capital requirements. Risk-based capital is a method developed by the NAIC to determine the minimum amount of statutory capital appropriate for an insurance company or HMO to support its overall business operations in consideration of its size and risk profile. The formula for determining the amount of risk-based capital specifies various factors, weighted based on the perceived degree of risk, which are applied to certain financial balances and financial activity. Below minimum risk-based capital requirements are classified within certain levels, each of which requires specified corrective action. Additionally, the DMHC regulated entities are subject to capital and solvency requirements as prescribed by the DMHC. As of December 31, 2014 and 2013, all of our regulated subsidiaries exceeded the minimum risk-based capital requirements and/or capital and solvency requirements of their applicable governmental regulator. The statutory risk-based capital necessary to satisfy regulatory requirements of our statutory basis insurance and HMO subsidiaries was approximately \$3,400.0 as of December 31, 2014 and 2013. The tangible net equity required for the DMHC regulated entities was approximately \$520.0 and \$450.0 as of December 31, 2014 and 2013, respectively.

Statutory-basis capital and surplus of our insurance and HMO subsidiaries and capital and surplus of our other regulated subsidiaries, excluding the DMHC regulated entities, was \$9,727.2 and \$9,992.7 at December 31, 2014 and 2013, respectively. Statutory-basis net income of our insurance and HMO subsidiaries and net income of our other regulated subsidiaries, excluding the DMHC regulated entities, was \$2,403.8, \$2,635.8 and \$2,800.0 for 2014, 2013 and 2012, respectively. GAAP equity of the DMHC regulated entities was \$1,696.1 and \$1,449.2 at December 31, 2014 and 2013, respectively. GAAP net income of the DMHC regulated entities was \$453.6, \$487.7 and \$469.7 for the years ended December 31, 2014, 2013 and 2012, respectively.

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

22. Selected Quarterly Financial Data (Unaudited)

Selected quarterly financial data is as follows:

	For the Quarter Ended			
	March 31	June 30	September 30	December 31
2014				
Total revenues	\$ 17,859.4	\$ 18,473.4	\$ 18,557.0	\$ 18,984.3
Income from continuing operations before income taxes	1,130.1	1,263.7	1,087.2	887.1
Income from continuing operations	691.4	731.1	630.9	506.7
Income from discontinued operations	9.6	—	—	—
Net income	701.0	731.1	630.9	506.7
Basic net income per share - continuing operations	\$ 2.43	\$ 2.64	\$ 2.31	\$ 1.88
Basic net income per share - discontinued operations	0.03	—	—	—
Basic net income per share	2.46	2.64	2.31	1.88
Diluted net income per share - continuing operations	\$ 2.37	\$ 2.56	\$ 2.22	\$ 1.80
Diluted net income per share - discontinued operations	0.03	—	—	—
Diluted net income per share	2.40	2.56	2.22	1.80
2013				
Total revenues	\$ 17,576.0	\$ 17,690.3	\$ 17,855.5	\$ 17,901.7
Income from continuing operations before income taxes	1,282.5	1,208.1	879.7	469.9
Income from continuing operations	872.3	799.3	653.8	308.9
Income (loss) from discontinued operations	12.9	0.8	2.4	(160.7)
Net income	885.2	800.1	656.2	148.2
Basic net income per share - continuing operations	\$ 2.88	\$ 2.67	\$ 2.20	\$ 1.05
Basic net income (loss) per share - discontinued operations	0.04	—	0.01	(0.55)
Basic net income per share	2.92	2.67	2.21	0.50
Diluted net income per share - continuing operations	\$ 2.85	\$ 2.64	\$ 2.15	\$ 1.02
Diluted net income (loss) per share - discontinued operations	0.04	—	0.01	(0.53)
Diluted net income per share	2.89	2.64	2.16	0.49

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE.

There have been no changes in or disagreements with our independent registered public accounting firm on accounting or financial disclosures.

ITEM 9A. CONTROLS AND PROCEDURES.

Evaluation of Disclosure Controls and Procedures

We carried out an evaluation as of December 31, 2014, under the supervision and with the participation of our management, including our Chief Executive Officer and Chief Financial Officer, of the effectiveness of the design and operation of our disclosure controls and procedures as defined in Rule 13a-15(e) of the Securities Exchange Act of 1934, as amended, or the Exchange Act. Based upon that evaluation, the Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures are effective in timely alerting them to material information relating to

us (including our consolidated subsidiaries) required to be disclosed in our reports under the Exchange Act. In addition, based on that evaluation, the Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective in ensuring that information required to be disclosed by us in the reports that we file or submit under the Exchange Act is accumulated and communicated to our management, including the Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosures.

Management's Report on Internal Control Over Financial Reporting

Management, under the supervision and with the participation of the principal executive officer and principal financial officer, of Anthem, Inc., or the Company, is responsible for establishing and maintaining effective internal control over financial reporting, or Internal Control, as such term is defined in the Exchange Act. The Company's Internal Control is designed to provide reasonable assurance regarding the reliability of the Company's financial reporting and the preparation of financial statements for external reporting purposes in accordance with U.S. generally accepted accounting principles, or GAAP. The Company's Internal Control includes those policies and procedures that (i) pertain to the maintenance of records that in reasonable detail accurately and fairly reflect the transactions and dispositions of the assets of the Company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the financial statements.

Because of inherent limitations in any Internal Control, no matter how well designed, misstatements due to error or fraud may occur and not be detected. Accordingly, even effective Internal Control can provide only reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with GAAP.

Management, under the supervision and with the participation of the principal executive officer and principal financial officer, assessed the effectiveness of the Company's Internal Control as of December 31, 2014. Management's assessment was based on criteria established in Internal Control—Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission.

Based on management's assessment, management has concluded that the Company's Internal Control was effective as of December 31, 2014 to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external reporting purposes in accordance with GAAP.

Ernst & Young LLP, the Company's independent registered public accounting firm, has audited the consolidated financial statements of the Company for the year ended December 31, 2014, and has also issued an audit report dated February 24, 2015, on the effectiveness of the Company's internal control over financial reporting as of December 31, 2014, which is included in this Annual Report on Form 10-K.

/s/ JOSEPH R. SWEDISH
President and Chief Executive Officer

/s/ WAYNE S. DEVEYDT
Executive Vice President and Chief Financial Officer

Changes in Internal Control over Financial Reporting

There have been no changes in our internal control over financial reporting that occurred during the three months ended December 31, 2014 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Shareholders of Anthem, Inc.

We have audited Anthem, Inc.'s internal control over financial reporting as of December 31, 2014, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). Anthem, Inc.'s management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, Anthem, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2014, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Anthem, Inc. as of December 31, 2014 and 2013, and the related consolidated statements of income, comprehensive income, shareholders' equity, and cash flows for each of the three years in the period ended December 31, 2014 of Anthem, Inc. and our report dated February 24, 2015 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Indianapolis, Indiana
February 24, 2015

ITEM 9B. OTHER INFORMATION.

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE.

The information required by this Item concerning our Executive Officers, Directors and nominees for Director, Audit Committee members and financial expert(s) and concerning disclosure of delinquent filers under Section 16(a) of the Exchange Act and our Standards of Business Conduct is incorporated herein by reference from our definitive Proxy Statement for our 2015 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 11. EXECUTIVE COMPENSATION.

The information required by this Item concerning remuneration of our Executive Officers and Directors, material transactions involving such Executive Officers and Directors and Compensation Committee interlocks, as well as the Compensation Committee Report, are incorporated herein by reference from our definitive Proxy Statement for our 2015 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS.

The information required by this Item concerning the stock ownership of management and five percent beneficial owners and securities authorized for issuance under equity compensation plans is incorporated herein by reference from our definitive Proxy Statement for our 2015 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE.

The information required by this Item concerning certain relationships and related person transactions and director independence is incorporated herein by reference from our definitive Proxy Statement for our 2015 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES.

The information required by this Item concerning principal accounting fees and services is incorporated herein by reference from our definitive Proxy Statement for our 2015 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES.

(a) 1. Financial Statements:

The following consolidated financial statements of the Company are set forth in Part II, Item 8

Report of Independent Registered Public Accounting Firm

Consolidated Balance Sheets as of December 31, 2014 and 2013

Consolidated Statements of Income for the years ended December 31, 2014, 2013, and 2012

Consolidated Statements of Comprehensive Income for the years ended December 31, 2014, 2013, and 2012

Consolidated Statements of Shareholders' Equity for the years ended December 31, 2014, 2013 and 2012

Consolidated Statements of Cash Flows for the years ended December 31, 2014, 2013 and 2012

Notes to Consolidated Financial Statements

2. Financial Statement Schedule:

The following financial statement schedule of the Company is included in Item 15(c):

Schedule II—Condensed Financial Information of Registrant (Parent Company Only).

All other schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore, have been omitted.

3. Exhibits:

A list of exhibits required to be filed as part of this report is set forth in the Index to Exhibits, which immediately precedes such exhibits, and is incorporated herein by reference.

(b) Exhibits

The response to this portion of Item 15 is submitted as a separate section of this report.

(c) Financial Statement Schedule

Schedule II—Condensed Financial Information of Registrant (Parent Company Only).

Schedule II—Condensed Financial Information of Registrant

**Anthem, Inc. (Parent Company Only)
Balance Sheets**

(In millions, except share data)

	December 31, 2014	December 31, 2013
Assets		
Current assets:		
Cash and cash equivalents	\$ 739.8	\$ 1,174.5
Investments available-for-sale, at fair value:		
Fixed maturity securities (amortized cost of \$1,798.8 and \$897.4)	1,753.4	900.4
Equity securities (cost of \$148.7 and \$52.6)	206.7	89.6
Other invested assets, current	5.7	1.9
Other receivables	44.6	35.6
Income taxes receivable	227.9	154.4
Net due from subsidiaries	327.3	893.4
Securities lending collateral	224.8	46.2
Deferred tax assets, net	22.0	11.8
Other current assets	233.2	183.1
Total current assets	3,785.4	3,490.9
Long-term investments available-for-sale, at fair value:		
Equity securities (cost of \$6.6 and \$6.7)	6.6	6.7
Other invested assets, long-term	654.5	615.7
Property and equipment, net	134.0	148.3
Deferred tax assets, net	—	2.9
Investments in subsidiaries	35,647.2	35,516.2
Other noncurrent assets	220.6	152.3
Total assets	\$ 40,448.3	\$ 39,933.0
Liabilities and shareholders' equity		
Liabilities		
Current liabilities:		
Accounts payable and accrued expenses	\$ 599.9	\$ 592.1
Security trades pending payable	14.0	28.9
Securities lending payable	224.8	46.2
Current portion of long-term debt	625.0	518.0
Other current liabilities	280.1	213.4
Total current liabilities	1,743.8	1,398.6
Long-term debt, less current portion	14,102.3	13,548.6
Deferred tax liabilities, net	37.2	—
Other noncurrent liabilities	313.7	220.6
Total liabilities	16,197.0	15,167.8
Commitments and contingencies—Note 5		
Shareholders' equity		
Preferred stock, without par value, shares authorized - 100,000,000; shares issued and outstanding - none	—	—
Common stock, par value \$0.01, shares authorized - 900,000,000; shares issued and outstanding - 268,109,932 and 293,273,830	2.7	2.9
Additional paid-in capital	10,062.3	10,765.2
Retained earnings	14,014.4	13,813.9
Accumulated other comprehensive income	171.9	183.2
Total shareholders' equity	24,251.3	24,765.2
Total liabilities and shareholders' equity	\$ 40,448.3	\$ 39,933.0

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Income

(In millions)	Years ended December 31		
	2014	2013	2012
Revenues			
Net investment income	\$ 87.4	\$ 61.2	\$ 95.3
Net realized losses on investments	(27.1)	(83.2)	(28.5)
Other-than-temporary impairment losses on investments:			
Total other-than-temporary impairment losses on investments	(35.5)	(51.6)	(15.3)
Portion of other-than-temporary impairment losses recognized in other comprehensive income	7.0	0.2	1.3
Other-than-temporary impairment losses recognized in income	(28.5)	(51.4)	(14.0)
Other revenue	4.8	4.4	3.5
Total revenues (losses)	36.6	(69.0)	56.3
Expenses			
General and administrative expense	20.3	196.6	211.9
Interest expense	597.8	598.4	507.0
Loss on extinguishment of debt	81.1	145.3	—
Total expenses	699.2	940.3	718.9
Loss before income tax credits and equity in net income of subsidiaries	(662.6)	(1,009.3)	(662.6)
Income tax credits	(255.4)	(369.7)	(172.1)
Equity in net income of subsidiaries	2,976.9	3,129.3	3,146.0
Net income	\$ 2,569.7	\$ 2,489.7	\$ 2,655.5

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Comprehensive Income

(in millions)

	Years ended December 31		
	2014	2013	2012
Net income	\$ 2,569.7	\$ 2,489.7	\$ 2,655.5
Other comprehensive (loss) income, net of tax:			
Change in net unrealized gains/losses on investments	118.6	(294.7)	189.9
Change in non-credit component of other-than-temporary impairment losses on investments	(3.9)	1.7	4.5
Change in net unrealized gains/losses on cash flow hedges	(3.6)	3.0	0.1
Change in net periodic pension and postretirement costs	(118.1)	172.7	(10.9)
Foreign currency translation adjustments	(4.3)	1.4	0.6
Other comprehensive (loss) income	(11.3)	(115.9)	184.2
Total comprehensive income	<u>\$ 2,558.4</u>	<u>\$ 2,373.8</u>	<u>\$ 2,839.7</u>

See accompanying notes.

Anthem, Inc. (Parent Company Only)
Statements of Cash Flows

(In millions)

	Years ended December 31		
	2014	2013	2012
Operating activities			
Net income	\$ 2,569.7	\$ 2,489.7	\$ 2,655.5
Adjustments to reconcile net income to net cash provided by operating activities:			
Distributed (undistributed) earnings of subsidiaries	244.3	(78.5)	(432.0)
Net realized losses on investments	27.1	83.2	28.5
Other-than-temporary impairment losses recognized in income	28.5	51.4	14.0
Loss on extinguishment of debt	81.1	145.3	—
Loss on disposal of assets	3.9	3.6	—
Deferred income taxes	52.7	(4.5)	49.2
Amortization, net of accretion	17.5	25.2	23.2
Depreciation expense	67.4	45.7	13.1
Share-based compensation	168.9	146.0	146.5
Excess tax benefits from share-based compensation	(46.4)	(30.1)	(28.8)
Changes in operating assets and liabilities, net of effect of business combinations:			
Receivables, net	(16.6)	3.5	9.6
Other invested assets, current	(3.8)	(0.3)	0.2
Other assets	55.6	42.3	(31.7)
Amounts due from/to subsidiaries	566.1	(983.1)	754.7
Accounts payable and accrued expenses	(111.4)	111.8	(34.5)
Other liabilities	(113.8)	(18.6)	8.9
Income taxes	(36.0)	83.9	(204.0)
Net cash provided by operating activities	3,554.8	2,116.5	2,972.4
Investing activities			
Purchases of investments	(1,819.3)	(1,964.3)	(5,383.2)
Proceeds from sales, maturities, calls and redemptions of investments	820.7	2,443.3	5,554.5
Settlement of non-hedging derivatives	(67.4)	(109.8)	(59.8)
Capitalization of subsidiaries	(321.8)	(121.2)	(6,085.1)
Changes in securities lending collateral	(178.8)	(17.0)	73.8
Purchases of property and equipment, net of sales	(57.0)	(87.4)	(117.1)
Other, net	(38.0)	(18.9)	(114.4)
Net cash (used in) provided by investing activities	(1,661.6)	124.7	(6,131.3)
Financing activities			
Net repayments of commercial paper borrowings	(379.2)	(191.7)	(229.0)
Proceeds from long-term borrowings	2,700.0	1,250.0	6,468.9
Repayments of long-term borrowings	(1,730.1)	(1,245.0)	(800.0)
Changes in securities lending payable	178.6	17.1	(72.7)
Changes in bank overdrafts	55.5	71.8	30.5
Premiums paid on equity options	—	(25.8)	—
Repurchase and retirement of common stock	(2,998.8)	(1,620.1)	(2,496.8)
Cash dividends	(501.6)	(465.9)	(380.9)
Proceeds from issuance of common stock under employee stock plans	301.3	524.7	110.8
Excess tax benefits from share-based compensation	46.4	30.1	28.8
Net cash (used in) provided by financing activities	(2,327.9)	(1,654.8)	2,659.6
Change in cash and cash equivalents	(434.7)	586.4	(499.3)
Cash and cash equivalents at beginning of year	1,174.5	588.1	1,087.4
Cash and cash equivalents at end of year	\$ 739.8	\$ 1,174.5	\$ 588.1

See accompanying notes.

Anthem, Inc.
(Parent Company Only)
Notes to Condensed Financial Statements

December 31, 2014
(In Millions, Except Per Share Data)

1. Basis of Presentation and Significant Accounting Policies

In the parent company only financial statements of Anthem, Inc., or Anthem, Anthem's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. Anthem's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting.

Certain amounts presented in the parent company only financial statements are eliminated in the consolidated financial statements of Anthem.

Anthem's parent company only financial statements should be read in conjunction with Anthem's audited consolidated financial statements and the accompanying notes included in this Annual Report on Form 10-K.

2. Subsidiary Transactions

Dividends from Subsidiaries

Anthem received cash dividends from subsidiaries of \$3,234.5, \$3,046.5 and \$2,935.1 during 2014, 2013 and 2012, respectively.

Dividends to Subsidiaries

Certain subsidiaries of Anthem own shares of Anthem common stock. Anthem paid cash dividends to subsidiaries related to these shares of common stock in the amount of \$20.9, \$17.9 and \$13.8 during 2014, 2013 and 2012, respectively.

Investments in Subsidiaries

Capital contributions to subsidiaries were \$321.8, \$121.2 and \$6,085.1 during 2014, 2013 and 2012, respectively.

Amounts Due to and From Subsidiaries

At December 31, 2014 and 2013, Anthem reported \$327.3 and \$893.4 due from subsidiaries, respectively. The amounts due to or from subsidiaries primarily include amounts for allocated administrative expenses or cash held overnight at the parent level resulting from daily cash management activities. These items are routinely settled, and as such, are classified as current assets or liabilities.

3. Derivative Financial Instruments

The information regarding derivative financial instruments contained in Note 5, "Derivative Financial Instruments," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries is incorporated herein by reference.

4. Long-Term Debt

The information regarding long-term debt contained in Note 12, "Debt," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries is incorporated herein by reference.

5. Commitments and Contingencies

The information regarding commitments and contingencies contained in Note 13, "Commitments and Contingencies," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries is incorporated herein by reference.

6. Capital Stock

The information regarding capital stock contained in Note 14, "Capital Stock," of the Notes to Consolidated Financial Statements of Anthem and its subsidiaries is incorporated herein by reference.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

ANTHEM, INC.

By: /s/ JOSEPH R. SWEDISH
Joseph R. Swedish
President and Chief Executive Officer

Dated: February 24, 2015

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

<u>Signature</u>	<u>Title</u>	<u>Date</u>
<u>/s/ JOSEPH R. SWEDISH</u> Joseph R. Swedish	President and Chief Executive Officer, Director (Principal Executive Officer)	February 24, 2015
<u>/s/ WAYNE S. DEVEYDT</u> Wayne S. DeVeydt	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 24, 2015
<u>/s/ JOHN E. GALLINA</u> John E. Gallina	Senior Vice President and Chief Accounting Officer (Principal Accounting Officer)	February 24, 2015
<u>/s/ GEORGE A. SCHAEFER, JR.</u> George A. Schaefer, Jr.	Chair of the Board	February 24, 2015
<u>/s/ R. KERRY CLARK</u> R. Kerry Clark	Director	February 24, 2015
<u>/s/ ROBERT L. DIXON, JR.</u> Robert L. Dixon, Jr.	Director	February 24, 2015
<u>/s/ LEWIS HAY III</u> Lewis Hay III	Director	February 24, 2015
<u>/s/ JULIE A. HILL</u> Julie A. Hill	Director	February 24, 2015
<u>/s/ RAMIRO G. PERU</u> Ramiro G. Peru	Director	February 24, 2015
<u>/s/ WILLIAM J. RYAN</u> William J. Ryan	Director	February 24, 2015
<u>/s/ JOHN H. SHORT</u> John H. Short	Director	February 24, 2015
<u>/s/ ELIZABETH E. TALLETT</u> Elizabeth E. Tallett	Director	February 24, 2015

INDEX TO EXHIBITS

<u>Exhibit Number</u>	<u>Exhibit</u>
2.1	Stock and Interest Purchase Agreement dated April 9, 2009, by and between the Company and Express Scripts, Inc., incorporated by reference to Exhibit 2.1 of the Company's Current Report on Form 8-K filed on April 13, 2009, SEC File No. 001-16751.
2.2	Agreement and Plan of Merger, dated as of July 9, 2012 by and among WellPoint, Inc. (now known as "Anthem, Inc."), WellPoint Merger Sub, Inc. and AMERIGROUP Corporation, incorporated by reference to Exhibit 2.1 to the Company's Current Report on Form 8-K filed on July 10, 2012.
(a)	Amendment No. 1 to Agreement and Plan of Merger, dated as of October 2, 2012, by and among WellPoint, Inc. (now known as "Anthem, Inc."), WellPoint Merger Sub, Inc. and AMERIGROUP Corporation, incorporated by reference to Exhibit 2.1(a) to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2012.
3.1	Amended and Restated Articles of Incorporation of the Company, as amended effective December 2, 2014, incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on December 2, 2014.
3.2	By-laws of the Company, as amended effective December 2, 2014, incorporated by reference to Exhibit 3.2 to the Company's Current Report on Form 8-K filed on December 2, 2014.
4.1	Amended and Restated Articles of Incorporation of the Company, as amended effective December 2, 2014 (included in Exhibit 3.1).
4.2	By-laws of the Company, as amended effective December 2, 2014 (Included in Exhibit 3.2).
4.3	Indenture, dated as of December 9, 2004, between the Company and The Bank of New York Trust Company, N.A., as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on December 15, 2004, SEC File No. 001-16751.
(a)	Form of the Company's 5.950% Notes due 2034 (included in Exhibit 4.3).
4.4	Indenture, dated as of January 10, 2006, between the Company and The Bank of New York Mellon Trust Company, N.A. (formerly known as The Bank of New York Trust Company, N.A.), as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on January 11, 2006, SEC File No. 001-16751.
(a)	Form of 5.85% Notes due 2036, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on January 11, 2006, SEC File No. 001-16751.
(b)	Form of 5.875% Notes due 2017, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on June 8, 2007, SEC File No. 001-16751.
(c)	Form of 6.375% Notes due 2037, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on June 8, 2007, SEC File No. 001-16751.
(d)	Form of 7.000% Notes due 2019, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on February 5, 2009, SEC File No. 001-16751.
(e)	Form of 4.350% Notes due 2020, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on August 12, 2010.
(f)	Form of 5.800% Notes due 2040, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 12, 2010.
(g)	Form of 2.375% Notes due 2017, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on August 15, 2011.
(h)	Form of 3.700% Notes due 2021, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 15, 2011.

**Exhibit
Number**

Exhibit

- (i) Form of 3.125% Notes due 2022, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on May 7, 2012.
- (j) Form of 4.625% Notes due 2042, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on May 7, 2012.
- (k) Form of 1.250% Notes due 2015, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on September 10, 2012.
- (l) Form of 1.875% Notes due 2018, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on September 10, 2012.
- (m) Form of 3.300% Notes due 2023, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on September 10, 2012.
- (n) Form of 4.650% Notes due 2043, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on September 10, 2012.
- (o) Form of 2.300% Notes due 2018, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on July 31, 2013.
- (p) Form of 5.100% Notes due 2044, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on July 31, 2013.
- (q) Form of 2.250% Notes due 2019, incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on August 12, 2014.
- (r) Form of 3.500% Notes due 2024, incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on August 12, 2014.
- (s) Form of 4.650% Notes due 2044, incorporated by reference to Exhibit 4.4 to the Company's Current Report on Form 8-K filed on August 12, 2014.
- (t) Form of 4.850% Notes due 2054, incorporated by reference to Exhibit 4.5 to the Company's Current Report on Form 8-K filed on August 12, 2014.
- 4.5 Indenture dated as of October 9, 2012 between the Company and The Bank of New York Mellon Trust Company, N.A. as trustee, incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on October 9, 2012.
 - (a) Form of the 2.750% Senior Convertible Debentures due 2042 (included in Exhibit 4.5).
- 4.6 Upon the request of the Securities and Exchange Commission, the Company will furnish copies of any other instruments defining the rights of holders of long-term debt of the Company or its subsidiaries.
- 10.1 * Anthem 2001 Stock Incentive Plan, amended and restated as of January 1, 2003, incorporated by reference to Exhibit 10.1(iii) to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2003, SEC File No. 001-16751.
 - (a) Form of Stock Incentive Plan General Stock Option Grant Agreement as of March 1, 2006, incorporated by reference to Exhibit 10.1(b) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2006, SEC File No. 001-16751.
- 10.2 * Anthem Incentive Compensation Plan, as amended and restated effective December 2, 2014, incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed on December 2, 2014.
 - (a) Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement under the 2006 Incentive Compensation Plan, incorporated by reference to Exhibit 10.2(j) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2007, SEC File No. 001-16751.
 - (b) Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2008 under the 2006 Incentive Compensation Plan, incorporated by reference to Exhibit 10.2(k) to the Company's Annual Report on Form 10-K for the year ended December 31, 2007, SEC File No. 001-16751.

Exhibit
Number

Exhibit

- (c) Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2009 under the 2006 Incentive Compensation Plan, incorporated by reference to Exhibit 10.2(m) to the Company's Annual Report on Form 10-K for the year ended December 31, 2008, SEC File No. 001-16751.
 - (d) Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement, incorporated by reference to Exhibit 10.2(o) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2010.
 - (e) Form of Incentive Compensation Plan Performance Share Award Agreement, Grant A for 2012, incorporated by reference to Exhibit 10.2(p) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2012.
 - (f) Form of Incentive Compensation Plan Performance Share Award Agreement, Grant B for 2012, incorporated by reference to Exhibit 10.2(q) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2012.
 - (g) Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement, incorporated by reference to Exhibit 10.2(t) to the Company's Current Report on Form 8-K filed on September 14, 2012.
 - (h) Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2013, incorporated by reference to Exhibit 10.2(s) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2013.
 - (i) Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2013, incorporated by reference to Exhibit 10.2(t) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2013.
 - (j) Form of Incentive Compensation Plan Performance Share Award Agreement for 2013, incorporated by reference to Exhibit 10.2(u) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2013.
 - (k) Form of Incentive Compensation Plan Nonqualified Stock Option Award Agreement for 2014, incorporated by reference to Exhibit 10.2(p) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014.
 - (l) Form of Incentive Compensation Plan Restricted Stock Unit Award Agreement for 2014, incorporated by reference to Exhibit 10.2(q) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014.
 - (m) Form of Incentive Compensation Plan Performance Share Award Agreement for 2014, incorporated by reference to Exhibit 10.2(r) to the Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014.
- 10.3 * Anthem, Inc. Comprehensive Nonqualified Deferred Compensation Plan, as amended and restated effective December 2, 2014.
- 10.4 * Anthem, Inc. Executive Agreement Plan, amended and restated effective December 2, 2014.
- 10.5 * WellPoint, Inc. Executive Salary Continuation Plan effective January 1, 2006, incorporated by reference to Exhibit 10.59 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2006, SEC File No. 001-016751.
- 10.6 * WellPoint Directed Executive Compensation Plan amended effective January 1, 2014, incorporated by reference to Exhibit 10.6 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2013.
- 10.7 * WellPoint, Inc. Board of Directors Compensation Program, as amended effective May 14, 2014, incorporated by reference to Exhibit 10.7 to the Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014.
- 10.8 * Anthem Board of Directors' Deferred Compensation Plan, as amended and restated effective December 2, 2014.

Exhibit
Number

Exhibit

- 10.9 * Amerigroup Corporation 2009 Equity Incentive Plan effective May 7, 2009, incorporated by reference to Exhibit 99.1 to the Company's Registration Statement on Form S-8 filed on December 26, 2012 (Registration No. 333-185675).
- 10.10 * Employment Agreement between Anthem Insurance Companies, Inc. and Samuel R. Nussbaum, M.D., dated as of January 2, 2001 (with respect to Section 5(b) only), incorporated by reference to Exhibit 10.5 to the Company's Registration Statement on Form S-1 (Registration No. 333-67714).
 - (a) Amendment dated September 30, 2011 to Employment Agreement between Anthem Insurance Companies, Inc. and Samuel R. Nussbaum, M.D., dated as of January 2, 2001, incorporated by reference to Exhibit 10.12 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2011.
- 10.11 * (a) Form of Employment Agreement between the Company and each of the following: Ken R. Goulet and Samuel R. Nussbaum, M.D., incorporated by reference to Exhibit 10.43 to the Company's Annual Report on Form 10-K for the year ended December 31, 2005, SEC File No. 001-16751.
 - (b) Form of Employment Agreement between the Company and Wayne S. DeVeydt, incorporated by reference to Exhibit A to Exhibit 10.7 to the Company's Current Report on Form 8-K filed on November 2, 2006, SEC File No. 001-16751.
 - (c) Form of Employment Agreement between the Company and each of the following: Jose D. Tomas, Gloria McCarthy, Peter D. Haytaian, Martin Silverstein, M.D. and Thomas C. Zielinski incorporated by reference to Exhibit A to Exhibit 10.41 to the Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2007, SEC File No. 001-16751.
 - (d) Form of Employment Agreement between the Company and Joseph R. Swedish, incorporated by reference to Exhibit A to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on February 12, 2013.
- 10.12 * Employment Agreement between the Company and Richard C. Zoretic dated as of July 9, 2012 and effective December 24, 2012, incorporated by reference to Exhibit 10.16 to the Company's Annual Report on Form 10-K for the year ended December 31, 2012, filed on February 22, 2013.
 - (a) First Amendment to Employment Agreement between the Company and Richard C. Zoretic dated as of October 26, 2012 and effective December 24, 2012, incorporated by reference to Exhibit 10.16(a) to the Company's Annual Report on Form 10-K for the year ended December 31, 2012, filed on February 22, 2013.
 - (b) Second Amendment to Employment Agreement between the Company and Richard C. Zoretic dated as of April 23, 2013, incorporated by reference to Exhibit 10.16(b) to the Company's Current Report on Form 8-K filed on April 23, 2013.
- 10.13 Blue Cross License Agreement by and between Blue Cross Blue Shield Association and the Company, including revisions, if any, adopted by the Member Plans through November 21, 2014.
- 10.14 Blue Shield License Agreement by and between Blue Cross Blue Shield Association and the Company, including revisions, if any, adopted by the Member Plans through November 21, 2014.
- 10.15 Undertakings to California Department of Managed Health Care, dated October 15, 2012, delivered by Blue Cross of California, incorporated by reference to Exhibit 10.19 to the Company's Annual Report on Form 10-K for the year ended December 31, 2012.
- 10.16 * Offer Letter, by and between WellPoint, Inc. and Joseph R. Swedish, dated as of February 6, 2013, incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on February 12, 2013.
- 21 Subsidiaries of the Company.
- 23 Consent of Independent Registered Public Accounting Firm.
- 31.1 Certification of Chief Executive Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.

**Exhibit
Number**

Exhibit

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| 31.2 | Certification of Chief Financial Officer pursuant to Rule 13a-14(a) and Rule 15d-14(a) of the Exchange Act Rules, as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002. |
| 32.1 | Certification of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002. |
| 32.2 | Certification of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002. |
| 101 | The following materials from Anthem, Inc.'s Annual Report on Form 10-K for the year ended December 31, 2014, formatted in XBRL (Extensible Business Reporting Language): (i) the Consolidated Balance Sheets; (ii) the Consolidated Statements of Income; (iii) the Consolidated Statements of Comprehensive Income; (iv) the Consolidated Statements of Cash Flows; (v) the Consolidated Statements of Shareholders' Equity; (vi) the Notes to Consolidated Financial Statements and (vii) Financial Statement Schedule II. |

* Indicates management contracts or compensatory plans or arrangements.

Exhibit 10.3

ANTHEM, INC.
COMPREHENSIVE NON-QUALIFIED DEFERRED
COMPENSATION PLAN
(AS AMENDED AND RESTATED EFFECTIVE
DECEMBER 2, 2014)

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ANTHEM, INC.
COMPREHENSIVE NON-QUALIFIED DEFERRED
COMPENSATION PLAN
(AS AMENDED AND RESTATED EFFECTIVE
DECEMBER 2, 2014)

ARTICLE I
HISTORY AND PURPOSE

1.01 History. Anthem, Inc. (filch WellPoint, Inc.) (the "Company") established the WellPoint, Inc. 2005 Comprehensive Executive Non-Qualified Retirement Plan, originally effective January 1, 2005 ("WellPoint Plan"), as a new plan for certain types of deferred compensation subject to Section 409A of the Internal Revenue Code of 1986, as amended (the "Code"), which governs nonqualified deferred compensation arrangements. The Company amended and restated the WellPoint Plan effective January 1, 2006, and renamed it the WellPoint, Inc. Comprehensive Non-Qualified Deferred Compensation Plan (the "Plan"). The Company amended and restated the Plan effective as of November 1, 2006, then restated it again effective as of January 1, 2009 for compliance with the final regulations issued under Code Section 409A. The Company subsequently amended and restated the Plan effective January 1, 2011, and again effective as of January 1, 2014. The Company hereby amends and restates the Plan effective as of December 2, 2014 to reflect a change in the Company's name from WellPoint, Inc. to Anthem, Inc. and to rename the Plan the "Anthem, Inc. Comprehensive Non-Qualified Deferred Compensation Plan."

(a) Merged Plans. In addition, effective January 1, 2005, the Company, one of its predecessors or entities related to the Company or a predecessor also established the following nonqualified deferred compensation plans applicable to amounts subject to Code Section 409A.

- (i) the 2005 Anthem Supplemental Executive Retirement Plan;
- (ii) the 2005 Anthem Deferred Compensation Plan;
- (iii) the 2005 Trigon Insurance Company 401(k) Restoration Plan; and
- (iv) the 2005 Supplemental Retirement Plan for Certain Employees of Trigon Insurance Company.

Each of the foregoing plans were separately maintained for the 2005 calendar year and cover deferred compensation that related solely to the 2005 calendar year. The Company subsequently ceased accruals and merged each of the plans into the Anthem Plan effective as of December 31, 2005 and are referred to herein as the Merged Plans (either alone or collectively).

(b) Predecessor Plans. The Company or one of its predecessors separately maintained the following nonqualified deferred compensation plans, which cover

amounts earned and vested as of December 31, 2004 (including vested bonuses earned in 2004 and paid in 2005):

- (i) each pre-2005 Anthem Long-Term Incentive Plan;
- (ii) the WellPoint Health Networks Inc. Comprehensive Executive Non-Qualified Retirement Plan;
- (iii) the Anthem Supplemental Executive Retirement Plan;
- (iv) the Anthem Deferred Compensation Plan;
- (v) the Trigon Insurance Company 401(k) Restoration Plan; and
- (vi) the Supplemental Retirement Plan for Certain Employees of Trigon Insurance Company.

Each of the foregoing plans are referred to as a "Predecessor Plan(s)." Benefits ceased to accrue under the Predecessor Plans effective December 31, 2004 and, as such, are grandfathered for purposes of Code Section 409A. Solely for administrative purposes, Predecessor Plan Account balances, determined as of December 31, 2005, became accounted for under the 2005 WellPoint Plan effective as of January 1, 2006. In all other respects, each Predecessor Plan Account remains subject exclusively to the terms of the Predecessor Plan to which it relates.

1.02 Purpose. Except as otherwise provided herein, the Plan applies only to Participants to whose Account contributions are credited under Article IV and Article V. The purpose of the Plan is for certain management and highly compensated employees to (1) restore certain benefits that cannot be provided under the tax-qualified plans maintained by the Company and its affiliates and (2) provide additional opportunities to defer one or more items of their compensation.

The Plan is intended to comply with Code Section 409A and shall be interpreted, administered and operated as necessary to comply with the requirements of Code Section 409A and applicable Treasury Regulations. The Plan is further intended to be a plan that is unfunded and maintained by Anthem, Inc. primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees within the meaning of the Employee Retirement Income Security Act of 1974 ("ERISA").

ARTICLE II DEFINITIONS

In this Plan, the following terms have the meanings indicated below:

2.01 "Account" means the account maintained under the Plan for each Participant which is credited with amounts under Article IV and Article V of the Plan and adjusted periodically for investment performance under Article VI of the Plan and distributions or withdrawals in accordance with Article VIII. The Account of each Participant who is also a

Predecessor Plan Participant shall also include the Predecessor Plan Account maintained on behalf of that Predecessor Plan Participant, as adjusted periodically for investment performance under Article VI of the Plan and distributions or withdrawals in accordance with the terms of the Predecessor Plan to which it relates. Each Participant's Account shall be divided into a series of Plan Year subaccounts, one for each Plan Year for which the Participant defers any Compensation under the Plan. To the extent it considers necessary or appropriate, the Administrator may further divide each such Plan Year subaccount into a series of separate subaccounts so that each category of deferred Compensation may be credited to its own separate subcategories within that particular Plan Year subaccount.

2.02 "Administrator" means the Executive Vice President and Chief Human Resources Officer of the Company and, if the context requires, the Human Resources Department of the Company, in charge of the day-to-day administration of the Plan.

2.03 "Affiliate" means an entity other than the Company whose employees participate in the tax-qualified retirement plans of ATH Holding Company, LLC or National Government Services, Inc. or whose employees are authorized to participate in the Plan by the Committee.

2.04 "Anthem LTIP" means each pre-2005 Anthem Long-Term Incentive Plan.

2.05 "Anthem Plan" means the Anthem Deferred Compensation Plan.

2.06 "Anthem SERP" means the Anthem Supplemental Executive Retirement Plan.

2.07 "Anthem SERP Participant" means an individual who is eligible on or after January 1, 2006 to earn a benefit under the 2005 Anthem SERP.

2.08 "Beneficiary" means the person or persons, trust or estate designated in writing, to receive a Participant's vested Account if the Participant dies before distribution of the entire vested balance credited to that Account. A Participant may designate one or more primary Beneficiaries and one or more secondary Beneficiaries. A Participant's Beneficiary designation must be made in writing pursuant to such procedures as the Administrator may establish and delivered to the Administrator before the Participant's death. The Participant may revoke or change this designation at any time before his or her death by following such procedures as the Administrator will establish. If the Administrator has not received a Participant's Beneficiary designation before the Participant's death or if the Participant does not otherwise have an effective Beneficiary designation on file when he or she dies, the vested balance of such Participant's Account will be distributed to his or her estate.

2.09 "Bonus" means an amount awarded to an Eligible Employee under an annual incentive plan maintained by the Company as determined by the Administrator.

2.10 "Bonus Deferral" means an election by a Participant to defer the receipt of a Bonus in accordance with the requirements of Article IV.

2.11 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.12 "Committee" means the Compensation Committee of the Company's Board of Directors or a subcommittee of two or more members thereof. The Committee shall have full discretionary authority to administer and interpret the Plan, to determine eligibility for Plan benefits, to select employees for Plan participation, to determine the benefit entitlement of each Participant and Beneficiary hereunder and to correct errors. The Committee may delegate any of its duties and responsibilities not otherwise delegated hereunder to the Executive Vice President and Chief Human Resources Officer as Administrator, and unless the Committee expressly provides to the contrary, any such delegation will carry with it the Committee's full discretionary authority with respect to the delegated duties and responsibilities. In no event, however, shall the Committee delegate its authority to amend or terminate the Plan pursuant to the provisions of Section 12.06. Decisions of the Committee or its delegate will be final and binding on all persons.

2.13 "Company" means Anthem, Inc., an Indiana corporation.

2.14 "Company Contribution" means, for any one Plan Year, the amount determined in accordance with Section 4.04.

2.15 "Compensation" means the respective definitions of compensation as set forth in the Savings Plan for elective deferrals and matching contributions, as constituted from time to time and as the context requires. In either case, the respective definition of compensation as set forth in the Savings Plan is determined without regard to the application of the limitation under Code Section 401(a)(17).

2.16 "Compensation Deferral" means an election by a Participant to defer the receipt of the portion of his or her Compensation in accordance with the requirements of Article IV.

2.17 "Election Form" means the form or forms established from time to time by the Administrator that a Participant completes, signs and returns to the Administrator to make a deferral election, make or change a payment election, and/or make or change an investment election. To the extent authorized by the Administrator, such form may be electronic or set forth in some other media or format.

2.18 "Eligible Employee" means each employee of the Company or an Affiliate whose Compensation is equal to or in excess of the Code Section 401(a)(17) compensation limit in effect at the time the employee's eligibility is determined in accordance with Section 3.01.

2.19 "In-Service Payout" means a complete distribution of a Participant's vested Plan Year subaccount (including the related Matching Contribution) as of a specified date elected by a Participant.

2.20 "Key Employee" means for the period January 1 through December 31 each individual identified by the Administrator as of the immediately preceding September 30 as a "key employee," as defined under Code Section 416(i), disregarding Code Section 416(i)(5).

2.21 "Make-Up Contribution" means the contribution described under Section 4.04.

2.22 "Matching Contribution" means a matching contribution pursuant to Section 4.03.

2.23 "Merged Plan" means the 2005 Anthem SERP, the 2005 Anthem Plan, the 2005 Trigon Plan or the 2005 Trigon SERP.

2.24 "Participant" means a current or former Eligible Employee for whom an Account (including one or more Plan Year subaccounts) is maintained. A Participant shall also include a Predecessor Plan Participant for the limited purposes set forth in the Plan.

2.25 "Pension Benefit" means the benefit payable to an individual under the Pension Plan or the UGS Pension Plan, as the context requires.

2.26 "Pension Plan" means the qualified pension plan maintained by ATH Holding Company, LLC or its predecessors under which a Participant is actively accruing a benefit, which may include the WellPoint Cash Balance Pension Plan B, as amended from time to time or renamed, and/or such other qualified pension plan maintained by ATH Holding Company, LLC.

2.27 "Plan" means this Anthem, Inc. Comprehensive Non-Qualified Deferred Compensation Plan, as amended from time to time.

2.28 "Plan Year" means the calendar year.

2.29 "Predecessor Plan" means any of the WellPoint Plan, the Anthem SERP, the Anthem Plan, the various Anthem LTIPs, the Trigon Plan or the Trigon SERP, each of which cover grandfathered benefits not subject to Code Section 409A.

2.30 "Predecessor Plan Account" means a hypothetical or bookkeeping account reflecting a grandfathered benefit under a Predecessor Plan, the amount of which was transferred to the Plan on December 31, 2005. Such account is credited with additional earnings pursuant to Article VI.

2.31 "Predecessor Plan Participant" means an individual who was eligible to participate in one or more of the Predecessor Plans and who, as of December 31, 2005 (the date Predecessor Plan Accounts were transferred to the Plan), has a Predecessor Plan Account.

2.32 "Regulations" mean Treasury Regulations issued under the Code.

2.33 "Savings Plan" means the WellPoint 401(k) Retirement Savings Plan, as amended from time to time or renamed.

2.34 "Separation from Service" means termination of the Participant's employment relationship (within the meaning of Code Section 409A and Regulations issued thereunder) with the Company and its affiliates and any other service relationship defined in such applicable Regulations, other than by reason of death. For purposes of the foregoing, whether an entity is affiliated with the Company shall be determined pursuant to the controlled group rules of Code Section 414, as modified by Code Section 409A. However, the Participant's employment relationship with the Employer shall be treated as continuing intact while the individual is on a military leave, sick leave or other bona fide leave of absence if the period of such leave does not exceed six months (or longer, if required by statute or contract). If the period of the leave

exceeds six months and the Participant's right to reemployment is not provided either by statute or contract, the employment relationship is deemed to terminate on the first date immediately following such six-month period for purposes of Code Section 409A only.

2.35 "Trigon Plan" means the Trigon Insurance Company 401(k) Restoration Plan.

2.36 "Trigon SERP" means the Supplemental Retirement Plan for Certain Employees of Trigon Insurance Company.

2.37 "UGS Pension Plan" means the UGS Pension Plan, as amended from time to time, and any predecessor qualified pension plan maintained by National Government Services, Inc.

2.38 "WellPoint Plan" means the WellPoint Health Networks Inc. Comprehensive Executive Non-Qualified Retirement Plan.

2.39 "WellPoint SERP Participant" means an individual who is eligible on or after January 1, 2006 to earn a benefit under Section 4.01 of the 2005 WellPoint Plan.

2.40 "2005 Anthem SERP" means the 2005 Anthem Supplemental Executive Retirement Plan.

2.41 "2005 WellPoint Plan" means the WellPoint, Inc. 2005 Comprehensive Executive Non-Qualified Retirement Plan, as in effect on December 31, 2005.

2.42 "2005 Anthem Plan" means the 2005 Anthem Deferred Compensation Plan.

2.43 "2005 Trigon Plan" means the 2005 Trigon Insurance Company 401(k) Restoration Plan.

2.44 "2005 Trigon SERP" means the 2005 Supplemental Retirement Plan for Certain Employees of Trigon Insurance Company.

ARTICLE III ELIGIBILITY AND PARTICIPATION

3.01 Eligibility. Determination of an individual as an Eligible Employee is made on a Plan Year by Plan Year basis. The Administrator may determine the individual is an Eligible Employee for the immediately following Plan Year pursuant to any such rules and requirements regarding the criteria for, and manner in, which individuals are determined to be an Eligible Employee. Such rules and requirements do not need to be consistent from Plan Year to Plan Year or among individuals. An individual who is determined to be an Eligible Employee shall be permitted to make a Compensation Deferral and Bonus Deferral election effective for the Plan Year that begins immediately following the Administrator's determination of the individual as an Eligible Employee in accordance with the rules set forth in Article IV. An individual who is determined to be an Eligible Employee shall not be permitted to make a Compensation Deferral with respect to Compensation earned or a Bonus Deferral with respect to the Bonus paid in the Plan Year in which he or she is determined to be an Eligible Employee. Such an individual may make a Bonus Deferral for the Bonus earned in such Plan Year pursuant to the rules set forth in

Article IV provided the individual becomes an Eligible Employee before or during the enrollment period established for such Plan Year.

Notwithstanding any Plan provision to the contrary, the Committee may, in its sole discretion, place further requirements and/or limitations on an Eligible Employee's participation in any portion of the Plan.

3.02 Participation. To begin participation in the Plan, an Eligible Employee shall properly complete and timely submit an Election Form to the Administrator in accordance with the Administrator's rules. An Eligible Employee shall become a Participant on the first day on which a deferral of an elected amount or contribution is first credited to his or her Account. The Administrator may establish from time to time such other enrollment requirements as it determines in its sole discretion are necessary.

3.03 Enrollment Requirements. Election Forms shall be completed and filed with the Administrator by the time periods set forth in Article IV for the particular type of compensation to be deferred or during such other enrollment period as the Administrator determines in accordance with such Article. Subject to Section 8.05, a Participant may change or revoke a deferral or distribution election any time before such election becomes irrevocable, which shall occur as of the applicable deadline specified in Article IV unless the Administrator establishes an earlier deadline. Unless the Administrator determines otherwise, a new Election Form shall be required for each Plan Year in which an Eligible Employee wants to defer his or her Compensation or Bonus. A Participant's Election Form shall specify the form of payment, which shall be paid at the times specified in Article VIII. Unless otherwise specified herein or determined by the Administrator, the election made by the Participant for each Plan Year shall apply to all amounts credited to the Participant's Plan Year subaccount for such Plan Year.

3.04 Cessation of Participation.

(a) **Loss of Eligibility.** An individual who qualifies as an Eligible Employee for a particular Plan Year will continue to be an Eligible Employee until such time as the Administrator determines otherwise, including that the Eligible Employee no longer satisfies the Plan's eligibility requirements or is not a member of a select group of management or highly compensated employees. Any determination of ineligibility shall be effective for an immediately following Plan Year. Any individual who ceases to be an Eligible Employee shall continue to be a Participant with respect to amounts credited to his or her Account until such amounts are completely distributed to him or her in accordance with the Plan.

(b) **Committee Discretion.** Notwithstanding any Plan provision to the contrary, the Committee shall have the sole discretionary authority to exclude a Participant from making further deferrals under the Plan with such exclusion becoming effective as of the first day of the next succeeding Plan Year. Such Participant shall remain a Participant in the Plan until his Account balance is paid in full.

(c) **Hardship Withdrawals.** Elective or deemed deferrals made by a Participant who receives a hardship withdrawal shall be canceled pursuant to

Section 8.07. The Participant shall remain a Participant in the Plan until his Account balance is paid in full.

(d) Separation from Service or Death. Notwithstanding anything in the Plan to the contrary, upon a Participant's Separation from Service or death, if earlier, any outstanding distribution election shall be given effect to the extent any amounts covered by such election are paid after such event.

ARTICLE IV DEFERRALS AND CONTRIBUTIONS

4.01 Compensation.

(a) Elections. Subject to Article III, an Eligible Employee may make a Compensation Deferral by filing an Election Form with the Administrator before the beginning of the Plan Year in which the Compensation is earned. All deferrals shall be made on a pre-tax basis. The Administrator may prescribe such rules and requirements regarding Compensation Deferral elections as it deems appropriate. An Eligible Employee's Savings Plan election cannot be changed during the Plan Year to which the Compensation Deferral election relates.

(b) Amount. For each Plan Year, an Eligible Employee may elect to make a Compensation Deferral for each payroll period in a percentage (not to exceed 60%) of his or her Compensation net of any required taxes, Savings Plan deferrals and salary reduction amounts described in Code Section 125. Deferrals to the Plan shall begin after the Eligible Employee has made the maximum salary deferrals permitted under the Savings Plan for the Plan Year under Code Section 402(g). For purposes of the preceding sentence, for any given Plan Year and for all Eligible Employees, the Administrator may determine whether such maximum salary deferral includes catch-up contributions (within the meaning of Code Section 402(g)).

(c) No Changes. Subject to Section 3.03, a Compensation Deferral election shall be irrevocable as of the first day of the Plan Year to which the Election Form relates.

(d) Crediting. Compensation Deferrals made by a Participant will be credited to his or her applicable Plan Year subaccount as soon as practical after the date that the Compensation amount to which those Compensation Deferrals relate would have otherwise been paid.

4.02 Bonus.

(a) Elections. The Administrator may prescribe such rules and requirements regarding Bonus Deferral elections.

(i) Generally. Subject to Article III, an Eligible Employee may make a Bonus Deferral by filing an Election Form with the

Administrator before the beginning of the Plan Year in which the Bonus is earned. All deferrals shall be made on a pre-tax basis.

- (ii) Performance-Based Compensation. Notwithstanding anything in the Plan to the contrary, to the extent the Committee determines that a Bonus constitutes "performance-based compensation" (within the meaning of Code Section 409A and Regulations issued thereunder), the Committee may permit an Eligible Employee to file an Election Form with the Administrator on or before a date that occurs no later than six months before the end of the performance period provided that (A) the Eligible Employee performs services continuously from the later of the beginning of the performance period or the date the criteria are established through the date the Election Form is submitted and (B) the compensation is not readily ascertainable (within the meaning of Code Section 409A and Regulations issued thereunder) as of the date the Election Form is filed. If a Bonus Deferral election is made pursuant to this paragraph after the beginning of the Plan Year in which the Bonus is earned, such election shall be void if the Bonus becomes payable as a result of the Eligible Employee's death before the satisfaction of the performance criteria.

(b) Amount. For each Plan Year, an Eligible Employee may elect to make a Bonus Deferral with respect to any amount of his or her Bonus net of any required taxes and salary reduction amounts described in Code Section 125. Further, the amount deferred will be equal to the percentage elected for his or her Bonus Deferral plus the percentage elected for his Compensation Deferral. The total amount of Compensation Deferrals and Bonus Deferrals for a given Plan Year cannot exceed 80% of his or her Compensation.

(c) No Changes. Subject to Section 3.03, such Bonus Deferral election shall be irrevocable as of the first day of the Plan Year to which the Election Form relates or the deadline established by the Administrator for performance-based compensation, as the case may be.

(d) Crediting. Bonus Deferrals made by the Participant will be credited to his or her applicable Plan Year subaccount as soon as practical after the date that the Bonus amount to which those Bonus Deferrals relate would have otherwise been paid.

4.03 Matching Contributions.

(a) Eligibility. Participants shall be entitled to a Matching Contribution under the Plan only to the extent he or she has satisfied the eligibility requirements for an employer matching contribution under the Savings Plan.

(b) Amount. The amount of the Matching Contribution to which a Participant is entitled will be a percentage of Compensation that he or she elects to defer under the

Plan applied to the matching contribution formula then in effect under the Savings Plan less the amount of matching contribution made, if any, under the Savings Plan.

(c) Crediting. The Matching Contributions to which the Participant is entitled will be credited to his or her applicable Plan Year subaccount at such time and in such manner as determined by the Administrator and as applied uniformly to all Participants.

4.04 Non-Elective Contributions.

(a) Eligibility. For each Plan Year, the Company or an Affiliate, in its sole discretion, may, but is not required to, credit any amount it desires as a Company Contribution and/or Make-Up Contribution to the Plan Year subaccount of one or more Participants, on such terms as it determines, which need not be the same for each Participant.

(b) Company Contribution.

(i) Form of Payment. A Participant who receives a Company

Contribution may make a separate election as to the form of payment for such Amount. Any Election Form pursuant to which a Participant selects a form of payment must be filed with the Administrator either:

- (A) During a period of at least 30 days, or as otherwise specified by the Administrator in its discretion, that occurs before the beginning of the Plan Year in which the Company Contribution is earned or begins to be earned, as the case may be, or
- (B) Within 30 days after the Company Contribution is awarded, provided the Company Contribution is subject to a vesting schedule of at least 12 months from the date the completed Election Form is filed with the Administrator (taking into account any automatic vesting provisions that may be provided upon certain terminations from employment that may occur before such 12 month period).

If no such Election Form is filed, then the form of payment shall be a lump sum at Separation from Service.

(ii) No Changes. Subject to Section 3.03, a Participant's Election

Form shall be irrevocable as of the first day of the Plan Year to which the Election Form relates.

(iii) Amount. The Company Contribution credited to a Participant shall

be determined by the Committee or the Administrator, in their discretion. Such contribution may be smaller or larger than the amount credited to any other Participant, and the amount credited

to any Participant for a Plan Year may be zero, even though one or more other Participants receive a Company Contribution for that Plan Year. Crediting of a Company Contribution for one Plan Year does not guarantee a Company Contribution for subsequent Plan Years.

(c) Make-Up Contribution.

- (i) Form of Payment. If a Participant is credited with a Make-Up Contribution, such contribution shall be paid in a lump sum at the earlier of the Participant's Separation from Service or death.
- (ii) Amount. The Make-Up Contribution credited to a Participant shall be determined by the Committee or the Administrator, in their discretion.

(d) Crediting. Company and Make-Up Contributions will be credited to a Participant's applicable Plan Year subaccount as soon as practical after the date that the Company or Affiliate determines such contributions shall be made.

ARTICLE V
SUPPLEMENTAL PENSION PLAN CONTRIBUTIONS

5.01 Eligibility for Supplemental Pension Contribution. A Participant whose benefit under the Pension Plan or UGS Pension Plan, as the case may be, is limited as a result of Code Section 401(a)(17) or Code Section 415, shall be credited with a Supplemental Pension Contribution as described in this Article.

5.02 In General. Except as otherwise provided in this Article, the Supplemental Pension Contribution shall be equal to the difference between the amount which was actually credited to his account under the Pension Plan or the UGS Pension Plan, as the case may be, and the amount which would have been credited to his account had the amount not been limited as a result of Code Section 401(a)(17) or Code Section 415. The Supplemental Pension Contribution to which the Participant is entitled will be credited to his applicable Plan Year subaccount as of the date that the Pension Benefit to which such Supplemental Pension Contribution relates would otherwise have been credited under the Pension Plan.

5.03 Former DeCare Dental Pension Plan Participants. An individual who was a named participant in the DeCare Dental Deferred Compensation Plan and/or the DeCare Dental Restoration Plan as of such plans' termination on or about April 9, 2009, became a Participant under this Article as of April 9, 2009. Such Participant shall be eligible for a Supplemental Pension Contribution if *he* previously participated in the DeCare Dental Pension Plan, met the Rule of 65 (as defined under the Pension Plan) as of December 31, 2009 and became a Participant in the Pension Plan on January 1, 2010. In such circumstance, the Supplemental Pension Contribution will be equal to the "Supplemental Part A Benefit," the "Supplemental A* Benefit," if any, plus the "Supplemental Part B Benefit," if any, each as further described below.

- (a) The Supplemental Part A Benefit will be equal to:

- (i) the Part A Benefit (as determined under and set forth in the Pension Plan) that would have been payable to the Participant without regard to Code Section 401(a)(17) or Code Section 415, as of December 31, 2014 (or such earlier Separation from Service) less the Part A Benefit actually payable to the Participant under the Pension Plan and determined in an annuity, less
- (ii) an annuity equivalent of any lump sum amount received by the Participant from (i) the DeCare Dental Deferred Compensation Plan and the DeCare Dental Restoration Plan upon the respective plans' termination, and (ii) if applicable, the non-qualified plans sponsored by BCBSM, Inc. (d/b/a Blue Cross Blue Shield of Minnesota) that provided benefits in excess of the benefits provided under such entity's qualified plans.

The Part A Benefit formula uses a Participant's actual "Salary" (as defined in Exhibit S of the Pension Plan), to determine the Part A Benefit. In the event a Participant has an individual agreement that provides for certain assumptions to apply in the determination of Salary, the terms of the agreement shall be given effect.

The Supplemental Part A Benefit will be credited to a Plan Year subaccount as soon as administratively feasible after December 31, 2014, or Separation from Service, as the case may be.

(b) If the Participant continues to be eligible to participate in the Pension Plan after December 31, 2014, the Supplemental Part A* Benefit will be equal to the Benefit Transition Adjustment (as determined and defined under the Pension Plan) without regard to Code Section 401(a)(17) less the actual Benefit Transition Adjustment payable to the Participant under the Pension Plan. Such Benefit Transition Adjustment will be determined each Plan Year. The Supplemental Part A* Benefit to which the Participant is entitled will be credited to his applicable Plan Year subaccount as of the date that the Benefit Transition Adjustment to which such Supplemental Part A* Benefit relates would otherwise have been credited under the Pension Plan.

(c) If the Participant continues to be eligible to participate in the Pension Plan after December 31, 2014, the Supplemental Part B Benefit will be determined under, and credited pursuant to, Section 5.02 of this Article.

5.04 QSERP. Notwithstanding anything in this Article to the contrary and subject to Section 12.06, the Company reserves the discretion to credit some or all of a Participant's Supplemental Pension Contributions including earnings on such amounts, on a prospective or retroactive basis, to the Pension Plan or the UGS Pension Plan, as the case may be. Any such credit shall only be made if it is consistent with applicable rules governing the Pension Plan and/or the UGS Pension Plan and Code Section 409A and Regulations issued thereunder.

ARTICLE VI EARNINGS

6.01 Investment Funds. Amounts credited to a Participant's Account under the Plan shall be credited with earnings, at periodic intervals determined by the Administrator, at a rate equal to the actual rate of return for such period on the investment fund or funds or index or indices or vehicle or vehicles selected by that Participant. The investment options shall be comparable to those offered under the Savings Plan, from time to time, except for the option to invest in Anthem common stock or the Vanguard brokerage option (or other self-managed account option that may be offered under the Savings Plan). The Committee may offer other investment options in its discretion. The rate of return on such investment vehicles shall be tracked solely for the purpose of determining the phantom investment gain, earnings and losses to be credited to the Participant's Account during the deferral period. Neither the Company nor any of its affiliates shall be obligated to make any actual investment.

6.02 Conversion of Investments from Predecessor Plans and Merged Plans. Before January 1, 2006, amounts representing Predecessor Plan Account balances and account balances from Merged Plans were credited with earnings based on investment options available under the Predecessor Plan or Merged Plan to which they related. Effective as of January 1, 2006, those Predecessor Plan Accounts (or accounts from Merged Plans) shall be credited with earnings in accordance with Section 6.01. Before January 1, 2006, the Committee shall prescribe rules (that may vary among classes of Participants) that provide each Predecessor Plan Participant (and Participant with a Merged Plan account balance) an opportunity to select the investment fund or funds or index or indices to be used as the basis for crediting his or her Predecessor Plan Account (or Merged Plan account) with earnings as of January 1, 2006. To the extent the Committee has not received investment direction from a Participant before December 15, 2005 with respect to his or her Predecessor Plan Account or Merged Plan account, such Predecessor Plan Account or Merged Plan account shall be credited with earnings based upon a default investment option under the Savings Plan designated as such by the Committee or in accordance with such other rules as may be adopted by the Committee and applied on a consistent, uniform basis.

ARTICLE VII VESTING

7.01 Elective Deferrals under the Plan.

(a) Each Participant will be 100% vested in that portion of his or her Account attributable to Compensation Deferrals and Bonus Deferrals made on or after January 1, 2006. For periods on or after January 1, 2006 and before January 1, 2014, this provision also applied to Salary Deferrals made pursuant to the Plan terms then in effect.

(b) Deferrals made under the Plan are 100% vested except as follows::

- (i) To the extent any item of Compensation deferred under the Plan before January 1, 2006 would have been subject to additional vesting requirements if not deferred, then the portion of the

Participant's Plan Year subaccount attributable to that item shall be subject to those additional vesting requirements.

- (ii) Each Participant will vest in the portion of each Plan Year subaccount attributable to "Supplemental Special Deferred Compensation Arrangements" (as those terms were defined in the Plan before January 1, 2006) in the manner described in the "Supplemental Special Deferred Compensation Arrangement."

7.02 Supplemental Pension Plan Contributions. All Supplemental Pension Plan Contributions as determined in accordance with Article V of the Plan shall be 100% vested.

7.03 Predecessor or Merged Plans. Vesting of a Participant's Account attributable to deferrals made and accruals earned before January 1, 2006 under a Predecessor Plan or Merged Plan were governed by the terms of the Predecessor Plan or Merged Plan to which they relate.

7.04 Company and/or Make-Up Contributions. Vesting of any Company Contributions and Make-Up Contributions shall be determined by the Company or Affiliate, in its sole discretion, and need not be the same for all Participants.

ARTICLE VIII DISTRIBUTIONS

8.01 Annual Election. Participants must indicate on an Election Form which of the distribution options described below will govern payment of the Plan Year subaccount to which deferred amounts are credited before the beginning of the Plan Year in which the compensation is earned or such earlier or later time as may be specified by the Administrator pursuant to Article III or Article IV. Unless otherwise specified in the Plan or permitted by the Administrator, such distribution election applies to all amounts credited to the Plan Year subaccount, including, but not limited to, Matching Contributions and Supplemental Pension Contributions.

8.02 Time for Distribution. Except as otherwise provided in Section 8.07, distribution of a Participant's Account shall be made on the earliest to occur of:

- (a) The date elected by a Participant under Section 8.03 with respect to an In-Service Payout;
- (b) The date set forth in Section 8.04 with respect to the Participant's Separation from Service; or
- (c) The date set forth in Section 8.06 with respect to the Participant's death.

8.03 In-Service Payout. A Participant may irrevocably select, on his or her Election Form, a specified date to receive a lump sum In-Service Payout of all vested amounts credited to a Plan Year subaccount. Payment shall be made as soon as administratively feasible following the specified date and before the later of (i) December 31 of the calendar year containing the specified date, or (ii) the 15th day of the third month following the specified date. If any amounts

are unvested at the time of the elected In-Service Payout date, but later become vested, such remaining amounts shall be paid at the earlier of the Participant's Separation from Service or Death.

8.04 Separation from Service. Upon a Participant's Separation from Service for any reason other than death, a Participant's vested Plan Year subaccount shall be paid or begin to be paid as soon as administratively feasible following Separation from Service and before the later of (i) December 31 of the calendar year in which the Participant's Separation from Service occurs, or (ii) the 15¹¹¹ day of the third month following the Participant's Separation from Service. Notwithstanding the foregoing, distributions made to a Key Employee upon such separation shall be paid or begin to be paid no earlier than the first day following the six month anniversary of the Participant's Separation from Service unless the Participant dies before or during such six-month period, in which case, such six-month delay shall not apply and payment shall be made pursuant to Section 8.06. Subsequent installment payments shall be made thereafter on or about the anniversary of the first installment payment.

Payment shall be made to the Participant in such form as determined below in subsection (a), (b), or (c).

(a) Lump Sum. A Participant's Plan Year subaccount balance shall be paid in a lump sum if:

- (i) timely elected by the Participant pursuant to the Plan; or
- (ii) no valid payment election is in effect when distribution is to be made.

(b) Annual Installments. A Participant may elect to receive payment of his or her Plan Year subaccount balance in either:

- (i) five annual installments; or
- (ii) ten annual installments.

(c) Exceptions. Notwithstanding the foregoing provisions, the following shall apply:

- (i) If a Participant's Account balance constituting contributions (other than Company and Make-Up Contributions) for all Plan Years at Separation from Service or death, whichever is earlier, is equal to or less than the limit then in effect under Code Section 402(g)(1)(B), such balance shall be paid in a lump sum in lieu of any election to receive installments.
- (ii) A Participant who is entitled to receive a Supplemental Part A Benefit, as provided under Article V, shall receive such benefit in a lump sum. Payment of the Supplemental Part A* Benefit, if any,

and Supplemental Part B Benefit, if any, shall be made as otherwise specified in the Plan.

8.05 Subsequent Changes in Elections.

(a) Participants who previously elected to receive an In-Service Payout pursuant to Section 8.03 shall be permitted to change his or her election to delay the time for payment until the fifth anniversary of the date the lump sum distribution would otherwise have been made. However, no such change of election under this Section shall have any force or effect or become effective until the expiration of the 12-month period measured from the filing date of such election. In addition, each such change of election with respect to an original election to receive an In-Service Payout shall be valid only if such election is made at least 12 months before the date of the scheduled distribution. In no event, however, may any change to the time for payment in effect for the Plan Year subaccount result in any acceleration of the distribution of that subaccount. Notwithstanding anything in this Section to the contrary, in the event of the Participant's Separation from Service or death after a subsequent election is made but before the end of the five-year delay described above, payment shall instead be made upon such Separation from Service or death, as the case may be.

(b) Notwithstanding any provision in the Plan to the contrary, on or before December 31, 2008, Participants may make changes to distribution elections previously filed with respect to amounts deferred under the Plan that relate to Plan Years 2005 through 2008 consistent with transition relief provided by the Department of the Treasury in Notice 2006-79, Notice 2007-86 and proposed regulations promulgated under Code Section 409A.

8.06 Death. If a Participant dies with a vested balance credited to one or more of his or her Plan Year subaccounts, whether or not the Participant was receiving payouts from those subaccounts at the time of his or her death, then the Participant's Beneficiary will receive the vested balance of each of those Plan Year subaccounts in a lump sum. If a Participant has any unvested Matching Contributions or Supplemental Pension Contributions credited to the Participant's Account as of death, such amounts will become fully vested, nonforfeitable and distributed pursuant to this Section.

8.07 Hardship Withdrawal. This Section shall only apply to amounts credited to a Participant's Account that are subject to Code Section 409A. Any hardship withdrawal right with respect to grandfathered amounts (within the meaning of Code Section 409A) shall be subject to rules, if any, of the Predecessor Plans. If a Participant (A) incurs a severe financial hardship as a result of (i) an illness or accident involving the Participant, his or her spouse, Beneficiary or any dependent (as determined pursuant to Code Section 152(a)), (ii) a casualty loss involving the Participant's property or (iii) other similar extraordinary and unforeseeable event beyond the Participant's control and (B) does not have any other resources available, whether through reimbursement or compensation (by insurance or otherwise) or liquidation of existing assets (to the extent such liquidation would not itself result in financial hardship), to satisfy such financial emergency, then the Participant may apply to the Administrator for an immediate distribution from the vested portion of his or her Account (but not the Predecessor

Plan Account) in an amount necessary to satisfy such financial hardship and the tax liability attributable to such distribution. The Administrator shall have complete discretion to accept or reject the request and shall in no event authorize a distribution in an amount in excess of that reasonably required to meet such financial hardship and the tax liability attributable to that distribution.

Any hardship withdrawal shall be made only to the extent permitted in accordance with Regulation Section 1.409A-3(i)(3). As a condition of the Administrator's acceptance of a request for a hardship withdrawal under this Section, the Participant's election to make Compensation Deferrals and/or Bonus Deferrals shall be terminated for the remainder of the Plan Year in which the hardship withdrawal is taken. In addition, such Participant shall be suspended from making Compensation Deferrals and Bonus Deferrals for the Plan Year immediately after the Plan Year in which the hardship withdrawal is taken. Such Participant, if then an Eligible Employee, may make a deferral election that relates to the second Plan Year following the Plan Year in which the hardship withdrawal was made in accordance with Article III and Article IV.

8.08 Valuation. The amount to be distributed from any Plan Year subaccount pursuant to this Article VIII shall be determined on the basis of the vested balance credited to that subaccount as of the most recent practicable date (as determined by the Administrator or its delegate) preceding the date of the actual distribution.

8.09 Tax Withholding. Income taxes and other taxes payable with respect to an Account shall be deducted from amounts payable under the Plan. All federal, state or local taxes that the Administrator determines are required to be withheld from any payments made pursuant to this Article VIII shall be withheld.

8.10 Payment of Small Accounts. The Administrator may, in its sole discretion which shall be evidenced in writing no later than the date of payment, elect to pay the value of the Participant's Account in a single lump sum if the balance of such Account is not greater than the applicable dollar amount under Code Section 402(g)(1)(B), provided the payment represents the complete liquidation of the Participant's interest in the Plan and all other account balance plans as determined pursuant to Regulation Section 1.409A-1(c) (2).

8.11 Right of Offset. The Company or an Affiliate shall have the right to offset any amounts payable to a Participant under the Plan to reimburse the Company or an Affiliate for liabilities or obligations of the Participant to the Company or Affiliate if the following conditions are met:

- (a) the liabilities or obligations of the Participant to the Company or Affiliate were incurred in the ordinary course of the service relationship between the Participant and the Company or Affiliate;
- (b) the entire amount to be offset does not exceed \$5,000 in any taxable year of the Participant; and
- (c) the offset is made at the same time and in the same amount as the liabilities or obligations otherwise would have been due and collected from the Participant.

8.12 Bona Fide Dispute. The Committee or the Administrator shall have the discretion to accelerate the time or schedule of payment under the Plan pursuant to Regulation Section 1.409A-3(j)(4)(xiv) where such payment occurs as part of an arm's length settlement of a bona fide dispute between the Company or an Affiliate and a Participant as to the Participant's right to the deferred amount.

8.13 Income Inclusion Under Code Section 409A. The Committee or the Administrator shall have the discretion to accelerate the time or schedule of payment under the Plan if the Plan fails to meet the requirements of Code Section 409A and Regulations issued thereunder, provided that any such payment does not exceed the amount required to be included in income as a result of such failure.

8.14 Effect of Rehire. In the event a Participant experiences a Separation from Service, begins receiving payment of his or her Account and is subsequently rehired by the Company or an Affiliate, distributions shall continue as regularly scheduled.

ARTICLE IX

EFFECT ON PREDECESSOR AND MERGED PLANS

9.01 Coordination With Predecessor Plans. Solely for ease of administration, the Predecessor Plans may be attached as exhibits to the Plan and are incorporated by reference herein. Except as otherwise specifically provided in the Plan, eligibility for and entitlement to benefits under the Predecessor Plans are governed solely by the terms of those Predecessor Plans. Effective January 1, 2005 (or such earlier date as may be provided in a Predecessor Plan), Participants ceased to accrue further benefits under the Predecessor Plans; however, Predecessor Plan benefits continue to accrue earnings per the Predecessor Plan terms before January 1, 2006 and pursuant to the Plan effective as of January 1, 2006.

9.02 Predecessor Plan Accounts. Although benefits accrued under Predecessor Plans are grandfathered for purposes of Code Section 409A to the extent such amounts were earned and vested as of December 31, 2004, for administrative purposes, the December 31, 2005 Predecessor Plan Account balance of any Predecessor Plan Participant became accounted for under the Plan as of January 1, 2006 and shall be subject to Article VI. In all other respects, each Predecessor Plan Account shall remain subject exclusively to the terms of the Predecessor Plan to which it relates, including without limitation the existing distribution election (commencement date and form of distribution) applicable to the Predecessor Participant's Predecessor Plan Account. Any change in that distribution election must be made in compliance with the applicable provisions of the applicable Predecessor Plan.

9.03 Merged Plans. The 2005 Anthem Plan, the 2005 Anthem SERP, the 2005 Trigon Plan and the 2005 Trigon SERP were merged into the Plan effective as of December 31, 2005. All benefits accrued under such merged plans are subject to Code Section 409A. In conjunction with the merger, on and after January 1, 2006, benefits ceased to accrue under the 2005 Anthem Plan, the 2005 Anthem SERP, the 2005 Trigon Plan, and the 2005 Trigon SERP except as otherwise provided in the Plan. The rights and obligations of participants in the Merged Plans before their effective dates of merger shall be governed solely by the terms of the Merged Plans; provided, however, that to the extent minimally necessary to comply with the requirements of

Section 409A of the Code, the requirements and restrictions of Sections 5.01(a)-(c) and 8.01(a)-(d) of the 2005 WellPoint Plan shall apply, effective as of January 1, 2005, to the portion of the Participant's Account attributable to the 2005 Anthem Plan. Distributions of amounts attributable to Merged Plan benefits are made pursuant to a Participant's election in effect under the applicable Merged Plan. If no such election is on file, amounts shall be distributed in a single lump sum payment.

ARTICLE X CLAIMS PROCEDURES

10.01 Presentation of Claim. No application is required for the commencement of benefits under the Plan. However, if a Participant or Beneficiary ("Claimant") believes that he or she is entitled to a greater benefit under the Plan, the Claimant may submit a signed, written application to the Committee for such a greater benefit. If such a claim relates to the contents of a notice received by the Claimant, the claim must be made within 90 days after such notice was received by the Claimant. All other claims shall be made within 180 days of the date on which the event that caused the claim to arise occurred. The claim shall state with particularity the determination desired by the Claimant. A claim shall be considered to have been made when a written communication made by the Claimant or the Claimant's representative is received by the Committee or its authorized delegate. References to the Committee in this Article includes references to the Executive Vice President and Chief Human Resources Officer and, if applicable, such officer's delegate. The Executive Vice President and Chief Human Resources Officer may further delegate, orally or in writing, authority to decide certain claims under this Article.

10.02 Decision on Initial Claim. The Committee shall consider a Claimant's claim and provide written notice to the Claimant of any denial within a reasonable time, but no later than 90 days after receipt of the claim. If an extension of time beyond the initial 90-day period for processing is required, written notice of the extension shall be provided to the Claimant before the initial 90-day period expires indicating the special circumstances requiring an extension of time and the date by which the Committee expects to render a final decision. In no event shall the period, as extended, exceed 180 days. If the Committee denies, in whole or in part, the claim, the notice shall set forth in a manner calculated to be understood by the Claimant:

- (a) The specific reasons for the denial of the claim, or any part thereof;
- (b) Specific references to pertinent Plan provisions upon which such denial was based;
- (c) A description of any additional material or information necessary for the Claimant to perfect the claim, and an explanation of why such material or information is necessary; and
- (d) An explanation of the claim review procedure, which explanation shall also include a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following a denial of the claim upon review.

10.03 Right to Review. A Claimant is entitled to appeal any claim that has been denied in whole or in part. To do so, the Claimant must submit a signed, written request for review with the Committee within 60 days after receiving a notice from the Committee that a claim has been denied, in whole or in part. Absent receipt by the Committee of a written request for review within such 60-day period, the claim shall be deemed to be conclusively denied. The Claimant (or the Claimant's duly authorized representative) may:

(a) Review and/or receive copies of, upon request and free of charge, all documents, records, and other information relevant to the Claimant's claim; and/or

(b) Submit written comments, documents, records or other information relating to her claim, which the Committee shall take into account in considering the claim on review, without regard to whether such information was submitted or considered in the initial review of the claim.

If a Claimant requests to review and/or receive copies of relevant information pursuant to subsection (a) above before filing a written request for review, the 60-day period for submitting the written request for review will be tolled during the period beginning on the date the Claimant makes such request and ending on the date the Claimant reviews or receives such relevant information.

10.04 Decision on Review. The Committee shall render its decision on review promptly, and not later than 60 days after it receives a written request for review of the denial, unless other special circumstances require additional time. In such case, the Committee will notify the Claimant, before the expiration of the initial 60-day period and in writing, of the need for additional time, the reason the additional time is necessary, and the date (no later than 60 days after expiration of the initial 60-day period) by which the Committee expects to render its decision on review. Notwithstanding the foregoing, if the Committee determines that an extension of the initial 60-day period is required due to the Claimant's failure to submit information necessary for the Committee to decide the claim, the time period by which the Committee must make its determination on review shall be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information. The decision on review shall be written in a manner calculated to be understood by the Claimant, and shall contain:

(a) Specific reasons for the decision;

(b) Specific references to the pertinent Plan provisions upon which the decision was based;

(c) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant (within the meaning of Department of Labor Regulation Section 2560.503-1(m)(8)) to the Claimant's claim;

(d) A statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following a wholly or partially denied claim for benefits; and

(e) Such other matters as the Committee deems relevant.

10.05 Form of Notice and Decision. Any notice or decision by the Committee under this Article may be furnished electronically in accordance with Department of Labor Regulation Section 2520.104b-(1)(c)(i), (iii) and (iv).

10.06 Legal Action. Any final decision by the Committee shall be binding on all parties. A Claimant's compliance with the foregoing provisions of this Article is a mandatory prerequisite to a Claimant's right to commence any legal action with respect to any claim for benefits under the Plan. Any such legal action must be initiated no later than 180 days after the Committee renders its final decision. If a final determination of the Committee is challenged in court, such determination shall not be subject to de novo review and shall not be overturned unless proven to be arbitrary and capricious based on the evidence considered by the Committee at the time of such determination.

ARTICLE XI ADMINISTRATION

11.01 Plan Administration. The Committee has overall responsibility for the Plan, but the Administrator shall have responsibility for the day-to-day administration of the Plan, as specified herein and as otherwise delegated by the Committee. The Administrator and members of the Committee may be Participants under this Plan. Any individual serving on the Committee who is a Participant shall not vote or act on any matter relating solely to himself or herself. The Chief Executive Officer, Executive Vice President and Chief Human Resources Officer or any other individual charged with administrative authority may not act on any matter involving such individual's own participation in the Plan.

11.02 Powers, Duties and Procedures. The Committee shall have full and complete discretionary authority to (i) make, amend, interpret and enforce all appropriate rules and regulations for the administration of the Plan, including any rules relating to trading restrictions as it determines necessary, and (ii) decide or resolve any and all questions including interpretations of the Plan, as may arise in connection with the claims procedures set forth in Article X or otherwise with regard to the Plan. The Committee shall have complete control and authority to determine the rights and benefits of all claims, demands and actions arising out of the provisions of the Plan of any Participant or Beneficiary or other person having or claiming to have any interest under the Plan. When making a determination or calculation, the Committee may rely on information furnished by a Participant or the Company, an Affiliate or other related entity. Benefits under the Plan shall be paid only if the Committee decides in its sole discretion that the Participant or Beneficiary is entitled to them. The Committee may delegate such powers and duties as it determines for the efficient administration of the Plan.

11.03 Agents. In the administration of this Plan, the Committee or the Administrator may, from time to time, employ agents and delegate to them such administrative duties as it sees fit (including acting through a duly appointed representative) and may from time to time consult with counsel who may be counsel to the Company, an Affiliate or other related entity.

11.04 Binding Effect of Decisions. Notwithstanding any other provision of the Plan to the contrary, the Committee or its delegate shall have complete discretion to interpret the Plan and to decide all matters under the Plan. Any such interpretation shall be final, conclusive and binding on all Participants, Beneficiaries and any person claiming under or through any Participant, in the absence of clear and convincing evidence that the Committee or its delegate acted arbitrarily and capriciously.

11.05 Information. To enable the Committee and the Administrator to perform its functions, the Company, an Affiliate or other related entity shall supply full and timely information to the Committee or the Administrator, as the case may be, on all matters relating to the compensation of its Participants, the dates of the death or Separation from Service and such other pertinent information as the Committee or Administrator may reasonably require.

11.06 Coordination with Other Benefits. The benefits provided to a Participant and the Beneficiary under the Plan are in addition to any other benefits available to such Participant under any other plan or program for employees of the Company, an Affiliate or other related entity. The Plan shall supplement and shall not supersede, modify or amend any other such plan or program except as may otherwise be expressly provided.

ARTICLE XII MISCELLANEOUS

12.01 Limitation of Rights. Participation in the Plan does not give any individual the right to be retained in the service of the Company, any Affiliate or other related entity, or to interfere with the right of the Company, any Affiliate or other related entity to discipline or discharge the individual at any time, with or without cause, or to modify the Salary, Compensation or Bonus of such individual at any time.

12.02 Additional Restrictions. If the Administrator determines that additional restrictions or limitations must be placed on the investment vehicles utilized for measuring the return on the amounts credited to Participant Accounts, the right of Participants to make investment elections with respect to their Accounts, their ability to make or change distribution elections, their ability to defer distributions or to change the commencement date for the distribution of their benefits or the method of such distribution or their rights or status as creditors under the Plan in order to avoid current income taxation of amounts deferred under the Plan, the Administrator may, in its sole discretion, amend the Plan to impose such restrictions or limitations, cease deferrals under the Plan and/or defer distribution dates under the Plan.

12.03 Indemnification. The Company will indemnify and hold harmless the Directors, the members of the Committee and any delegate of the Committee, and employees of the Company and its Affiliates, from and against any and all liabilities, claims, costs and expenses, including attorneys' fees, arising out of an alleged breach in the performance of their fiduciary duties under the Plan, other than such liabilities, claims, costs and expenses as may result from the gross negligence or willful misconduct of such persons. The Company shall have the right, but not the obligation, to conduct the defense of such persons in any proceeding to which this Section applies.

12.04 Assignment. To the fullest extent permitted by law, benefits under the Plan and rights thereto are not subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, attachment, or garnishment by creditors of a Participant or a Beneficiary.

12.05 Inability to Locate Recipient. If a benefit under the Plan remains unpaid for two (2) years from the date it becomes payable, solely by reason of the inability of the Administrator to locate the Participant or Beneficiary entitled to the payment, the benefit shall be treated as forfeited. Any amount forfeited in this manner shall be restored without interest upon presentation of an authenticated written claim by the person entitled to the benefit.

12.06 Amendment and Termination.

(a) The Committee may, at any time, amend or terminate the Plan. Any amendment must be made in writing; no oral amendment will be effective. Except to the limited extent authorized pursuant to Section 12.02, no amendment may, without the consent of an affected Participant (or, if the Participant is deceased, the Participant's Beneficiary), adversely affect the Participant's or the Beneficiary's rights and obligations under the Plan with respect to amounts already credited to a Participant's Account, and all amounts deferred under the Plan before the date of any such amendment or termination of the Plan shall continue to become due and payable in accordance with the distribution provisions of Article VIII as in effect immediately before such amendment or termination.

(b) Notwithstanding subsection (a), if the Company exercises its discretion under Article V and determines an amendment is necessary to the Plan, participant consent shall only be required if the amendment impacts Supplemental Contributions and earnings credited through December 31, 2008.

(c) Upon termination of the Plan, the Committee reserves the discretion to accelerate distribution of the Accounts of Participants in accordance with regulations promulgated by the Department of Treasury under Code Section 409A.

12.07 Applicable Law. To the extent not governed by Federal law, the laws of the State of Indiana shall govern the Plan. If any provision of the Plan is held to be invalid or unenforceable, the remaining provisions of the Plan will continue to be fully effective.

12.08 No Funding. The obligation to pay the vested balance of each Participant's Account shall at all times be an unfunded and unsecured obligation of the Company or its Affiliates, as the case may be, and Participants and Beneficiaries shall have the status of general unsecured creditors of the Company or applicable Affiliate. Except to the extent provided below in Section 12.09, Plan benefits will be paid from the general assets of the Company, and nothing in the Plan will be construed to give any Participant or any other person rights to any specific assets of the Company or its Affiliates. In all events, it is the intention of the Company and its Affiliates and all Participants that the Plan be treated as unfunded for tax purposes and for purposes of Title I of ERISA.

12.09 Trust. The benefits under the Plan will be paid from the assets of a grantor trust (the "Trust") established by the Company to assist it and its Affiliates in meeting their

obligations hereunder and, to the extent that such assets are not sufficient, by the Company or the applicable Affiliate out of their general assets. The Trust shall conform to the terms of the Internal Revenue Service Model Trust in Internal Revenue Service Procedure 92-64 (or any successor procedure).

* * *

IN WITNESS WHEREOF, Anthem, Inc. has caused the Plan to be executed by its duly authorized representative as of the date indicated above.

ANTHEM, INC.

By: /s/ Joseph R. Swedish

Joseph R. Swedish

President & Chief Executive Officer

Exhibit 10.4

Anthem, Inc.

EXECUTIVE AGREEMENT PLAN

(Amended and Restated Effective December 2, 2014)

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**Anthem, Inc.
Executive Agreement Plan
Amended and Restated
Effective December 2, 2014**

ARTICLE I

ESTABLISHMENT, AMENDMENT, PURPOSE AND INTENT

1.1 Establishment, Amendment, Purpose and Intent. Anthem, Inc. (f/k/a WellPoint, Inc.), an Indiana corporation with its principal place of business in Indianapolis, Indiana ("Anthem"), established the WellPoint, Inc. Executive Agreement Plan ("Plan"), effective as of January 1, 2006, and amended and restated the Plan effective November 1, 2006, and again effective October 1, 2007. The Plan was further amended and restated in its entirety, effective January 1, 2009 in response to final regulations issued under Code Section 409A. The Plan is hereby further amended and restated effective December 1, 2014 to reflect a change in the Company's name and to incorporate amendments adopted since the last restatement. The Plan is hereby renamed the Anthem, Inc. Executive Agreement Plan.

The Plan is intended to protect key executive employees of Anthem and its subsidiaries and affiliates (collectively, the "Company") against an involuntary loss of employment so as to attract and retain such employees, and motivate them to enhance the value of the Company. The Plan is intended to be an unfunded welfare plan subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"); or to the extent it is a pension plan subject to ERISA, as an unfunded pension plan maintained primarily for the purpose of providing deferred compensation to a select group of management or highly compensated employees. Words and phrases used with initial capitals in the Plan and not otherwise defined in the Plan have the meanings defined for them in Article 8.

ARTICLE 2

ELIGIBILITY AND PARTICIPATION

2.1 Participation. Each Executive shall become a Participant ("Participant") upon mutual execution by the eligible Executive and the Company of an agreement (an "Employment Agreement") substantially in the form of that attached as Exhibit A. Each such executed Employment Agreement shall form part of this Plan and is incorporated into this Plan by this reference. As soon as practicable after the date that the individual becomes an Executive, the Committee shall deliver a copy of the Plan to the Executive, advise the Executive of his or her eligibility, and offer him or her for a period of forty-five (45) days the opportunity to enter into an Employment Agreement substantially in the form of that attached as Exhibit A. If an Executive does not enter into an Employment Agreement within forty-five (45) days of such advice the Executive shall have no further opportunity to become a Participant in the Plan unless either the Chief Executive Officer or the Chief Human Resources Officer of the Company in his or her sole discretion affords the Executive a new or extended opportunity to become a Participant in the Plan.

2.2 Termination of Participation. A Participant's participation in the Plan shall automatically terminate, without notice to or consent of the Participant, upon the earliest to occur of the following events:

- (a) termination of the Participant's employment with the Company for any reason (including but not limited to death, disability, Transfer of Business or other disposition of the subsidiary of the Company which employs the Participant) that is not an Eligible Separation from Service (as defined in Section 3.1); or
- (b) expiration of the Employment Agreement.

2.3 Employment Period. Subject to the termination provisions hereinafter provided, the initial term of Executive's employment under this Plan shall commence on the date provided as the "Agreement Date" in the Employment Agreement and shall end on the date that is one year after the Agreement Date; provided, however, that commencing on the day following the Agreement Date the term will automatically be extended each day by one day, until a date (the "Expiration Date") which is the first annual anniversary of the first date on which either the Company or Executive delivers to the other written notice of non renewal. The term beginning on the Agreement Date and ending on the Expiration Date shall constitute the "Employment Period" for purposes of the Plan. Expiration of the Employment Agreement shall not be construed to terminate the employment of Executive. If the employment of Executive does not terminate on or before the Expiration Date in accordance with the Plan, Executive shall continue to be an employee at will of the Company after the Expiration Date unless such employment is otherwise terminated by the Company or Executive.

ARTICLE 3

SEVERANCE BENEFITS

3.1 Eligible Separation from Service. Each Participant shall be entitled to severance and other benefits under the Plan in the amount set forth in Sections 3.2 and 3.3 below ("Severance Benefits") if the Participant incurs an Eligible Separation from Service. Entitlement to Severance Benefits is subject to the Participant's compliance with Sections 3.6 and 3.7 of the Plan and the other terms and conditions of this Plan, and subject to the execution and delivery of a valid and unrevoked Waiver and Release Agreement as required by Section 3.5 and to the other conditions set forth below. For this purpose an "Eligible Separation from Service" is:

- (a) a Separation from Service by reason of a termination of the Participant's employment by the Company for any reason other than death, disability, Cause, or Transfer of Business;
- (b) a Separation from Service by reason of a termination of the Participant's employment by the Participant for Good Reason;
- (c) a Separation from Service during an Imminent Change in Control Period by reason of a termination of the Participant's employment by the Company for any reason other than death, disability, Cause, or Transfer of Business.

No Severance Benefits shall be payable in respect of a Separation from Service that is not an Eligible Separation from Service. For avoidance of doubt, none of the following shall be an Eligible Separation from Service: (i) termination of the Participant's employment upon death or disability, (ii) termination of the Participant's employment by the Company for Cause or upon Transfer of Business, or (iii) any voluntary resignation that does not constitute a termination of the Participant's employment for Good Reason. No Severance Benefits shall be payable merely upon termination of an Employment Agreement without a Separation from Service.

3.2 Amount of Severance Pay.

(a) The amount of severance pay ("Severance Pay") to which the Participant is entitled over the applicable severance period ("Severance Period") under the Plan shall be the product of the amount described in (i) multiplied by the percentage described in (ii), with such product reduced by the amount described in (iii):

(i) if a Vice President, Senior Vice President, or Executive Vice President, the sum of the Participant's Annual Salary and Annual Target Bonus or if an Other Key Executive, Annual Salary;

(ii) the applicable percentage set forth below opposite the Participant's employment classification at the time of Separation from Service (disregarding any adverse change in employment classification during an Imminent Change in Control Period or after a Change in Control);

(iii) the sum of (A) severance or similar payments made pursuant to any Federal, state or local law, including but not limited to payments under the Federal Worker Adjustment and Retraining Notification Act (WARN), and (B) any termination or severance payments under any other termination or severance plans, policies or programs of the Company or any of its subsidiaries and affiliates that the Participant receives notwithstanding subsection (c) below.

(iv) In the event the Participant's Eligible Separation from Service occurs outside an Imminent Change in Control Period or outside the thirty-six month period following a Change in Control, the applicable percentage shall be the percentage set forth in column (A) below and the Severance Period shall be the period set forth in column (B) below. In the event the Participant's Eligible Separation from Service occurs within an Imminent Change in Control Period, provided the contemplated Change in Control occurs within one year of the Participant's Eligible Separation from Service, or within the thirty-six month period following a Change in Control, the applicable percentage shall be the percentage set forth in column (C) below and the applicable Severance Period shall be the period set forth in column (D) below.

	(A)	(B)	(C)	(D)
Position	Percentage absent Change in Control	Severance Period, absent Change in Control, Over Which Severance Pay will be Paid	Percentage -- Change in Control	Severance Period -- Change in Control Over Which Severance Pay will be Paid
Other Key Executive	100%	One year	100%	One year
Senior Vice President ¹ and Vice President	100%	One year	100%	One year
Senior Vice President ²	150%	One and one-half years	250%	Two and one-half years
Executive Vice President	200%	Two years	300%	Three years

¹The percentage and corresponding severance period applies to an Executive classified as a Senior Vice President at the time of an Eligible Separation from Service as provided in (ii) of Section 3.2(a) and who either (a) first became a Participant on or after August 6, 2013, or (b) is a Participant as of August 6, 2013 in another employment classification and his employment classification changes to Senior Vice President on or after August 6, 2013.

²The percentage and corresponding severance period applies to an Executive who became a Participant before August 6, 2013, is classified as a Senior Vice President as of August 6, 2013 and remains a Senior Vice President until the time of an Eligible Separation from Service as provided in (ii) of Section 3.2(a).

(b) There shall be no duplication of severance benefits in any manner. Severance Pay under this Plan shall be in lieu of any termination or severance payments to which the Participant may be entitled under any other termination or severance plans, policies or programs of the Company or any of its subsidiaries and affiliates. No Participant shall be entitled to Severance Pay hereunder for more than one position with the Company.

(c) A Participant shall not be obligated to secure new employment, but each Participant shall report promptly to the Company any actual employment obtained during the Severance Period. Severance Pay under the Plan shall not be subject to mitigation except as provided (i) in Section 3.2(a) and (b) hereof for other severance pay from the Company and (ii) in Section 3.3 for determining continuing eligibility for health and life benefits coverage. Severance Pay shall be subject to Section 3.7.

(d) Severance Periods shall be measured from the date of the Eligible Separation from Service.

3.3 Other Benefits.

(a) A Participant entitled to Severance Pay pursuant to Section 3.2 shall be entitled during the applicable Severance Period to receive the following additional benefits:

(i) continued participation for him or her (and for his or her eligible dependents) in the Company's health benefit plan on the same basis (excluding payment of contributions) as apply to active employees from time to time; provided that the Participant and his or her eligible dependents assume the cost, on an after-tax basis, for such continued coverage, and further provided that this coverage shall terminate prior to the end of the Severance Period when the Participant (or his or her eligible dependents, as applicable) becomes entitled to health benefit plan coverage (whether or not comparable to plans of the Company) from any successor employer; and

(ii) on or about January 31 of the year following the year in which the Separation from Service occurs and continuing on or about each January 31 until the year following the year in which the Participant's health benefit plan coverage continues pursuant to Section 3.3(a)(i), the Company will make a payment to the Participant equal to the amount the Participant paid during the immediately preceding calendar year for health benefit plan continuation coverage described in Section 3.3(a)(i) that exceeds the amount that the Participant would have paid if the Participant paid for such continued health benefit plan coverage on the same basis as applicable to active employees, provided that each such cash payment by the Company pursuant to this Section 3.3(a)(ii) shall be considered a separate payment and not one of a series of payments for purposes of Section 409A; and

(iii) continued participation for him or her in the Company's life insurance benefit plan on the same basis (including payment of contributions) as apply to active employees from time to time; provided that this coverage shall terminate prior to the end of the Severance Period when the Participant (or his or her eligible dependents, as applicable) becomes entitled to health and life insurance benefit plan coverage (whether or not comparable to plans of the Company) from any successor employer; and

(iv) if the cash credits portion of the Directed Executive Compensation program is available to the active employees at the Participant's Executive level, the continuation of Directed Executive Compensation monthly cash payments, provided that each such cash payment by the Company pursuant to this Section 3.3(a)(iv) shall be considered a separate payment and not one of a series of payments for purposes of Section 409A; and

(v) if financial planning services are available to the active employees at the Participant's Executive level, the Company shall reimburse the Participant's expenses for financial planning incurred during the Severance Period. Such reimbursement shall be made no later than the last day of the calendar year following the calendar year in which the Participant incurs the financial planning expense. In no event will the amount of expenses so reimbursed by the Company in one year affect the amount of expenses eligible for reimbursement, or in-kind benefits to be provided, in any other taxable year. Each reimbursement of the Participant's expenses for financial planning pursuant to this Section 3.3(a)(v) shall be considered a separate payment and not one of a series of payments for purposes of Section 409A.

Neither Executive nor his dependents shall be eligible for continued participation in any disability income plan, travel accident insurance plan or tax-qualified retirement plan. Nothing herein shall be deemed to restrict the right of the Company to amend or terminate any plan in a manner generally applicable to active employees.

(b) The period of continuation coverage to which the Participant is entitled under Section 601 et seq. of ERISA (the "COBRA Continuation Period") shall begin after the Severance Period.

(c) Eligible Participants shall be entitled to reasonable outplacement counseling with an outplacement firm of the Company's selection in a form and manner determined by the Company, provided, however, that a Participant must conclude such services by December 31st of the second taxable year following the Participant's Separation from Service or such earlier date established by the Company. The Company shall reimburse the Participant for such expenses, or pay the outplacement firm as the case may be, no later than December 31st of the third taxable year following the Participant's Separation from Service.

3.4 Payment. Severance Pay (including payments pursuant to Section 4.5) and payments provided under Section 3.3(a)(ii), if any, shall commence to be paid as soon as practicable after the 45th day after the Eligible Separation from Service and shall be paid in substantially equal monthly (or more frequent periodic installments corresponding to the Company's normal payroll practices for Executive employees) payments over the Severance Period. Each such payment shall be considered a separate payment and not part of a series of installments for purposes of the short-term deferral rules under Treasury Regulation Section 1.409A-1(b)(4)(i), and the exemption for involuntary terminations under separation pay plans under Treasury Regulation Section 1.409A-1(b)(9)(iii). As a result, the following payments are exempt from the requirements of Section 409A of the Code:

(a) Payments that are made on or before the 15th day of the third month of the calendar year following the year of the Eligible Separation from Service, and

(b) Any additional payments that are made on or before the last day of the second calendar year following the year of the Executive's Eligible Separation from Service and that do not exceed the lesser of two times:

(i) The Executive's annualized compensation based upon the annual rate of pay for services provided to the Company for the Executive's taxable year that precedes the taxable year in which the Eligible Separation from Service occurs (adjusted for any increase during that year that was expected to continue indefinitely if the Executive had not incurred a Separation from Service); or

(ii) the limit under Section 401(a)(17) of the Code then in effect.

Notwithstanding the foregoing, in the event Severance Pay is paid to an Executive who is a Key Employee during the taxable year in which the Separation from Service occurs, to the extent the payments to be made during the first six month period following the Executive's Eligible Separation from Service exceed the amounts exempt from Section 409A of the Code under Sections 3.4(a) and 3.4(b) above, the excess amount shall be withheld and will be instead paid on the first day of the seventh month following the Executive's Separation from Service. Any withheld amount shall include, together with interest thereon from the date that they would have been paid absent such delay through the date of payment at 120% of the applicable six month short-term federal rate, determined under Section 1274(d) of the Code (the "AFR").

3.5 Waiver and Release. In order to receive benefits under the Plan, a Participant must execute and deliver to the Company a valid Waiver and Release Agreement within thirty (30) days of his or her date of Separation from Service, in a form tendered by the Company,

which shall be substantially in the form of the Waiver and Release Agreement attached hereto as Exhibit B, with any changes thereto approved by Anthem's counsel prior to execution. No benefits shall be paid under the Plan until the Participant has executed his or her Waiver and Release Agreement and the period within which a Participant may revoke his or her Waiver and Release Agreement has expired without revocation. A Participant may revoke his or her signed Waiver and Release Agreement within seven (7) days (or such other period provided by law) after his or her signing the Waiver and Release Agreement. Any such revocation must be made in writing and must be received by the Company within such seven (7) day (or such other) period. A Participant who does not submit a signed Waiver and Release Agreement to the Company within thirty (30) days of his or her Separation from Service shall not be eligible to receive any Severance Benefits under the Plan. A Participant who timely revokes his or her Waiver and Release Agreement shall not be eligible to receive any Severance Benefits under the Plan.

3.6 Restrictive Covenants. As a condition of participation in this Plan each Participant agrees as follows:

(a) Confidentiality.

(i) The Participant recognizes that the Company derives substantial economic value from information created and used in its business which is not generally known by the public, including, but not limited to, plans, designs, concepts, computer programs, formulae, and equations; product fulfillment and supplier information; customer and supplier lists, and confidential business practices of the Company, its affiliates and any of its customers, vendors, business partners or suppliers; profit margins and the prices and discounts the Company obtains or has obtained or at which it sells or has sold or plans to sell its products or services (except for public pricing lists); manufacturing, assembling, labor and sales plans and costs; business and marketing plans, ideas, or strategies; confidential financial performance and projections; employee compensation; employee staffing and recruiting plans and employee personal information; and other confidential concepts and ideas related to the Company's business (collectively, "Confidential Information"). The Participant expressly acknowledges and agrees that by virtue of his or her employment with the Company, the Participant will have access and will use in the course of the Participant's duties certain Confidential Information and that Confidential Information constitutes trade secrets and confidential and proprietary business information of the Company, all of which is the exclusive property of the Company. For purposes of this Agreement, Confidential Information includes the foregoing and other information protected under the Indiana Uniform Trade Secrets Act (the "Act"), or to any comparable protection afforded by applicable law, but does not include information that the Participant establishes by clear and convincing evidence is or may become known to the Participant or to the public from sources outside the Company and through means other than a breach of this Agreement.

(ii) The Participant agrees that the Participant will not for himself or herself or for any other person or entity, directly or indirectly, without the prior written consent of the Company, while employed by the Company and thereafter: (i) use Confidential Information for the benefit of any person or entity other than the Company or its

affiliates; (ii) remove, copy, duplicate or otherwise reproduce any document or tangible item embodying or pertaining to any of the Confidential Information, except as required to perform the Participant's duties for the Company or its affiliates; or (iii) while employed and thereafter, publish, release, disclose or deliver or otherwise make available to any third party any Confidential Information by any communication, including oral, documentary, electronic or magnetic information transmittal device or media. Upon termination of employment, the Participant shall return all Confidential Information and all other property of the Company. This obligation of non-disclosure and non-use of information shall continue to exist for so long as such information remains Confidential Information.

(b) Disclosure and Assignment of Inventions and Improvements. Without prejudice to any other duties express or implied imposed on the Participant hereunder it shall be part of the Participant's normal duties at all times to consider in what manner and by what methods or devices the products, services, processes, equipment or systems of the Company and any customer or vendor of the Company might be improved and promptly to give to the Chief Executive Officer of the Company or his or her designee full details of any improvement, invention, research, development, discovery, design, code, model, suggestion or innovation (collectively called "Work Product"), which the Participant (alone or with others) may make, discover, create or conceive in the course of the Participant's employment. The Participant acknowledges that the Work Product is the property of the Company. To the extent that any of the Work Product is capable of protection by copyright, the Participant acknowledges that it is created within the scope of the Participant's employment and is a work made for hire. To the extent that any such material may not be a work made for hire, the Participant hereby assigns to the Company all rights in such material. To the extent that any of the Work Product is an invention, discovery, process or other potentially patentable subject matter (the "Inventions"), the Participant hereby assigns to the Company all right, title, and interest in and to all Inventions. The Company acknowledges that the assignment in the preceding sentence does not apply to an Invention that the Participant develops entirely on his or her own time without using the Company's equipment, supplies, facilities or trade secret information, except for those Inventions that either:

- (1) relate at the time of conception or reduction to practice of the Invention to the Company's business, or actual or demonstrably anticipated research or development of the Company, or
- (2) result from any work performed by the Participant for the Company.

Execution of the Employment Agreement constitutes the Participant's acknowledgment of receipt of written notification of this Section and of notice of the general exception to assignments of Inventions provided under ~~the~~ Uniform Employee Patents Act, in the form adopted by the state having jurisdiction over this Plan or provision, or any comparable applicable law.

(c) Non-Competition. During the Employment Period and any period in which the Participant is employed by the Company during or after the Employment Period, and during a

period of time after the Participant's termination of employment (the "Restriction Period") which is eighteen (18) months for Executive Vice Presidents, fifteen (15) months for Senior Vice Presidents who became a Participant before August 6, 2013, and twelve (12) months for all other Participants (including Senior Vice Presidents who first *become* Participants on or after August 6, 2013 or were Participants as of August 6, 2013 in another employment classification and whose employment classification changes to Senior Vice President on or after August 6, 2013), the Participant will not, without prior written consent of the Company, directly or indirectly seek or obtain a Competitive Position in a Restricted Territory and perform a Restricted Activity with a Competitor, as those terms are defined herein.

(i) Competitive Position means any employment or performance of services with a Competitor (A) in which the Participant has executive level duties for such Competitor, or (B) in which the Participant will use any Confidential Information of the Company.

(ii) Restricted Territory means any geographic area in which the Company does business and in which the Participant had responsibility for, or Confidential Information about, such business, within the thirty-six (36) months prior to the Participant's termination of employment from the Company.

(iii) Restricted Activity means any activity for which the Participant had responsibility for the Company within the thirty-six (36) months prior to the termination of the Participant's employment from the Company or about which the Participant had Confidential Information.

(iv) Competitor means any entity or individual (other than the Company or its affiliates) engaged in management of network-based managed care plans and programs, or the performance of managed care services, health insurance, long term care insurance, dental, life or disability insurance, behavioral health, vision, flexible spending accounts and COBRA administration or other products or services substantially the same or similar to those offered by the Company while the Participant was employed, or other products or services offered by the Company within twelve (12) months after the termination of Participant's employment if the Participant had responsibility for, or Confidential Information about, such other products or services while the Participant was employed by the Company.

(d) Non-Solicitation of Customers. During the Employment Period and any period in which the Participant is employed by the Company during or after the Employment Period, and during the Restriction Period after the Participant's termination of employment, the Participant will not, either individually or as an employee, partner, consultant, independent contractor, owner, agent, or in any other capacity, directly or indirectly, for a Competitor of the Company as defined in subsection (c) above: (i) solicit business from any client or account of the Company or any of its affiliates with which the Participant had contact, participated in the contact, or responsibility for, or about which the Participant had knowledge of Confidential Information by reason of the Participant's employment with the Company, (ii) solicit business from any client or account which was pursued by the Company or any of its affiliates and with which the Participant had contact, or responsibility for, or about which the Participant had knowledge of

Confidential Information by reason of the Participant's employment with the Company, within the twelve (12) month period prior to termination of employment. For purposes of this provision, an individual policyholder in a plan maintained by the Company or by a client or account of the Company under which individual policies are issued, or a certificate holder in such plan under which group policies are issued, shall not be considered a client or account subject to this restriction solely by reason of being such a policyholder or certificate holder.

(e) Non-Solicitation of Employees. During the Employment Period and any period in which the Participant is employed by the Company during or after the Employment Period, and during the Restriction Period after the Participant's termination of employment as set forth on Schedule A to the Employment Agreement, the Participant will not, either individually or as an employee, partner, independent contractor, owner, agent, or in any other capacity, directly or indirectly solicit, hire, attempt to solicit or hire, or participate in any attempt to solicit or hire, for any non-Company affiliated entity, any person who on or during the six (6) months immediately preceding the date of such solicitation or hire is or was an officer or employee of the Company, or whom the Participant was involved in recruiting while the Participant was employed by the Company.

(f) Non-Disparagement. The Participant agrees that he or she will not, nor will he or she cause or assist any other person to, make any statement to a third party or take any action which is intended to or would reasonably have the effect of disparaging or harming the Company or the business reputation of the Company's directors, employees, officers and managers. Further, the Participant will not at any time make any verbal or written statement to any media outlet regarding the Company.

3.7 Return of Consideration.

(a) If at any time a Participant breaches any provision of Section 3.6 or Section 3.10, then: (i) the Company shall cease to provide any further Severance Pay or other benefits under Section 3.2 or Section 3.3 and the Participant shall repay to the Company all Severance Pay and other benefits previously received under Section 3.2 or Section 3.3; (ii) all unexercised Company stock options under any Designated Plan (defined below) whether or not otherwise vested shall cease to be exercisable and shall immediately terminate; (iii) the Participant shall forfeit any outstanding restricted stock or other outstanding equity award made under any Designated Plan and not otherwise vested on the date of breach; and (iv) the Participant shall pay to the Company (A) for each share of common stock of the Company ("Common Share") acquired on exercise of an option under a Designated Plan within the 24 months prior to such breach, the excess of the fair market value of a Common Share on the date of exercise over the exercise price, and (B) for each share of restricted stock that became vested under any Designated Plan within the 24 months prior to such breach, the fair market value (on the date of vesting) of a Common Share. Any amount to be repaid pursuant to this Section 3.7 shall be held by the Participant in constructive trust for the benefit of the Company and shall, upon written notice from the Company, within 10 days of such notice, be paid by the Participant to the Company with interest from the date such Common Share was acquired or the share of restricted stock became vested, as the case may be, to the date of payment, at 120% of the applicable six month short-term AFR. Any amount described in clauses (i), (ii) and (iii) that the Participant forfeits as a result of a

breach of the provisions of Sections 3.6 or 3.10 shall not reduce any money damages that would be payable to the Company as compensation for such breach.

(b) The amount to be repaid pursuant to this Section 3.7 shall be determined on a gross basis, without reduction for any taxes incurred, as of the date of the realization event, and without regard to any subsequent change in the fair market value of a Common Share. The Company shall have the right to offset such amount against any amounts otherwise owed to the Participant by the Company (whether as wages, vacation pay, or pursuant to any benefit plan or other compensatory arrangement other than any amount pursuant to any nonqualified deferred compensation plan under Section 409A of the Code).

(c) For purposes of this Section 3.7, a "Designated Plan" is each annual bonus and incentive plan, stock option, restricted stock, or other equity compensation or long-term incentive compensation plan, deferred compensation plan, or supplemental retirement plan, listed on Exhibit C.

(d) The provisions of this Section 3.7 shall apply to awards described in clauses (i), (ii), (iii), and (iv) of subsection (a) earned or made after the date the Executive becomes a Participant in this Plan and executes an Employment Agreement, and to awards earned or made prior thereto which by their terms are subject to cessation and recoupment under terms similar to those of this Section 3.7.

3.8 Equitable Relief and Other Remedies. As a condition of participation in this Plan:

(a) The Participant acknowledges that each of the provisions of Section 3.6 and 3.7 of the Plan are reasonable and necessary to preserve the legitimate business interests of the Company, its present and potential business activities and the economic benefits derived therefrom; that they will not prevent him or her from earning a livelihood in the Participant's chosen business and are not an undue restraint on the trade of the Participant, or any of the public interests which may be involved.

(b) The Participant agrees that beyond the amounts otherwise to be provided under this Plan and the Employment Agreement, the Company will be damaged by a violation of the terms of this Plan and the amount of such damage may be difficult to measure. The Participant agrees that if the Participant commits or threatens to commit a breach of any of the covenants and agreements contained in Sections 3.6 or 3.10 to the extent permitted by applicable law, then the Company shall have the right to seek and obtain all appropriate injunctive and other equitable remedies, without posting bond therefor, except as required by law, in addition to any other rights and remedies that may be available at law or under this Plan, it being acknowledged and agreed that any such breach would cause irreparable injury to the Company and that money damages would not provide an adequate remedy. Further, if the Participant violates Section 3.6 hereof the Participant agrees that the period of violation shall be added to the period in which the Participant's activities are restricted.

(c) Notwithstanding the foregoing, the Company will not seek injunctive relief to prevent a Participant residing in California from engaging in post termination competition in

California under Section 3.6(c) or (d) of this Plan, provided that the Company may seek and obtain relief to enforce Section 3.7 of this Plan with respect to such Participants.

(d) The parties agree that the covenants contained herein are severable. If an arbitrator or court shall hold that the duration, scope, area or activity restrictions stated herein are unreasonable under circumstances then existing, the parties agree that the maximum duration, scope, area or activity restrictions reasonable and enforceable under such circumstances shall be substituted for the stated duration, scope, area or activity restrictions to the maximum extent permitted by law. The parties further agree that the Company's rights under Section 3.7 should be enforced to the fullest extent permitted by law irrespective of whether the Company seeks equitable relief in addition to relief provided therein or if the arbitrator or court deems equitable relief to be inappropriate.

3.9 Survival of Provisions. The obligations contained in Sections 3.6, 3.7, 3.8 and Section 3.10 below shall survive the cessation of the Employment Period (as defined in the Employment Agreement) and the Participant's employment with the Company and shall be fully enforceable thereafter.

3.10 Cooperation. Upon the receipt of reasonable notice from the Company (including from outside counsel to the Company), the Participant agrees that while employed by the Company and for two years (or, if longer, for so long as any claim referred to in this Section remains pending) after the termination of Participant's employment for any reason, the Participant will respond and provide information with regard to matters in which the Participant has knowledge as a result of the Participant's employment with the Company, and will provide reasonable assistance to the Company, its affiliates and their respective representatives in defense of any claims that may be made against the Company or its affiliates, and will assist the Company and its affiliates in the prosecution of any claims that may be made by the Company or its affiliates, to the extent that such claims may relate to the period of the Participant's employment with the Company (or any predecessor); provided, that with respect to periods after the termination of the Participant's employment, the Company shall reimburse the Participant for any out-of-pocket expenses incurred in providing such assistance and if the Participant is required to provide more than ten (10) hours of assistance per week after his termination of employment then the Company shall pay the Participant a reasonable amount of money for his services at a rate agreed to between the Company and the Participant; and provided further that after the Participant's termination of employment with the Company such assistance shall not unreasonably interfere with the Participant's business or personal obligations. The Participant agrees to promptly inform the Company if the Participant becomes aware of any lawsuits involving such claims that may be filed or threatened against the Company or its affiliates. The Participant also agrees to promptly inform the Company (to the extent the Participant is legally permitted to do so) if the Participant is asked to assist in any investigation of the Company or its affiliates (or their actions), regardless of whether a lawsuit or other proceeding has then been filed against the Company or its affiliates with respect to such investigation, and shall not do so unless legally required.

ARTICLE 4

ADDITIONAL CHANGE IN CONTROL BENEFITS

4.1 Equity Vesting Upon Change in Control.

(a) If the conditions of Section 4.1(b) are satisfied, then as of the date of the Change in Control, all Options and SARs of a Participant shall become fully and immediately exercisable, all Restricted Stock shall become fully vested and nonforfeitable and forthwith delivered to a Participant if not previously delivered, and there shall be paid out in cash to the Participant within 30 days following the effective date of the Change in Control the value of the Performance Shares to which the Participant would have been entitled if performance achieved 100% of the target performance goals established for such Performance Shares.

(b) Both of the following conditions must be satisfied in order for Section 4.1(a) to apply:

(i) A Change in Control must occur, and

(ii) on or prior to such Change in Control either (A) Anthem has not confirmed the continuation of the following awards without economic change, or (B) the successor to Anthem in such Change in Control has not on or prior to such Change in Control assumed and continued the following awards without economic change:

- (1) any and all outstanding options ("Options") to purchase Common Shares (or stock that has been converted into Common Shares),
- (2) any and all stock appreciation rights ("SARs") based on appreciation in the value of Common Shares,
- (3) any and all restricted Common Shares (or deferred rights thereto), regardless whether such restrictions are scheduled to lapse based on service or on performance or both ("Restricted Stock"), and
- (4) any outstanding awards providing for the payment of a variable number of Common Shares dependent on the achievement of performance goals, or of an amount based on the fair market value of such shares or the appreciation thereof ("Performance Shares"), in each case awarded to a Participant under any Plan, contract or arrangement for Options, SARs, Restricted Stock or Performance Shares.

4.2 Guaranteed Annual Bonus for the Year of a Change in Control. This Section 4.2 does not apply to Participants who are classified as Other Key Executives. If a Change in Control occurs, each Participant's annual bonus for the fiscal year in which the Change in Control occurs shall be in an amount ("Guaranteed Amount") equal to the greater of (i) the Participant's Target Bonus for such fiscal year, or (ii) the bonus that is determined in the

ordinary course under each annual bonus or short-term incentive plan (as determined by the Committee in its sole discretion) (a "Bonus Plan") covering the Participant for the fiscal year in which the Change in Control occurs. The Guaranteed Amount shall be paid in a lump sum at the normal time for the payment of a bonus under the applicable Bonus Plan.

4.3 Equity Vesting Upon Termination Without Cause or for Good Reason. This Section 4.3 does not apply to Participants who are classified as Other Key Executives.

(a) If the conditions of Section 4.3(b) are satisfied, then as of the date of the Participant's Eligible Separation from Service (i) all Pre-Change (as defined below) Options and Pre-Change SARs of such Participant shall become fully and immediately exercisable, (ii) all Pre-Change Restricted Stock shall become fully vested and nonforfeitable and forthwith delivered to the Participant if not previously delivered, and (iii) there shall be paid out in cash to the Participant within 45 days following the Separation from Service the value of the Pre-Change Performance Shares to which the Participant would have been entitled if performance achieved 100% of the target performance goals established for such Performance Shares.

(b) Both of the following conditions must be satisfied in order for Section 4.3(a) to apply:

(i) the Participant must have had a Separation from Service within the thirty-six (36) month period following a Change in Control by reason of (A) a termination of the Participant's employment by the Company other than for Cause, death or disability, or (B) a termination of the Participant's employment by the Participant for Good Reason; and

(ii) the Participant must have executed and delivered a valid Waiver and Release Agreement as required by Section 3.5, and the period for revoking such Waiver and Release Agreement must have elapsed.

(c) For purposes of this Section 4.3 a "Pre-Change" Option, SAR, Restricted Stock or Performance Shares means (i) an award of an Option, SAR, Restricted Stock or Performance Shares which was outstanding on both the date of the Change in Control and the date of the Eligible Separation from Service, and (ii) an award of an Option, SAR, Restricted Stock or Performance Shares assumed and continued by a successor to Anthem in such Change in Control without economic change.

4.4 Pro-Rata Bonus Payment Upon Termination Without Cause or for Good Reason.

This Section 4.4 does not apply to Participants who are classified as Other Key Executives.

(a) If the conditions of Section 4.4(b) are satisfied, then for the fiscal year in which the Participant's Eligible Separation from Service occurs, the Participant shall be entitled to a pro-rata bonus (the "Pro-Rata Bonus") equal to the product of the applicable amount described in (i), multiplied by the fraction determined in (ii):

(i) the applicable amount is the Guaranteed Amount described in Section 4.2 for the fiscal year in which the Eligible Separation from Service occurs, and

- (ii) a fraction, the numerator of which is the number of days in such fiscal year before the date of the Eligible Separation from Service, and the denominator of which is the total number of days in such fiscal year.

The Pro-Rata Bonus shall be paid in a lump sum at the normal time for payment of a bonus under the applicable Bonus Plan.

- (b) Both of the following conditions must be satisfied in order for Section 4.3(a) to apply:

- (i) the Participant must have had a Eligible Separation from Service within the thirty-six (36) month period following a Change in Control by reason of (A) a termination of the Participant's employment by the Company other than for Cause, death or disability, or (B) a termination of the Participant's employment by the Participant for Good Reason; and

- (ii) the Participant must have executed and delivered a valid and Waiver and Release Agreement as required by Section 3.5, and the period for revoking such Waiver and Release Agreement must have elapsed.

4.5 Qualified and Supplemental Pension and 401(k) Match Contribution. This Section 4.5 does not apply to Participants who are classified as Other Key Executives.

(a) Severance Pay pursuant to Sections 3.2 and 3.4 shall be increased by an amount equal to the value of Anthem ongoing contributions to the Participant's qualified and supplemental cash balance pension accounts, and qualified and supplemental 401(k) accounts if Severance Pay had been considered covered earnings in those programs. This amount, is equal to the product of:

- (i) Severance Pay multiplied by

- (ii) a fraction, the numerator of which is (a) the Participant's cash balance pension contribution percentage, if any, plus (b) the Participant's maximum Anthem 401(k) matching percentage, and the denominator of which is 100%.

4.6 Gross-up for Certain Taxes.

(a) If it is determined that any benefit received or deemed received by the Participant from the Company pursuant to this Plan or otherwise (collectively, "Payments") is or will become subject to any excise tax under Section 4999 of the Code or any similar tax payable under any United States federal, state, local or other law, but not including any tax payable under Section 409A of the Code (such excise tax and all such similar taxes collectively, "Excise Taxes"), then the Participant shall receive in respect of such Payments whichever of (i) or (ii) below would result in the Participant retaining, after application of all applicable income, Excise, and other taxes ("All Applicable Taxes"), the greater after-tax amount (the "After-Tax Benefit"); where:

- (i) is the Payments; and

(ii) is a reduced amount of Payments sufficient to avoid the imposition of Excise Taxes.

ARTICLE 5

CLAIMS

5.1 Good Reason and Competition Determinations. Any Participant believing he or she has a right to resign for Good Reason may apply to the Committee for written confirmation that an event constituting Good Reason has occurred with respect to such Participant. The Committee shall confirm or deny in writing that Good Reason exists within 21 days following receipt of any such application. Any Participant may apply to the Committee for written confirmation that specified activities proposed to be undertaken by the Participant will not violate Section 3.6 of the Plan. The Committee shall confirm or deny in writing that specified activities proposed to be undertaken by the Participant will not violate Section 3.6 of the Plan within 21 days of receipt of any such application unless the Committee determines that it has insufficient facts on which to make that determination, in which event the Committee shall advise the Participant of information necessary for the Committee to make such determination. Any confirmation of Good Reason by the Committee shall be binding on the Company. Any confirmation that specified activities to be undertaken by the Participant will not violate Section 3.6 of the Plan shall be binding on the Company provided that all material facts have been disclosed to the Committee and there is no change in the material facts. For purposes of this Section 5.1, reference to the Committee includes reference to the Committee's delegate.

5.2 Claims Procedure. If any Participant has (a) a claim for compensation or benefits which are not being paid under the Plan or the Employment Agreement, (b) another claim for benefits under the Plan or Employment Agreement, (c) a claim for clarification of his or her rights under the Plan (to the extent not provided for in Section 5.1) or Employment Agreement, or (d) a claim for breach by the Company of the Employment Agreement, then the Participant (or his or her designee) (a "Claimant") may file with the Committee a written claim setting forth the amount and nature of the claim, supporting facts, and the Claimant's address. A claim shall be filed within six (6) months of (1) the date on which the claim first arises or (ii) if later, the earliest date on which the Participant knows or should know of the facts giving rise to a claim. The Committee shall notify each Claimant of its decision in writing by registered or certified mail within 90 days after its receipt of a claim, unless otherwise agreed by the Claimant. In special circumstances the Committee may extend for a further 90 days the deadline for its decision, provided the Committee notifies the Claimant of the need for the extension within 90 days after its receipt of a claim. If a claim is denied, the written notice of denial shall set forth the reasons for such denial, refer to pertinent provisions of the Plan or Employment Agreement on which the denial is based, describe any additional material or information necessary for the Claimant to realize the claim, and explain the claim review procedure under the Plan.

5.3 Claims Review Procedure. A Claimant whose claim has been denied or such Claimant's duly authorized representative may file, within 60 days after notice of such denial is received by the Claimant, a written request for review of such claim by the Committee. If a request is so filed, the Committee shall review the claim and notify the Claimant in writing of its decision within 60 days after receipt of such request, unless otherwise agreed by the Claimant.

In special circumstances, the Committee may extend for up to 60 additional days the deadline for its decision, provided the Committee notifies the Claimant of the need for the extension within 60 days after its receipt of the request for review. The notice of the final decision of the Committee shall include the reasons for its decision and specific references to the Plan or Employment Agreement on which the decision is based. The decision of the Committee shall be final and binding on all parties in accordance with but subject to Section 5.4(a) below.

5.4 Arbitration.

(a) In the event of any dispute arising out of or relating to this Plan (including the Employment Agreement) the determinations of fact and the construction of this Plan (including the Employment Agreement) or any other determination by the Committee in its sole and absolute discretion pursuant to Section 6.3 of the Plan shall be final and binding on all persons and may not be overturned in any arbitration or any other proceeding unless the party challenging the Committee's determination can demonstrate by clear and convincing evidence that a determination of fact is clearly erroneous or any other determination by the Committee is arbitrary and capricious; provided, however, that if a claim relates to benefits due following a Change in Control, the Committee's determination shall not be final and binding if the party challenging the Committee's determination establishes by a preponderance of the evidence that he or she is entitled to the benefits in dispute.

(b) Any dispute arising out of or relating to this Plan (including the Employment Agreement) shall first be presented to the Committee pursuant to the claims procedure set forth in Section 5.2 of the Plan and the claims review procedure of Section 5.3 of the Plan within the times therein provided. In the event of any failure timely to use and exhaust such claims procedure and the claims review procedures, the decision of the Committee on any matter respecting the Plan (including the Employment Agreement) shall be final and binding and may not be challenged by further arbitration, or any other proceeding.

(c) Any dispute arising out of or relating to this Plan (including the Employment Agreement), including the breach, termination or validity of the Employment Agreement, which has not been resolved as provided in subsection (b) of this Section as provided herein shall be finally resolved by arbitration in accordance with the CPR Rules for Non-Administered Arbitration then currently in effect, by a sole arbitrator. The Company shall be initially responsible for the payment of any filing fee and advance in costs required by CPR or the arbitrator, provided, however, if the Participant initiates the claim, the Participant will contribute an amount not to exceed \$250.00 for these purposes. During the arbitration, each party shall pay for its own costs and attorneys fees, if any. Attorneys fees and costs shall be awarded by the arbitrator to the prevailing party pursuant to subsection (h) below.

(d) The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16 and judgment upon the award rendered by the arbitrator may be entered by any court having jurisdiction thereof. The arbitrator shall not have the right to award speculative damages or punitive damages to either party except as expressly permitted by statute (notwithstanding this provision by which both parties hereto waive the right to such damages) and shall not have the power to amend this Agreement. The arbitrator shall be required to follow applicable law. The

place of arbitration shall be Indianapolis, Indiana. Any application to enforce or set aside the arbitration award shall be filed in a state or federal court located in Indianapolis, Indiana.

(e) Any demand for arbitration must be made or any other proceeding filed within six (6) months after the date of the Committee's decision on review pursuant to Section 5.3.

(f) Notwithstanding the foregoing provisions of this Section, an action to enforce the Plan (including the Employment Agreement) shall be filed within eighteen (18) months after the party seeking relief had actual or constructive knowledge of the alleged violation of the Plan (including the Employment Agreement) in question or any party shall be able to seek immediate, temporary, or preliminary injunctive or equitable relief from a court of law or equity if, in its judgment, such relief is necessary to avoid irreparable damage. To the extent that any party wishes to seek such relief from a court, the parties agree to the following with respect to the location of such actions. Such actions brought by the Participant shall be brought in a state or federal court located in Indianapolis, Indiana. Such actions brought by the Company shall be brought in a state or federal court located in Indianapolis, Indiana; the Participant's state of residency; or any other form in which the Participant is subject to personal jurisdiction. The Participant specifically consents to personal jurisdiction in the State of Indiana for such purposes.

(g) IF FOR ANY REASON THIS ARBITRATION CLAUSE BECOMES NOT APPLICABLE, THEN EACH PARTY, TO THE FULLEST EXTENT PERMITTED BY APPLICABLE LAW, HEREBY IRREVOCABLY WAIVES ALL RIGHT TO TRIAL BY JURY AS TO ANY ISSUE RELATING HERETO IN ANY ACTION, PROCEEDING, OR COUNTERCLAIM ARISING OUT OF OR RELATING TO THIS AGREEMENT OR ANY OTHER MATTER INVOLVING THE PARTIES HERETO.

(h) In the event of any contest arising under or in connection with this Plan, the arbitrator or court, as applicable, shall award the prevailing party attorneys' fees and costs to the extent permitted by applicable law.

ARTICLE 6

ADMINISTRATION

6.1 Committee. The Chief Human Resources Officer of Anthem ("CHRO") shall appoint not less than three (3) members of a committee, to serve at the pleasure of the CHRO to administer this Plan. Members of the Committee may but need not be employees of the Company and may but need not be Participants in the Plan, but a member of the Committee who is a Participant shall not vote or act upon any matter which relates solely to such member as a Participant. All decisions of the Committee shall be by a vote or written evidence of intention of the majority of its members and all decisions of the Committee shall be final and binding except as provided in Section 5.4(a).

6.2 Committee Membership. Any member of the Committee may resign at any time by giving thirty days' advance written notice to the CHRO and to the remaining members (if any) of the Committee. A member of the Committee who at the time of his or her appointment to the Committee was an employee or director of the Company, and who for any reason becomes

neither an employee nor director of the Company, shall cease to be a member of the Committee effective on the date he or she is neither an employee nor a director of the Company unless the CHRO affirmatively continues his or her appointment as a member of the Committee. If there is any vacancy in the membership of the Committee, the remaining members shall constitute the full Committee. The CHRO may fill any vacancy in the membership of the Committee, or enlarge the Committee, by giving written notice of appointment to the person so appointed and to the other members (if any) of the Committee, effective as stated in such written notice. However, the CHRO shall not be required to fill any vacancy in the membership of the Committee if there remain at least three members of the Committee. Any notice required by this Section may be waived by the person entitled thereto.

6.3 Duties. The Committee shall have the power and duty in its sole and absolute discretion to do all things necessary or convenient to effect the intent and purposes of the Plan, whether or not such powers and duties are specifically set forth herein, and, by way of amplification and not limitation of the foregoing, the Committee shall have the power in its sole and absolute discretion to:

- (a) provide rules for the management, operation and administration of the Plan, and, from time to time, amend or supplement such rules;
- (b) construe the Plan in its sole and absolute discretion to the fullest extent permitted by law, which construction shall be final and conclusive upon all persons except as provided in Section 5.4(a);
- (c) correct any defect, supply any omission, or reconcile any inconsistency in the Plan in such manner and to such extent as it shall deem appropriate in its sole discretion to carry the same into effect;
- (d) make all determinations relevant to a Participant's eligibility for benefits under the Plan, including determinations as to Separation from Service, Cause, Good Reason, Transfer of Business, and the Participant's compliance or not with Sections 3.6, 3.7, 3.8 and 3.10 of the Plan;
- (e) to enforce the Plan in accordance with its terms and the Committee's construction of the Plan as provided in subsection (b) above;
- (f) do all other acts and things necessary or proper in its judgment to carry out the purposes of the Plan in accordance with its terms and intent.

6.4 Binding Authority. The decisions of the Committee or its duly authorized delegate within the powers conferred by the Plan shall be final and conclusive for all purposes of the Plan, and shall not be subject to any appeal or review other than pursuant to Sections 5.2, 5.3, and 5.4.

6.5 Exculpation. No member of the Committee nor any delegate of the Committee serving as Plan Administrator nor any other officer or employee of the Company acting on behalf of the Company with respect to this Plan shall be directly or indirectly responsible or

otherwise liable by reason of any action or default as a member of that Committee, Plan Administrator or other officer or employee of the Company acting on behalf of the Company with respect to this Plan, or by reason of the exercise of or failure to exercise any power or discretion as such person, except for any action, default, exercise or failure to exercise resulting from such person's gross negligence or willful misconduct. No member of the Committee shall be liable in any way for the acts or defaults of any other member of the Committee, or any of its advisors, agents or representatives.

6.6 Indemnification. The Company shall indemnify and hold harmless each member of the Committee, any delegate of the Committee serving as Plan Administrator, and each other officer or employee of the Company acting on behalf of the Company with respect to this Plan, against any and all expenses and liabilities arising out of his or her own membership on the Committee, service as Plan Administrator, or other actions respecting this Plan on behalf of the Company, except for expenses and liabilities arising out of such person's gross negligence or willful misconduct. A person indemnified under this Section who seeks indemnification hereunder ("Indemnitee") shall tender to the Company a request that the Company defend any claim with respect to which the Indemnitee seeks indemnification under this Section and shall fully cooperate with the Company in the defense of such claim. If the Company shall fail to timely assume the defense of such claim then the Indemnitee may control the defense of such claim. However, no settlement of any claim otherwise indemnified under this Section shall be subject to indemnity hereunder unless the Company consents in writing to such settlement.

6.7 Information. The Company and each Participant shall furnish to the Committee in writing all information the Committee may deem appropriate for the exercise of their powers and duties in the administration of the Plan. Such information may include, but shall not be limited to, the names of all Participants, their earnings and their dates of birth, employment, retirement or death. Such information shall be conclusive for all purposes of the Plan, and the Committee shall be entitled to rely thereon without any investigation thereof.

ARTICLE 7

GENERAL PROVISIONS

7.1 No Property Interest. The Plan is unfunded. Severance pay shall be paid exclusively from the general assets of the Company and any liability of the Company to any person with respect to benefits payable under the Plan shall give rise solely to a claim as an unsecured creditor against the general assets of the Company. Any Participant who may have or claim any interest in or right to any compensation, payment or benefit payable hereunder, shall rely solely upon the unsecured promise of the Company for the payment thereof, and nothing herein contained shall be construed to give to or vest in the Participant or any other person now or at any time in the future, any right, title, interest or claim in or to any specific asset, fund, reserve, account, insurance or annuity policy or contract, or other property of any kind whatsoever owned by the Company, or in which the Company may have any right, title or interest now or at any time in the future.

7.2 Other Rights. Except as provided in Sections 3.2(a), 3.7 and 7.9, the Plan shall not affect or impair the rights or obligations of the Company or a Participant under any other

written plan, contract, arrangement, or pension, profit sharing or other compensation plan. Participation in the Plan is voluntary and no Executive shall be required to enter into an Employment Agreement.

7.3 Amendment or Termination. The Plan, including but not limited to any provision of the Plan incorporated by reference in an Employment Agreement, may be amended, modified, suspended, or terminated unilaterally by Anthem at any time; provided, however, that no such amendment, modification, suspension or termination shall adversely affect the rights to which a Participant would be entitled under his or her Employment Agreement if the Participant incurred a Separation from Service on the date of the amendment or termination unless: (i) the affected Participant approves such amendment in writing, or (ii) the amendment is effective no earlier than one (1) year after Participants have received written notice of the amendment, or (iii) the amendment is required (as determined by the Committee) by law (including any provision of the Code) whether such requirement impacts the Company or any Participant. Amendment or termination of the Plan shall not accelerate (or defer) the time of any payment under the Plan that is deferred compensation subject to Section 409A of the Code if such acceleration (or deferral) would subject such deferred compensation to additional tax or penalties under Section 409A.

7.4 Successors. All obligations of Anthem under the Plan shall be binding on any successor to Anthem, whether the existence of such successor is the result of a direct or indirect purchase, merger, consolidation, or otherwise, of all or substantially all of the business and/or assets of Anthem, and any such successor shall be required to perform the obligations of Anthem under the Plan in the same manner and to the same extent that Anthem would be required to perform such obligations if no such succession had taken place.

7.5 Severability. If any term or condition of the Plan shall be invalid or unenforceable to any extent or in any application, then the remainder of the Plan, with the exception of such invalid or unenforceable provision, shall not be affected thereby and shall continue in effect and application to its fullest extent. If, however, the Committee determines in its sole discretion that any term or condition of the Plan (including any Employment Agreement) which is invalid or unenforceable is material to the interests of the Company, the Committee may declare the Plan (including any Employment Agreement) null and void in its entirety or may declare any affected Employment Agreement null and void in its entirety.

7.6 No Employment Rights. Except as provided in the Employment Agreement, neither the establishment of the Plan, any provisions of the Plan, nor any action of the Committee shall be held or construed to confer upon any employee the right to a continuation of employment by the Company. Subject to the applicable Employment Agreement, the Company reserves the right to dismiss any employee, or otherwise deal with any employee to the same extent as though the Plan had not been adopted.

7.7 Transferability of Rights. The Company shall have the right to transfer all of its obligations under the Plan and an Employment Agreement with respect to one or more Participants to any purchaser of all or any part of the Company's business in a Transfer of Business or otherwise without the consent of any Participant. No Participant or spouse of a Participant shall have any right to commute, encumber, transfer or otherwise dispose of or alienate any present or future right or expectancy which the Participant or such spouse may have

at any time to receive payments of benefits hereunder, which benefits and the right thereto are expressly declared to be non-assignable and nontransferable, except to the extent required by law. Any attempt to transfer or assign a benefit, or any rights granted hereunder, by a Participant or the spouse of a Participant shall, in the sole discretion of the Committee (after consideration of such facts as it deems pertinent), be grounds for terminating any rights of the Participant or his or her spouse to any portion of the Plan benefits not previously paid.

7.8 Beneficiary. Any payment due under this Plan after the death of the Participant shall be paid to such person or persons, jointly or successively, as the Participant may designate, in writing filed by Participant with the Committee during the Participant's lifetime in a form acceptable to the Committee, which the Participant may change without the consent of any beneficiary by filing a new designation of beneficiary in like manner. If no designation of beneficiary is on file with the Committee or no designated beneficiary is living or in existence upon the death of the Participant, such payments shall be made to the surviving spouse of the Participant, if any, or if none to the Participant's estate. If and to the extent Section 409A permits acceleration of payments of deferred compensation upon death, the Committee in its sole discretion may accelerate and pay in a lump sum, discounted at a rate approved by the payee, any Severance Pay payable after the death of a Participant.

7.9 Company Action. Any action required or permitted of Anthem or the Company under this Plan shall be duly and properly taken if taken by the Compensation Committee of the Board of Directors, or by any officer of the Anthem to which the Compensation Committee has delegated (generally or specifically) and not withdrawn the right or power to take such action.

7.10 Entire Document. The Plan (including Employment Agreements) as set forth herein, supersedes any and all prior practices, understandings, agreements, descriptions or other non-written arrangements respecting severance, except for written employment or severance contracts signed by the Company with individuals other than Participants.

7.11 Plan Year. The fiscal records of the Plan shall be kept on the basis of a plan year which is the calendar year.

7.12 Governing Law. This is an employee benefit plan subject to ERISA and shall be governed by and construed in accordance with ERISA and, to the extent applicable and not preempted by ERISA, the law of the State of Indiana applicable to contracts made and to be performed entirely within that State, without regard to its conflict of law principal.

ARTICLE 8

DEFINITIONS

8.1 Definitions. The following words and phrases as used herein shall have the following meanings, unless a different meaning is required by the context:

8.1.1 "Annual Salary" means the highest annualized rate of regular salary in effect for the Participant (i) during the one-year period before Separation from Service or, if

higher, (ii) during the period commencing one year prior to a Change in Control, and ending upon Separation from Service.

8.1.2 "Board of Directors" means the Board of Directors of Anthem.

8.1.3 "Cause", unless otherwise defined for purposes of termination of employment in a written employment agreement between the Company and the Participant, shall mean any act or failure to act on the part of the Participant which constitutes:

- (i) fraud, embezzlement, theft or dishonesty against the Company;
- (ii) material violation of law in connection with or in the course of the Participant's duties or employment with the Company,
- (iii) commission of any felony or crime involving moral turpitude;
- (iv) any violation of Section 3.6 of the Plan;
- (v) any other material breach of the Employment Agreement;
- (vi) material breach of any written employment policy of the Company;
- (vii) conduct which tends to bring the Company into substantial public disgrace or disrepute; or
- (viii) a material violation of the Company's Standards of Ethical Business Conduct.

provided, however, that with respect to a termination of employment during an Imminent Change in Control Period or within the thirty-six (36) month period after a Change in Control, clauses (vi) and (viii) shall apply only if such material breach or violation is grounds for immediate termination under the terms of such written employment policy or standard of ethical business conduct; and clauses (iv), (v), (vi), and (vii) shall apply only if such violation, breach or conduct is willful.

8.1.4 "Change in Control" means the first to occur of the following events with respect to the Anthem:

- (a) any person (as such term is used in Rule 13d-5 of the Securities and Exchange Commission ("SEC") under the Securities Exchange Act of 1934 (the "Exchange Act") or group (as such term is defined in Section 13(d) of the Exchange Act), other than a subsidiary of Anthem or any employee benefit plan (or any related trust) of the Company, becomes the beneficial owner (as defined in Rule 13d-3 under the Exchange Act) of 20% or more of the common stock of Anthem ("Common Stock") or of other voting securities representing 20% or more of the combined voting power of all voting securities Anthem; provided, however, that (1) no Change in Control shall be deemed to have occurred solely by reason of any such acquisition by a corporation with respect to which, after such acquisition, more than 80% of both the common stock of such corporation and the combined voting power of the voting securities of

such corporation are then beneficially owned, directly or indirectly, by the persons who were the Beneficial Owners of the Common Stock and other voting securities of Anthem immediately before such acquisition, in substantially the same proportion as their ownership of the Common Shares and other voting securities of Anthem immediately before such acquisition; (ii) if any person or group owns 20% or more but less than 30% of the combined voting power of the Common Stock and other voting securities of Anthem and such person or group has a "No Change in Control Agreement" (as defined below) with the Company, no Change in Control shall be deemed to have occurred solely by reason of such ownership for so long as the No Change in Control Agreement remains in effect and such person or group is not in violation of the No Change in Control Agreement; and (iii) once a Change in Control occurs under this subsection (a), the occurrence of the next Change in Control (if any) under this subsection (a) shall be determined by reference to a person or group other than the person or group whose acquisition of Beneficial Ownership created such prior Change in Control unless the original person or group has in the meantime ceased to own 20% or more of the Common Shares of Anthem or other voting securities representing 20% or more of the combined voting power of all voting securities of Anthem; or

(b) within any period of thirty-six (36) or fewer consecutive months individuals who, as of the first day of such period were members of the Board of Directors of Anthem (the "Incumbent Directors") cease for any reason to constitute at least 75% of the members of the Board; provided, however, that (i) any individual who becomes a Member of the Board of Directors after the first day of such period whose nomination for election to the Board was approved by a vote or written consent of at least 75% of the Members of the Board of Directors who are then Incumbent Directors shall be considered an Incumbent Director, but excluding, for this purpose, any such individual whose initial assumption of office is in connection with an actual or threatened election contest relating to the election of the directors of the Company (as such terms are used in Rule 14a-11 of the SEC under the Exchange Act) or an Imminent Change in Control or other transaction described in subsection (a) above or (c) below; and (ii) once a Change in Control occurs under this subsection (b), the occurrence of the next Change in Control (if any) under this subsection (b) shall be determined by reference to a period of thirty-six (36) or fewer consecutive months beginning not earlier than the date immediately after the date of such prior Change in Control; or

(c) closing of a transaction which is any of the following:

(i) a merger, reorganization or consolidation of Anthem ("Merger"), after which (A) the individuals and entities who were the respective beneficial owners of the Common Stock and other voting securities of Anthem immediately before such Merger do not beneficially own, directly or indirectly, more than 60% of, respectively, the Common Stock or the combined voting power of the common stock and voting securities of the corporation resulting from such Merger, in substantially the same proportion as their ownership of the Common Stock and other voting securities of Anthem immediately before such Merger;

(ii) a Merger after which individuals who were members of the Board of Directors of Anthem immediately before the Merger do not comprise a majority of the members of the Board of Directors of the corporation resulting from such Merger;

(iii) a sale or other disposition by Anthem of all or substantially all of the assets owned by it (a "Sale") after which the individuals and entities who were the respective beneficial owners of the Common Stock and other voting securities of Anthem immediately before such Sale do not beneficially own, directly or indirectly, more than 60% of, respectively, the Common Stock or the combined voting power of the common stock and voting securities of the transferee in such Sale in substantially the same proportion as their ownership of the Common Stock and other voting securities of Anthem immediately before such Sale; or

(iv) a Sale after which individuals who were members of the Board of Directors of Anthem immediately before the Sale do not comprise a majority of the members of the board of directors of the transferee corporation.

8.1.5 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

8.1.6 "Committee" means a committee appointed by the Chief Executive Officer of Anthem to administer this Plan.

8.1.7 "Executive" means any person employed by the Company in a position of Vice President, Senior Vice President, or Executive Vice President; and any other key executive of the Company employed in a position below that of Vice President ("Other Key Executive") whom the Chief Executive Officer of Anthem expressly determines shall be eligible to be a Participant in this Plan.

8.1.8 "Good Reason" for a termination of employment shall mean for Participants who are classified as Executive Vice President, Senior Vice President or Vice President (a) the occurrence of the events set forth in clauses (ii) or (v) below within the thirty-six (36) month period after a Change in Control, or (b) the occurrence of the events set forth in clauses (i), (iii) or (iv) below at any time before or after a Change in Control:

(i) a material reduction during any twenty-four (24) consecutive month period in the Participant's Annual Salary, or in the Participant's annual total cash compensation (including Annual Salary and Target Bonus), but excluding in either case any reduction both (A) applicable to management employees generally, and (B) and not implemented during an Imminent Change in Control Period or within the thirty-six (36) month period after a Change in Control);

(ii) a material adverse change without the Participant's prior consent in the Participant's position, duties, or responsibilities as an Executive of the Company and provided, however, that this clause shall not apply in connection with a Transfer of Business if the position offered to the Participant by the transferee is substantially comparable in position, duties, or responsibilities with the position, duties and responsibilities of the Participant prior to such Transfer of Business and is not in violation of the Participant's rights under the Employment Agreement;

- (iii) a material breach of the Employment Agreement or this Plan by the Company;
- (iv) a change in the Participant's principal work location to a location more than 50 miles from the Participant's prior work location and more than 50 miles from the Participant's principal residence as of the date of such change in work location;
- (v) the failure of any successor to Company by merger, consolidation, or acquisition of all or substantially all of the business of the Company or by Transfer of Business to assume the Company's obligations under this Plan (including any Employment Agreements).

Notwithstanding the foregoing provisions of this definition, Good Reason shall not exist if the Participant has in his or her sole discretion agreed in writing that such event shall not be Good Reason. A Separation from Service shall not be considered to be for Good Reason unless (A) within sixty (60) days of the occurrence of the events claimed to be Good Reason the Participant notifies the Committee in writing of the reasons why he or she believes that Good Reason exists, (B) the Company has failed to correct the circumstance that would otherwise be Good Reason within thirty (30) days of receipt of such notice, and (C) the Participant terminates his or her employment within 60 days of such thirty (30) day period (or if earlier within 60 days of the date the Committee has confirmed to the Participant pursuant to Section 5.1 that Good Reason exists).

8.1.9 "Imminent Change in Control Period" means the period (i) beginning on the date of (A) the public announcement (whether by advertisement, press release, press interview, public statement, SEC filing or otherwise) of a proposal or offer which if consummated would be a Change in Control, (B) the making to a director or executive officer of the Company of a written proposal which if consummated would be a Change in Control, or (C) approval by the Board of Directors or the stockholders of Anthem of a transaction that upon closing would be a Change in Control; and (ii) ending upon the first to occur of (A) a public announcement that the prospective Change in Control contemplated by the event(s) described in clause (i) has been terminated or abandoned, (B) the occurrence of the contemplated Change in Control, or (C) the first annual anniversary of the beginning of the Imminent Change in Control Period.

8.1.10 "Key Employee" means for the period January 1 through December 31 each individual identified by the Company as of the immediately preceding September 30 as a "key employee," as defined under Code Section 416(i), disregarding Code Section 416(i)(5).

8.1.11 "No Change in Control Agreement" means a legal, binding and enforceable agreement executed by and in effect between a person or all members of a group and Anthem that provides that: (1) such person or group shall be bound by the agreement for the time period of not less than five (5) years from its date of execution; (2) such person or group shall not acquire beneficial ownership or voting control equal to a percentage of the Common Stock or the voting power of other voting securities of Anthem that exceeds a percentage specified in the agreement which percentage shall in all events be less than 30%; (3) such person or group may not designate for election as directors a number of directors in excess of 25% of the number of directors on the Board; and (4) such person or group shall vote the Common Stock

and other voting securities of Anthem in all matters in the manner directed by the majority of the Incumbent Directors. If any agreement described in the preceding sentence is violated by such person or group or is amended in a fashion such that it no longer satisfies the requirements of the preceding sentence, such agreement shall, as of the date of such violation or amendment, be treated for purposes hereof as no longer constituting a No Change in Control Agreement.

8.1.12 "Participant" means any Executive who is eligible to participate in the Plan and has become a Participant in accordance with Section 2.1, and has not had such participation terminated pursuant to Section 2.2.

8.1.13 "Separation from Service" means a termination of the Participant's employment with the Company which constitutes a "separation from service" within the meaning of Section 409A(a)(2)(A)(i) of the Code. Notwithstanding the preceding sentence a Separation from Service shall not include:

(i) the disposition by the Company of the subsidiary or affiliate which employs the Participant if such employing subsidiary or affiliate adopts this Plan and continues (by assignment or otherwise) to be the employer of the Participant under the Employment Agreement, or

(ii) a termination of employment in a Transfer of Business in connection with which the Participant receives a bona fide offer of employment from the transferee (or an affiliate of the transferee), whether or not accepted, for which purpose a bona fide offer of employment is an offer of employment effective on the closing of the Transfer of Business on terms that does not have an effect described in clauses (i), (ii), (iv) or (v) of Section 8.1.9 (defining "Good Reason").

(iii) A Participant shall cooperate with the transferee in a Transfer of Business by completing such employment applications and providing such other information as the transferee may need in order to make a bona fide offer of employment. A Participant who fails to provide such cooperation shall be deemed to have received and rejected a bona fide offer of employment.

8.1.14 "Target Bonus" means the Target Bonus Percentage times the Annual Salary.

8.1.15 "Target Bonus Percentage" means the sum of the highest annualized target bonus percentage(s) (as a percentage of salary) in effect for the Participant (i) during the one-year period before Separation from Service or, if higher, (ii) during the period commencing one year prior to a Change in Control, and ending upon Separation of Service under each regular annual bonus or a short-term incentive plan including but not limited to Anthem's Annual Incentive Plan or successor plans and any sales incentive plans (as determined by the Committee in its sole discretion) covering the Participant.

8.1.16 "Transfer of Business" means a transfer of the Participant's position to another entity, as part of either (i) a transfer to such entity as a going concern of all or part of the

business function of the Company in which the Participant was employed, or (ii) an outsourcing to another entity of a business function of the Company in which the Participant was employed.

IN WITNESS WHEREOF Anthem has caused this Amendment and Restatement of the Plan to be executed on its behalf by an authorized officer this 11th day of November, 2014.

Anthem, Inc.

/s/ Joseph R. Swedish

Joseph R. Swedish
President & Chief Executive Officer

EXHIBIT A

EMPLOYMENT AGREEMENT

EMPLOYMENT AGREEMENT (the “Agreement”) dated as of _____ (the “Agreement Date”), between Anthem, Inc., an Indiana corporation (“Anthem”) with its headquarters and principal place of business in Indianapolis, Indiana (Anthem, together with its subsidiaries and affiliates are collectively referred to herein as the “Company”), and the person listed on Schedule A (the “Executive”).

WITNESSETH

WHEREAS, the Company desires to retain the services of Executive and to provide Executive an opportunity to receive severance to which Executive is not otherwise entitled in return for the diligent and loyal performance of Executive’s duties and Executive’s agreement to reasonable and limited restrictions on Executive’s post-employment conduct to protect the Company’s investments in its intellectual property, employee workforce, customer relationships and goodwill;

WHEREAS, the Company has established the Anthem, Inc. Executive Agreement Plan (“Plan”) to provide certain benefits for participants who enter into an employment agreement in the form of this Agreement; and

WHEREAS, Executive is not required to execute this Agreement as a condition of continued employment; rather, Executive is entering into this Agreement to enjoy the substantial additional payments and benefits available under the Plan and the Designated Plans (as hereinafter defined).

NOW THEREFORE, in consideration of the foregoing, of the mutual promises contained herein and of other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows:

1. **POSITION/DUTIES.**

(a) During the Employment Period (as defined in Section 2 below), Executive shall serve in the position set forth on Schedule A, or in such other position of comparable duties, authorities and responsibilities commensurate with the skills and talents of Executive to which the Company may from time to time assign Executive. In this capacity, Executive shall have such duties, authorities and responsibilities as the Company shall designate that are commensurate with Executive’s position.

(b) During the Employment Period, Executive shall comply with Company policies and procedures, and shall devote all of Executive’s business time, energy and skill, best efforts and undivided business loyalty to the performance of Executive’s duties with the Company. Executive further agrees that while employed by the Company he shall not perform any services for remuneration for or on behalf of any other entity without the advance written consent of the Company.

2. **EMPLOYMENT PERIOD.** Subject to the termination provisions hereinafter provided, the initial term of Executive’s employment under this Agreement shall commence on the Agreement Date listed above and end on the Anniversary Date which is one year after the Agreement Date; provided, however, that commencing on the day following the Agreement Date the term will automatically be extended each day by one day, until a date (the “Expiration Date”) which is the first annual anniversary of the first date on

which either the Company or Executive delivers to the other written notice of non-renewal. The term beginning on the Agreement Date and ending on the Expiration Date shall constitute the "Employment Period" for purposes of this Agreement. Expiration of this Agreement shall not be construed to terminate the employment of Executive. If the employment of Executive does not terminate on or before the Expiration Date in accordance with this Agreement, Executive shall continue to be an employee at will of the Company after the Expiration Date unless such employment is otherwise terminated by the Company or Executive.

3. **BASE SALARY.** The Company agrees to pay Executive a base salary at an annual rate set forth on Schedule A, payable in accordance with the regular payroll practices of the Company. Executive's Base Salary shall be subject to annual review by the Company. The base salary as determined herein from time to time shall constitute "Base Salary" for purposes of this Agreement.

4. **BONUS.** During the Employment Period, Executive shall be eligible to receive consideration for an annual bonus upon such terms as adopted from time to time by the Company. The Target Bonus for which Executive is eligible for the year in which this Agreement is executed is specified in Schedule A to this Agreement.

5. **BENEFITS.** Executive, his or her spouse and their eligible dependents shall be entitled to participate in any employee benefit plan that the Company has adopted or may adopt, maintain or contribute to for the benefit of its executives at a level commensurate with Executive's position, subject to satisfying the applicable eligibility requirements therefor, in addition to the benefits available under the Plan. Notwithstanding the foregoing, the Company may modify or terminate any employee benefit plan at any time in accordance with its terms.

6. **TERMINATION.** Executive's employment and the Employment Period shall terminate on the first of the following to occur:

(a) **DISABILITY.** Subject to applicable law, upon 10 days' prior written notice by the Company to Executive of termination due to Disability. "Disability" shall have the meaning defined in the Company's Long Term Disability Plan.

(b) **DEATH.** Automatically on the date of death of Executive.

(c) **CAUSE.** The Company may terminate Executive's employment hereunder for Cause immediately upon written notice by the Company to Executive of a termination for Cause. "Cause" shall have the meaning defined for that term in the Plan.

(d) **WITHOUT CAUSE.** Upon written notice by the Company to Executive of an involuntary termination without Cause, other than for death or Disability.

(e) **BY EXECUTIVE.** Upon written notice by the Executive to the Company with or without Good Reason as defined in the plan.

7. **CONSEQUENCES OF TERMINATION.** The Executive's entitlement to payments and benefits upon termination shall be as set forth in the Plan.

8. **RELEASE.** Any and all amounts payable and benefits or additional rights provided pursuant to this Agreement beyond Accrued Benefits shall only be payable if Executive delivers to the Company and does not revoke a general release of all claims in a form tendered by the Company which shall be substantially similar to the form attached as Exhibit B to the Plan or such other form acceptable to the Company within thirty (30) days of Executive's termination of employment.

9. **RESTRICTIVE COVENANTS.**

(a) **CONFIDENTIALITY.**

(i) Executive recognizes that the Company derives substantial economic value from information created and used in its business which is not generally known by the public, including, but not limited to, plans, designs, concepts, computer programs, formulae, and equations; product fulfillment and supplier information; customer and supplier lists, and confidential business practices of the Company, its affiliates and any of its customers, vendors, business partners or suppliers; profit margins and the prices and discounts the Company obtains or has obtained or at which it sells or has sold or plans to sell its products or services (except for public pricing lists); manufacturing, assembling, labor and sales plans and costs; business and marketing plans, ideas, or strategies; confidential financial performance and projections; employee compensation; employee staffing and recruiting plans and employee personal information; and other confidential concepts and ideas related to the Company's business (collectively, "Confidential Information"). Executive expressly acknowledges and agrees that by virtue of his or her employment with the Company, Executive will have access and will use in the course of Executive's duties certain Confidential Information and that Confidential Information constitutes trade secrets and confidential and proprietary business information of the Company, all of which is the exclusive property of the Company. For purposes of this Agreement, Confidential Information includes the foregoing and other information protected under the Indiana Uniform Trade Secrets Act (the "Act"), or to any comparable protection afforded by applicable law, but does not include information that Executive establishes by clear and convincing evidence, is or may become known to Executive or to the public from sources outside the Company and through means other than a breach of this Agreement.

(ii) Executive agrees that Executive will not for himself or herself or for any other person or entity, directly or indirectly, without the prior written consent of the Company, while employed by the Company and thereafter: (1) use Confidential Information for the benefit of any person or entity other than the Company or its affiliates; (2) remove, copy, duplicate or otherwise reproduce any document or tangible item embodying or pertaining to any of the Confidential Information, except as required to perform Executive's duties for the Company or its affiliates; or (3) while employed and thereafter, publish, release, disclose or deliver or otherwise make available to any third party any Confidential Information by any communication, including oral, documentary, electronic or magnetic information transmittal device or media. Upon termination of employment, Executive shall return all Confidential Information and all other property of the Company. This obligation of non-disclosure

and non-use of information shall continue to exist for so long as such information remains Confidential Information.

(b) **DISCLOSURE AND ASSIGNMENT OF INVENTIONS AND IMPROVEMENTS.** Without prejudice to any other duties express or implied imposed on Executive hereunder it shall be part of Executive's normal duties at all times to consider in what manner and by what methods or devices the products, services, processes, equipment or systems of the Company and any customer or vendor of the Company might be improved and promptly to give to the Chief Executive Officer of the Company or his or her designee full details of any improvement, invention, research, development, discovery, design, code, model, suggestion or innovation (collectively called "Work Product"), which Executive (alone or with others) may make, discover, create or conceive in the course of Executive's employment. Executive acknowledges that the Work Product is the property of the Company. To the extent that any of the Work Product is capable of protection by copyright, Executive acknowledges that it is created within the scope of Executive's employment and is a work made for hire. To the extent that any such material may not be a work made for hire, Executive hereby assigns to the Company all rights in such material. To the extent that any of the Work Product is an invention, discovery, process or other potentially patentable subject matter (the "Inventions"), Executive hereby assigns to the Company all right, title, and interest in and to all Inventions. The Company acknowledges that the assignment in the preceding sentence does not apply to an Invention that Executive develops entirely on his or her own time without using the Company's equipment, supplies, facilities or trade secret information, except for those Inventions that either:

- (1) relate at the time of conception or reduction to practice of the Invention to the Company's business, or actual or demonstrably anticipated research or development of the Company, or
- (2) result from any work performed by Executive for the Company.

Execution of this Agreement constitutes Executive's acknowledgment of receipt of written notification of this Section and of notice of the general exception to assignments of Inventions provided under the Uniform Employee Patents Act, in the form adopted by the state having jurisdiction over this Agreement or provision, or any comparable applicable law.

(c) **NON-COMPETITION.** During the Employment Period, and any period in which Executive is employed by the Company during or after the Employment Period, and during the period of time after Executive's termination of employment as set forth in Schedule A, Executive will not, without prior written consent of the Company, directly or indirectly seek or obtain a Competitive Position in a Restricted Territory and perform a Restricted Activity with a Competitor, as those terms are defined herein.

(i) Competitive Position means any employment or performance of services with a Competitor (A) in which Executive has executive level duties for such Competitor, or (B) in which Executive will use any Confidential Information of the Company.

(ii) Restricted Territory means any geographic area in which the Company does business and in which the Executive had responsibility for, or

Confidential Information about, such business within the thirty six (36) months prior to Executive's termination of employment from the Company.

(iii) **Restricted Activity** means any activity for which Executive had responsibility for the Company within the thirty-six (36) months prior to Executive's termination of employment from the Company or about which Executive had Confidential Information.

(iv) **Competitor** means any entity or individual (other than the Company), engaged in management of network-based managed care plans and programs, or the performance of managed care services, health insurance, long term care insurance, dental, life or disability insurance, behavioral health, vision, flexible spending accounts, COBRA administration or other products or services substantially the same or similar to those offered by the Company while Executive was employed, or other products or services offered by the Company within twelve (12) months after the termination of Executive's employment if the Executive had responsibility for, or Confidential Information about, such other products or services while Executive was employed by the Company.

(d) **NON-SOLICITATION OF CUSTOMERS**. During the Employment Period, and any period in which Executive is employed by the Company during or after the Employment Period, and for the period of time after Executive's termination of employment as set forth in the Plan, Executive will not, either individually or as a employee, partner, consultant, independent contractor, owner, agent, or in any other capacity, directly or indirectly, for a Competitor of the Company as defined in Section 9(c)(iv) above: (i) solicit business from any client or account of the Company or any of its affiliates with which Executive had contact, or responsibility for, or about which Executive had knowledge of Confidential Information by reason of Executive's employment with the Company, (ii) solicit business from any client or account which was pursued by the Company or any of its affiliates and with which Executive had contact, or responsibility for, or about which Executive had knowledge of Confidential Information by reason of Executive's employment with the Company, within the twelve (12) month period prior to termination of employment. For purposes of this provision, an individual policyholder in a plan maintained by the Company or by a client or account of the Company under which individual policies are issued, or a certificate holder in such plan under which group policies are issued, shall not be considered a client or account subject to this restriction solely by reason of being such a policyholder or certificate holder.

(e) **NON-SOLICITATION OF EMPLOYEES**. During the Employment Period, and any period in which Executive is employed by the Company during or after the Employment Period, and for the period of time after Executive's termination of employment as set forth in the Plan, Executive will not, either individually or as a employee, partner, independent contractor, owner, agent, or in any other capacity, directly or indirectly solicit, hire, attempt to solicit or hire, or participate in any attempt to solicit or hire, for any non-Company affiliated entity, any person who on or during the six (6) months immediately preceding the date of such solicitation or hire is or was an officer or employee of the Company, or whom Executive was involved in recruiting while Executive was employed by the Company.

(f) **NON-DISPARAGEMENT.** Executive agrees that he or she will not, nor will he or she cause or assist any other person to, make any statement to a third party or take any action which is intended to or would reasonably have the effect of disparaging or harming the Company or the business reputation of the Company's directors, employees, officers and managers.

(g) **CESSATION AND RECOUPMENT OF SEVERANCE PAYMENTS AND OTHER BENEFITS .** If at any time Executive breaches any provision of this Section 9 or Section 10, then: (i) the Company shall cease to provide any further severance Pay or other benefits previously received under the Plan and Executive shall repay to the Company all Severance Pay and other benefits previously received under the Plan, (ii) all unexercised Company stock options under any Designated Plan (as defined in the Plan) whether or not otherwise vested shall cease to be exercisable and shall immediately terminate; (iii) Executive shall forfeit any outstanding restricted stock or other outstanding equity award made under any Designated Plan and not otherwise vested on the date of breach; and (iv) the Executive shall pay to the Company (A) for each share of common stock of the Company ("Common Share") acquired on exercise of an option under a Designated Plan within the 24 months prior to such breach, the excess of the fair market value of a Common Share on the date of exercise over the exercise price, and (B) for each Share of restricted stock that became vested under any Designated Plan within the 24 months prior to such breach, the fair market value (on the date of vesting) of a Common Share. Any amount to be repaid pursuant to this Section 9(g) shall be held by the Executive in constructive trust for the benefit of the Company and shall, upon written notice from the Company, within 10 days of such notice, be paid by Executive to the Company with interest from the date such Common Share was acquired or the share of restricted stock became vested, as the case may be, to the date of payment, at 120% of the applicable federal rate, determined under Section 1274(d) of the Internal Revenue Code of 1986, as amended from time to time (the "Code"). Any amount described in clauses (i), (ii) or (iii) that the Executive forfeits as a result of a breach of the provisions of Sections 9 and 10 shall not reduce any money damages that would be payable to the Company as compensation for such breach. The amount to be repaid pursuant to this Section 9(g) shall be determined on a gross basis, without reduction for any taxes incurred, as of the date of the realization event, and without regard to any subsequent change in the fair market value of a Common Share. The Company shall have the right to offset such gain against any amounts otherwise owed to Executive by the Company (whether as wages, vacation pay, or pursuant to any benefit plan or other compensatory arrangement other than any amount pursuant to any nonqualified deferred compensation plan under Section 409A of the Code). For purposes of this Section 9(g), a "Designated Plan" is each annual bonus and incentive plan, stock option, restricted stock, or other equity compensation or long-term incentive compensation plan, deferred compensation plan, or supplemental retirement plan, listed on Exhibit C to the Plan. The provisions of this Section 9(g) shall apply to awards described in clauses (i), (ii), (iii) and (iv) of this Section earned or made after the date Executive becomes a participant in the Plan and executes this Agreement, and to awards earned or made prior thereto which by their terms are subject to cessation and recoupment under terms similar to those of this paragraph.

(h) **EQUITABLE RELIEF AND OTHER REMEDIES - CONSTRUCTION.**

(i) Executive acknowledges that each of the provisions of this Agreement are reasonable and necessary to preserve the legitimate business interests of the Company, its present and potential business activities and the economic benefits derived therefrom; that they will not prevent him or her from earning a livelihood in Executive's chosen business and are not an undue restraint on the trade of Executive, or any of the public interests which may be involved.

(ii) Executive agrees that beyond the amounts otherwise to be provided under this Agreement and the Plan, the Company will be damaged by a violation of this Agreement and the amount of such damage may be difficult to measure. Executive agrees that if Executive commits or threatens to commit a breach of any of the covenants and agreements contained in Sections 9 and 10 to the extent permitted by applicable law, then the Company shall have the right to seek and obtain all appropriate injunctive and other equitable remedies, without posting bond therefor, except as required by law, in addition to any other rights and remedies that may be available at law or under this Agreement, it being acknowledged and agreed that any such breach would cause irreparable injury to the Company and that money damages would not provide an adequate remedy. Further, if Executive violates Section 9(b) - (e) hereof Executive agrees that the period of violation shall be added to the Period in which Executive's activities are restricted.

(iii) Notwithstanding the foregoing, the Company will not seek injunctive relief to prevent an Executive residing in California from engaging in post termination competition in California under Section 9(c) or 9(d) of this Agreement provided that the Company may seek and obtain relief to enforce Section 9(g) of this Section with respect to such Executives.

(iv) The parties agree that the covenants contained in this Agreement are severable. If an arbitrator or court shall hold that the duration, scope, area or activity restrictions stated herein are unreasonable under circumstances then existing, the parties agree that the maximum duration, scope, area or activity restrictions reasonable and enforceable under such circumstances shall be substituted for the stated duration, scope, area or activity restrictions to the maximum extent permitted by law. The parties further agree that the Company's rights under Section 9(g) should be enforced to the fullest extent permitted by law irrespective of whether the Company seeks equitable relief in addition to relief provided thereon or if the arbitrator or court deems equitable relief to be inappropriate.

(i) **SURVIVAL OF PROVISIONS.** The obligations contained in this Section 9 and Section 10 below shall survive the cessation of the Employment Period and Executive's employment with the Company and shall be fully enforceable thereafter.

10. **COOPERATION.** While employed by the Company and for two years (or, if longer, for so long as any claim referred to in Section 3.10 of the Plan remains pending) after the termination of Executive's employment for any reason, Executive will provide cooperation and assistance to the Company as provided in Section 3.10 of the Plan.

11. **NOTIFICATION OF EXISTENCE OF AGREEMENT** . Executive agrees that in the event that Executive is offered employment with another employer (including service as a partner of any partnership or service as an independent contractor) at any time during the existence of this Agreement, or such other period in which post termination obligations of this Agreement apply, Executive shall immediately advise said other employer (or partnership) of the existence of this Agreement and shall immediately provide said employer (or partnership or service recipient) with a copy of Sections 9 and 10 of this Agreement.

12. **NOTIFICATION OF SUBSEQUENT EMPLOYMENT** . Executive shall report promptly to the Company any employment with another employer (including service as a partner of any partnership or service as an independent contractor or establishment of any business as a sole proprietor) obtained during the period in which Executive's post termination obligations set forth in Section 9(b) - (f) apply.

13. **NOTICE**. For the purpose of this Agreement, notices and all other communications provided for in this Agreement shall be in writing and shall be deemed to have been duly given (i) on the date of delivery if delivered by hand, (ii) on the date of transmission, if delivered by confirmed facsimile or e-mail, (iii) on the first business day following the date of deposit if delivered by guaranteed overnight delivery service, or (iv) on the fourth business day following the date delivered or mailed by United States registered or certified mail, return receipt requested, postage prepaid, addressed as follows:

If to Executive:

At the address (or to the facsimile number) shown
on the records of the Company

If to the Company:

Executive Vice President and Chief Human Resources Officer
Anthem, Inc.
120 Monument Circle
Indianapolis, IN 46204

or to such other address as either party may have furnished to the other in writing in accordance herewith, except that notices of change of address shall be effective only upon receipt.

14. **SECTION HEADINGS; INCONSISTENCY**. The section headings used in this Agreement are included solely for convenience and shall not affect, or be used in connection with, the interpretation of this Agreement. In the event of any inconsistency between the terms of this Agreement and any form, award, plan or policy of the Company, the terms of this Agreement shall control.

15. **SUCCESSORS AND ASSIGNS - BINDING EFFECT** . This Agreement shall be binding upon and inure to the benefit of the parties and their successors and permitted assigns, as the case may be. The Company may assign this Agreement to any affiliate of the Company and to any successor or assign of all or a substantial portion of the Company's

business. Executive may not assign or transfer any of his rights or obligations under this Agreement.

16. **SEVERABILITY.** The provisions of this Agreement shall be deemed severable and the invalidity or unenforceability of any provision shall not affect the validity or enforceability of the other provisions hereof.

17. **DISPUTE RESOLUTION.**

(a) In the event of any dispute arising out of or relating to this Agreement the determinations of fact and the construction of this Agreement or any other determination by the Committee in its sole and absolute discretion pursuant to Section 6.3 of the Plan shall be final and binding on all persons and may not be overturned in any arbitration or any other proceeding unless the party challenging the Committee's determination can demonstrate by clear and convincing evidence that a determination of fact is clearly erroneous or any other determination by the Committee is arbitrary and capricious; provided, however, that if a claim relates to benefits due following a Change in Control (as defined in the Plan), the Committee's determination shall not be final and binding if the party challenging the Committee's determination establishes by a preponderance of the evidence that he or she is entitled to the benefit in dispute.

(b) Any dispute arising out of or relating to this Agreement shall first be presented to the Committee pursuant to the claims procedure set forth in Section 5.2 of the Plan and the claims review procedure of Section 5.3 of the Plan within the times therein provided. In the event of any failure timely to use and exhaust such claims procedure, and the claims review procedures, the decision of the Committee on any matter respecting this Agreement shall be final and binding and may not be challenged by further arbitration, or any other proceeding.

(c) Any dispute arising out of or relating to this Agreement, including the breach, termination or validity thereof, which has not been resolved as provided in paragraph (b) of this Section as provided herein shall be finally resolved by arbitration in accordance with the CPR Rules for Non-Administered Arbitration then currently in effect, by a sole arbitrator. The Company shall be initially responsible for the payment of any filing fee and advance in costs required by CPR or the arbitrator, provided, however, if the Executive initiates the claim, the Executive will contribute an amount not to exceed \$250.00 for these purposes. During the arbitration, each Party shall pay for its own costs and attorneys fees, if any. Attorneys fees and costs should be awarded by the arbitrator to the prevailing party pursuant to Section 19 below.

(d) The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16, and judgment upon the award rendered by the arbitrator may be entered by any court having jurisdiction thereof. The arbitrator shall not have the right to award speculative damages or punitive damages to either party except as expressly permitted by statute (notwithstanding this provision by which both parties hereto waive the right to such damages) and shall not have the power to amend this Agreement. The arbitrator shall be required to follow applicable law. The place of arbitration shall be Indianapolis, Indiana. Any application to enforce or set aside the arbitration award shall be filed in a state or federal court located in Indianapolis, Indiana.

(e) Any demand for Arbitration must be made or any other proceeding filed within six (6) months after the date of the Committee's decision on review pursuant to Section 5.3 of the Plan.

(f) Notwithstanding the foregoing provisions of this Section, an action to enforce this Agreement shall be filed within eighteen (18) months after the party seeking relief had actual or constructive knowledge of the alleged violation of the Employment Agreement in question or any party shall be able to seek immediate, temporary, or preliminary injunctive or equitable relief from a court of law or equity if, in its judgment, such relief is necessary to avoid irreparable damage. To the extent that any party wishes to seek such relief from a court, the parties agree to the following with respect to the location of such actions. Such actions brought by the Executive shall be brought in a state or federal court located in Indianapolis, Indiana. Such actions brought by the Company shall be brought in a state or federal court located in Indianapolis, Indiana; the Executive's state of residency; or any other forum in which the Executive is subject to personal jurisdiction. The Executive specifically consents to personal jurisdiction in the State of Indiana for such purposes.

(g) **IF FOR ANY REASON THIS ARBITRATION CLAUSE BECOMES NOT APPLICABLE, THEN EACH PARTY, TO THE FULLEST EXTENT PERMITTED BY APPLICABLE LAW, HEREBY IRREVOCABLY WAIVES ALL RIGHT TO TRIAL BY JURY AS TO ANY ISSUE RELATING HERETO IN ANY ACTION, PROCEEDING, OR COUNTERCLAIM ARISING OUT OF OR RELATING TO THIS AGREEMENT OR ANY OTHER MATTER INVOLVING THE PARTIES HERETO.**

18. **GOVERNING LAW.** This Agreement forms part of an employee benefit plan subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), and shall be governed by and construed in accordance with ERISA and, to the extent applicable and not preempted by ERISA, the law of the State of Indiana applicable to contracts made and to be performed entirely within that State, without regard to its conflicts of law principles.

19. **ATTORNEYS' FEES.** In the event of any contest arising under or in connection with this Agreement, the arbitrator or court, as applicable, shall award the prevailing party attorneys' fees and costs to the extent permitted by applicable law.

20. **MISCELLANEOUS.** No provision of this Agreement may be modified, waived or discharged unless such waiver, modification or discharge is agreed to in writing and signed by Executive and such officer or director as may be designated by the Company. No waiver by either party hereto at any time of any breach by the other party hereto of, or compliance with, any condition or provision of this Agreement to be performed by such other party shall be deemed a waiver of similar or dissimilar provisions or conditions at the same or at any prior or subsequent time. This Agreement and the Plan and together with all exhibits thereto sets forth the entire agreement of the parties hereto in respect of the subject matter contained herein. No agreements or representations, oral or otherwise, express or implied, with respect to the subject matter hereof have been made by either party which are not expressly set forth in this Agreement.

21. **OTHER EMPLOYMENT ARRANGEMENTS.** Except as set forth on Schedule A or provided in Section 2.1(a) (i) of the Plan, any severance or change in control plan or agreement (other than the Plan) or other similar agreements or arrangements between

Executive and the Company including without limitation the Executive Agreement (the Anthem Non-Competition Agreement), shall, effective as of the Effective Date, be superseded by this Agreement and the Plan and shall therefore terminate and be null and void and of no force or effect.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first written above.

ANTHEM, INC.

By:

Name:

Its:

Date: _____

EXECUTIVE

Date: _____

SCHEDULE A

1. Name of Executive
2. Position
3. Agreement Date
4. Base Salary
5. Annual Bonus Target Opportunity
6. Severance Payments and Benefits in the case of a Termination Without Cause or With Good Reason and in the absence of a Change in Control to be paid over the period indicated at times corresponding with the Company's normal payroll dates
7. Severance Payments and Benefits in the case of a Termination Without Cause during an Imminent Change in Control period or during the thirty-six (36) month period after a Change in Control or a Termination by Executive with Good Reason during the thirty-six (36) month period after a Change in Control
8. Non Solicitation and Non Competition Period following Termination of Employment for any reason

*Notwithstanding the severance pay and benefits identified above, your employment classification at the time of an Eligible Separation from Service (as defined in the Anthem, Inc. Executive Agreement Plan, as amended and/or restated from time to time) will control the payout level. As a result, any changes in your position (identified above) may impact the level of severance pay and benefits that may be paid upon an Eligible Separation from Service.

EXHIBIT B WAIVER AND RELEASE

This is a Waiver and Release ("Release") between _____ ("Executive") and Anthem, Inc. (the "Company"). The Company and the Executive agree that they have entered into this Release voluntarily, and that it is intended to be a legally binding commitment between them.

1. In consideration for the promises made herein by the Executive, the Company agrees as follows:

- (a) Severance Pay. The Company will pay to the Executive severance or change of control payments and bonus pay in the amount set forth in the Anthem, Inc. Executive Agreement Plan (the "Plan") and the entire Employment Agreement executed in connection therewith. The Company will also pay Executive accrued but unused vacation pay for all of his or her accrued but unused vacation days.
-

(b) Other Benefits. The Executive will be eligible to receive other benefits as described in the Plan.

(c) Unemployment Compensation. The Company will not contest the decision of the appropriate regulatory commission regarding unemployment compensation that may be due to the Executive.

2. In consideration for and contingent upon the Executive's right to receive the severance pay and other benefits described in the Plan and the Employment Agreement and this Release, Executive hereby agrees as follows:

(a) General Waiver and Release. Except as provided in Paragraph 2.(f) below, Executive and any person acting through or under the Executive hereby release, waive and forever discharge the Company, its past subsidiaries and its past and present affiliates, and their respective successors and assigns, and their respective present or past officers, trustees, directors, shareholders, executives and agents of each of them, from any and all claims, demands, actions, liabilities and other claims for relief and remuneration whatsoever (including without limitation attorneys' fees and expenses), whether known or unknown, absolute, contingent or otherwise (each, a "Claim"), arising or which could have arisen up to and including the date of his execution of this Release, arising out of or relating to Executive's employment or cessation and termination of employment, or any other written or oral agreement, any change in Executive's employment status, any benefits or compensation, any tortious injury, breach of contract, wrongful discharge (including any Claim for constructive discharge), infliction of emotional distress, slander, libel or defamation of character, and any Claims arising under Title VII of the Civil Rights Act of 1964 (as amended by the Civil Rights Act of 1991), the Americans With Disabilities Act, the Rehabilitation Act of 1973, the Equal Pay Act, the Older Workers Benefits Protection Act, the Age Discrimination in Employment Act, the Employee Retirement Income Security Act of 1974, or any other federal, state or local statute, law, ordinance, regulation, rule or executive order, any tort or contract

claims, and any of the claims, matters and issues which could have been asserted by Executive against the Company or its subsidiaries and affiliates in any legal, administrative or other proceeding. Executive agrees that if any action is brought in his or her name before any court or administrative body, Executive will not accept any payment of monies in connection therewith.

(b) Waiver Under Section 1542 of the California Civil Code. Executive, for Executive's predecessors, successors and assigns, hereby waives all rights which Executive may have under Section 1542 of the Civil Code of the State of California, which reads as follows:

A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor.

This waiver is not a mere recital but is a knowing waiver of the rights and benefits otherwise available under said Section 1542.

(c) Miscellaneous. Executive agrees that this Release specifies payment from the Company to himself or herself, the total of which meets or exceeds any and all funds due him or her by the Company, and that he or she will not seek to obtain any additional funds from the Company with the exception of non-reimbursed business expenses. This covenant does not preclude the Executive from seeking workers compensation, unemployment compensation, or benefit payments under the Company's employee benefit plans that could be due him or her.

(d) Non-Competition, Non-Solicitation and Confidential Information and Inventions. Executive warrants that Executive has, and will continue to comply fully with Sections 9 and 10 of the Employment Agreement and the requirements of the Plan.

(e) **THE COMPANY AND THE EXECUTIVE AGREE THAT THE SEVERANCE PAY AND BENEFITS DESCRIBED IN THIS RELEASE AND THE PLAN ARE CONTINGENT UPON THE EXECUTIVE SIGNING THIS RELEASE. THE EXECUTIVE FURTHER UNDERSTANDS AND AGREES THAT IN SIGNING THIS RELEASE, EXECUTIVE IS RELEASING POTENTIAL LEGAL CLAIMS AGAINST THE COMPANY. THE EXECUTIVE UNDERSTANDS AND AGREES THAT IF HE OR SHE DECIDES NOT TO SIGN THIS RELEASE, OR IF HE OR SHE REVOKES THIS RELEASE, THAT HE OR SHE WILL IMMEDIATELY REFUND TO THE COMPANY ANY AND ALL SEVERANCE PAYMENTS AND OTHER BENEFITS HE OR SHE MAY HAVE ALREADY RECEIVED.**

(f) The waiver contained in Section 2(a) and (b) above does not apply to any Claims with respect to:

(i) Any claims under employee benefit plans subject to the Employee Retirement Income Security Act of 1974 ("ERISA") in accordance with the terms of the applicable employee benefit plan,

(ii) Any Claim under or based on a breach of this Release,

(iii) Rights or Claims that may arise under the Age Discrimination in Employment Act after the date that Executive signs this Release,

(iv) Any right to indemnification or directors and officers liability insurance coverage to which the Executive is otherwise entitled in accordance with the Company's articles or by-laws.

(v) **EXECUTIVE ACKNOWLEDGES THAT HE OR SHE HAS READ AND IS VOLUNTARILY SIGNING THIS RELEASE. EXECUTIVE ALSO ACKNOWLEDGES THAT HE OR SHE IS HEREBY ADVISED TO CONSULT WITH AN ATTORNEY, HE OR SHE HAS BEEN GIVEN AT LEAST 30 DAYS TO CONSIDER THIS RELEASE BEFORE THE DEADLINE FOR SIGNING IT, AND HE OR SHE UNDERSTANDS THAT HE OR SHE MAY REVOKE THE RELEASE WITHIN SEVEN (7) DAYS AFTER SIGNING IT. IF NOT REVOKED WITHIN SUCH PERIOD, THIS RELEASE WILL BECOME EFFECTIVE ON THE EIGHTH (8) DAY AFTER IT IS SIGNED BY EXECUTIVE.**

BY SIGNING BELOW, BOTH THE COMPANY AND EXECUTIVE AGREE THAT THEY UNDERSTAND AND ACCEPT EACH PART OF THIS RELEASE.

DATE

ANTHEM, INC.

DATE

EXHIBIT C

DESIGNATED PLANS

Anthem 2001 Stock Incentive Plan

Anthem Incentive Compensation Plan (f/k/a WellPoint Incentive Compensation Plan)

Exhibit 10.8

**ANTHEM
BOARD OF DIRECTORS'
DEFERRED COMPENSATION PLAN**

As Amended and Restated Effective December 2, 2014

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ANTHEM
BOARD OF DIRECTORS'
DEFERRED COMPENSATION PLAN
(AS AMENDED AND RESTATED DECEMBER 2, 2014)

PREAMBLE

The Anthem Board of Directors' Deferred Compensation Plan (the "Plan") is an unfunded supplemental retirement plan for directors of Anthem, Inc. ("Anthem") This Plan was originally adopted as of January 1, 2005 to provide deferrals on terms compliant with the requirements of Section 409A of the Internal Revenue Code of 1986, as amended (the "Code"). It was further amended and restated effective January 1, 2009 to comply with final regulations issued by the Department of Treasury under Code Section 409A. It is further amended and restated to reflect the change in WellPoint, Inc.'s name to Anthem, Inc.

The Anthem Board of Directors' Deferred Compensation Plan as it existed as of December 31, 2004 (the "Prior Plan") was frozen effective December 31, 2004 and has not and shall not be amended in any manner that would constitute a material modification as defined in Treas. Reg. § 1.409A-6(a)(4). The Prior Plan, as it existed on December 31, 2004 is attached hereto strictly for purpose of reference as Appendix A. The rights, duties and obligations of Anthem and the Prior Plan Participants with respect to the Prior Plan shall be governed exclusively by the terms of the Prior Plan.

ARTICLE 1
DEFINITIONS

Section 1.01 Administrator. The term "Administrator" means the individual or individuals appointed by the Chief Executive Officer of Anthem, which individual or individuals shall have the authority to manage and control the operation of this Plan.

Section 1.02 Anthem. The term "Anthem" means Anthem, Inc., and any successor thereof.

Section 1.03 Anthem Common Stock. The term "Anthem Common Stock" means the common stock of Anthem.

Section 1.04 Beneficiary. The term "Beneficiary" means, for a Participant, the individual or individuals designated by that Participant in the last Beneficiary Designation Form executed by that Participant to receive benefits in the event of that Participant's death.

Section 1.05 Cash Participation Account. The term "Cash Participation Account" means the bookkeeping account maintained by the Company for each Participant reflecting cash Compensation amounts deferred under this Plan (as adjusted from time to time) and cash dividends on Anthem Common Stock deferred under this Plan and credited to the Participant's Phantom Stock Participation Account, plus interest accruing at the Interest Rate on such amounts.

Section 1.06 Company. The term “Company” means and shall include the entities listed on Appendix A.

Section 1.07 Compensation. The term “Compensation” means for each Participant in any Plan Year the total amount of remuneration (including retainers, meeting fees and, if applicable, incentive compensation) for director services as paid to that Participant by the Company in that Plan Year.

Section 1.08 Director. The term “Director” means each non-employee member of the Board of Directors of the Company.

Section 1.09 Forms. The term “Forms” means the forms used by the Company for Plan operation and shall include the following:

(a) Enrollment Form. The term “Enrollment Form” shall be the form on which a Participant designates the amount and type (i.e. cash or Anthem Common Stock) of Compensation to be deferred under the Plan and when and how the Participant’s Participation Account shall be distributed.

(b) Beneficiary Designation Form. The term “Beneficiary Designation Form” means the form on which a Participant designates the Participant’s Beneficiary.

Section 1.10 Interest Rate. The term “Interest Rate” means the annual rate of return credited to amounts held in the Participant’s Cash Participation Account. The rate shall change each January 1. The rate shall be equal to the average of the monthly average rates of the 10-year United States Treasury Notes for the twelve (12) months ending on September 30 immediately preceding such January 1 plus one hundred and fifty (150) basis points, but not to exceed one hundred twenty percent (120%) of the applicable federal long-term rate, with compounding (as prescribed under Section 1274(d) of the Code); provided, however, that the Company reserves the right to change the method of determining or to increase or decrease the Interest Rate which is credited to a Participant’s Cash Participation Account as long as the Interest Rate shall not be decreased for periods prior to such action.

Section 1.11 Participant. The term “Participant” means any individual who fulfills the eligibility requirements contained in Article II of this Plan.

Section 1.12 Participation Account. The term “Participation Account” means the Cash Participation Account and/or the Phantom Stock Participation Account, as applicable. A Participation Account is a bookkeeping account and is not required to be funded in any manner. The Participation Account shall be divided into a series of Plan Year Participation Accounts, one for each Plan Year for which the Participant defers any Compensation under the Plan.

Section 1.13 Phantom Stock. The term “Phantom Stock” means a unit of measurement equivalent to one (1) share of Anthem Common Stock, with none of the attendant rights that a Anthem shareholder has with respect to a share of Anthem Common Stock, including, without limitation, the right to vote such share and the right to receive dividends or other distributions thereunder.

Section 1.14 Phantom Stock Participation Account. The term “Phantom Stock Participation Account” means the bookkeeping account maintained by the Company for each Participant reflecting Anthem Common Stock Compensation deferred under this Plan (as adjusted from time to time) and deemed to be invested in Phantom Stock consistent with Article III. The Phantom Stock Participation Accounts are established solely for accounting purposes and shall not require a segregation of any Company assets.

Section 1.15 Plan. The term “Plan” means the plan embodied by this instrument as now in effect or hereafter amended.

Section 1.16 Plan Year. The term “Plan Year” means the calendar year.

Section 1.17 Plan Year Participation Account. The term “Plan Year Participation Account” means the portion of a Participation Account attributable to deferrals in a particular Plan Year.

Section 1.18 Separation from Service. The term “Separation from Service” means the termination of the Director’s service as a Director with the Company and any entity in its controlled group, other than by reason of death, in compliance with Code Section 409A and the applicable Treasury Regulations issued thereunder. For purposes of the foregoing, whether an entity is in the Company’s controlled group shall be determined under the rules of Code Section 414, as modified by Code Section 409A.

ARTICLE II PARTICIPATION IN THE PLAN

Section 2.01 Eligibility. All Directors are eligible to become Participants in this Plan; provided, however, that former Directors shall be eligible to participate to the extent they are entitled to consulting fees or continuing director fees.

Section 2.02 Deferral Amounts.

(a) Amount of Deferral. The amount of Compensation to be deferred in a Plan Year shall be designated by each Participant in the Enrollment Form executed by that Participant for that Plan Year and returned to the Administrator before the beginning of the Plan Year to which it relates; provided, however, that with respect to any Compensation that is “performance based compensation” under Section 409A of the Code, such election shall be due no later than six (6) months before the end of the performance period for which such Compensation would otherwise be paid. For the Plan Year during which a person first becomes eligible to become a Participant, the Participant shall be provided by the Company the opportunity to make a special election for such Plan Year with respect to the Compensation (other than performance-based compensation) paid in such Plan Year after the date on which the person becomes an eligible Participant by completing and returning to the Administrator an Enrollment Form no later than 30 days after becoming a Participant.

(b) No Changes. Any election by a Participant to defer Compensation with respect to a particular Plan Year may not be revoked, modified or suspended after the start of that

Plan Year, except to the extent permitted under Code Section 409A and the Treasury Regulations thereunder.

(c) Crediting of Deferral. The following rules govern the crediting of the deferral of Compensation under this Plan:

(i) Compensation deferred by a Participant shall be effected pro-rata from each payment of Compensation during the Plan Year.

(ii) For purposes of the allocations described in Article III, the amount of any Compensation deferred hereunder shall be credited to a Participant's Cash Participation Account and/or Phantom Stock Participation Account, as required by Article III, on the day, but for the deferral, the deferred Compensation would have been paid.

(d) Date of Payout of a Participant's Participation Account. Each Participant must, prior to the start of each Plan Year, elect the manner in which his or her Participation Account attributable to deferrals in a particular Plan Year will be distributed. Accordingly, the Participant shall make a separate distribution election with respect to each Plan Year by following the procedures described below and by satisfying such additional requirements as the Administrator may determine.

(i) At the same time the Participant files his or her deferral election for Compensation to be earned in the upcoming Plan Year, the Participant must also elect, in writing, on his or her Enrollment Form, which of the distribution options described below will govern the payment of the Plan Year Participation Account to which those deferred items of Compensation are credited.

(ii) A Participant's Plan Year Participation Account shall be distributed as of the earliest of: (A) the July 1 following the date of the Participant's Separation from Service, (B) the July 1 following the date of the Participant's death, or (C) the date elected by the Participant in his or her Enrollment Form. Under distribution option (C), the date elected must be longer than the minimum deferral period or at least twelve months after the date the initial deferral election for that Plan Year Participation Account is filed.

(iii) A Participant's Plan Year Participation Account will be distributed, based on the Participant's election under clause (i) above in one of the following forms: (A) a lump sum, (B) five annual installments, or (C) ten annual installments. The amount of each annual installment will be either the amount (if any) specified by the Participant in his or her selected distribution schedule or the remaining balance of the Participant's Plan Year Participation Account divided by the number of installments remaining (including the installment to be made).

(iv) Notwithstanding anything in the Plan to the contrary, upon a Participant's Separation from Service, any outstanding deferral election shall be given effect to the extent any amounts covered by such election are paid after such event. In such circumstance, payment of deferred amounts shall be made pursuant to clause (i).

(e) Subsequent Election. A Participant may change the distribution election in effect for a Plan Year Participation Account by submitting that change to the Administrator in writing. No such election shall have any force or effect or become effective until the expiration of the twelve month period measured from the filing date of such election. In addition, each such election shall be valid only if:

(i) such election defers any distribution to be made (other than an election to have distribution made upon the Participant's death) for at least five years after the date that distribution would have otherwise been made or commenced in the absence of such subsequent election, and

(ii) in the case of a scheduled distribution to be made pursuant to a date specified by the Participant, such election is made at least twelve months before the date of the first scheduled distribution. In no event, however, may any change to the distribution election in effect for a Plan Year Participation Account result in any acceleration of the distribution with respect to that Participation Account. For purposes of this subsection (e), in accordance with the applicable Treasury Regulations, a series of annual installments shall be treated as a single payment.

Notwithstanding anything in this subsection (e) to the contrary, in the event of the Participant's Separation from Service or death after a subsequent election is made but before the end of the five-year delay described in clause (i) above, payment shall instead be made upon such Separation from Service or death, as the case may be.

(f) Default Rule. If a Participant fails to complete an Enrollment Form, amounts credited to the Participant's Plan Year Participation Account shall automatically be distributed in a single lump sum on the July 1 immediately following the earlier of the Participant's Separation from Service or death.

(g) Payment of Small Accounts. Notwithstanding anything in this Plan to the contrary and only to the extent permitted under Section 409A of the Code, if a Participant becomes entitled to a distribution of his or her Plan Year Participation Account by reason of his or her termination of eligibility to participate in this Plan and the value of the Participant's Participation Account balance is equal to or less than the limit then in effect under Code Section 402(g), then the Administrator may, in its sole discretion, pay to the Participant his or her entire Participation Account balance in a single lump sum cash payment. Any such payment will be made as soon as administratively feasible following the Participant's termination of eligibility to participate in this Plan and before the later of:

(i) December 31 of the calendar year in which the Participant's termination of eligibility to participate in this Plan occurs, or

(ii) the fifteenth (15th) day of the third month following the Participant's termination of eligibility to participate in this Plan.

(h) 409A Transition Elections. Notwithstanding any provision in the Plan to the contrary, on or before December 31, 2008, Participants may make changes to distribution elections previously filed with respect to amounts deferred under the Plan that relate to Plan Years 2005

through 2008 consistent with transition relief provided by the Department of the Treasury in Notice 2006-79, Notice 2007-86 and proposed regulations promulgated under Code Section 409A.

ARTICLE III
PARTICIPATION ACCOUNTS

Section 3.01 Deferral of Compensation. All cash Compensation deferred hereunder shall be credited to the Participant's Cash Participation Account and all Anthem Common Stock Compensation deferred hereunder shall be credited in Phantom Stock to the Participant's Phantom Stock Participation Account.

Section 3.02 Cash Participation Account. Any monies credited to a Participant's Cash Participation Account shall be credited with interest at the Interest Rate, earned daily, posted monthly and compounded annually, on the amounts held in such Cash Participation Account. At the end of the deferral period elected by the Participant, the Company, consistent with Section 2.02, shall pay the Participant in cash the value of the Participant's Cash Participation Account.

Section 3.03 Phantom Stock Participation Account. An amount of Phantom Stock equal to the number of shares of Anthem Common Stock Compensation deferred hereunder shall be credited to a Participant's Phantom Stock Participation Account. If at any time there is Phantom Stock credited to a Participant's Phantom Stock Participation Account and there is a cash dividend on Anthem Common Stock, then an amount equal to the cash dividend shall be paid on the Phantom Stock held in the Participant's Phantom Stock Participation Account as if a share of Phantom Stock was a share of Anthem Common Stock, by crediting such amount to the Participant's Cash Participation Account. The number of shares of Phantom Stock allocated to the Participant's Phantom Stock Participation Account shall be adjusted by the Administrator, as it deems appropriate in its discretion, in the event of any subdivision or combination of shares of Anthem Common Stock or any stock dividend, stock split, reorganization, recapitalization, or consolidation or merger with Anthem, as the surviving corporation, or if additional shares or new or different shares or other securities of Anthem or any other issuer are distributed with respect to shares of Anthem Common Stock through a spin-off or other extraordinary distribution, as if such Phantom Stock were shares of Anthem Common Stock. At the end of the deferral period elected by the Participant, the Company, consistent with Section 2.02, shall pay the Participant in shares of Anthem Common Stock the number of shares of Phantom Stock credited to the Participant's Phantom Stock Participation Account.

ARTICLE IV
DEATH BENEFITS

If a Participant dies prior to the commencement of the Participant's benefits under Article II, the Beneficiary of that Participant, as determined pursuant to the last Beneficiary Designation Form executed by that Participant and on file with the Administrator, shall receive the balance contained in his Participation Account in cash and/or in Anthem Common Stock, as applicable, in a single payment on the July 1 immediately following the Participant's death. If a Participant dies after the commencement of the Participant's benefits under Article III, payment of any remaining

installments due shall be made to the Participant's Beneficiary at the same times that the installments would have been paid to the Participant.

ARTICLE V
ADMINISTRATION

Section 5.01 Delegation of Responsibility. The Company may delegate duties involved in the administration of this Plan to such person or persons whose services are deemed by it to be necessary or convenient.

Section 5.02 Payment of Benefits. The amounts allocated to a Participant's Participation Account and payable as benefits under this Plan shall be paid solely from the general assets of the Company. The Plan is unfunded. Any Compensation paid in Anthem Common Stock deferred under this Plan and converted into Phantom Stock shall be, on the date on which such deferred Anthem Common Stock is to be distributed pursuant to this Plan, converted back into Anthem Common Stock and be paid in Anthem Common Stock pursuant to the plan, agreement or arrangement under which such Compensation was paid; provided, however, fractional shares shall not be issued to a Participant but the value of such fractional shares shall be paid in cash. The payment of a benefit obligation shall be allocated among the Companies based on the portion of the Compensation which would have been paid by the applicable Company but for the deferral. No Participant shall have any interest in any specific assets of the Company under the terms of this Plan. This Plan shall not be considered to create an escrow account, trust fund or other funding arrangement of any kind or a fiduciary relationship between any Participant and the Company. The Companies' obligations under this Plan are purely contractual and shall not be funded or secured in any way.

Section 5.03 Administration. Except as otherwise provided in the Plan, the Plan shall be administered by the Administrator, which shall have the final authority to adopt rules and regulations for carrying out the Plan, and to interpret, construe, and implement the provisions of the Plan.

Section 5.04 Liability. Any decision made or action taken by the Board of Directors, the Administrator, or any employee of the Company or any of its subsidiaries, arising out of or in connection with the construction, administration, interpretation, or effect of the Plan, shall be absolutely discretionary, and shall be conclusive and binding on all parties. Neither the Administrator nor a member of the Board of Directors and no employee of the Company or any of its subsidiaries shall be liable for any act or action hereunder, whether of omission or commission, by any other member or employee or by any agent to whom duties in connection with the administration of the Plan have been delegated or, except in circumstances involving bad faith, for anything done or omitted to be done.

ARTICLE VI
AMENDMENT OR TERMINATION OF PLAN

Section 6.01 Termination. The Company may at any time terminate this Plan. No additional amounts shall be permitted to be deferred from any Participant's Compensation effective as of the first day of the Plan Year immediately following the date of Plan termination. The Company

shall pay to each such Participant the balance contained in the Participant's Participation Account at such time designated by that Participant in the Forms executed by that Participant. Upon termination of the Plan, the Company reserves the discretion to accelerate distribution of the Participation Accounts in accordance with regulations promulgated by the Department of Treasury under Code Section 409A.

Section 6.02 Amendment. The Company may amend the provisions of this Plan at any time; provided, however, that no amendment shall adversely affect the rights of Participants or their Beneficiaries with respect to the balances contained in their Participation Accounts immediately prior to the amendment.

ARTICLE VII MISCELLANEOUS

Section 7.01 Successors. This Plan shall be binding upon the successors of the Company.

Section 7.02 Choice of Law. This Plan shall be construed and interpreted pursuant to, and in accordance with, the laws of the State of Indiana.

Section 7.03 No Service Contract. This Plan shall not be construed as affecting in any manner the rights or obligations of the Company or of any Participant to continue or to terminate director status at any time.

Section 7.04 Non-Alienation. No Participant or such Participant's Beneficiary shall have any right to anticipate, pledge, alienate, assign, sell or otherwise transfer (except by will or applicable laws of descent and distribution) any of such Participant's rights under this Plan, and any effort to do so shall be null and void. The benefits payable under this Plan shall be exempt from the claims of creditors or other claimants and from all orders, decrees, levies and executions and any other legal process to the fullest extent that may be permitted by law.

Section 7.05 Disclaimer. The Company makes no representations or assurances and assumes no responsibility as to the performance by any parties, solvency, compliance with state and federal securities regulation or state and federal tax consequences of this Plan or participation therein. It shall be the responsibility of the respective Participants to determine such issues or any other pertinent issues to their own satisfaction.

Section 7.06 Designation of Beneficiaries. Each Participant shall designate in such Participant's Beneficiary Designation Form such Participant's Beneficiary and such Participant's contingent Beneficiary to whom death benefits due hereunder at the date of such Participant's death shall be paid; provided, however, that the Beneficiary and contingent Beneficiary designated by a Participant in the last Beneficiary Designation Form executed by that Participant and on file with the Administrator shall supersede all other Beneficiary or contingent Beneficiary designations made by that Participant in any earlier Beneficiary Designation Form executed by that Participant. If any Participant fails to designate a Beneficiary or if the designated Beneficiary predeceases any Participant, death benefits due hereunder at that Participant's death shall be paid to the deceased

Participant's contingent Beneficiary or, if none, to the deceased Participant's surviving spouse, if any, and if none to the deceased Participant's estate.

Section 7.07 Ownership of Shares. A Participant shall have no rights as a shareholder of Anthem Common Stock with respect to any shares of Anthem Common Stock until the shares of Anthem Common Stock are issued or transferred to the Participant on the books of Anthem.

This Plan has been executed on this 11th day of November, 2014. This Plan, as amended and restated herein, shall be effective as of December 2, 2014. Nothing herein shall invalidate or adversely affect any previous election, designation, deferral, or accrual in accordance with the terms of this Plan that were in effect prior to the effective date of this amended and restated Plan.

ANTHEM, INC.

/s/ Joseph R. Swedish

Joseph R. Swedish

President & Chief Executive Officer

APPENDIX A

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**ANTHEM
BOARD OF DIRECTORS'
DEFERRED COMPENSATION PLAN
(AS FROZEN DECEMBER 31, 2004)**

PREAMBLE

The Anthem Board of Directors' Deferred Compensation Plan (the "Plan") is an unfunded supplemental retirement plan for directors of Anthem, Inc. ("Anthem") and such other subsidiaries and affiliates of Anthem which have adopted the Plan and which are listed on Appendix A.

**ARTICLE I
DEFINITIONS**

Section 1.01 Administrator. The term "Administrator" means the Director Benefits Committee which committee is appointed by the Chief Executive Officer of Anthem and which committee shall have the authority to manage and control the operation of this Plan.

Section 1.02 Anthem. The term "Anthem" means Anthem, Inc., and any successor thereof.

Section 1.03 Anthem Common Stock. The term "Anthem Common Stock" means the common stock of Anthem.

Section 1.04 Beneficiary. The term "Beneficiary" means, for a Participant, the individual or individuals designated by that Participant in the last Beneficiary Designation Form executed by that Participant to receive benefits in the event of that Participant's death.

Section 1.05 Cash Participation Account. The term "Cash Participation Account" means the bookkeeping account maintained by the Company for each Participant reflecting cash Compensation amounts deferred under this Plan (as adjusted from time to time) and cash dividends on Anthem Common Stock deferred under this Plan and credited to the Participant's Phantom Stock Participation Account, plus interest accruing at the Interest Rate on such amounts.

Section 1.06 Company. The term "Company" means and shall include the entities listed on Appendix A.

Section 1.07 Compensation. The term "Compensation" means for each Participant in any Plan Year the total amount of remuneration (including retainers, meeting fees and, if applicable, incentive compensation) for director services as paid to that Participant by the Company in that Plan Year.

Section 1.08 Director. The term "Director" means each non-employee member of the Board of Directors of the Company.

Section 1.09 Effective Date. The term "Effective Date" means January 1, 1999.

Section 1.10 Forms. The term “Forms” means the forms used by the Company for Plan operation and shall include the following:

(a) Enrollment Form. The term “Enrollment Form” shall be the form on which a Participant designates the amount and type (i.e. cash or Anthem Common Stock) of Compensation to be deferred under the Plan.

(b) Beneficiary Designation Form. The term “Beneficiary Designation Form” means the form on which a Participant designates the Participant’s Beneficiary.

(c) Distribution Election Form. The term “Distribution Election Form” means the form on which a Participant designates when and how the Participant’s Participation Account shall be distributed.

Section 1.11 Interest Rate. The term “Interest Rate” means the annual rate of return credited to amounts held in the Participant’s Cash Participation Account. The rate shall change each January 1. The rate shall be equal to the average of the monthly average rates of the 10-year United States Treasury Notes for the twelve (12) months ending on September 30 immediately preceding such January 1 plus one hundred and fifty (150) basis points; provided, however, that the Company reserves the right to change the method of determining or to increase or decrease the Interest Rate which is credited to a Participant’s Cash Participation Account as long as the Interest Rate shall not be decreased for periods prior to such action.

Section 1.12 Participant. The term “Participant” means any individual who fulfills the eligibility requirements contained in Article II of this Plan.

Section 1.13 Participation Account. The term “Participation Account” means the Cash Participation Account and/or the Phantom Stock Participation Account, as applicable. A Participation Account is a bookkeeping account and is not required to be funded in any manner.

Section 1.14 Phantom Stock. The term “Phantom Stock” means a unit of measurement equivalent to one (1) share of Anthem Common Stock, with none of the attendant rights that an Anthem shareholder has with respect to a share of Anthem Common Stock, including, without limitation, the right to vote such share and the right to receive dividends or other distributions thereunder.

Section 1.15 Phantom Stock Participation Account. The term “Phantom Stock Participation Account” means the bookkeeping account maintained by the Company for each Participant reflecting Anthem Common Stock Compensation deferred under this Plan (as adjusted from time to time) and deemed to be invested in Phantom Stock consistent with Article III. The Phantom Stock Participation Accounts are established solely for accounting purposes and shall not require a segregation of any Company assets.

Section 1.16 Plan. The term “Plan” means the plan embodied by this instrument as now in effect or hereafter amended.

Section 1.17 Plan Year. The term “Plan Year” means the calendar year.

ARTICLE II
PARTICIPATION IN THE PLAN

Section 2.01 Eligibility. As of the Effective Date, all Directors shall be eligible to become Participants in this Plan; provided, however, that former Directors shall be eligible to participate to the extent they are entitled to consulting fees or continuing director fees.

Section 2.02 Deferral Amounts.

(a) Amount of Deferral. The amount of Compensation to be deferred in a Plan Year shall be designated by each Participant in the Enrollment Form executed by that Participant for that Plan Year prior to the beginning of that Plan Year and within the time period established by Administrator.

(b) Special Rules for New Directors. For the Plan Year during which a person first becomes eligible to become a Participant, the Participant shall be provided by the Company the opportunity to make a special election for such Plan Year with respect to the Compensation paid in such Plan Year after the date on which the person becomes an eligible Participant.

(c) Timing of Deferral. The following rules govern the timing of the deferral of Compensation under this Plan:

(i) Compensation deferred by a Participant shall be effected pro-rata from each payment of Compensation during the Plan Year.

(ii) For purposes of the allocations described in Article III, the amount of any Compensation deferred hereunder shall be credited to a Participant’s Cash Participation Account and/or Phantom Stock Participation Account, as required by Article III, on the day, but for the deferral, the deferred Compensation would have been paid.

(d) Date of Payout of a Participant’s Participation Account. The date on which a Participant’s Participation Account attributable to deferrals in a Plan Year is to be distributed to that Participant under the provisions of this Plan shall be designated by that Participant in the most recent Distribution Election Form executed by that Participant. The distribution options available to a Participant shall include:

(i) lump sum, or

(ii) five (5) or ten (10) annual installments

The Participant shall designate in the Distribution Election Form the year in which distribution is to be made or begin. Any lump sum payment or installment under this Plan for a Plan Year shall be made on or about July 1.

(c) Special Rules. Notwithstanding anything contained in this Article II to the contrary, the following special rules shall govern distributions made under this Plan;

(i) A Participant shall be permitted to change the date on which the Participant's Participation Account shall be distributed by completing a new Distribution Election Form which is delivered to the Company at least one (1) calendar year before the earlier of the date on which the Participant ceases to be a Director or the date on which distribution of the Participant's Participation Account would have been made but for the change in election; provided, however, that any completed Distribution Election Form which was not received prior to the beginning of the one (1) year period described above shall be null and void.

(ii) If the aggregate amount in a Participant's Participation Account on the initial installment date is equal to or less than fifty-five thousand dollars (\$55,000) in value, payment of the Participant's Participation Account shall be required to be made in a single lump sum.

(iii) If a Participant fails to complete a Distribution Election Form, amounts credited to the Participant's Participation Account shall automatically be distributed in a single lump sum on the July 1 immediately following the date on which the Participant ceases to be eligible to participate in this Plan.

(iv) With respect to any amounts credited to a Participant's Participation Account attributable to deferrals made before January 1, 1999 and except as otherwise provided in Subsection (ii) above, any quarterly or annual installment election made by the Participant prior to January 1, 1999 shall be given effect.

ARTICLE III PARTICIPATION ACCOUNTS

Section 3.01 Deferral of Compensation. All cash Compensation deferred hereunder shall be credited to the Participant's Cash Participation Account and all Anthem Common Stock Compensation deferred hereunder shall be credited in Phantom Stock to the Participant's Phantom Stock Participation Account.

Section 3.02 Cash Participation Account. Any monies credited to a Participant's Cash Participation Account shall be credited with interest at the Interest Rate, earned daily, posted monthly and compounded annually, on the amounts held in such Cash Participation Account. At the end of the deferral period elected by the Participant, the Company, consistent with Section 2.02, shall pay the Participant in cash the value of the Participant's Cash Participation Account.

Section 3.03 Phantom Stock Participation Account. An amount of Phantom Stock equal to the number of shares of Anthem Common Stock Compensation deferred hereunder shall be credited to a Participant's Phantom Stock Participation Account. If at any time there is Phantom Stock credited to a Participant's Phantom Stock Participation Account and there is a cash dividend

on Anthem Common Stock, then an amount equal to the cash dividend shall be paid on the Phantom Stock held in the Participant's Phantom Stock Participation Account as if a share of Phantom Stock was a share of Anthem Common Stock, by crediting such amount to the Participant's Cash Participation Account. The number of shares of Phantom Stock allocated to the Participant's Phantom Stock Participation Account shall be adjusted by the Administrator, as it deems appropriate in its discretion, in the event of any subdivision or combination of shares of Anthem Common Stock or any stock dividend, stock split, reorganization, recapitalization, or consolidation or merger with Anthem, as the surviving corporation, or if additional shares or new or different shares or other securities of Anthem or any other issuer are distributed with respect to shares of Anthem Common Stock through a spin-off or other extraordinary distribution, as if such Phantom Stock were shares of Anthem Common Stock. At the end of the deferral period elected by the Participant, the Company, consistent with Section 2.02, shall pay the Participant in shares of Anthem Common Stock the number of shares of Phantom Stock credited to the Participant's Phantom Stock Participation Account.

ARTICLE IV DEATH BENEFITS

If a Participant dies prior to the commencement of the Participant's benefits under Article II, the Beneficiary of that Participant, as determined pursuant to the last Beneficiary Designation Form executed by that Participant, shall receive the balance contained in his Participation Account in cash and/or in Anthem Common Stock, as applicable, in a single payment on the July 1 immediately following the Participant's death. If a Participant dies after the commencement of the Participant's benefits under Article III, payment of any remaining installments due shall be made to the Participant's Beneficiary at the same times that the installments would have been paid to the Participant.

ARTICLE V ADMINISTRATION

Section 5.01 Delegation of Responsibility. The Company may delegate duties involved in the administration of this Plan to such person or persons whose services are deemed by it to be necessary or convenient.

Section 5.02 Payment of Benefits. The amounts allocated to a Participant's Participation Account and payable as benefits under this Plan shall be paid solely from the general assets of the Company. The Plan is unfunded. Any Compensation paid in Anthem Common Stock deferred under this Plan and converted into Phantom Stock shall, on the date on which such deferred Anthem Common Stock is to be distributed pursuant to this Plan, converted back into Anthem Common Stock and be paid in Anthem Common Stock pursuant to the plan, agreement or arrangement under which such Compensation was paid; provided, however, fractional shares shall not be issued to a Participant but the value of such fractional shares shall be paid in cash. The payment of benefit obligation shall be allocated among the Companies based on the portion of the Compensation which would have been paid by the applicable Company but for the deferral. No Participant shall have any interest in any specific assets of

the Company under the terms of this Plan. This Plan shall not be considered to create an escrow account, trust fund or other funding arrangement of any kind or a fiduciary relationship between any Participant and the Company. The Companies' obligations under this Plan are purely contractual and shall not be funded or secured in any way.

Section 5.03 Administration. Except as otherwise provided in the Plan, the Plan shall be administered by the Administrator, which shall have the final authority to adopt rules and regulations for carrying out the Plan, and to interpret, construe, and implement the provisions of the Plan.

Section 5.04 Liability. Any decision made or action taken by the Board of Directors, the Administrator, or any employee of the Company or any of its subsidiaries, arising out of or in connection with the construction, administration, interpretation, or effect of the Plan, shall be absolutely discretionary, and shall be conclusive and binding on all parties. Neither the Administrator nor a member of the Board of Directors and no employee of the Company or any of its subsidiaries shall be liable for any act or action hereunder, whether of omission or commission, by any other member or employee or by any agent to whom duties in connection with the administration of the Plan have been delegated or, except in circumstances involving bad faith, for anything done or omitted to be done.

ARTICLE VI AMENDMENT OR TERMINATION OF PLAN

Section 6.01 Termination. The Company may at any time terminate this Plan. As of the date on which this Plan is terminated, no additional amounts shall be deferred from any Participant's Compensation. The Company shall pay to each such Participant the balance contained in the Participant's Participation Account at such time designated by that Participant in the Forms executed by that Participant; provided, however, that the Administrator, in its sole and complete discretion, may direct the Company to pay out to the Participants their Participation Accounts in a single payment of cash and/or Anthem Common Stock, as applicable, as soon as practicable after the Plan termination.

Section 6.02 Amendment. The Company may amend the provisions of this Plan at any time; provided, however, that no amendment shall adversely affect the rights of Participants or their Beneficiaries with respect to the balances contained in their Participation Accounts immediately prior to the amendment.

ARTICLE VII MISCELLANEOUS

Section 7.01 Successors. This Plan shall be binding upon the successors of the Company.

Section 7.02 Choice of Law. This Plan shall be construed and interpreted pursuant to, and in accordance with, the laws of the State of Indiana.

Section 7.03 No Service Contract. This Plan shall not be construed as affecting in any manner the rights or obligations of the Company or of any Participant to continue or to terminate director status at any time.

Section 7.04 Non-Alienation. No Participant or such Participant's Beneficiary shall have any right to anticipate, pledge, alienate, assign, sell or otherwise transfer (except by will or applicable laws of descent and distribution) any of such Participant's rights under this Plan, and any effort to do so shall be null and void. The benefits payable under this Plan shall be exempt from the claims of creditors or other claimants and from all orders, decrees, levies and executions and any other legal process to the fullest extent that may be permitted by law.

Section 7.05 Disclaimer. The Company makes no representations or assurances and assumes no responsibility as to the performance by any parties, solvency, compliance with state and federal securities regulation or state and federal tax consequences of this Plan or participation therein. It shall be the responsibility of the respective Participants to determine such issues or any other pertinent issues to their own satisfaction.

Section 7.06 Designation of Beneficiaries. Each Participant shall designate in such Participant's Beneficiary Designation Form such Participant's Beneficiary and such Participant's contingent Beneficiary to whom death benefits due hereunder at the date of such Participant's death shall be paid; provided, however, that the Beneficiary and contingent Beneficiary designated by a Participant in the last Beneficiary Designation Form executed by that Participant shall supersede all other Beneficiary or contingent Beneficiary designations made by that Participant in any earlier Beneficiary Designation Form executed by that Participant. If any Participant fails to designate a Beneficiary or if the designated Beneficiary predeceases any Participant, death benefits due hereunder at that Participant's death shall be paid to the deceased Participant's contingent Beneficiary or, if none, to the deceased Participant's surviving spouse, if any, and if none to the deceased Participant's estate.

Section 7.07 Ownership of Shares. A Participant shall have no rights as a shareholder of Anthem Common Stock with respect to any shares of Anthem Common Stock until the shares of Anthem Common Stock are issued or transferred to the Participant on the books of Anthem.

This Plan has been executed on this 29 day of August, 2003. This Plan was effective on January 1, 1999. This Plan, as amended and restated herein, shall be effective as of January 1, 2004. Nothing herein shall invalidate or adversely affect any previous election, designation, deferral, or accrual in accordance with the terms of this Plan that were in effect prior to the effective date of this amended and restated Plan.

ANTHEM, INC.

By:___

Its:___

Exhibit 10.13

BLUE CROSS LICENSE AGREEMENT
(Includes revisions, if any, adopted by Member Plans through their November 21, 2014 meeting)

This agreement by and between Blue Cross and Blue Shield Association ("BCBSA") and The Blue Cross Plan, known as _____ (the "Plan").

Preamble

WHEREAS, the Plan and/or its predecessor(s) in interest (collectively the "Plan") had the right to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") for health care plans in its service area, which was essentially local in nature;

WHEREAS, the Plan was desirous of assuring nationwide protection of the Licensed Marks, maintaining uniform quality controls among Plans, facilitating the provision of cost effective health care services to the public and otherwise benefiting the public;

WHEREAS, to better attain such ends, the Plan and the predecessor of BCBSA in 1972 simultaneously executed the BCA License Agreement (s) and the Ownership Agreement; and

WHEREAS, BCBSA and the Plan desire to supercede said Agreement(s) and to revise certain provisions of the Ownership Agreement to reflect their current practices and to assure the continued integrity of the Licensed Marks and of the BLUE CROSS system;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

Agreement

1. BCBSA hereby grants to the Plan, upon the terms and conditions of this License Agreement ("Agreement" or "Primary License Agreement", the right to use BLUE CROSS in its trade and/or corporate name (the "Licensed Name"), and the right to use the Licensed Marks, in the sale, marketing and administration of health care plans and related services in the Service Area set forth and defined in paragraph 5 below. As used herein, health care plans and related services shall include acting as a nonprofit health care plan, a for-profit health care plan, or mutual health insurer operating on a not-for-profit or for-profit basis, under state law; financing access to health care services; when working with a bank that holds the relevant license to use the Licensed Name and Marks, offering: (i) tax-favored savings accounts for medical expenses and means for accessing such accounts, such as debit cards or checks, that are provided solely to support access to such tax-favored savings accounts, all pursuant to such license, or (ii) prepaid rewards cards that are provided for completion of a wellness program, all pursuant to such license; providing health care management and administration; administering, but not underwriting, non-health portions of Worker's Compensation insurance; delivering health care services, except hospital services (as defined in the Guidelines to Membership Standards Applicable to Regular Members); and performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by a group account to its members, including benefit plans not provided by the Plan, provided that the Plan has contracted to provide Health Coverage under the Licensed Marks to the account (as the terms "Health Coverage," "Eligibility" and "Enrollment" are defined in Exhibit 4, Paragraph 2.t.).

2. The Plan may use the Licensed Marks and Name in connection with the offering of: i) health care plans and related services in the Service Area through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License Agreement"); and: ii) insurance coverages offered by life insurers under the applicable law in the Service Area, other than those which the Plan may offer in its own name, provided through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1A hereto (the "Controlled Affiliate License Agreement Applicable to Life Insurance Companies") or the Agreement attached as Exhibit 1A1 hereto (the "Controlled Affiliate Trademark License Agreement for Life and Disability Insurance Products") and further provided that the offering of such services does not and will not dilute or tarnish the unique value of the Licensed Marks and Name; and iii) administration and underwriting of Workers' Compensation Insurance Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License."); and iv) regional Medicare Advantage PPO products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1B hereto (the "Controlled Affiliate License Agreement Applicable to Regional Medicare Advantage PPO Products"); and v) regional Medicare Part D Prescription Drug Plan products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1C hereto (the "Controlled Affiliate License Agreement Applicable to Regional Medicare Part D Prescription Drug Plan Products"). As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans and, if the entity meets the standards of Paragraph 2a.B but not Paragraph 2a.A, the entity, its owners, and persons

Amended as of September 19, 2014

with authority to select or appoint members or board members, other than a Plan or Plans, have received written approval of BCBSA. Absent written approval by BCBSA of an alternative method of control, bona fide control shall have the meaning set forth in Paragraphs 2a. and 2b.

2a. With respect to the Controlled Affiliate Licenses authorized in clauses i) through iii) of Paragraph 2, bona fide control shall mean that a Plan (the "Sponsoring Plan") authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to this Primary License Agreement with BCBSA must have:

- A. The legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; (b) to exercise control over the policy and operations of the Controlled Affiliate; (c) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate; or
- B. The legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; (c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan. Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:
 - 1. Change its legal and/or trade name;
 - 2. Change the geographic area in which it operates;
 - 3. Change any of the types of businesses in which it engages;
 - 4. Create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;
 - 5. Sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;
 - 6. Make any loans or advances except in the ordinary course of business;

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7. Enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners of the Controlled Affiliate or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

8. Conduct any business other than under the Licensed Marks and Name;

9. Take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks or Names.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate; or

C. With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid products and services, the legal authority together with such other Plans (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B to Exhibit 1 attached hereto.

2b. With respect to the Controlled Affiliate License Agreements authorized in clauses iv) and v) of Paragraph 2, bona fide control shall mean that the Controlled Affiliate is organized and operated in such a manner that it meets the following requirements:

A. The Controlled Affiliate is owned or controlled by two or more Plans authorized to use the Licensed Marks pursuant to this License Agreement with BCBSA (for purposes of this subparagraph A. through subparagraph C., the "Controlling Plans"); and

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B. Each Controlling Plan is authorized pursuant to this Agreement to use the Licensed Marks in a geographic area in the Region (as that term is defined in such Controlled Affiliate License Agreements) and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

C. The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur; and (c) to exercise control over the policy and operations of the Controlled Affiliate. Notwithstanding anything to the contrary in (a) through (c) of this subparagraph E., the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

1. Change its legal and/or trade names;
2. Change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
3. Change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
4. Take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

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3. With respect to a Controlled Affiliate that is not licensed to use the Licensed Marks and Name, the Plan may, in communications that contain the Licensed Marks or Name, indicate its corporate relationship to the Affiliate and permit such Affiliate to indicate its corporate relationship to the Plan, solely in the circumstances, style and manner specified by BCBSA from time-to-time in regulations of general application consistent with the avoidance of confusion or mistake or the dilution or tarnishment of the Licensed Marks and Name. No rights are hereby created in any Controlled Affiliate to use the Licensed Marks or Name in its own name or otherwise.

4. The Plan recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Plan further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide. The Plan agrees (a) to maintain in good standing its membership in BCBSA; (b) promptly to pay its dues to BCBSA, said dues to represent the royalties for this License Agreement; (c) materially to comply with all applicable laws; (d) to comply with the Membership Standards Applicable to Regular Members of BCBSA, a current copy of which is attached as Exhibit 2 hereto; and (e) reasonably to permit BCBSA, upon a written, good faith request and during reasonable business hours, to inspect the Plan's books and records necessary to ascertain compliance herewith. As to other Plans and third parties, BCBSA shall maintain the confidentiality of all documents and information furnished by the Plan pursuant hereto, or pursuant to the Membership Standards, and clearly designated by the Plan as containing proprietary information of the Plan.

5. The rights hereby granted are exclusive to the Plan within the geographical area(s) served by the Plan on June 30, 1972, and/or as to which the Plan has been granted a subsequent license, which is hereby defined as the "Service Area," except that BCBSA reserves the right to use the Licensed Marks in said Service Area, and except to the extent that said Service Area may overlap areas served by one or more other licensed Blue Cross Plans as of said date or subsequent license, as to which overlapping areas the rights hereby granted are nonexclusive as to such other Plan or Plans only.

Amended as of June 19, 2014

6. Except as expressly provided by BCBSA with respect to National Accounts, Government Programs and certain other necessary and collateral uses, the current rules and regulations governing which are attached as Exhibit 3 and Exhibit 4 hereto, and are contained in other documents referenced herein, or as expressly provided herein, the Plan may not use the Licensed Marks and Name outside the Service Area or in connection with other goods and services, nor may the Plan use the Licensed Marks or Name in a manner which is intended to transfer in the Service Area the goodwill associated therewith to another mark or name. Nothing herein shall be construed to prevent the Plan from engaging in lawful activity anywhere under other marks and names not confusingly similar to the Licensed Marks and Name, provided that engaging in such activity does and will not dilute or tarnish the unique value of the Licensed Marks and Name. In addition to any and all remedies available hereunder, BCBSA may impose monetary fines on the Plan for the Plan's use of the Licensed Marks and Names outside the Service Area, and provided that the procedure used in imposing a fine is consistent with procedures specifically prescribed by BCBSA from time to time in regulations of general application. In the case of regional Medicare Advantage PPO and regional Medicare Part D Prescription Drug Plan products offered by consenting and participating Plans in a region that includes the Service Areas, or portions thereof, of more than one Plan, such fine may be imposed jointly on the consenting and participating Plans for use of the Licensed Marks and Name in any geographic area of the region in which a Plan having exclusive rights to the Licensed Marks and Name does not consent to and participate in such offering, provided that the basis for imposition of such fine is consistent with rules specifically prescribed by BCBSA from time to time in regulations of general application.

7. The Plan agrees that it will display the Licensed Marks and Name only in such form, style and manner as shall be specifically prescribed by BCBSA from time-to-time in regulations of general application in order to prevent impairment of the distinctiveness of the Licensed Marks and Name and the goodwill pertaining thereto. The Plan shall cause to appear on all materials on or in connection with which the Licensed Marks or Name are used such legends, markings and notices as BCBSA may reasonably request in order to give appropriate notice of service mark or other proprietary rights therein or pertaining thereto.

8. BCBSA agrees that: (a) it will not grant any other license effective during the term of this License Agreement for the use of the Licensed Marks or Name which is inconsistent with the rights granted to the Plan hereunder; and (b) it will not itself use the Licensed Marks in derogation of the rights of the Plan or in a manner to deprive the Plan of the full benefits of this License Agreement, provided that BCBSA shall have the right to use the Licensed Marks in conjunction with any national offering under the Federal Employees Health Benefits Program in the manner set forth in Exhibit 4, Paragraph 4 (including subparagraphs) to this License Agreement. The Plan agrees that it will not attack the title of BCBSA in and to the Licensed Marks or Name or attack the validity of the Licensed Marks or of this License Agreement. The Plan further agrees that all use by it of the Licensed Marks and Name or any similar mark or name shall inure to the benefit of BCBSA, and the Plan shall cooperate with BCBSA in effectuating the assignment to BCBSA of any service mark or trademark registrations of the Licensed Marks or any similar mark or name held by the Plan or a Controlled Affiliate of the Plan, all or any portion of which registration consists of the Licensed Marks.

Amended as of November 16, 2006

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9. (a). Should the Plan fail to comply with the provisions of paragraphs 2-4, 6, 7 and/or 12, and not cure such failure within thirty (30) days of receiving written notice thereof (or commence curing such failure within such thirty day period and continue diligent efforts to complete the curing of such failure if such curing cannot reasonably be completed within such thirty day period), BCBSA shall have the right to issue a notice that the Plan is in a state of noncompliance. Except as to the termination of a Plan's License Agreement or the merger of two or more Plans, disputes as to noncompliance, and all other disputes between or among BCBSA, the Plan, other Plans and/or Controlled Affiliates, shall be submitted promptly to mediation and mandatory dispute resolution pursuant to the rules and regulations of BCBSA, a current copy of which is attached as Exhibit 5 hereto, and shall be timely presented and resolved. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. If a state of noncompliance as aforesaid is undisputed by the Plan or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the License Agreement. Except, however, as provided in paragraphs 9(d)(iii), 15(a)(i)-(viii), and 15(a)(x) below, no Plan's license to use the Licensed Marks and Name may be finally terminated for any reason without the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

(b). Notwithstanding any other provision of this License Agreement, a Plan's license to use the Licensed Marks and Name may be forthwith terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to Member Plans for: (i) failure to comply with any minimum capital or liquidity requirement under the Membership Standard on Financial Responsibility; or (ii) impending financial insolvency; or (iii) the pendency of any action instituted against the Plan seeking its dissolution or liquidation or its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property of business, unless this License Agreement has been earlier terminated under paragraph 15(a); or (iv) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans and/or the Licensed Marks.

Amended as of March 16, 2006

(c). To the extent not otherwise provided therein, neither: (i) the Membership Standards Applicable to Regular Members of BCBSA; nor (ii) the rules and regulations governing Government Programs and certain other uses; nor (iii) the rules and regulations governing mediation and mandatory dispute resolution, may be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans. The rules and regulations governing National Accounts and other national programs required by the Membership Standards Applicable to Regular Members of BCBSA (Exhibit 2) are contained, in addition to those set forth in Exhibit 3, in the following documents, as amended from time to time: (1) the Inter-Plan Programs Policies and Provisions; (2) Inter-Plan Medicare Advantage Program Policies and Provisions. The voting requirements specified in rules and regulations governing such national programs may not be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans.

Amended as of November 21, 2014

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

(i) The Plan shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement and the Plan's membership in BCBSA.

(ii) The Plan shall not use the licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Plan in any securities market. The Plan shall use the licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(iii) The Plan's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Plan knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Plan ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Plan knows, or there is an SEC filing indicating that, any Noninstitutional Investor has become the Beneficial Owner of securities representing 5% or more of the voting power of the Plan ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Plan knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner of 20% or more of the Plan's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 9(d)(iv) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Plan went public constituted the Board of Directors of the Plan (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Plan went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Plan consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Plan in a writing received by BCBSA prior to such automatic termination becoming effective, the provisions of this paragraph 9(d)(iii) may be waived, in whole or in part,

Amended as of September 17, 1997

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upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 9(d)(iii)(a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Plan's license to use the Licensed Marks and Name is terminated pursuant to this Paragraph 9(d)(iii), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Plan demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(iv) The Plan shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities or (iii) such other securities as the Plan may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(v) For purposes of paragraph 9(d)(iii), the following definitions shall apply:

(a) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(b) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(i) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

Amended as of September 17, 1997

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(ii) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(iii) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (b)(ii)(B) above) or disposing of any securities of the Plan.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Plan, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(c) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

(d) "Noninstitutional Investor" means any Person who is not an Institutional Investor.

(e) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

Amended as of September 17, 1997

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10. This License Agreement shall remain in effect: (a) until terminated as provided herein; or (b) until this and all such other License Agreements are terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans; or (c) until termination of aforesaid Ownership Agreement; or (d) until terminated by the Plan upon eighteen (18) months written notice to BCBSA or upon a shorter notice period approved by BCBSA in writing at its sole discretion.

11. Except as otherwise provided in paragraph 15 below or by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans, or unless this and all such other License Agreements are simultaneously terminated by force of law, the termination of this License Agreement for any reason whatsoever shall cause the reversion to BCBSA of all rights in and to the Licensed Marks and Name, and the Plan agrees that it will promptly discontinue all use of the Licensed Marks and Name, will not use them thereafter, and will promptly, upon written notice from BCBSA, change its corporate name so as to eliminate the Licensed Name therefrom.

12. The license hereby granted to Plan to use the Licensed Marks and Name is and shall be personal to the Plan so licensed and shall not be assignable by any act of the Plan, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Plan mortgage or part with possession or control of this license or any right hereunder, and the Plan shall have no right to grant any sublicense to use the Licensed Marks and Name.

13. BCBSA shall maintain appropriate service mark registrations of the Licensed Marks and BCBSA shall take such lawful steps and proceedings as may be necessary or proper to prevent use of the Licensed Marks by any person who is not authorized to use the same. Any actions or proceedings undertaken by BCBSA under the provisions of this paragraph shall be at BCBSA's sole cost and expense. BCBSA shall have the sole right to determine whether or not any legal action shall be taken on account of unauthorized use of the Licensed Marks, such right not to be unreasonably exercised. The Plan shall report any unlawful usage of the Licensed Marks to BCBSA in writing and agrees, free of charge, to cooperate fully with BCBSA's program of enforcing and protecting the service mark rights, trade name rights and other rights in the Licensed Marks.

14. The Plan hereby agrees to save, defend, indemnify and hold BCBSA and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of the activities of the Plan or of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan. BCBSA hereby agrees to save, defend, indemnify and hold the Plan and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of BCBSA.

Amended as of June 21, 2012

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15. (a). This Agreement shall automatically terminate upon the occurrence of any of the following events: (i) a voluntary petition shall be filed by the Plan or by BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against the Plan or BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Plan or BCBSA respectively, or (iii) an order for relief is entered against the Plan or BCBSA in any case under the bankruptcy laws of the United States, or the Plan or BCBSA is adjudged bankrupt or insolvent (as that term is defined in the Uniform Commercial Code as enacted in the state of Illinois) by any court of competent jurisdiction, or (iv) the Plan or BCBSA makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of the Plan or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Plan or BCBSA respectively, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of the Plan's or BCBSA's property or business is appointed, or the Plan or BCBSA is ordered dissolved or liquidated, or (ix) the Plan shall fail to pay its dues and shall not cure such failure within thirty (30) days of receiving written notice thereof, or (x) if, due to regulatory action, the Plan together with any applicable Controlled Affiliate becomes unable to do business using the Names and Marks in any State or portion thereof included in its Service Area, provided that: (i) automatic termination shall not occur prior to the exhaustion by any such Plan of its rights to appeal or challenge such regulatory action; and (ii) in the event the Plan is licensed to do business using the Names and Marks in multiple States or portions of States, the termination of its License Agreement shall be solely limited to the State(s) or portions thereof in which the regulatory action applies. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Plan's or BCBSA's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 15(a)(vii) and (viii) of this Agreement.

Amended as of September 14, 2004

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(b). BCBSA, or the Plans (as provided and in addition to the rights conferred in Paragraph 10(b) above), may terminate this Agreement immediately upon written notice upon the occurrence of either of the following events: (a) the Plan or BCBSA becomes insolvent (as that term is defined in the Uniform Commercial Code enacted in the state of Illinois), or (b) any final judgment against the Plan or BCBSA remains unsatisfied or unbonded of record for a period of sixty (60) days or longer.

(c). If this License Agreement is terminated as to BCBSA for any reason stated in subparagraphs 15(a) and (b) above, the ownership of the Licensed Marks shall revert to each of the Plans as provided in the Ownership Agreement.

(d). Upon termination of this License Agreement or any Controlled Affiliate License Agreement of a Larger Controlled Affiliate, as defined in Exhibit 1 to this License Agreement, the following conditions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 15 (a)(x)(ii) of this Agreement, the notices, national account listing, payment and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

(i) The terminated entity shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the terminated entity or its Controlled Affiliates under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination or, if termination is pursuant to paragraph 10(d) of this Agreement, within 15 days after the written notice to BCBSA described in paragraph 10(d).

(ii) The terminated entity shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the terminated entity is involved (in a Control, Participating or Servicing capacity), identifying the national account and the terminated entity's role therein. For those accounts where the terminated entity is the Control Plan, the Plan must also indicate the Participating and Servicing Plans in the national account syndicate.

Amended as of June 16, 2005

(iii) Unless the cause of termination is an event stated in paragraph 15(a) or (b) above respecting BCBSA, the Plan and its Licensed Controlled Affiliates shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. The Re-Establishment Fee shall be indexed to a base fee of \$80. The Re-Establishment Fee through December 31, 2005 shall be \$80. The Re-Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was \$278.60, \$285.00 and \$290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be \$83.27 (100% of the base fee plus \$1.84 for calendar year 2005 and \$1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (a) the end of the last fiscal year of the terminated entity which ended prior to termination or (b) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph (d)(iii) shall be due only to the extent that, in BCBSA's

Amended as of June 16, 2005

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opinion, it does not cause the net worth of the Plan to fall below 100% of the Health Risk-Based Capital formula or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans), measured as of the date of termination and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plan or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage.

At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Plan (and/or its Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph only to the extent that such payments exceed the amounts due to BCBSA pursuant to subparagraph 15(d)(vi) and any costs associated with reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the terminated entity.

- (iv) The terminated entity shall comply with all financial settlement procedures set forth in BCBSA's License Termination Contingency Plan, as amended from time

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to time and shall work diligently and in good faith with BCBSA, any Alternative Control Licensee or Replacement Licensee and any existing or potential new account for Blue-branded products and services to minimize the disruption of termination, and honor, to the fullest extent possible, the desire of accounts to continue to receive or obtain Blue-branded products and services through a new Licensee ("Transition"). Such diligence and good faith on the part of the terminated entity shall include, but not be limited to: (a) working cooperatively with BCBSA to protect the Names and Marks from potential harm; (b) cooperating with BCBSA's use of the Names and Marks in the terminated entity's former service area during the termination and Transition; (c) transmitting, upon the request of an existing Blue account or of BCBSA with consent and on behalf of an existing Blue account, all member and account-data relating to the Federal Employee Program to BCBSA, and all member and account data relating to other programs to an Alternative Control Licensee or Replacement Licensee; (d) working with BCBSA and the Alternative Control or Replacement Licensee with respect to potential new Blue accounts headquartered in the terminated entity's former service area; (e) continuing to service Blue accounts during the Transition; (f) continuing to comply with National Programs, Federal Employee Program and NASCO policies and procedures and all voluntary BCBSA programs, policies and performance standards, such as Away From Home Care, including being responsible for payment of all penalties for non-compliance duly levied in conformity with the License Agreements, Membership Standards, or the Federal Employee Program agreements, that may arise during the Transition; (g) maintaining and providing access to its provider networks, as defined by Federal Employee Program agreements and National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and making those networks and discounts available to members and providers who participate in National Programs and the Federal Employee Program during the Transition; (h) maintaining its technical connections and processing capabilities during the Transition; and (i) working diligently to conclude all financial settlements and account reconciliations as negotiated in the termination transition agreement.

Amended as of November 16, 2006

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- (v) Notwithstanding any other provision in this Agreement, BCBSA shall have the right, with the approval of its Board of Directors, to assess additional fines against the terminated entity during the Transition in the event it fails to maintain and provide access to provider networks as defined by Federal Employee Program agreements, National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and/or pass on applicable discounts. Such fines shall be in addition to any other assessments, fees or liquidated damages payable herein, or under existing policies and programs and shall be imposed to make whole BCBSA and/or the Plans. Terminated entity shall pay any such fines to BCBSA no later than 30 days after they are approved by the Board of Directors.
- (vi) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third-party auditor to examine and audit the books and records of the terminated entity and its Licensed Controlled Affiliates to verify compliance with the terms and requirements this paragraph 15(d).
- (vii) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.
- (viii) As to a breach of 15 (d) (i), (ii), (iii), (iv), (vi), or (vii) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 15 (d) (i), (ii), (iv), (vi), or (vii) by the Plan, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

Amended as of November 16, 2006

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- (ix) In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Plan and its Licensed Controlled Affiliates shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

(e). BCBSA shall be entitled to enjoin the Plan or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this License Agreement unless the License Agreement has been terminated pursuant to paragraph 10 (d) of this Agreement upon the required six (6) month written notice.

(f). BCBSA acknowledges that it is not the owner of assets of the Plan.

Amended as of June 16, 2005

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16. This Agreement supersedes any and all other agreements between the parties with respect to the subject matter herein, and contains all of the covenants and agreements of the parties as to the licensing of the Licensed Marks and Name. This Agreement may be amended only by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

17. If any provision or any part of any provision of this Agreement is judicially declared unlawful, each and every other provision, or any part of any provision, shall continue in full force and effect notwithstanding such judicial declaration.

18. No waiver by BCBSA or the Plan of any breach or default in performance on the part of BCBSA or the Plan or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

19a. All notices provided for hereunder shall be in writing and shall be sent in duplicate by regular mail to BCBSA or the Plan at the address currently published for each by BCBSA and shall be marked respectively to the attention of the President and, if any, the General Counsel, of BCBSA or the Plan.

Amended as of November 20, 1997

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19b. Except as provided in paragraphs 9(b), 9(d)(iii), 15(a), and 15(b) above, this Agreement may be terminated for a breach only upon at least 30 days' written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Member Plans.

19c. For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

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Amended as of June 16, 2005

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20. Nothing herein contained shall be construed to constitute the parties hereto as partners or joint venturers, or either as the agent of the other, and Plan shall have no right to bind or obligate BCBSA in any way, nor shall it represent that it has any right to do so. BCBSA shall have no liability to third parties with respect to any aspect of the business, activities, operations, products, or services of the Plan.

21. This Agreement shall be governed, construed and interpreted in accordance with the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By_____

Title_____

Date_____

PLAN:

By_____

Title_____

Date_____

EXHIBIT 1

**BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT
(Includes revisions adopted by Member Plans through their November 21, 2014 meeting)**

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan, known as _____ ("Plan" or "Sponsoring Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non-health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the Sponsoring Plan's net subscription revenue.

This grant of rights is non-exclusive and is limited to the Service Area served by the Plan. Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

Amended as of September 19, 2014

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that the Sponsoring Plan has:

(1) The legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and

(c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

(iii) change any of the type(s) of businesses in which it engages;

Amended September 19, 2014

- (iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;
- (v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;
- (vi) make any loans or advances except in the ordinary course of business;
- (vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);
- (viii) conduct any business other than under the Licensed Marks and Name;
- (ix) take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate.

Or

(2) the legal authority directly or indirectly through wholly-owned subsidiaries:

- (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and
- (c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate.

Or

(3) With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid products and services, the legal authority together with such other Plans:

Amended as of September 19, 2014

- (a) to select all members of the Controlled Affiliate's governing body; and
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and
- (c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such control and ownership by Plans must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License attached hereto as Exhibit B.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this Agreement, Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name.

Amended September 19, 2014

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to: (i) Controlled Affiliate's rendering of services under the Licensed Marks and Name; or (ii) the activities of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan or Controlled Affiliate.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) the Plan ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement the Plan ceases to be authorized to use the Licensed Names and Marks in the geographic area served by the Controlled Affiliate provided, however, that if the Controlled Affiliate is serving more than one State or portions thereof, the termination of this Agreement shall be limited to the State(s) or portions thereof in which the Plan's license to use the Licensed Marks and Names is terminated. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

Amended as of June 21, 2012

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(e); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Controlled Affiliate shall no longer comply with item 2(E) above;
- (2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or
- (3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(e)(3)(vii) and (viii) of this Agreement

Amended as of March 18, 2004

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(b) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 7.G. shall not apply and the following provisions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 7(B)(ii) of this Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area.

Amended as of June 16, 2005

The Re-Establishment Fee shall be indexed to a base fee of \$80. The Re-Establishment Fee through December 31, 2005 shall be \$80. The Re-establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was \$278.60, \$285.00 and \$290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be \$83.27 (100% of base fee plus \$1.84 for calendar year 2005 and \$1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Plan or its other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.M. and

Amended as of June 16, 2005

any costs associated with reestablishing the Service Area, including payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third party auditor to examine and audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 7.H.

(5) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

(6) As to a breach of 7.H.(1), (2), (3), (4) or (5) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. This Agreement shall remain in effect until terminated by the Controlled Affiliate or the Plan upon not less than eighteen (18) months written notice to the Association or upon a shorter notice period approved by BCBSA in writing at its sole discretion, or until terminated as otherwise provided herein. The Plan's right to terminate without cause upon such notice is unfettered and may be exercised in the Plan's sole discretion.

J. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3. and M. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

K. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of the Plan's license agreement upon the required 6 month written notice.

L. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

M. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E)(2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 7(C) and 7(D) above shall require the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

Amended as of September 19, 2014

N. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit C.

10. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

Amended as of September 19, 2014

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2005

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15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: _____

Date: _____

Plan:

By: _____

Date: _____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: _____

Date: _____

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS

November 2014

PREAMBLE

For purposes of definition:

A "smaller Controlled Affiliate:" (1) comprises less than fifteen percent (15%) of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers' compensation insurance and has total premium revenue less than 15 percent of the Sponsoring Plan's net subscription revenue.

A "larger Controlled Affiliate" comprises fifteen percent (15%) or more of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate's status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate's health and workers' compensation administration business reaches or surpasses fifteen percent (15%) of the total member enrollment of the Sponsoring Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

Amended as of September 19, 2014

EXHIBIT A (continued)

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA "Health Risk-Based Capital (HRBC)" as defined by the NAIC and state-established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and
2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers' compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

*For purposes of this calculation,

The numerator equals:

Applicant Controlled Affiliate's member enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Sponsoring Plan and all other licensed Controlled Affiliates' member enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

Amended as of September 19, 2002

EXHIBIT A (continued)

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

Each licensed controlled affiliate shall be subject to certain standards as determined below:

1. What percent of the licensed controlled affiliate is controlled by the Sponsoring Plan and other Plans?

More than 50% by Sponsoring Plan ↓ Standard 1A, 4	50% by Sponsoring Plan ↓ Standard 1B, 4	100% Plan control but less than 50% Sponsoring Plan Control and its offers solely Medicaid products and services ↓ Standard 1(C)
---	---	--

IN ADDITION,

2. Is risk being assumed?

Yes			No	
↗	↓	↘	↗	↓
Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance ↓ Standards 7A-7E, 11	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance ↓ Standard 2 (Guidelines 1.1, 1.2) and Standard 11	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance ↓ Standard 6H	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates ↓ Standard 2 (Guidelines 1.1, 1.3) and Standard 11	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates ↓ Standard 6H

IN ADDITION,

3. Is medical care being directly provided?

Yes ↓ Standard 3A	No ↓ Standard 3B
-------------------------	------------------------

IN ADDITION,

4. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total member enrollment of Plan and its licensed controlled affiliates?

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

EXHIBIT A (continued)

Standard 1 - Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA, (the "Sponsoring Plan"), has the legal authority, directly or indirectly through wholly-owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate.

1B.) The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA, (the "Sponsoring Plan"), has the legal authority, directly or indirectly through wholly-owned subsidiaries:

- 1) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and
- 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and
- 3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan.

Amended as of September 19, 2014

EXHIBIT A (continued)

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by Sponsoring Plan before the Controlled Affiliate can:

- o change the geographic area in which it operates
- o change its legal and/or trade names
- o change any of the types of businesses in which it engages
- o create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- o sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- o make any loans or advances except in the ordinary course of business
- o enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- o conduct any business other than under the Licensed Marks and Name
- o take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate.

1C.) The Standard for 100% Plan control but less than 50% Sponsoring Plan Control:

A Controlled Affiliate shall be organized and operated in such a manner that (i) it offers solely Medicaid products and services; and (ii) a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA (the "Sponsoring Plan,") has the legal authority together with Other Plans:

Amended September 19, 2014

- 1) to select all members of the Controlled Affiliate's governing body; and
- 2) to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; and
- 3) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License.

Amended September 19, 2014

EXHIBIT A (continued)

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk-assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk-assuming Controlled Affiliate ceases operations for any reason, Sponsoring Plan will provide for services to its customers. The requirements of the preceding two sentences shall apply to all lines of business unless a line of business is specially exempted from the requirement(s) by the BCBSA Board of Directors.

Standard 3 - State Licensure/Certification

3A.)The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.)The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Amended as of September 19, 2014

EXHIBIT A (continued)

Standard 5 - Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its Sponsoring licensed Plan shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Other Standards for Larger Controlled Affiliates

Standards 6(A) - (I) that follow apply to larger Controlled Affiliates.

Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost-effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Amended as of September 19, 2014

EXHIBIT A (continued)

Such programs are applicable to licensees, and include:

1. BlueCard Program;
2. Inter-Plan Teleprocessing System (ITS);
3. National Account Programs;
4. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
5. Inter-Plan Medicare Advantage Program.

Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter-licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Local and National Best Efforts

Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this License Agreement, during each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross Mark.

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. **Amended as of November 21, 2014**

EXHIBIT A (continued)

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

- A) BCBSA Controlled Affiliate Licensure Information Request; and
- B) Biennial trade name and service mark usage material, including disclosure material; and
- C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and
- D) Semi-annual "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

Amended as of November 17, 2011

EXHIBIT A (continued)

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 - Other Standards for Risk-Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) - (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

- A. BCBSA Controlled Affiliate Licensure Information Request; and
 - B. Biennial trade name and service mark usage materials, including disclosure materials; and
 - C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk-Based Capital Worksheets for Property and Casualty Insurers; and
 - D. Quarterly Estimated Risk-Based Capital for Property and Casualty Insurers, Insurance Department Examination Report; and
- Amended as of November 17,
2011**

EXHIBIT A (continued)

- E. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and
- F. Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended as of November 16, 2000

EXHIBIT A (continued)

Standard 8 - Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

A smaller controlled affiliate that formerly was a Primary Licensee shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of November 21, 2014

EXHIBIT A (continued)

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

C. Reporting requirements include:

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

Amended as of June 13, 2002

EXHIBIT A (continued)

Standard 9(B) - Participation in National Programs by Smaller Controlled Affiliates

A smaller controlled affiliate shall participate in national programs in accordance with BlueCard and other relevant Policies and Provisions shall effectively and efficiently participate in national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of June 20, 2013

EXHIBIT A (continued)

Standard 10 - Participation in Inter-Plan Medicare Advantage Program

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

- A. Inter-Plan Medicare Advantage Program.

EXHIBIT A (continued)

Standard 11: Participation in Master Business Associate Agreement by Smaller Controlled Affiliate Licensees

Effective April 14, 2003, all smaller controlled affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of September 19, 2014

EXHIBIT B

ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1C.

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Cross Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association ("Licensor"), _____ ("Controlled Affiliate Licensee") and _____ ("Sponsoring Plan") dated the ____ day of _____, _____ ("Agreement"). The parties to this Addendum are Licensor, Controlled Affiliate Licensee, Sponsoring Plan, and the undersigned other Plans ("Other Plans"). This Addendum is made and shall be deemed effective as of the date of the Agreement.

WHEREAS, the Sponsoring Plan asserts that it can serve the Medicaid market in its Service Area more efficiently and with less risk though a Medicaid enterprise jointly owned and controlled with other Plans than through a wholly owned and controlled Medicaid enterprise;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1C. permits the licensing of a Controlled Affiliate that is less than 50% owned and controlled by the Sponsoring Plan but which is 100% owned and controlled by Plans including the Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan and all such other owning and controlling Plans enter into this Addendum.;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. The Sponsoring Plan shall participate operationally in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that participation may take many forms, one of which should be providing a network of providers in the Service Area of the Controlled Affiliate for the Medicaid services being offered under the Agreement and being involved in network development and provider relations.
2. Each of the Other Plans agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it will not take any action, either individually or jointly with any of the Other

Plans, that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail to take any action, either individually or jointly with any of the Other Plans, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

3. Each of the Other Plans acknowledges that it has reviewed the Agreement and understands that Sponsoring Plan has the right to terminate the Agreement without cause upon notice as provided in Paragraph 7 of the Agreement, and that such right is unfettered and may be exercised by Sponsoring Plan in its sole discretion.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By: _____

[Controlled Affiliate Licensee]

By: _____

[Sponsoring Plan]

By: _____

[Other Plan 1]

By: _____

[Other Plan 2]

By: _____

Amended September 19 2014

EXHIBIT C

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENT**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of \$5,000 per license for a Controlled Affiliate subject to Standard 7.

Amended as of September 19, 2014

EXHIBIT C (continued)

FOR NONRISK PRODUCTS:

For third-party administrative business, an amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For non-third party administrative business (e.g., case management, provider networks, etc.), an amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

- 1) An annual fee of \$5,000 per license for a Controlled Affiliate subject to Standard 6 D.
- 2) An annual fee of \$2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Amended as of September 19, 2014

EXHIBIT 1A

**CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO LIFE INSURANCE COMPANIES**

(Includes revisions adopted by Member Plans through their November 21, 2014 meeting)

This agreement by and among Blue Cross and Blue Shield Association ("BCBSA")

_____, ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as
_____, ("Plan").

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, the Plan and the Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name");

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Controlled Affiliate the exclusive right to use the licensed Marks and Names in connection with and only in connection with those life insurance and related services authorized by applicable state law, other than health care plans and related services (as defined in the Plan's License Agreements with BCBSA) which services are not separately licensed to Controlled Affiliate by BCBSA, in the Service Area served by the Plan, except that BCBSA reserves the right to use the Licensed Marks and Name in said Service Area, and except to the extent that said Service Area may overlap the area or areas served by one or more other licensed Blue Cross Plans as of the date of this License as to which overlapping areas the rights hereby granted are non-exclusive as to such other Plan or Plans and their respective Licensed Controlled Affiliates only. Controlled Affiliate cannot use the Licensed Marks or Name outside the Service Area or in its legal or trade name; provided, however, that if and only for so long as Controlled Affiliate also holds a Blue Cross Controlled Affiliate License Agreement applicable to health care plans and related services, Controlled Affiliate may use the Licensed Marks and Name in its legal and trade name according to the terms of such license agreement.

Amended as of June 12, 2003

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in relation to the sale, marketing and rendering of authorized products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A as it may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having not less than 51% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Plan or Plans shall own at least 51% of any for-profit Controlled Affiliate. If the Controlled Affiliate is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items (a) and (c) above, proxies representing 51% of the votes at any meeting of the policyholders and shall demonstrate that there is no reason to believe this such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

3. SERVICE MARK USE

Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks, and shall comply with such rules (applicable to all Controlled Affiliates licensed to use the Marks) relative to service mark use, as are issued from time-to-time by BCBSA. If there is any public reference to the affiliation between the Plan and the Controlled Affiliate, all of the Controlled Affiliate's licensed services in the Service Area of the Plan shall be rendered under the Licensed Marks. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENTS

Controlled Affiliate shall promptly notify Plan and BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate hereby agrees to save, defend, indemnify and hold Plan and BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Controlled Affiliate's rendering of health care services under the Licensed Marks.

7. LICENSE TERM

The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods upon evidence satisfactory to the Plan and BCBSA that Controlled Affiliate meets the then applicable quality control standards, unless one of the parties hereto notifies the other party of the termination hereof at least sixty (60) days prior to expiration of any license period.

This Agreement may be terminated by the Plan or by BCBSA for cause at any time provided that Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Controlled Affiliate's failure to abide by the quality control provisions of Paragraph 2, above, shall be considered a proper ground for cancellation of this Agreement.

This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

A. Controlled Affiliate shall no longer comply with Standard No. 1 (Organization and Governance) of Exhibit A or, following an opportunity to cure, with the remaining quality control provisions of Exhibit A, as it may be amended from time-to-time; or

B. Plan ceases to be authorized to use the Licensed Marks; or

C. Appropriate dues for Controlled Affiliate pursuant to item 8 hereof, which are the royalties for this License Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks including any use in its trade name.

In the event of any disagreement between Plan and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of the Blue Cross and Blue Shield Association and provide instruction on how the customer can contact the Blue Cross and Blue Shield Association or a designated licensee to obtain further information on securing coverage. The written notification required by this paragraph shall be in writing and in a form approved by the Association. The Association shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. DUES

Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

▲ An annual fee of five thousand dollars (\$5,000) per license, plus

▲ .05% of gross revenue per year from branded group products, plus

▲ .5% of gross revenue per year from branded individual products plus

▲ .14% of gross revenue per year from branded individual annuity products.

The foregoing percentages shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® license are issued to the same entity. In the event that any License period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Plan will promptly and timely transmit to BCBSA all dues owed by Controlled Affiliate as determined by the above formula and if Plan shall fail to do so, Controlled Affiliate shall pay such dues directly.

Amended as of November 20, 1997

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9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

9A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

10. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

Amended as of June 16, 2005

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(The next page is page 5)

11. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by a writing executed by all parties.

12. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way effect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

13. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: _

Date: _

Controlled Affiliate:

By: _

Date: _

Plan:

By: _

Date: _

EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES
Page 1 of 2

PREAMBLE

The standards for licensing Life Insurance Companies (Life and Health Insurance companies, as defined by state statute) are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote of all Plans. Each Licensed Plan is required to use a standard controlled affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Life Insurance Company maintains compliance with the license standards.

An organization meeting the following standards shall be eligible for a license to use the Licensed Marks within the service area of its sponsoring Licensed Plan to the extent and the manner authorized under the Controlled Affiliate License applicable to Life Insurance Companies and the principal license to the Plan.

Standard 1 - Organization and Governance

The LIC shall be organized and operated in such a manner that it is controlled by a licensed Plan or Plans which have, directly or indirectly: 1) not less than 51% of the voting control of the LIC; and 2) the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the LIC with which it does not concur; and 3) operational control of the LIC.

If the LIC is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items 1 and 2 above, proxies representing at least 51% of the votes at any policyholder meeting and shall demonstrate that there is no reason to believe such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

Standard 2 - State Licensure

The LIC must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life and health insurance company in each state in which the LIC does business.

EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES
Page 2 of 2

Standard 3 - Records and Examination

The LIC and its sponsoring licensed Plan(s) shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the LIC as may be required in order to establish compliance with the license agreement. The LIC and its sponsoring licensed Plan(s) shall permit BCBSA to examine the affairs of the LIC and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the sponsoring Plan(s).

Standard 4 - Mediation

The LIC and its sponsoring Plan(s) shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed controlled affiliate, a licensed Plan or BCBSA.

Standard 5 - Financial Responsibility

The LIC shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with Affiliate License Performance Response Process Protocol

The LIC and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing LIC compliance problems identified thereunder.

Exhibit 1A1

Exhibit 1A1

**CONTROLLED AFFILIATE
TRADEMARK LICENSE AGREEMENT
FOR LIFE AND DISABILITY INSURANCE PRODUCTS**

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____, ("Life and Disability Controlled Affiliate") which is a company offering life and disability insurance products owned and controlled by _____, _____ (individually, "Sponsoring Plan" and when referred to collectively, "Sponsoring Plans").

Whereas, BCBSA is the owner of the BLUE CROSS and BLUE SHIELD word and design service marks and any derivatives thereof ("Licensed Marks");

Whereas, each Sponsoring Plan is licensed separately by BCBSA to use one or more of the Licensed Marks in a particular Service Area;

Whereas, the Sponsoring Plans and the Life and Disability Controlled Affiliate desire that the latter be entitled to use the appropriate Licensed Marks in connection with life and disability insurance products in some or all of such Sponsoring Plans' Service Areas and in the Service Areas of other Regular Member Plans, as defined in the BCBSA By-laws, ("Blue Plans") consistent with the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

A. Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Life and Disability Controlled Affiliate the limited right to use the Licensed Marks in connection with and only in connection with the following life and disability insurance products authorized by state law: (1) Group: Term Life, Long Term Disability, Whole Life, Benefit Life, Universal Life; (2) Individual: Term Life, Whole Life, Dependent Life, Spouse Life; (3) Other: Disability Income, Short Term Disability, Long Term Disability, Income Replacement; and (4) such other life and disability products approved by BCBSA in writing ("Licensed Products") in the Service Areas served by the Sponsoring Plans or in the Service Area or Areas of one or more other licensed Blue Plans, provided that such Blue Plans have consented to such use as authorized by this Agreement. Life and Disability Controlled Affiliate may not use the Licensed Marks in its legal or trade name.

B. Notwithstanding that the license granted to Life and Disability Controlled Affiliate is a license to use all of the Licensed Marks, Life and Disability Controlled Affiliate may only use those of the Licensed Marks in

the Service Area of a Sponsoring Plan or other consenting Blue Plan as described below that such Plan is authorized to use as a Blue Plan pursuant to its separate license agreements with BCBSA.

C. Life and Disability Controlled Affiliate may use the Licensed Marks in the Service Areas of Sponsoring Plans or in the Service Area of a Blue Plan that is not a signatory to this Agreement only after such Sponsoring Plan(s) or non-signatory Blue Plan consents to such use by executing a written consent in substantially the same form as the Consent Agreement attached as Exhibit B.

D. The following provisions apply with respect to Consent Agreements once such agreements have been fully and properly executed:

(1) All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in the Service Area of Sponsoring Plan or consenting Blue Plan (hereinafter, such consenting Sponsoring Plan or consenting Blue Plan collectively referred to "Consenting Plan(s)") must clearly identify the Consenting Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");

(2) To the extent the Consenting Plan has separate divisions or other Affiliates that use the Licensed Marks in distinct geographic areas within its Service Area, consent obtained under this Agreement may be limited to one or more of such specific geographic areas as specified by the Consenting Plan in its signed Consent Agreement. For purposes of this entire Agreement, all references to the Service Area of a Sponsoring Plan, Blue Plan or Consenting Plan may include the entire Service Area or a distinct geographic area within such Service Area as specified in this Section 1 D (2);

(3) Where BCBSA has licensed two or more Blue Plans to use the same Licensed Marks in the same Service Area, in addition to the requirements set forth in Section D (1) above, the sales, marketing and advertising materials referenced in such section above must be communicated to the Consenting Plan's existing and prospective accounts through or with the approval of such Consenting Plan, and the personnel of such Consenting Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the Consenting Plan;

(4) Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the Consenting Plan has been granted by BCBSA the license to use under its Blue Plan license agreements (for example, if a Consenting Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

(5) If a Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless BCBSA and the Consenting Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

2. QUALITY CONTROL

A. Life and Disability Controlled Affiliate agrees to use the Licensed Marks only in relation to the sale, marketing and administration of the Licensed Products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A and the Guidelines to Administer the Standards for Trademark License Agreement for Life and Disability Insurance Products attached thereto.

B. Life and Disability Controlled Affiliate agrees that BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Life and Disability Controlled Affiliate's rendering of service and use of the Licensed Marks.

C. Life and Disability Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by BCBSA) a report to BCBSA demonstrating Life and Disability Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Life and Disability Controlled Affiliate is defined as: An entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control

thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

3. SERVICE MARK USE

Life and Disability Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and shall ensure all uses of the Licensed Marks comply with the BCBSA Brand Regulations, as amended by BCBSA from time to time. Life and Disability Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Life and Disability Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

The license hereby granted to Life and Disability Controlled Affiliate to use the Licensed Marks is and shall be personal to Life and Disability Controlled Affiliate and shall not be assignable by any act of the Life and Disability Controlled Affiliate, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Life and Disability Controlled Affiliate mortgage or part with possession or control of this license or any right hereunder, and the Life and Disability Controlled Affiliate shall have no right to grant any sublicense to use the Licensed Marks.

5. INFRINGEMENTS

Life and Disability Controlled Affiliate shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Life and Disability Controlled Affiliate shall not be entitled to require BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Life and Disability Controlled Affiliate agrees to render to BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA. BCBSA shall have sole control of the defense and resolution of any claim of infringement brought or threatened by others.

6. LIABILITY INDEMNIFICATION

Life and Disability Controlled Affiliate hereby agrees to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Life and Disability Controlled Affiliate's conduct.

7. LICENSE TERM

A. The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods, unless either BCBSA or Life and Disability Controlled Affiliate notifies the other party in writing of the termination hereof at least sixty (60) days prior to expiration of any license period.

B. This Agreement may be terminated by BCBSA for cause at any time provided that Life and Disability Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Life and Disability Controlled Affiliate's failure to abide by the conditions regarding use of the Licensed Marks set forth in Section 1 of this Agreement or the quality control provisions of Section 2 (other than with respect to Section 2 D which is subject to immediate termination as stated in Section 7 C (1) below) shall be considered proper grounds for termination of this Agreement.

C. This Agreement and all of Life and Disability Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Life and Disability Controlled Affiliate shall no longer comply with Section 2 D (or Standard No. 1 (Organization and Governance) of Exhibit A); or

(2) Any Sponsoring Plan ceases to be authorized to use the Licensed Marks; or

(3) Appropriate fees for Life and Disability Controlled Affiliate pursuant to Section 8 of this Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Life and Disability Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks.

In the event of any disagreement between Life and Disability Controlled Affiliate and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Life and Disability Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. ROYALTIES

Life and Disability Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars (\$5,000) per license, plus
- .05% of gross revenue per year from group products sold under the Licensed Marks, plus
- .5% of gross revenue per year from individual products sold under the Licensed Marks

In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Life and Disability Controlled Affiliate will promptly and timely transmit to BCBSA all fees owed by Life and Disability Controlled Affiliate as determined by the above formula.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between any Sponsoring Plan and Life and Disability Controlled Affiliate or between among them and/or BCBSA.

10. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the

Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by: (a) a writing signed by all parties; or (b) a writing approved by the affirmative vote of three-fourths of the Blue Plans and three-fourths of the total then current weighted vote of all the Blue Plans as officially recorded by the BCBSA Corporate Secretary. Upon such adoption by the Blue Plans, this Agreement and all other Trademark License Agreements for Life and Disability Insurance Products then in effect shall simultaneously be amended.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Life and Disability Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: _

Date: _

Life and Disability Controlled Affiliate:

By: _

Date: _

Sponsoring Plan:

By: _

Date: _

Name: _____

Sponsoring Plan:

By: _

Date: _

Name: _____

[Add other Sponsoring Plans as necessary]

EXHIBIT A

**LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE
AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS
Page 1 of 2**

Standard 1 - Organization and Governance

Any Life and Disability Controlled Affiliate licensed under the Trademark License Agreement for Life and Disability Insurance Products ("licensee") shall be organized and operated in such a manner that it is an entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

Standard 2 - State Licensure

The licensee must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life company in each state in which the licensee does business.

Standard 3 - Records and Examination

The licensee shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the licensee as may be required in order to establish compliance with the Agreement. The licensee shall permit BCBSA to examine the affairs of the licensee and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the Sponsoring Plan(s).

Standard 4 - Mediation

The licensee, its Sponsoring Plan(s) and all consenting Blue Plans shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed Life and Disability Controlled Affiliate, a Sponsoring Plan and or consenting Blue Plan or BCBSA.

EXHIBIT A

**LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE
AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS
Page 2 of 2**

Standard 5 - Financial Responsibility

The licensee shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with BCBSA Governance

The licensee shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of and in addressing licensee compliance problems that may be identified in connection with the operation or administration of the Trademark License Agreement for Life and Disability Insurance Products.

EXHIBIT B
CONSENT AGREEMENT

This Consent Agreement is made and entered into by and among the undersigned Blue Plan, and _____ ("Life and Disability Controlled Affiliate"), and the Blue Cross and Blue Shield Association ("BCBSA") and shall be deemed effective on _____ ("Effective Date").

Whereas, BCBSA owns the Blue Cross and Blue Shield word and design service marks and any derivative mark thereof (the "Brands");

Whereas, the undersigned Blue Plan is licensed to use one or more of the Brands within a specific geographic area ("Service Area");

Whereas Life and Disability Controlled Affiliate is licensed by BCBSA to use one or more of the Brands to offer life and disability insurance products ("Products") as defined and authorized in the Trademark License Agreement for Life and Disability Insurance Products ("Life and Disability License Agreement");

Whereas neither the Blue Plan nor its affiliates offer the Products under any of the Brands in such Blue Plan's Service Area or portion thereof where Blue Plan has consented to sale of the Products by Life and Disability Controlled Affiliate; and

Whereas BCBSA and the undersigned Blue Plan desire to consent to Life and Disability Controlled Affiliate's use of the Brands in Blue Plan's Service Area consistent with the terms of the Life and Disability License Agreement and this Consent Agreement.

Now, therefore, in consideration of the obligations and conditions stated in this Agreement, Blue Plan, Life and Disability Controlled Affiliate and BCBSA agree as follows:

1. Life and Disability Controlled Affiliate may market, sell, administer and underwrite the Products in Blue Plan's Service Area under the Brands licensed to Blue Plan in such Service Area subject to the terms of this Consent Agreement, the Life and Disability License Agreement and Blue Plan's license agreement(s) with BCBSA. Life and Disability Controlled Affiliate's rights under the Brands to offer the Products under the Brands are limited to offering the Products only under the Brand(s) licensed to the consenting Blue Plan.
2. Life and Disability Controlled Affiliate shall work with the undersigned Blue Plan to develop a written sales and marketing agreement that identifies the relationship between it and Blue Plan for the sales, marketing and customer service for the Products. The term of the sales and marketing agreement shall be the same as the term of this Consent Agreement.

3. All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in a consenting Blue Plan's Service Area must clearly identify the consenting Blue Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");
4. Life and Disability Controlled Affiliate may use the Brands to sell the Products in the following Service Area or portion thereof as designated by Blue Plan:

5. If two or more Blue Plans to use the same Licensed Marks in the same Service Area, Life and Disability Controlled Affiliate shall work with the consenting Blue Plan in the following manner: (a) the sales, marketing and advertising materials must be communicated to the consenting Blue Plan's existing and prospective accounts through or with the approval of such Blue Plan, and (b) the personnel of such Blue Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the consenting Blue Plan;
6. Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the consenting Blue Plan has been granted by BCBSA the license to use under its license agreement (for example, if a consenting Blue Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).
7. If this Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless each BCBSA and the Blue Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

8. The term of this Consent Agreement shall be one year from the Effective Date. Unless either Blue Plan or Life and Disability Controlled Affiliate provides the other party with written notice of its desire not to renew this Consent Agreement at least 60 days prior to expiration of the term or any extended term or unless terminated as provided in Paragraph 9 below, this Consent Agreement shall automatically renew for subsequent one year periods.
9. This Consent Agreement may be terminated as follows:
 - A. Upon mutual written consent of Life and Disability Controlled Affiliate and Blue Plan;
 - B. By Blue Plan or Life and Disability Controlled Affiliate upon 60 days advance written notice to the non-terminating party and BCBSA; or
 - C. By Blue Plan immediately if Life and Disability Controlled Affiliate does not comply with this Consent Agreement or the sales protocol agreement.
10. This Consent Agreement shall automatically terminate if Blue Plan's primary licensee agreement terminates for any reason or if the Life and Disability License Agreement terminates for any reason.

Agreed and Accepted by:

[Blue Plan]:

By: _____

Title: _____

BLUE CROSS AND BLUE SHIELD ASSOCIATION:

By: _____

Title: _____

LIFE AND DISABILITY CONTROLLED AFFILIATE:

By: _____

Title: _____

Exhibit 1B

**BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS
(Adopted by Member Plans at their November 21, 2014 meeting)**

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Advantage PPO products in geographic regions designated by CMS (hereafter "regional MAPPO products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name") to offer regional MAPPO products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional MAPPO products and related services.

This grant of rights is non-exclusive and is limited to the following states: _____ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

- (3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:
- (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
 - (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
 - (c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional MAPPO products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this

Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or
(4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Controlled Affiliate shall no longer comply with item 2(E) above;
- (2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

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G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Cross License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to \$25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such

geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

Amended as of September 19, 2014

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11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with

0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: _____

Date: _____

Controlling Plan:

By: _____

Date: _____

Controlling Plan:

By: _____

Date: _____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: _____

Date: _____

EXHIBIT A

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

November 2014

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Advantage PPO Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
- (2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
- (3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:
 - (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
 - (b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
 - (c) exercise control over the policy and operations of the Controlled Affiliate; and

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

- a. the structure of the Blue Cross and Blue Shield System; and
- b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross Marks.

Standard 7 - Participation in Certain National Programs

A Controlled Affiliate shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area.

National program requirements include:

- a. Inter-Plan Teleprocessing System (ITS); and
- b. Inter-Plan Medicare Advantage Program.

Standard 8 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of November 15, 2007

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EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional MAPPO products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

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Exhibit 1C

BLUE CROSS
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS
(Adopted by Member Plans at their November 21, 2014 meeting)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE CROSS and BLUE CROSS Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Part D Prescription Drug Plan products in geographic regions designated by CMS (hereafter "regional PDP products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE CROSS and BLUE CROSS Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE CROSS in a trade name ("Licensed Name") to offer regional PDP products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional PDP products and related services.

This grant of rights is non-exclusive and is limited to the following states: _____ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

- (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
- (c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional PDP products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this

Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or
(4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Controlled Affiliate shall no longer comply with item 2(E) above;

(2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Cross License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to \$25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such

geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Cross and Blue Cross Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with

0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: _____

Date: _____

Controlling Plan:

By: _____

Date: _____

Controlling Plan:

By: _____

Date: _____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: _____

Date: _____

EXHIBIT A

**CONTROLLED AFFILIATE LICENSE STANDARDS
APPLICABLE TO REGIONAL MEDICARE
PART D PRESCRIPTION DRUG PLAN PRODUCTS
November 2014**

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Part D Prescription Drug Plan Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
- (2) Each Controlling Plan is authorized pursuant to a separate Blue Cross License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
- (3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:
 - (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
 - (b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
 - (c) exercise control over the policy and operations of the Controlled Affiliate; and

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

- a. the structure of the Blue Cross and Blue Shield System; and
- b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Cross Marks.

Standard 7 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional PDP products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

EXHIBIT 2

Membership Standards

Page 1 of 5

Preamble

The Membership Standards apply to all organizations seeking to become or to continue as Regular Members of the Blue Cross and Blue Shield Association. Any organization seeking to become a Regular Member must be found to be in substantial compliance with all Membership Standards at the time membership is granted and the organization must be found to be in substantial compliance with all Membership Standards for a period of two (2) years preceding the date of its application. If Membership is sought by an entity which controls or is controlled by one or more Plans, such compliance shall be determined on the basis of compliance by such Plan or Plans.

The Regular Member Plans shall have authority to interpret these Standards.

A Regular Member Plan that operates as a "Shell Holding Company" is defined as an entity that assumes no underwriting risk and has less than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) and less than 5% of the consolidated enterprise net general and administrative expenses.

A Regular Member Plan that operates as a "Hybrid Holding Company" is defined as an entity that assumes no underwriting risk and has either more than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) or more than 5% of the consolidated enterprise net general and administrative expenses.

StandardA Plan shall maintain a governing Board, which shall control the Plan and ensure that the Plan follows appropriate practices of corporate governance. A Plan's Board shall not be controlled by any special interest group, shall make an annual determination that a majority of its directors are independent, and shall act in the best interest of its Corporation and its customers. The Board shall be composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Amended as of March 15, 2007

EXHIBIT 2

Membership Standards

Page 2 of 5

StandardA Plan shall furnish to the Association on a timely and accurate basis reports and records relating to compliance with
2: these Standards and the License Agreements between the Association and the Plans. Such reports and records are the following:

- A. BCBSA Membership Information Request;
 - B. Biennial trade name and service mark usage material, including disclosure material under Standard 7;
 - C. Changes in the governance of the Plan, including changes in a Plan's Charter, Articles of Incorporation, or Bylaws, changes in a Plan's Board composition, or changes in the identity of the Plan's Principal Officers;
 - D. Quarterly Financial Report, Semi-annual "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC, Annual Budget, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), Plan, Subsidiary and Affiliate Report; and
- Plans that are a Shell Holding Company as defined in the Preamble hereto are required to furnish only a calendar year-end "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC.

Amended as of November 17, 2011

EXHIBIT 2

Membership Standards

Page 3 of 5

E. Quarterly Enrollment Report, Quarterly Member Touchpoint Measures Index (MTM) through 12/31/2011, and Semi-annual MTM Index starting 1/1/2012 and thereafter.

•For purposes of MTM reporting only, a Plan shall file a separate MTM report for each Geographic Market.

Standard A Plan shall be operated in a manner that provides reasonable financial assurance that it can fulfill its contractual obligations to its customers.

Standard 4:A Plan shall be operated in a manner responsive to customer needs and requirements.

StandardA Plan shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the Plans and ease of claims processing for customers receiving benefits outside of the Plan's Service Area.

Such programs are applicable to Blue Cross and Blue Shield Plans, and include:

- A. Inter-Plan Teleprocessing System (ITS);
- B. BlueCard Program;
- C. National Account Programs;
- D. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
- E. Inter-Plan Medicare Advantage Program.

Amended as of November 21, 2014

EXHIBIT 2

Membership Standards

Page 4 of 5

StandardIn addition to requirements under the national programs listed in Standard 5: Participation in National Programs, a Plan
6: shall take such action as required to ensure its financial performance in programs and contracts of an inter-Plan nature or where the Association is a party.

StandardA Plan shall make adequate disclosure in contracting with third parties and in disseminating public statements of (i) the
7: structure of the Blue Cross and Blue Shield System, (ii) the independent nature of every Plan, and (iii) the Plan's financial condition.

StandardA Plan shall cooperate with the Association's Board of Directors and its Brand Enhancement & Protection Committee in
8: the administration of the Plan Performance Response Process and in addressing Plan performance problems identified thereunder.

StandardA Plan shall obtain a rating of its financial strength from an independent rating agency approved by the Association's
9: Board of Directors for such purpose.

StandardNotwithstanding any other provision in this License Agreement, during each year, a Plan and its Controlled Affiliate(s)
10: engaged in providing licensable services (excluding Life Insurance and Charitable Foundation Services) shall use their best efforts to promote and build the value of the Blue Cross Marks.

StandardNeither a Plan nor any Larger Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled
11: Affiliate thereof to obtain control of the Plan or Larger Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Amended as of June 16, 2005

EXHIBIT 2

Membership Standards

Page 5 of 5

StandardNo provider network, or portion thereof, shall be rented or otherwise made available to a National Competitor if the
12: Licensed Marks or Names are used in any way with such network.

A provider network may be rented or otherwise made available, provided there is no
use of the Licensed Marks or Names with respect to the network being rented.

Amended as of March 18, 2004

EXHIBIT 3

GUIDELINES WITH RESPECT TO USE OF LICENSED NAME AND MARKS IN CONNECTION WITH NATIONAL ACCOUNTS

Page 1 of 3

1. The strength of the Blue Cross/Blue Cross National Accounts mechanism, and the continued provision of cost effective, quality health care benefits to National Accounts, are predicated on locally managed provider networks coordinated on a national scale in a manner consistent with effective service to National Account customers and consistent with the preservation of the integrity of the Blue Cross/Blue Shield system and the Licensed Marks. These guidelines shall be interpreted in keeping with such ends.
2. A National Account is an entity with employee and/or retiree locations in more than one Plan's Service Area. Unless otherwise agreed, a National Account is deemed located in the Service Area in which the corporate headquarters of the National Account is located. A local plant, office or division headquarters of an entity may be deemed a separate National Account when that local plant, office or division headquarters 1) has employee locations in more than one Service Area, and 2) has independent health benefit decision-making authority for the employees working at such local plant, office or division headquarters and for employees working at other locations outside the Service Area. In such a case, the local plant, office or division headquarters is a National Account that is deemed located in the Service Area in which such local plant, office or division headquarters is located. The Control Plan of a National Account is the Plan in whose Service Area the National Account is located. A participating ("Par") Plan is a Plan in whose Service Area the National Account has employee and/or retiree locations, but in which the National Account is not located. In the event that a National Account parent company consolidates health benefit-decision making for itself and its wholly-owned subsidiary companies, the parent company and the subsidiary companies shall be considered one National Account. The Control Plan for such a National Account shall be the Plan in whose Service Area the parent company headquarters is located.
3. The National Account Guidelines enunciated herein below shall be applicable only with respect to the business of new National Accounts acquired after January 1, 1991.
4. Control Plans shall utilize National Account identification cards complying with then currently effective BCBSA graphic standards in connection with all National Accounts business to facilitate administration thereof, to minimize subscriber and provider confusion, and to reflect a commitment to cooperation among Plans.

Amended as of June 12, 2003

EXHIBIT 3

Page 2 of 3

5. Disputes among Plans and/or BCBSA as to the interpretation or implementation of these Guidelines or as to other National Accounts issues shall be submitted to mediation and mandatory dispute resolution as provided in the License Agreement. For two years from the effective date of the License Agreement, however, such disputes shall be subject to mediation only, with the results of such mediation to be collected and reported in order to establish more definitive operating parameters for National Accounts business and to serve as ground rules for future binding dispute resolution.

6. The Control Plan may use the BlueCard Program (as defined by IPPC) to deliver benefits to employees and non-Medicare eligible retirees in a Participating Plan's service area if an alternative arrangement with the Participating Plan cannot be negotiated. The Participating Plan's minimum servicing requirement for those employees and non-Medicare retirees in its service area is to deliver benefits using the BlueCard Program. Account delivery is subject to the policies, provisions and procedures of the BlueCard Program.

7. For provider payments in a Participating Plan's area (on non-BlueCard claims), payment to the provider may be made by the Participating Plan or the Control Plan at the Participating Plan's option. If the Participating Plan elects to pay the provider, it may not withhold payment of a claim verified by the Control Plan or its designated processor, and payment must be in conformity with service criteria established by the Board of Directors of BCBSA (or an authorized committee thereof) to assure prompt payment, good service and minimum confusion with providers and subscribers. The Control Plan, at the Participating Plan's request, will also assure that measures are taken to protect the confidentiality of the data pertaining to provider reimbursement levels and profiles.

Amended as of June 14, 1996

EXHIBIT 3

Page 3 of 3

8. The Control Plan, in its financial agreements with a National Account, is expected to reasonably reflect the aggregate amount of differentials passed along to the Control Plan by all Participating Plans in a National Account.
9. Other than in contracting with health care providers or soliciting such contracts in areas contiguous to a Plan's Service Area in order to serve its subscribers or those of its licensed Controlled Affiliate residing or working in its Service Area, a Control Plan may not use the Licensed Marks and/or Name, as a tag line or otherwise, to negotiate directly with providers outside its Service Area.

Amended as of March 13, 2003

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GOVERNMENT PROGRAMS AND CERTAIN OTHER USES

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1. A Plan and its licensed Controlled Affiliate may use the Licensed Marks and Name in bidding on and executing a contract to serve a Government Program, and in thereafter communicating with the Government concerning the Program. With respect, however, to such contracts entered into after the 1st day of January, 1991, the Licensed Marks and Name will not be used in communications or transactions with beneficiaries or providers in the Government Program located outside a Plan's Service Area, unless the Plan can demonstrate to the satisfaction of BCBSA's governing body that such a restriction on use of the Licensed Marks and Name will jeopardize its ability to procure the contract for the Government Program. As to both existing and future contracts for Government Programs, Plans will discontinue use of the Licensed Marks and Name as to beneficiaries and Providers outside their Service Area as expeditiously as circumstances reasonably permit. Effective January 1, 1995, except as provided in the first sentence above, all use by a Plan of the Licensed Marks and Name in Government Programs outside of the Plan's Service Area shall be discontinued. Incidental communications outside a Plan's Service Area with resident or former resident beneficiaries of the Plan, and other categories of necessary incidental communications approved by BCBSA, are not prohibited. For purposes of this Paragraph 1, the term "Government Programs" shall mean Medicare Part A, Medicare Part B and other non-risk government programs.

2. In connection with activity otherwise in furtherance of the License Agreement, a Plan and its Controlled Affiliates that are licensed to use the Licensed Marks and Name in its Service Area pursuant to the Controlled Affiliate License Agreements authorized in clauses a) through c) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Plan's Service Area in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

2.1 Common Business Communications

- a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);
- b. distributing business cards other than in marketing and selling;
- c. advertising in publications or electronic media solely to persons for employment;

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2.2 Marketing Spillover

a. advertising in print, electronic or other media which serve, as a substantial market, the Service Area of the Plan or licensed Controlled Affiliate, provided that no Plan or Controlled Affiliate may advertise outside its Service Area on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Service Area;

b. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Plan's Service Area or that of a licensed Controlled Affiliate;

2.3 Provider Contracting

a. contracting with health care providers or soliciting such contracts in areas contiguous to the Plan's Service Area in order to serve its subscribers or those of such licensed Controlled Affiliates residing or working in its service area;

b. issuing a small sign containing the legal name or trade name of the Plan or such licensed Controlled Affiliates for display by a provider to identify the latter as a participating provider of the Plan or Controlled Affiliate;

c. negotiating rates with a health care provider for services to a specific member, provided that all of the following conditions are met:

(1) the health care provider does not have a contract, applicable to the services rendered or to be rendered, with the Licensee (or any of the Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located; and

(2) the Plan or Controlled Affiliate reasonably determines that the member did/does not have a reasonable opportunity to access a participating provider whose contract applies to the services rendered or to be rendered; and

(3) at least one of the following circumstances exists:

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- (i) the member received emergency services and the Plan or Controlled Affiliate knows or reasonably anticipates that the charges on the claim will meet or exceed \$5,000; or
 - (ii) a provider, in consultation pre- or post- treatment with the Plan or Controlled Affiliate, makes/made a treatment recommendation or referral to a non-par provider or to a par provider whose contract does not apply to the services to be rendered; or
 - (iii) the member inadvertently accessed a non-par provider or non-contracted services in the course of receiving services from a par provider (e.g., the member sees a non-par consulting specialist in a participating hospital); and
 - (4) the Licensee (and in the case of overlapping Service Areas, all of the Licensees) in whose Service Area the health care provider is located consent(s) in advance.
- d. contracting with a pharmacy management organization ("Pharmacy Intermediary") to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;

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- e. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided that (1) the Plan and the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Plan's Service Area, and (2) neither the Plan's or the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Plan's Service Area;
 - f. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;
 - g. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;
 - h. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Plan's Service Area;
 - i. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Plan's Service Area;
 - j. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Plan's Service Area;
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- k. contracting with a company that operates provider sites in the Plan's Service Area, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Plan's Service Area;
 - l. contracting with a company that makes health care professionals available in the Plan's Service Area (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Plan's Service Area.
- 2.4 Services to National Accounts
- a. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee (as those terms are defined in the Inter-Plan Programs Policies and Provisions ("IP Policies")) to offer Blue-branded Health Coverage to the National Account, offering Blue-branded Health and Wellness Programs to all members of the National Account, including members who have not enrolled in the Blue-branded Health Coverage ("non-Blue Health Coverage members"), provided that:
 - (i) the Plan and/or licensed Controlled Affiliate has no contact or interaction with providers outside of the Plan's Service Area regarding such non-Blue Health Coverage members, except as specifically provided in the IP Policies; and
 - (ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not offer Blue-branded Health and Wellness Programs to any employees working at such local plant, office or division without the consent of such other Licensee; and
 - (iii) if the Plan and/or licensed Controlled Affiliate provides an information card to the non-Blue Health Coverage members, the card may not display the Symbols in the masthead, must contain a prominent disclosure conveying that it is not a health insurance card, and otherwise must be designed so that it is dissimilar to a Blue member identification card.

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For purposes of this subparagraph a, the following definitions apply:

“Health and Wellness Program” shall mean a program that includes at least one of the following elements or a related element:

- Health Risk Assessment and/or Preventive Screenings
- Exercise and Fitness Programs
- Health and Wellness Events (e.g., attendance at a health fair, a 5K walk)
- Nutrition and Weight Management
- Health Education (e.g., smoking cessation classes)
- Prenatal and Parenting Education
- Disease or Chronic Condition Management

The above listing is intended to represent examples of the types of programs that may be offered, and other programs, including those offered through different media such as the internet or telephonically, may also be deemed Health and Wellness programs.

“Health Coverage” shall mean providing or administering medical, surgical, hospital, major medical, or catastrophic coverage, or any HMO, PPO, POS or other managed care plan for the foregoing services.

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2.4 Services to National Accounts (continued)

- b. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee to offer Blue-branded Health Coverage to the National Account, performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by the National Account to its members, including benefit plans that are not underwritten or administered by the Plan, provided that:
 - (i) in performing such functions, the Plan and/or licensed Controlled Affiliate does not use the Brands in any communications with health care providers outside of the Plan's Service Area, and otherwise limits its use of the Brands outside of the Service Area to communications with the account's members, the other benefit plan providers with which the account has contracted and other reasonably necessary communications to perform such functions; and
 - (ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not perform Eligibility and Enrollment functions for employees working at such local plant, office or division without the consent of such other Licensee;

For purposes of this subparagraph b, the following definitions apply:

"Health Coverage" has the meaning set forth in subparagraph 2.4.a.

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“Eligibility” means services that manage the account’s eligibility data and determine or process determinations relating to eligibility for benefit plans offered by the account to its employees, including such services as:

- monitoring and auditing data to ensure that only entitled individuals are enrolled in each such benefit plan;
- review of eligibility documentation (e.g. marriage licenses, birth certificates, student status verification letters, employment records);
- identification of key member segments such as over-age dependents, part-time employees, employees reaching certain milestones (e.g. Medicare-eligible, retirees);
- termination of coverage for those individuals found to be ineligible for coverage under a benefit plan, and, if applicable, generation of a COBRA event; and
- management of “hour-banking” for union environments in which union members can bank hours to remain eligible for benefits.

“Enrollment” means services that enroll eligible individuals and their spouses/dependents or terminate or change their enrollment in the account’s benefit plans on an ongoing basis and during open enrollment periods, including such services as:

- the coordination of each step in open enrollment process from project planning and system set-up to the generation of confirmation statements;
- ongoing enrollment support for new hires and changes due to life events and work status adjustments;
- evidence of insurability (EOI) administration for life and disability coverage;
- transmission of eligibility/enrollment information to the account’s benefit plan providers;
- review and reconciliation of error reports received from the account’s benefit plan providers; and
- transmission of information to the account’s payroll system (e.g., benefit deductions, employee demographic data).

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2.5 Knowledge Sharing

- a. submitting scholarly articles authored or co-authored by the Plan or Controlled Affiliate or its respective employees for publication in peer-reviewed journals;
- b. permitting an internal representative of the Plan or Controlled Affiliate (e.g., officer, employee) to speak or present at a conference or symposium for which the event sponsor will issue communications that will identify the Plan's or Controlled Affiliate's representative as a participant, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;

2.6 Other Uses

- a. entering into a license agreement between and among BCBSA, the Plan and a debit card issuer located outside the Plan's Service Area, and entering into a corresponding operating agreement or agreements, in order to offer a debit card bearing the Licensed Marks and Name to eligible persons as defined by the aforementioned license agreement;
- b. appearing in communications issued by an independent third party to recognize outstanding performance of the Plan or Controlled Affiliate or a member of the Plan's or Controlled Affiliate's senior management as part of an established program of the third party for which the Plan has provided information to be considered for the recognition, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;
- c. to identify itself as being a joint sponsor of an event, program or activity along with other Plans or such Plans' licensed Controlled Affiliates, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;
- d. hosting meetings or events in Washington, D.C. related to policy and business issues in the Plan's Service Area, or hosting events in conjunction with the assemblies or conventions of national political parties, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;

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- e. permitting an affiliate that is not licensed to use the Licensed Marks to identify its corporate relationship with the Plan, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time.
3. In connection with activity otherwise in furtherance of the License Agreement, a Controlled Affiliate that is licensed to use the Licensed Marks and Name pursuant to a Controlled Affiliate License Agreement authorized in clauses d) or e) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Region (as that term is defined in such respective Controlled Affiliate License Agreements) in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:
- a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);
 - b. distributing business cards other than in marketing and selling;
 - c. contracting with health care providers or soliciting such contracts in areas contiguous to the Region in order to serve its subscribers residing in the Region, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans in connection with such contracting unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;
 - d. issuing a small sign containing the legal name or trade name of the Controlled Affiliate for display by a provider to identify the latter as a participating provider of the Controlled Affiliate, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans on such signs unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;
 - e. advertising in publications or electronic media solely to persons for employment;

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f. advertising in print, electronic or other media which serve, as a substantial market, the Region, provided that the Controlled Affiliate may not advertise outside its Region on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Region, and provided further that any such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to advertise in such media;

g. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Region, provided that such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to send direct mail to such zip code plus 4.

h. [Intentionally left blank, pending review by the Inter-Plan Programs Committee of the applicability of the case management rule to such Controlled Affiliates.]

i. contracting with a pharmacy management organization ("Pharmacy Intermediary") to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for the Controlled Affiliate's regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective Controlled Affiliate License Agreements, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;

j. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit to the Controlled Affiliate's regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective

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Controlled Affiliate License Agreements, provided that (1) the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Region, and (2) neither the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Region;

k. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for the Controlled Affiliate's regional Medicare Advantage PPO members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;

l. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for the Controlled Affiliate's regional Medicare Advantage members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;

m. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Controlled Affiliate's Region;

n. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Controlled Affiliate's Region;

o. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Region;

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- p. contracting with a company that operates provider sites in the Region, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Region;
 - q. contracting with a company that makes health care professionals available in the Region (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Region.
4. BCBSA shall retain the right to use the Licensed Marks in conjunction with the Federal Employee Program and with any other national offering made to federal employees pursuant to the Federal Employees Health Benefits Program (FEHBP), including the right to license such use to its vendors, but only in the following manner.
- a. the Licensed Marks may only be used by BCBSA with the term "Federal Employee Program", "Federal", "FEP", or similar language identifying the program as a benefit program for federal employees;
 - b. the Licensed Marks may not be used by BCBSA with the name(s) of a specific Plan or Plans and;
 - c. any use by BCBSA in conjunction with a new national FEHBP program proposed after the enactment of this amendment will require the approval of the BCBSA Board of Directors.

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5. Where required by applicable state or local law or regulation, a Plan or its licensed Controlled Affiliate may submit documents that contain the Brands to, and file forms that contain the Brands with, state or local regulators in a state not included in its Service Area, provided that it gives reasonable advance notice to the local Plan of its intent to submit such documents or file such forms. Notwithstanding, in no event may a Plan or its licensed Controlled Affiliate use the Brands to register, or to obtain or maintain a license, a certificate of authority, or an equivalent document authorizing it to act as a risk-bearing entity or third party administrator in a state not included in its Service Area. If the local Plan advises BCBSA that it believes its License Agreement has been or would be violated by any submission or filing, BCBSA shall determine whether such submission or filing is required by state or local law or regulation and violates the License Agreement, subject to the Plan's or licensed Controlled Affiliate's rights to obtain an independent review of such determination under Paragraph 9(a) and Exhibit 5 of its License Agreement or Paragraph 8 of the Controlled Affiliate License. For purposes of this paragraph, "local Plan" is defined as each Plan whose Service Area includes all or part of the state in which the foregoing applicable state or local law or regulation has been enacted.

Amended as of November 18, 2010

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MEDIATION AND MANDATORY DISPUTE RESOLUTION (MMDR) RULES

The Blue Cross and Blue Shield Plans ("Plans") and the Blue Cross Blue Shield Association ("BCBSA") recognize and acknowledge that the Blue Cross and Blue Shield system is a unique nonprofit and for-profit system offering cost effective health care financing and services. The Plans and BCBSA desire to utilize Mediation and Mandatory Dispute Resolution ("MMDR") to avoid expensive and time-consuming litigation that may otherwise occur in the federal and state judicial systems. Even MMDR should be viewed, however, as methods of last resort, all other procedures for dispute resolution having failed. Except as otherwise provided in the License Agreements, the Plans, their Controlled Affiliates and BCBSA agree to submit all disputes to MMDR pursuant to these Rules and in lieu of litigation.

1. Initiation of Proceedings

A. Pre-MMDR Efforts

Before filing a Complaint to invoke the MMDR process, the CEO of a complaining party, or his/her designated representative, shall undertake good faith efforts with the other side(s) to try to resolve any dispute.

B. Complaint

To commence a proceeding, the complaining party (or parties) shall provide by certified mail, return receipt requested, a written Complaint to the BCBSA Corporate Secretary (which shall also constitute service on BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) named therein. The Complaint shall contain:

- i. identification of the complaining party (or parties) requesting the proceeding;
- ii. identification of the respondent(s);
- iii. identification of any other persons or entities who are interested in a resolution of the dispute;
- iv. a full statement describing the nature of the dispute;
- v. identification of all of the issues that are being submitted for resolution;

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- vi. the remedy sought;
- vii. a statement as to whether the complaining party (or parties) elect(s) first to pursue Mediation;
- viii. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor; and
- ix. a statement signed by the CEO of the complaining party affirming that the CEO has undertaken efforts, or has directed efforts to be undertaken, to resolve the dispute before resorting to the MMDR process.

The complaining party (or parties) shall file and serve with the Complaint copies of all documents which the party (or parties) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

C. Answer

Within twenty (20) days after receipt of the Complaint, each respondent shall serve on BCBSA and on the complaining party (or parties);

- i. a full Answer to the aforesaid Complaint;
- ii. a statement of any Counterclaims against the complaining party (or parties), providing with respect thereto the information specified in Paragraph 1.B., above;
- iii. a statement as to whether the respondent elects to first pursue Mediation; and
- iv. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor.

The respondent(s) shall file and serve with the Answer or by the date of the Initial Conference set forth in Paragraph 3.C., below, copies of all documents which the respondent(s) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

Amended as of September 20, 2007

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D. Reply To Counterclaim

Within ten (10) days after receipt of any Counterclaim, the complaining party (or parties) shall serve on BCBSA and on the responding party (or parties), a Reply to the Counterclaim. Such Reply must provide the same information required by Paragraph 1.C., above.

2. Mediation

To facilitate the mediation of disputes between or among BCBSA, the Plans and/or their Controlled Affiliates, the BCBSA Board has provided for Mediation under these Rules. Mediation may be pursued in lieu of or in an effort to obviate the Mandatory Dispute Resolution process, and all parties are strongly urged, but not required, to exhaust the mediation procedure provided for herein. In the event any party refuses to proceed with Mediation, the parties shall proceed immediately to Mandatory Dispute Resolution, as provided in Section 3.

A. Selection of Mediators

If all parties agree to pursue Mediation, they shall promptly attempt to agree upon: (i) the number of mediators desired, not to exceed three mediators; and (ii) the selection of experienced mediator(s) from an independent entity to mediate all disputes set forth in the Complaint and Answer (and Counterclaim and Reply, if any). In the event the parties are unable to agree upon the selection or number of mediators, both within five (5) days of the service of the Answer or Reply to Counterclaim, whichever is later, the BCBSA Corporate Secretary shall immediately refer the matter to a nationally recognized professional ADR organization (such as CPR or JAMS) for mediation by a single mediator to be selected by the ADR organization.

B. Binding Decision

Before the Mediation Hearing described below, the BCBSA Corporate Secretary shall contact the parties to determine whether they wish to be bound by any recommendation of the selected mediator(s) for resolution of the disputes. If all wish to be bound, the Corporate Secretary will send appropriate documentation to them for their signatures before the Mediation Hearing begins.

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C. Mediation Procedure

The Mediator(s) shall apply the mediation procedures and processes provided for herein (not the rules of the ADR organization with which they are affiliated) and shall promptly advise the parties of a scheduled Mediation Hearing date. Unless a party requests an expedited procedure, or unless all parties to the proceeding agree to one or more extensions of time, the Mediation Hearing set forth below shall be completed within forty (40) days of BCBSA's receipt of the Complaint. The selected mediator(s), unless the parties otherwise agree, shall adhere to the following procedure:

- i. Each party must be represented by its CEO or other representative who has been delegated full authority to resolve the dispute. However, parties may send additional representatives as they see fit.
- ii. Each party will be given one-half hour to present its case, beginning with the complaining party (or parties), followed by the other party or parties. The parties are free to structure their presentations as they see fit, using oral statements or direct examination of witnesses. However, neither cross-examination nor questioning of opposing representatives will be permitted. At the close of each presentation, the selected mediator(s) will be given an opportunity to ask questions of the presenters and witnesses. All parties must be present throughout the Mediation Hearing. The selected mediator(s) may extend the time allowed for each party's presentation at the Mediation Hearing. The selected mediator(s) may meet in executive session, outside the presence of the parties, or may meet with the parties separately, to discuss the controversy.
- iii. After the close of the presentations, the parties will attempt to negotiate a settlement of the dispute. If the parties desire, the selected mediator(s), or any one or more of the selected mediators, will sit in on the negotiations.

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- iv. After the close of the presentations, the selected mediator(s) may meet privately to agree upon a recommendation for resolution of the dispute which would be submitted to the parties for their consideration and approval. If the parties have previously agreed to be bound by the results of this procedure, this recommendation shall be binding upon the parties.
- v. The purpose of the Mediation Hearing is to assist the parties to settle their grievances short of mandatory dispute resolution. As a result, the Mediation Hearing has been designed to be as informal as possible. Rules of evidence shall not apply. There will be no transcript of the proceedings, and no party may make a tape recording of the Mediation Hearing.
- vi. In order to facilitate a free and open discussion, the Mediation proceeding shall remain confidential. A "Stipulation to Confidentiality" which prohibits future use of settlement offers, all position papers or other statements furnished to the selected mediator(s), and decisions or recommendations in any Mediation proceeding shall be executed by each party.
- vii. Upon request of the selected mediator(s), or one of the parties, BCBSA staff may also submit documentation at any time during the proceedings.

D. Notice of Termination of Mediation

If the Mediation cannot be completed within the prescribed or agreed time period due to the lack of cooperation of any party, as determined by the selected mediator(s), or if the Mediation does not result in a final resolution of all disputes at the Mediation Hearing or within ten (10) days after the Mediation Hearing, any party or any one of the selected mediators shall so notify the BCBSA Corporate Secretary, who shall promptly issue a Notice of Termination of Mediation to all parties, to the selected mediator(s), and to the MDR Administrator. Such notice shall serve to bring the Mediation to an end and to initiate Mandatory Dispute Resolution. Upon agreement of all parties and the mediator(s), the Mediation process may continue at the same time the MDR process is invoked. In such case, the Notice of Termination of Mediation described above serves to initiate the MDR proceeding, but does not terminate mediation proceedings, which may proceed simultaneous with the MDR proceeding.

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3. Mandatory Dispute Resolution (MDR)

If any party elects not to first pursue Mediation, or if a Notice of Termination of Mediation is issued as set forth in Paragraph 2.D., above, then the unresolved disputes set forth in any Complaint and Answer (and Counterclaim and Reply, if any) shall be subject to mandatory binding arbitration (herein referred to as "MDR").

A. MDR Administrator

The Administrator for purposes of Mandatory Arbitration shall be an independent nationally recognized entity such as CPR or JAMS, specializing in alternative dispute resolution. In the event the parties pursued Mediation with CPR, JAMS or a similar organization, that organization also shall serve as the MDR Administrator, unless all parties notify the BCBSA Corporate Secretary in writing within two (2) days of receiving the Notice of Termination of Mediation that they wish to pursue MDR with another nationally recognized organization serving as MDR Administrator.

In the event the parties (i) did not pursue Mediation, (ii) pursued mediation with a Mediator not affiliated with an ADR organization that offers a panel of arbitrators, or (iii) all parties that pursued Mediation notified the BCBSA Corporate Secretary that they wish to have an MDR Administrator that is different from the organization with which their mediator was affiliated, they shall promptly attempt to agree on a nationally recognized ADR entity that supplies a panel of arbitrators. If they reach such agreement within five (5) days of the Notice of Termination of Mediation or receipt of the Answer or Reply to Counterclaim (whichever is later), the parties shall promptly inform the BCBSA Corporate Secretary of their agreed upon ADR organization. In the event the parties are unable to reach agreement on an MDR Administrator within that timeframe, the BCBSA Corporate Secretary shall immediately refer the matter to CPR, JAMS or a similar organization for MDR.

Any person who served as a Mediator shall not serve as an arbitrator for the same or similar dispute for purposes of MDR.

B. Rules for MDR

The rules controlling all aspects of MDR shall be exclusively those provided for herein. The rules promulgated or otherwise used by the MDR Administrator organization shall not apply.

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C. Initial Conference

Within seven (7) days after a Notice of Termination has issued or the matter has otherwise been referred to an MDR Administrator, or within five (5) days after the time for filing and serving the Answer or Reply to any Counterclaim (whichever is later) if the parties elect first not to mediate, the parties shall confer with the Administrator to discuss selecting a dispute resolution panel ("the Panel"). This conference (the "Initial Conference") may be by telephone. The parties are encouraged to agree to the composition of the Panel and to present that agreement to the Administrator at the Initial Conference. If the parties do not agree on the composition of the Panel by the time of the Initial Conference, or by any extension thereof agreed to by all parties and the Administrator, then the Panel Selection Process set forth in subparagraph D, below, shall be followed.

D. Panel Selection Process

The Administrator shall designate, prior to the Initial Conference, at least seven potential arbitrators. Each party shall be permitted to strike any designee for cause and the Administrator shall determine the sufficiency thereof in its sole discretion. The Administrator will designate a replacement for any designee so stricken. Each party shall then be permitted one peremptory strike from the list of designees. The Administrator shall set the dates for exercising all strikes, which shall be set to encourage the prompt selection of arbitrators.

After the parties exercise any designee strikes for cause and their peremptory strike against any designee of their choice, the parties shall each rank the remaining panel members in order of preference and provide the Administrator, without serving on any other party, their ranked list. The Administrator shall not disclose any party's ranked list to members of the panel or to other parties.

From the remaining designees, and after considering opportunities to maximize, so far as possible, the collectively stated arbitrator preferences provided by the parties on their ranked lists, the Administrator shall select a three member Panel. The Panel Selection Process shall be completed no later than ten (10) days after the Initial Conference.

Each Arbitrator shall be compensated at his or her normal hourly rate or, in the absence of an established rate, at a reasonable hourly rate to be promptly fixed by the Administrator for all time spent in connection with the proceedings and shall be reimbursed for any travel and other reasonable expenses.

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E. Duties Of The Arbitrators

The Panel shall promptly designate a Presiding Arbitrator for the purposes reflected below, but shall retain the power to review and modify any ruling or other action of said Presiding Arbitrator. Each Arbitrator shall be an independent Arbitrator, shall be governed by the Code of Ethics for Arbitrators in Commercial Disputes and shall at or prior to the commencement of any Arbitration Hearing take an oath to that effect. Each Arbitrator shall promptly disclose in writing to the Panel and to the parties any circumstances, whenever arising, that might cause doubt as to such Arbitrator's compliance, or ability to comply, with said Code of Ethics, and, absent resignation by such Arbitrator, the remaining Arbitrators shall determine in their sole discretion whether the circumstances so disclosed constitute grounds for disqualification and for replacement. With respect to such circumstances arising or coming to the attention of a party after an Arbitrator's selection, a party may likewise request the Arbitrator's resignation or a determination as to disqualification by the remaining Arbitrators. With respect to a sole Arbitrator, the determination as to disqualification shall be made by the Administrator.

There shall be no ex parte communication between the parties or their counsel and any member of the Panel.

F. Panel's Jurisdiction And Authority

The Panel's jurisdiction and authority shall extend to all disputes between or among the Plans, their Controlled Affiliates, and/or BCBSA, except for those disputes excepted from these MMDR procedures as set forth in the License Agreements.

With the exception of punitive or treble damages, the Panel shall have full authority to award the relief it deems appropriate to resolve the parties' disputes, including monetary awards and injunctions, mandatory or prohibitory. The Panel has no authority to award punitive or treble damages except that the Panel may allocate or assess responsibility for punitive or treble damages assessed by another tribunal. Subject to the above limitations, the Panel may, by way of example, but not of limitation:

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- i. interpret or construe the meaning of any terms, phrase or provision in any license between BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.
- ii. determine whether BCBSA, a Plan or a Controlled Affiliate has violated the terms or conditions of any license between the BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.
- iii. decide challenges as to its own jurisdiction.
- iv. issue such orders for interim relief as it deems appropriate pending Hearing and Award in any Arbitration.

It is understood that the Panel is expected to resolve issues based on governing principles of law, preserving to the maximum extent legally possible the continued integrity of the Licensed Marks and the BLUE CROSS/BLUE SHIELD system. The Panel shall apply federal law to all issues which, if asserted in the United States District Court, would give rise to federal question jurisdiction, 28 U.S.C. § 1331. The Panel shall apply Illinois law to all issues involving interpretation, performance or construction of any License Agreement or Controlled Affiliate License Agreement unless the agreement otherwise provides. As to other issues, the Panel shall choose the applicable law based on conflicts of law principles of the State of Illinois.

G. Administrative Conference

Within five (5) days of the Panel being selected, the Presiding Arbitrator shall confer with the parties and the other members of the Panel and shall schedule, in writing, a conference in which the parties and the Panel shall participate (the "Administrative Conference"). The Administrative Conference shall take place no later than fifteen (15) days after the Panel is selected. At the Administrative Conference the parties and the Panel shall discuss the scheduling of the Arbitration Hearing and any other matter appropriate to be considered, including but not limited to: any written discovery in the form of requests for production of documents or requests to admit facts; the identity of any witness whose deposition a party may desire and a showing of exceptional good cause for the taking of any such deposition; the desirability of bifurcation or other separation of the issues; the need for and the type of record of conferences and hearings, including the need for transcripts; the need for expert witnesses and

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how expert testimony should be presented; the appropriateness of motions to dismiss and/or for full or partial summary judgment; consideration of stipulations; the desirability of presenting any direct testimony in writing; and the necessity for any on-site inspection by the Panel. If the parties agree, the Administrative Conference may be by telephone.

H. Discovery

- i. ***Requests for Production of Documents:*** All requests for the production of documents must be served no later than five (5) days after the date of the Initial Conference. Within twenty (20) days after receipt of a request for production of documents, a party shall (a) serve responses and objections to the request, (b) produce all responsive, non-privileged documents to the requesting party, and (c) to the extent any responsive documents are withheld on the grounds of attorney-client privilege or work product, produce a log identifying such documents in the manner specified in Fed. R. Civ. P. 26(b)(5). If, after reviewing a privilege log, the requesting party believes attorney-client privilege or work product protection was improperly claimed by the producing party with respect to any document, the requesting party may ask the Presiding Arbitrator to conduct an in-camera inspection of the same. With respect to documentary and other discovery produced in any MDR proceeding by BCBSA, the fact that a party's CEO or other senior officers may serve on the BCBSA Board of Directors, BCBSA Board Committees or other BCBSA work groups, task forces and the like, shall not be a basis for defeating an otherwise valid claim of attorney-client privilege or work product protection over such documentary or other discovery materials by BCBSA.
- ii. ***Requests for Admissions:*** Requests for Admissions may be served up to twenty-one (21) days prior to the discovery cut-off set by the Presiding Arbitrator. A party served with Requests For Admissions must respond within twenty (20) days of receipt of said request. The good faith use of and response to Requests for Admissions is encouraged, and the Panel shall have full discretion, with reference to the Federal Rules of Civil Procedure, in awarding appropriate sanctions with respect to abuse of the procedure.

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- iii. **Depositions:** As a general rule, the parties will not be permitted to take party or non-party deposition testimony for discovery purposes. The Presiding Arbitrator, in his or her sole discretion, shall have the authority to permit a party to take such deposition testimony upon a showing of exceptional good cause. The parties will be permitted to take de bene esse deposition testimony to the fullest extent permitted by law of any witness who cannot be compelled to testify at the Arbitration Hearing. No deposition, for discovery purposes or otherwise, shall exceed three (3) hours, excluding objections and colloquy of counsel. Depositions may be recorded in any manner recognized by the Federal Rules of Civil Procedure and the parties shall specify in each notice of deposition or request for permission to take deposition testimony the manner in which such deposition shall be recorded.
- iv. **Expert witness(es):** If a party intends to present the testimony of an expert witness during the oral hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2) (B) ten (10) days prior to the discovery cut-off set by the Presiding Arbitrator. If a party intends to present the testimony of a rebuttal expert witness during the Arbitration Hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)(B) within twenty (20) days after the date on which the written statement of the expert witness whose testimony is to be rebutted was produced.
- v. **Discovery cut-off:** The Presiding Arbitrator shall determine the date on which the discovery period will end, but the discovery period shall not exceed thirty (30) days from the date of the Administrative Conference without the agreement of all parties.

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- vi. ***Additional discovery:*** Any additional discovery will be at the discretion of the Presiding Arbitrator.
- vii. ***Discovery Disputes:*** Any discovery disputes shall be raised by motion to the Presiding Arbitrator, who is authorized to resolve all such disputes, and whose resolution will be binding on the parties unless modified by the Arbitration Panel. Prior to raising any discovery dispute with the Presiding Arbitrator, the parties shall meet and confer, telephonically or in person, in an attempt to resolve or narrow the dispute. If a party refuses to comply with a decision resolving a discovery dispute, the Panel, in keeping with Fed. R. Civ. P. 37, may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for resolution adversely to that party.
- viii. ***Extensions:*** The time for responding to discovery requests may be extended by the Presiding Arbitrator for good and sufficient cause shown. Any request for such an extension shall be made in writing.

I. Panel Suggested Settlement/Mediation

At any point during the proceedings, the Panel at the request of any party or on its own initiative, may suggest that the parties explore settlement and that they do so at or before the conclusion of the Arbitration Hearing, and the Panel shall give such assistance in settlement negotiations as the parties may request and the Panel may deem appropriate. Alternatively, the Panel may direct the parties to endeavor to mediate their disputes as provided above, or to explore a mini-trial proceeding, or to have an independent party render a neutral evaluation of the parties' respective positions. The Panel shall enter such sanctions as it deems appropriate with respect to any party failing to pursue in good faith such Mediation or other alternate dispute resolution methods.

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J. Subpoenas on Third Parties

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq.*, and subject to Paragraph 3.G(iii) above, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan or any officer, employee or director of a third party Blue Plan, to compel deposition testimony or the production of documents, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena.

K. Arbitration Hearing

An Arbitration Hearing will be held within thirty (30) days after the Administrative Conference if no discovery is taken, or within thirty (30) days after the close of discovery, unless all parties and the Panel agree to extend the Arbitration Hearing date, or unless the parties agree in writing to waive the Arbitration Hearing. The parties may mutually agree on the location of the Arbitration Hearing. If the parties fail to agree, the Arbitration Hearing shall be held in Chicago, Illinois, or at such other location determined by the Presiding Arbitrator to be most convenient to the participants. The Panel will determine the date(s) and time(s) of the Arbitration Hearing(s) after consultation with all parties and shall provide reasonable notice thereof to all parties or their representatives.

L. Arbitration Hearing Memoranda

Twenty (20) days prior to the Arbitration Hearing, each party shall submit to the other party (or parties) and to the Panel an Arbitration Hearing Memorandum which sets forth the applicable law and any argument as to any relevant issue. The Arbitration Hearing Memorandum will supplement, and not repeat, the allegations, information and documents contained in or with the Complaint, Answer, Counterclaim and Reply, if any. Ten (10) days prior to the Arbitration Hearing, each party shall submit to each other party a list of all expert and fact witnesses (but not including rebuttal fact witness) that such party intends to have testify at the Arbitration Hearing and a brief summary of the testimony each such witness is expected to give. In addition, no later than five (5) days prior to the Arbitration, each party may submit to each other party and to the Panel a Response Arbitration Hearing Memorandum which sets forth any response to another party's Arbitration Hearing Memorandum.

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M. Notice For Testimony

Ten (10) days prior to the Arbitration Hearing, any party may serve a Notice on any other party (or parties) requesting the attendance at the Arbitration Hearing of any officer, employee or director of the other party (or parties) for the purpose of providing noncumulative testimony. If a party fails to produce one of its officers, employees or directors whose noncumulative testimony during the Arbitration Hearing is reasonably requested by an adverse party, the Panel may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for mandatory dispute resolution adversely to that party; provided, however, that a party may refuse to produce a director to testify if, within two (2) days of receiving a notice requesting the attendance of such director at the Arbitration Hearing, the party agrees to make the director available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. This Rule may not be used for the purpose of burdening or harassing any party, and the Presiding Arbitrator may impose such orders as are appropriate so as to prevent or remedy any such burden or harassment.

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq.*, twenty (20) days or more prior to the Arbitration Hearing, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan, BCBSA or any officer, employee or director of a third party Blue Plan or BCBSA for the purpose of providing noncumulative testimony at the Arbitration Hearing, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena; provided however, that a director of a third party Blue Plan or BCBSA may refuse to testify if, within two (2) days of receiving a subpoena requesting the attendance of such director at the Arbitration Hearing, the director agrees to make him/herself available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. Each Blue Plan agrees to waive, on its own behalf and on behalf of its directors and officers, any objection it otherwise might have to any such subpoena based on service, venue or extraterritoriality.

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N. Arbitration Hearing Procedures

- i. **Attendance at Arbitration Hearing:** Any person having a direct interest in the proceeding is entitled to attend the Arbitration Hearing. The Presiding Arbitrator shall otherwise have the power to require the exclusion of any witness, other than a party or other essential person, during the testimony of any other witness. It shall be discretionary with the Presiding Arbitrator to determine the propriety of the attendance of any other person.
- ii. **Confidentiality:** The Panel and all parties shall maintain the privacy of the Arbitration Proceeding. The parties and the Panel shall treat the Arbitration Hearing and any discovery or other proceedings or events related thereto, including any award resulting therefrom, as confidential except as otherwise necessary in connection with a judicial challenge to or enforcement of an award or unless otherwise required by law.
- iii. **Stenographic Record:** Any party, or if the parties do not object, the Panel, may request that a stenographic or other record be made of any Arbitration Hearing or portion thereof. The costs of the recording and/or of preparing the transcript shall be borne by the requesting party and by any party who receives a copy thereof. If the Panel requests a recording and/or a transcript, the costs thereof shall be borne equally by the parties.
- iv. **Oaths:** The Panel may require witnesses to testify under oath or affirmation administered by any duly qualified person and, if requested by any party, shall do so.
- v. **Order of Arbitration Hearing:** An Arbitration Hearing shall be opened by the recording of the date, time, and place of the Arbitration Hearing, and the presence of the Panel, the parties, and their representatives, if any. The Panel may, at the beginning of the Arbitration Hearing, ask for statements clarifying the issues involved.

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Unless otherwise agreed, the complaining party (or parties) shall then present evidence to support their claim(s). The respondent(s) shall then present evidence supporting their defenses and Counterclaims, if any. The complaining party (or parties) shall then present evidence supporting defenses to the Counterclaims, if any, and rebuttal.

Witnesses for each party shall submit to questions by adverse parties and/or the Panel.

The Panel has the discretion to vary these procedures, but shall afford a full and equal opportunity to all parties for the presentation of any material and relevant evidence.

- vi. **Evidence:** The parties may offer such evidence as is relevant and material to the dispute and shall produce such evidence as the Panel may deem necessary to an understanding and resolution of the dispute. Unless good cause is shown, as determined by the Panel or agreed to by all other parties, no party shall be permitted to offer evidence at the Arbitration Hearing which was not disclosed prior to the Arbitration Hearing by that party. The Panel may receive and consider the evidence of witnesses by affidavit upon such terms as the Panel deems appropriate.

The Panel shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence, other than enforcement of the attorney-client privilege and the work product protection, shall not be necessary. The Federal Rules of Evidence shall be considered by the Panel in conducting the Arbitration Hearing but those rules shall not be controlling. All evidence shall be taken in the presence of the Panel and all of the parties, except where any party is in default or has waived the right to be present.

Settlement offers by any party in connection with Mediation or MDR proceedings, decisions or recommendations of the selected mediators, and a party's position papers or statements furnished to the selected mediators shall not be admissible evidence or considered by the Panel without the consent of all parties.

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vii. **Closing of Arbitration Hearing:** The Presiding Arbitrator shall specifically inquire of all parties whether they have any further proofs to offer or witnesses to be heard. Upon receiving negative replies or if he or she is satisfied that the record is complete, the Presiding Arbitrator shall declare the Arbitration Hearing closed with an appropriate notation made on the record. Subject to being reopened as provided below, the time within which the Panel is required to make the award shall commence to run, in the absence of contrary agreement by the parties, upon the closing of the Arbitration Hearing.

With respect to complex disputes, the Panel may, in its sole discretion, defer the closing of the Arbitration Hearing for a period of up to thirty (30) days after the presentation of proofs in order to permit the parties to submit post-hearing briefs and argument, as the Panel deems appropriate, prior to making an award.

For good cause, the Arbitration Hearing may be reopened for up to thirty (30) days on the Panel's initiative, or upon application of a party, at any time before the award is made

O. Awards

An Award must be in writing and shall be made promptly by the Panel and, unless otherwise agreed by the parties or specified by law, no later than thirty (30) days from the date of closing the Arbitration Hearing. If all parties so request, the Award shall contain findings of fact and conclusions of law. The Award, and all other rulings and determinations by the Panel, may be by a majority vote.

Parties shall accept as legal delivery of the Award the placing of the Award or a true copy thereof in the mail addressed to a party or its representative at its last known address or personal service of the Award on a party or its representative.

Awards are binding only on the parties to the Arbitration and are not binding on any non-parties to the Arbitration and may not be used or cited as precedent in any other proceeding.

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After the expiration of twenty (20) days from initial delivery, the Award (with corrections, if any) shall be final and binding on the parties, and the parties shall undertake to carry out the Award without delay.

Proceedings to confirm, modify or vacate an Award shall be conducted in conformity with and controlled by the Federal Arbitration Act. 9 U.S.C. § 1, *et seq.*

P. Return of Documents

Within sixty (60) days after the Award and the conclusion of any judicial proceedings with respect thereto, each party and the Panel shall return any documents produced by any other party, including all copies thereof. If a party receives a discovery request in any other proceeding which would require it to produce any documents produced to it by any other party in a proceeding hereunder, it shall not produce such documents without first notifying the producing party and giving said party reasonable time to respond, if appropriate, to the discovery request.

4. Miscellaneous

A. Expedited Procedures

Any party to a Mediation may direct a request for an expedited Mediation Hearing to the Chairman of the Mediation Committee, to the selected Mediators, and to all other parties at any time. The Chairman of the Mediation Committee, or at his or her direction, the then selected Mediators, shall grant any request which is supported by good and sufficient reasons. If such a request is granted, the Mediation shall be completed within as short a period as practicable, as determined by the Chairman of the Mediation Committee or, at his or her direction, the then selected Mediators.

Any party to an Arbitration may direct a request for expedited proceedings to the Administrator, to the Panel, and to all other parties at any time. The Administrator, or the Presiding Arbitrator if the Panel has been selected, shall grant any such request which is supported by good and sufficient reasons. If such a request is granted, the Arbitration shall be completed within as short a time as practicable, as determined by the Administrator and/or the Presiding Arbitrator.

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B. Temporary or Preliminary Injunctive Relief

Any party may seek temporary or preliminary injunctive relief with the filing of a Complaint or at any time thereafter. If such relief is sought prior to the time that an Arbitration Panel has been selected, then the Administrator shall select a single Arbitrator who is a lawyer who has no interest in the subject matter of the dispute, and no connection to any of the parties, to hear and determine the request for temporary or preliminary injunction. If such relief is sought after the time that an Arbitration Panel has been selected, then the Arbitration Panel will hear and determine the request. The request for temporary or preliminary injunctive relief will be determined with reference to the temporary or preliminary injunction standards set forth in Fed. R. Civ. P. 65.

C. Defaults and Proceedings in the Absence of a Party

Whenever a party fails to comply with the MDR Rules in a manner deemed material by the Panel, the Panel shall fix a reasonable time for compliance and, if the party does not comply within said period, the Panel may enter an Order of default or afford such other relief as it deems appropriate. Arbitration may proceed in the event of a default or in the absence of any party who, after due notice, fails to be present or fails to obtain an extension. An Award shall not be made solely on the default or absence of a party, but the Panel shall require the party who is present to submit such evidence as the Panel may require for the making of findings, determinations, conclusions, and Awards.

D. Notice

Each party shall be deemed to have consented that any papers, notices, or process necessary or proper for the initiation or continuation of a proceeding under these rules or for any court action in connection therewith may be served on a party by mail addressed to the party or its representative at its last known address or by personal service, in or outside the state where the MDR proceeding is to be held.

The Corporate Secretary and the parties may also use facsimile transmission, telex, telegram, or other written forms of electronic communication to give the notices required by these rules.

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E. Expenses

The expenses of witnesses shall be paid by the party causing or requesting the appearance of such witnesses. All expenses of the MDR proceeding, including compensation, required travel and other reasonable expenses of the Panel, and the cost of any proof produced at the direct request of the Panel, shall be borne equally by the parties and shall be paid periodically on a timely basis, unless they agree otherwise or unless the Panel in the Award assesses such expenses, or any part thereof against any party (or parties). In exceptional cases, the Panel may award reasonable attorneys' fees as an item of expense, and the Panel shall promptly determine the amount of such fees based on affidavits or such other proofs as the Panel deems sufficient.

F. Disqualification or Disability of A Panel Member

In the event that any Arbitrator of a Panel with more than one Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the remaining Panel member(s):

- i. shall designate a replacement, subject to the right of any party to challenge such replacement for cause.
- ii. shall decide the extent to which previously held hearings shall be repeated.

If the remaining Panel members consider the proceedings to have progressed to a stage as to make replacement impracticable, the parties may agree, as an alternative to the recommencement of the Mandatory Dispute Resolution process, to resolution of the dispute by the remaining Panel members.

In the event that a single Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the Administrator shall appoint a successor, subject to the right of any party to challenge such successor for cause, and the successor shall decide the extent to which previously held proceedings shall be repeated.

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G. Extensions of Time

Subject to the provisions of Paragraph 3.H.(viii.), any time limit set forth in these Rules may be extended upon agreement of the parties and approval of: (1) the Mediator if the proceeding is then in Mediation; (2) the Administrator if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (3) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected.

H. Intervention

The Plans, their Controlled Affiliates, and BCBSA, to the extent subject to MMDR pursuant to their License Agreements, shall have the right to move to intervene in any pending Arbitration. A written motion for intervention shall be made to: (1) the Administrator, if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (2) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected. The written motion for intervention shall be delivered to the BCBSA Corporate Secretary (which shall also constitute service on the BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) which are parties to the proceeding. Any party to the proceeding can submit written objections to the motion to intervene. The motion for intervention shall be granted upon good cause shown. Intervention also may be allowed by stipulation of the parties to the Arbitration proceeding. Intervention shall be allowed upon such terms as the Arbitration Panel decides.

I. BCBSA Assistance in Resolution of Disputes

The resources and personnel of the BCBSA may be requested by any member Plan at any time to try to resolve disputes with another Plan.

J. Neutral Evaluation

The parties can voluntarily agree at any time to have an independent party render a neutral evaluation of the parties' respective positions.

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K. Recovery of Attorney Fees and Expenses

i. Motions to Compel

Notwithstanding any other provisions of these Rules, any Party subject to the License Agreements (for purposes of this Section K and all of its sub-sections only hereinafter referred to collectively and individually as a "Party") that initiates a court action or administrative proceeding solely to compel adherence to these Rules shall not be determined to have violated these Rules by initiating such action or proceeding.

ii. Recovery of Fees, Expenses and Costs

The Arbitration Panel may, in its sole discretion, award a Party its reasonable attorneys' fees, expenses and costs associated with a filing to compel adherence to these Rules and/or reasonable attorneys' fees, expenses and costs incurred in responding to an action filed in violation of these Rules; provided, however, that neither fees, expenses, nor costs shall be awarded by the Arbitration Panel if the Party from which the award is sought can demonstrate to the Arbitration panel, in its sole discretion, that it did not violate these Rules or that it had reasonable grounds for believing that its action did not violate these Rules.

iii. Requests for Reimbursement

For purposes of this Section K, any Party may request reimbursement of fees, expenses and/or costs by submitting said request in writing to the Arbitration Panel at any time before an award is delivered pursuant Paragraph to 3.O above with a copy to the Party from which reimbursement is sought, explaining why it is entitled to such reimbursement. The Party from which reimbursement is sought shall have twenty (20) days to submit a response to such request to the Arbitration Panel with a copy to the Party seeking reimbursement.

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L. Calculation of Time and Deadlines

In computing any period of time prescribed or allowed under these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not one of the aforementioned days. When the period of time prescribed is less than six (6) days, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation. As used in this rule, "legal holiday" includes New Year's Day, Martin Luther King, Jr. Day, Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day and any other day appointed as a holiday by the President or the Congress of the United States.

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Exhibit 10.14

BLUE SHIELD LICENSE AGREEMENT

(Includes revisions, if any, adopted by Member Plans through their November 21, 2014 meeting)

This agreement by and between Blue Cross and Blue Shield Association ("BCBSA") and The Blue Shield Plan, known as _____ (the "Plan").

Preamble

WHEREAS, the Plan and/or its predecessor(s) in interest (collectively the "Plan") had the right to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") for health care plans in its service area, which was essentially local in nature;

WHEREAS, the Plan was desirous of assuring nationwide protection of the Licensed Marks, maintaining uniform quality controls among Plans, facilitating the provision of cost effective health care services to the public and otherwise benefiting the public;

WHEREAS, to better attain such ends, the Plan and the predecessor of BCBSA executed the Agreement(s) Relating to the Collective Service Mark "Blue Shield"; and

WHEREAS, BCBSA and the Plan desire to supercede said Agreement(s) to reflect their current practices and to assure the continued integrity of the Licensed Marks and of the BLUE SHIELD system;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

Agreement

1. BCBSA hereby grants to the Plan, upon the terms and conditions of this License Agreement ("Agreement" or "Primary License Agreement", the right to use BLUE SHIELD in its trade and/or corporate name (the "Licensed Name"), and the right to use the Licensed Marks, in the sale, marketing and administration of health care plans and related services in the Service Area set forth and defined in paragraph 5 below. As used herein, health care plans and related services shall include acting as a nonprofit health care plan, a for-profit health care plan, or mutual health insurer operating on a not-for-profit or for-profit basis, under state law; financing access to health care services; when working with a bank that holds the relevant license to use the Licensed Name and Marks, offering: (i) tax-favored savings accounts for medical expenses and means for accessing such accounts, such as debit cards or checks, that are provided solely to support access to such tax-favored savings accounts, all pursuant to such license, or (ii) prepaid rewards cards that are provided for completion of a wellness program, all pursuant to such license; providing health care management and administration; administering, but not underwriting, non-health portions of Worker's Compensation insurance; delivering health care services, except hospital services (as defined in the Guidelines to Membership Standards Applicable to Regular Members); and performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by a group account to its members, including benefit plans not provided by the Plan, provided that the Plan has contracted to provide Health Coverage under the Licensed Marks to the account (as the terms "Health Coverage," "Eligibility" and "Enrollment" are defined in Exhibit 4, Paragraph 2.t.).

2. The Plan may use the Licensed Marks and Name in connection with the offering of: i) health care plans and related services in the Service Area through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License Agreement"); and ii) insurance coverages offered by life insurers under the applicable law in the Service Area, other than those which the Plan may offer in its own name, provided through Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1A hereto (the "Controlled Affiliate License Agreement Applicable to Life Insurance Companies") or the Agreement attached as Exhibit 1A1 hereto (the "Controlled Affiliate Trademark License Agreement for Life and Disability Insurance Products") and further provided that the offering of such services does not and will not dilute or tarnish the unique value of the Licensed Marks and Name; and iii) administration and underwriting of Workers' Compensation Insurance Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1 hereto (the "Controlled Affiliate License."); and iv) regional Medicare Advantage PPO Products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1B hereto (the "Controlled Affiliate License Agreement Applicable to Regional Medicare Advantage PPO Products"); and v) regional Medicare Part D Prescription Drug Plan products in cooperation with one or more other Plans through jointly-held Controlled Affiliates, provided that each such Controlled

Affiliate is separately licensed to use the Licensed Marks and Name under the terms and conditions contained in the Agreement attached as Exhibit 1C hereto (the "Controlled Affiliate License Agreement Applicable to Regional Medicare Part D Prescription Drug Plan Products"). As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans and, if the entity meets the standards of Paragraph 2a.B but not Paragraph 2a.A, the entity, its owners, and persons authority to select or appoint members or board members, other than a Plan or Plans, have received written approval of BCBSA. Absent written approval by BCBSA of an alternative method of control, bona fide control shall have the meaning set forth in Paragraphs 2a. and 2b.

Amended as of September 19, 2014

2a. With respect to the Controlled Affiliate Licenses authorized in clauses i) through iii) of Paragraph 2, bona fide control shall mean that a Plan (the "Sponsoring Plan") authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to this Primary License Agreement with BCBSA must have:

A. The legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; (b) to exercise control over the policy and operations of the Controlled Affiliate; (c) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate; or

B. The legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; (c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan. Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

1. Change its legal and/or trade name;
2. Change the geographic area in which it operates;
3. Change any of the types of businesses in which it engages;
4. Create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;
5. Sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;
6. Make any loans or advances except in the ordinary course of business;

Amended as of September 19, 2014

7. Enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners of the Controlled Affiliate or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);

8. Conduct any business other than under the Licensed Marks and Name;

9. Take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks or Names.

In addition, the Sponsoring Plan directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate; or

- C. With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid products and services, the legal authority together with such other Plans (a) to select all members of the Controlled Affiliate's governing body; (b) to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; (c) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the "Addendum to Controlled Affiliate License" attached as Exhibit B to Exhibit 1 attached hereto.

2b. With respect to the Controlled Affiliate License Agreements authorized in clauses iv) and v) of Paragraph 2, bona fide control shall mean that the Controlled Affiliate is organized and operated in such a manner that it meets the following requirements:

- A. The Controlled Affiliate is owned or controlled by two or more Plans authorized to use the Licensed Marks pursuant to this License Agreement with BCBSA (for purposes of this subparagraph A. through subparagraph C., the "Controlling Plans"); and

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- B. Each Controlling Plan is authorized pursuant to this Agreement to use the Licensed Marks in a geographic area in the Region (as that term is defined in such Controlled Affiliate License Agreements) and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
- C. The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur; and (c) to exercise control over the policy and operations of the Controlled Affiliate. Notwithstanding anything to the contrary in (a) through (c) of this subparagraph E., the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:
1. Change its legal and/or trade names;
 2. Change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
 3. Change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
 4. Take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

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3. With respect to a Controlled Affiliate that is not licensed to use the Licensed Marks and Name, the Plan may, in communications that contain the Licensed Marks or Name, indicate its corporate relationship to the Affiliate and permit such Affiliate to indicate its corporate relationship to the Plan, solely in the circumstances, style and manner specified by BCBSA from time-to-time in regulations of general application consistent with the avoidance of confusion or mistake or the dilution or tarnishment of the Licensed Marks and Name. No rights are hereby created in any Controlled Affiliate to use the Licensed Marks or Name in its own name or otherwise.

4. The Plan recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Plan further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide. The Plan agrees (a) to maintain in good standing its membership in BCBSA; (b) promptly to pay its dues to BCBSA, said dues to represent the royalties for this License Agreement; (c) materially to comply with all applicable laws; (d) to comply with the Membership Standards Applicable to Regular Members of BCBSA, a current copy of which is attached as Exhibit 2 hereto; and (e) reasonably to permit BCBSA, upon a written, good faith request and during reasonable business hours, to inspect the Plan's books and records necessary to ascertain compliance herewith. As to other Plans and third parties, BCBSA shall maintain the confidentiality of all documents and information furnished by the Plan pursuant hereto, or pursuant to the Membership Standards, and clearly designated by the Plan as containing proprietary information of the Plan.

5. The rights hereby granted are exclusive to the Plan within the geographical area(s) served by the Plan on June 30, 1972, and/or as to which the Plan has been granted a subsequent license, which is hereby defined as the "Service Area," except that BCBSA reserves the right to use the Licensed Marks in said Service Area, and except to the extent that said Service Area may overlap areas served by one or more other licensed Blue Shield Plans as of said date or subsequent license, as to which overlapping areas the rights hereby granted are nonexclusive as to such other Plan or Plans only.

Amended as of June 19, 2014

6. Except as expressly provided by BCBSA with respect to National Accounts, Government Programs and certain other necessary and collateral uses, the current rules and regulations governing which are attached as Exhibit 3 and Exhibit 4 hereto, and are contained in other documents referenced herein, or as expressly provided herein, the Plan may not use the Licensed Marks and Name outside the Service Area or in connection with other goods and services, nor may the Plan use the Licensed Marks or Name in a manner which is intended to transfer in the Service Area the goodwill associated therewith to another mark or name. Nothing herein shall be construed to prevent the Plan from engaging in lawful activity anywhere under other marks and names not confusingly similar to the Licensed Marks and Name, provided that engaging in such activity does and will not dilute or tarnish the unique value of the Licensed Marks and Name. In addition to any and all remedies available hereunder, BCBSA may impose monetary fines on the Plan for the Plan's use of the Licensed Marks and Names outside the Service Area, and provided that the procedure used in imposing a fine is consistent with procedures specifically prescribed by BCBSA from time to time in regulations of general application. In the case of regional Medicare Advantage PPO and regional Medicare Part D Prescription Drug Plan products offered by consenting and participating Plans in a region that includes the Service Areas, or portions thereof, of more than one Plan, such fine may be imposed jointly on the consenting and participating Plans for use of the Licensed Marks and Name in any geographic area of the region in which a Plan having exclusive rights to the Licensed Marks and Name does not consent to and participate in such offering, provided that the basis for imposition of such fine is consistent with rules specifically prescribed by BCBSA from time to time in regulations of general application.

7. The Plan agrees that it will display the Licensed Marks and Name only in such form, style and manner as shall be specifically prescribed by BCBSA from time-to-time in regulations of general application in order to prevent impairment of the distinctiveness of the Licensed Marks and Name and the goodwill pertaining thereto. The Plan shall cause to appear on all materials on or in connection with which the Licensed Marks or Name are used such legends, markings and notices as BCBSA may reasonably request in order to give appropriate notice of service mark or other proprietary rights therein or pertaining thereto.

8. BCBSA agrees that: (a) it will not grant any other license effective during the term of this License Agreement for the use of the Licensed Marks or Name which is inconsistent with the rights granted to the Plan hereunder; and (b) it will not itself use the Licensed Marks in derogation of the rights of the Plan or in a manner to deprive the Plan of the full benefits of this License Agreement, provided that BCBSA shall have the right to use the Licensed Marks in conjunction with any national offering under the Federal Employees Health Benefits Program in the manner set forth in Exhibit 4, Paragraph 4 (including subparagraphs) to this License Agreement. The Plan agrees that it will not attack the title of BCBSA in and to the Licensed Marks or Name or attack the validity of the Licensed Marks or of this License Agreement. The Plan further agrees that all use by it of the Licensed Marks and Name or any similar mark or name shall inure to the benefit of BCBSA, and the Plan shall cooperate with BCBSA in effectuating the assignment to BCBSA of any service mark or trademark registrations of the Licensed Marks or any similar mark or name held by the Plan or a Controlled Affiliate of the Plan, all or any portion of which registration consists of the Licensed Marks.

Amended as of November 16, 2006

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9. (a). Should the Plan fail to comply with the provisions of paragraphs 2-4, 6, 7 and/or 12, and not cure such failure within thirty (30) days of receiving written notice thereof (or commence curing such failure within such thirty day period and continue diligent efforts to complete the curing of such failure if such curing cannot reasonably be completed within such thirty day period), BCBSA shall have the right to issue a notice that the Plan is in a state of noncompliance. Except as to the termination of a Plan's License Agreement or the merger of two or more Plans, disputes as to noncompliance, and all other disputes between or among BCBSA, the Plan, other Plans and/or Controlled Affiliates, shall be submitted promptly to mediation and mandatory dispute resolution pursuant to the rules and regulations of BCBSA, a current copy of which is attached as Exhibit 5 hereto, and shall be timely presented and resolved. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. If a state of noncompliance as aforesaid is undisputed by the Plan or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the License Agreement. Except, however, as provided in paragraphs 9(d)(iii), 15(a)(i)-(viii), and 15(a)(x) below, no Plan's license to use the Licensed Marks and Name may be finally terminated for any reason without the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

(b). Notwithstanding any other provision of this License Agreement, a Plan's license to use the Licensed Marks and Name may be forthwith terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to Member Plans for: (i) failure to comply with any minimum capital or liquidity requirement under the Membership Standard on Financial Responsibility; or (ii) impending financial insolvency; or (iii) the pendency of any action instituted against the Plan seeking its dissolution or liquidation or its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property of business, unless this License Agreement has been earlier terminated under paragraph 15(a); or (iv) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans and/or the Licensed Marks.

Amended as of March 16, 2006

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(c). To the extent not otherwise provided therein, neither: (i) the Membership Standards Applicable to Regular Members of BCBSA; nor (ii) the rules and regulations governing Government Programs and certain other uses; nor (iii) the rules and regulations governing mediation and mandatory dispute resolution, may be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans. The rules and regulations governing National Accounts and other national programs required by the Membership Standards Applicable to Regular Members of BCBSA (Exhibit 2) are contained, in addition to those set forth in Exhibit 3, in the following documents, as amended from time to time: (1) the Inter-Plan Programs Policies and Provisions; (2) Inter-Plan Medicare Advantage Program Policies and Provisions. The voting requirements specified in rules and regulations governing such national programs may not be amended unless and until each such amendment is first adopted by the affirmative vote of three-fourths of the Plans and of three-fourths of the total then current weighted vote of all the Plans.

Amended as of November 21, 2014

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

(i) The Plan shall discharge all responsibilities which it has to the Association and to other Plans by virtue of this Agreement and the Plan's membership in BCBSA.

(ii) The Plan shall not use the licensed Marks and Name, or any derivative thereof, as part of its legal name or any symbol used to identify the Plan in any securities market. The Plan shall use the licensed Marks and Name as part of its trade name within its service area for the sale, marketing and administration of health care and related services in the service area.

(iii) The Plan's license to use the Licensed Marks and Name shall automatically terminate effective: (a) thirty days after the Plan knows, or there is an SEC filing indicating that, any Institutional Investor, has become the Beneficial Owner of securities representing 10% or more of the voting power of the Plan ("Excess Institutional Voter"), unless such Excess Institutional Voter shall cease to be an Excess Institutional Voter prior to such automatic termination becoming effective; (b) thirty days after the Plan knows, or there is an SEC filing indicating that, any Noninstitutional Investor has become the Beneficial Owner of securities representing 5% or more of the voting power of the Plan ("Excess Noninstitutional Voter") unless such Excess Noninstitutional Voter shall cease to be an Excess Noninstitutional Voter prior to such automatic termination becoming effective; (c) thirty days after the Plan knows, or there is an SEC filing indicating that, any Person has become the Beneficial Owner of 20% or more of the Plan's then outstanding common stock or other equity securities which (either by themselves or in combination) represent an ownership interest of 20% or more pursuant to determinations made under paragraph 9(d)(iv) below ("Excess Owner"), unless such Excess Owner shall cease to be an Excess Owner prior to such automatic termination becoming effective; (d) ten business days after individuals who at the time the Plan went public constituted the Board of Directors of the Plan (together with any new directors whose election to the Board was approved by a vote of 2/3 of the directors then still in office who were directors at the time the Plan went public or whose election or nomination was previously so approved) (the "Continuing Directors") cease for any reason to constitute a majority of the Board of Directors; or (e) ten business days after the Plan consolidates with or merges with or into any person or conveys, assigns, transfers or sells all or substantially all of its assets to any person other than a merger in which the Plan is the surviving entity and immediately after which merger, no person is an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner: provided that, if requested by the affected Plan in a writing received by BCBSA prior to such automatic termination becoming effective, the provisions of this paragraph 9(d)(iii) may be waived, in whole or in part,

Amended as of September 17, 1997

upon the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. Any waiver so granted may be conditioned upon such additional requirements (including but not limited to imposing new and independent grounds for termination of this License) as shall be approved by the affirmative vote of a majority of the disinterested Plans and a majority of the total then current weighted vote of the disinterested Plans. If a timely waiver request is received, no automatic termination shall become effective until the later of: (1) the conclusion of the applicable time period specified in paragraphs 9(d)(iii)(a)-(d) above, or (2) the conclusion of the first Member Plan meeting after receipt of such a waiver request.

In the event that the Plan's license to use the Licensed Marks and Name is terminated pursuant to this Paragraph 9(d)(iii), the license may be reinstated in BCBSA's sole discretion if, within 30 days of the date of such termination, the Plan demonstrates that the Person referred to in clause (a), (b) or (c) of the preceding paragraph is no longer an Excess Institutional Voter, an Excess Noninstitutional Voter or an Excess Owner.

(iv) The Plan shall not issue any class or series of security other than (i) shares of common stock having identical terms or options or derivatives of such common stock, (ii) non-voting, non-convertible debt securities or (iii) such other securities as the Plan may approve, provided that BCBSA receives notice at least thirty days prior to the issuance of such securities, including a description of the terms for such securities, and BCBSA shall have the authority to determine how such other securities will be counted in determining whether any Person is an Excess Institutional Voter, Excess Noninstitutional Voter or an Excess Owner.

(v) For purposes of paragraph 9(d)(iii), the following definitions shall apply:

(a) "Affiliate" and "Associate" shall have the respective meanings ascribed to such terms in Rule 12b-2 of the General Rules and Regulations under the Securities Exchange Act of 1934, as amended and in effect on November 17, 1993 (the "Exchange Act").

(b) A Person shall be deemed the "Beneficial Owner" of and shall be deemed to "beneficially own" any securities:

(i) which such Person or any of such Person's Affiliates or Associates beneficially owns, directly or indirectly;

Amended as of September 17, 1997

(ii) which such Person or any of such Person's Affiliates or Associates has (A) the right to acquire (whether such right is exercisable immediately or only after the passage of time) pursuant to any agreement, arrangement or understanding, or upon the exercise of conversion rights, exchange rights, warrants or options, or otherwise; or (B) the right to vote pursuant to any agreement, arrangement or understanding; provided, however, that a Person shall not be deemed the Beneficial Owner of, or to beneficially own, any security if the agreement, arrangement or understanding to vote such security (1) arises solely from a revocable proxy or consent given to such Person in response to a public proxy or consent solicitation made pursuant to, and in accordance with, the applicable rules and regulations promulgated under the Exchange Act and (2) is not also then reportable on Schedule 13D under the Exchange Act (or any comparable or successor report); or

(iii) which are beneficially owned, directly or indirectly, by any other Person (or any Affiliate or Associate thereof) with which such Person (or any of such Person's Affiliates or Associates) has any agreement, arrangement or understanding (other than customary agreements with and between underwriters and selling group members with respect to a bona fide public offering of securities) relating to the acquisition, holding, voting (except to the extent contemplated by the proviso to (b)(ii)(B) above) or disposing of any securities of the Plan.

Notwithstanding anything in this definition of Beneficial Ownership to the contrary, the phrase "then outstanding," when used with reference to a Person's Beneficial Ownership of securities of the Plan, shall mean the number of such securities then issued and outstanding together with the number of such securities not then actually issued and outstanding which such Person would be deemed to own beneficially hereunder.

(c) A Person shall be deemed an "Institutional Investor" if (but only if) such Person (i) is an entity or group identified in the SEC's Rule 13d-1(b)(1)(ii) as constituted on June 1, 1997, and (ii) every filing made by such Person with the SEC under Regulation 13D-G (or any successor Regulation) with respect to such Person's Beneficial Ownership of Plan securities shall have contained a certification identical to the one required by item 10 of SEC Schedule 13G as constituted on June 1, 1997.

(d) "Noninstitutional Investor" means any Person who is not an Institutional Investor.

(e) "Person" shall mean any individual, firm, partnership, corporation, trust, association, joint venture or other entity, and shall include any successor (by merger or otherwise) of such entity.

Amended as of September 17, 1997

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10. This License Agreement shall remain in effect: (a) until terminated as provided herein; or (b) until this and all such other License Agreements are terminated by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans; (c) until terminated by the Plan upon eighteen (18) months written notice to BCBSA or upon a shorter notice period approved by BCBSA in writing at its sole discretion.

11. Except as otherwise provided in paragraph 15 below or by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans, or unless this and all such other License Agreements are simultaneously terminated by force of law, the termination of this License Agreement for any reason whatsoever shall cause the reversion to BCBSA of all rights in and to the Licensed Marks and Name, and the Plan agrees that it will promptly discontinue all use of the Licensed Marks and Name, will not use them thereafter, and will promptly, upon written notice from BCBSA, change its corporate name so as to eliminate the Licensed Name therefrom.

12. The license hereby granted to Plan to use the Licensed Marks and Name is and shall be personal to the Plan so licensed and shall not be assignable by any act of the Plan, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Plan mortgage or part with possession or control of this license or any right hereunder, and the Plan shall have no right to grant any sublicense to use the Licensed Marks and Name.

13. BCBSA shall maintain appropriate service mark registrations of the Licensed Marks and BCBSA shall take such lawful steps and proceedings as may be necessary or proper to prevent use of the Licensed Marks by any person who is not authorized to use the same. Any actions or proceedings undertaken by BCBSA under the provisions of this paragraph shall be at BCBSA's sole cost and expense. BCBSA shall have the sole right to determine whether or not any legal action shall be taken on account of unauthorized use of the Licensed Marks, such right not to be unreasonably exercised. The Plan shall report any unlawful usage of the Licensed Marks to BCBSA in writing and agrees, free of charge, to cooperate fully with BCBSA's program of enforcing and protecting the service mark rights, trade name rights and other rights in the Licensed Marks.

14. The Plan hereby agrees to save, defend, indemnify and hold BCBSA and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of the activities of the Plan or of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan. BCBSA hereby agrees to save, defend, indemnify and hold the Plan and any other Plan(s) harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise exclusively and directly as a result of the activities of BCBSA.

Amended as of June 21, 2012

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15. (a). This Agreement shall automatically terminate upon the occurrence of any of the following events: (i) a voluntary petition shall be filed by the Plan or by BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against the Plan or BCBSA seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Plan or BCBSA respectively, or (iii) an order for relief is entered against the Plan or BCBSA in any case under the bankruptcy laws of the United States, or the Plan or BCBSA is adjudged bankrupt or insolvent (as that term is defined in the Uniform Commercial Code as enacted in the state of Illinois) by any court of competent jurisdiction, or (iv) the Plan or BCBSA makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of the Plan or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against the Plan or BCBSA seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by the Plan or BCBSA or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Plan or BCBSA respectively, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of the Plan's or BCBSA's property or business is appointed, or the Plan or BCBSA is ordered dissolved or liquidated, or (ix) the Plan shall fail to pay its dues and shall not cure such failure within thirty (30) days of receiving written notice thereof, or (x) if, due to regulatory action, the Plan together with any applicable Controlled Affiliate becomes unable to do business using the Names and Marks in any State or portion thereof included in its Service Area, provided that: (i) automatic termination shall not occur prior to the exhaustion by any such Plan of its rights to appeal or challenge such regulatory action; and (ii) in the event the Plan is licensed to do business using the Names and Marks in multiple States or portions of States, the termination of its License Agreement shall be solely limited to the State(s) or portions thereof in which the regulatory action applies. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Plan's or BCBSA's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 15(a)(vii) and (viii) of this Agreement.

Amended as of September 14, 2004

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(b). BCBSA, or the Plans (as provided and in addition to the rights conferred in Paragraph 10(b) above), may terminate this Agreement immediately upon written notice upon the occurrence of either of the following events: (a) the Plan or BCBSA becomes insolvent (as that term is defined in the Uniform Commercial Code enacted in the state of Illinois), or (b) any final judgment against the Plan or BCBSA remains unsatisfied or unbonded of record for a period of sixty (60) days or longer.

(c). If this License Agreement is terminated as to BCBSA for any reason stated in subparagraphs 15(a) and (b) above, the ownership of the Licensed Marks shall revert to each of the Plans.

(d). Upon termination of this License Agreement or any Controlled Affiliate License Agreement of a Larger Controlled Affiliate, as defined in Exhibit 1 to this License Agreement, the following conditions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 15 (a)(x)(ii) of this Agreement, the notices, national account listing, payment and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

(i) The terminated entity shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the terminated entity or its Controlled Affiliates under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination or, if termination is pursuant to paragraph 10(d) of this Agreement, within 15 days after the written notice to BCBSA described in paragraph 10(d).

(ii) The terminated entity shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the terminated entity is involved (in a Control, Participating or Servicing capacity), identifying the national account and the terminated entity's role therein. For those accounts where the terminated entity is the Control Plan, the Plan must also indicate the Participating and Servicing Plans in the national account syndicate.

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(iii) Unless the cause of termination is an event stated in paragraph 15(a) or (b) above respecting BCBSA, the Plan and its Licensed Controlled Affiliates shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the terminated entity and its Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area. The Re-Establishment Fee shall be indexed to a base fee of \$80. The Re-Establishment Fee through December 31, 2005 shall be \$80. The Re-Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was \$278.60, \$285.00 and \$290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be \$83.27 (100% of the base fee plus \$1.84 for calendar year 2005 and \$1.43 for calendar year 2006). Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (a) the end of the last fiscal year of the terminated entity which ended prior to termination or (b) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph (d)(iii) shall be due only

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to the extent that, in BCBSA's opinion, it does not cause the net worth of the Plan to fall below 100% of the Health Risk-Based Capital formula or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans), measured as of the date of termination and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plan or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Plan (and/or its Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph only to the extent that such payments exceed the amounts due to BCBSA pursuant to subparagraph 15(d)(vi) and any costs associated with reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the terminated entity.

- (iv) The terminated entity shall comply with all financial settlement procedures set forth in BCBSA's License Termination Contingency Plan, as amended from time

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to time and shall work diligently and in good faith with BCBSA, any Alternative Control Licensee or Replacement Licensee and any existing or potential new account for Blue-branded products and services to minimize the disruption of termination, and honor, to the fullest extent possible, the desire of accounts to continue to receive or obtain Blue-branded products and services through a new Licensee ("Transition"). Such diligence and good faith on the part of the terminated entity shall include, but not be limited to: (a) working cooperatively with BCBSA to protect the Names and Marks from potential harm; (b) cooperating with BCBSA's use of the Names and Marks in the terminated entity's former service area during the termination and Transition; (c) transmitting, upon the request of an existing Blue account or of BCBSA with consent and on behalf of an existing Blue account, all member and account-data relating to the Federal Employee Program to BCBSA, and all member and account data relating to other programs to an Alternative Control Licensee or Replacement Licensee; (d) working with BCBSA and the Alternative Control or Replacement Licensee with respect to potential new Blue accounts headquartered in the terminated entity's former service area; (e) continuing to service Blue accounts during the Transition; (f) continuing to comply with National Programs, Federal Employee Program and NASCO policies and procedures and all voluntary BCBSA programs, policies and performance standards, such as Away From Home Care, including being responsible for payment of all penalties for non-compliance duly levied in conformity with the License Agreements, Membership Standards, or the Federal Employee Program agreements, that may arise during the Transition; (g) maintaining and providing access to its provider networks, as defined by Federal Employee Program agreements and National Account Program Policies and Provisions, and Inter-Plan Programs Policies and Provisions, and making those networks and discounts available to members and providers who participate in National Programs and the Federal Employee Program during the Transition; (h) maintaining its technical connections and processing capabilities during the Transition; and (i) working diligently to conclude all financial settlements and account reconciliations as negotiated in the termination transition agreement.

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(v) Notwithstanding any other provision in this Agreement, BCBSA shall have the right, with the approval of its Board of Directors, to assess additional fines against the terminated entity during the Transition in the event it fails to maintain and provide access to provider networks as defined by Federal Employee Program agreements, National Account Program Policies and Provisions, and Inter-Plans Programs Policies and Provisions, and/or pass on applicable discounts. Such fines shall be in addition to any other assessments, fees or liquidated damages payable herein, or under existing policies and programs and shall be imposed to make whole BCBSA and/or the Plans. Terminated entity shall pay any such fines to BCBSA no later than 30 days after they are approved by the Board of Directors.

(vi) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third-party auditor to examine and audit the books and records of the terminated entity and its Licensed Controlled Affiliates to verify compliance with the terms and requirements of this paragraph 15(d).

(vii) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

(viii) As to a breach of 15 (d) (i), (ii), (iii), (iv), (vi), or (vii) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 15 (d) (i), (ii), (iv), (vi), or (vii) by the Plan, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

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(ix) In the event that the terminated entity's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Plan and its Licensed Controlled Affiliates shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

(e). BCBSA shall be entitled to enjoin the Plan or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this License Agreement unless the License Agreement has been terminated pursuant to paragraph 10 (d) of this Agreement upon the required six (6) month written notice.

(f). BCBSA acknowledges that it is not the owner of assets of the Plan.

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16. This Agreement supersedes any and all other agreements between the parties with respect to the subject matter herein, and contains all of the covenants and agreements of the parties as to the licensing of the Licensed Marks and Name. This Agreement may be amended only by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

17. If any provision or any part of any provision of this Agreement is judicially declared unlawful, each and every other provision, or any part of any provision, shall continue in full force and effect notwithstanding such judicial declaration.

18. No waiver by BCBSA or the Plan of any breach or default in performance on the part of BCBSA or the Plan or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

19a. All notices provided for hereunder shall be in writing and shall be sent in duplicate by regular mail to BCBSA or the Plan at the address currently published for each by BCBSA and shall be marked respectively to the attention of the President and, if any, the General Counsel, of BCBSA or the Plan.

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19b. Except as provided in paragraphs 9(b), 9(d)(iii), 15(a), and 15(b) above, this Agreement may be terminated for a breach only upon at least 30 days' written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Member Plans.

19c. For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

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Amended as of June 16, 2005

(The next page is page 9)

20. Nothing herein contained shall be construed to constitute the parties hereto as partners or joint venturers, or either as the agent of the other, and Plan shall have no right to bind or obligate BCBSA in any way, nor shall it represent that it has any right to do so. BCBSA shall have no liability to third parties with respect to any aspect of the business, activities, operations, products, or services of the Plan.

21. This Agreement shall be governed, construed and interpreted in accordance with the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By_____

Title_____

Date_____

Plan:

By_____

Title_____

Date_____

EXHIBIT 1

**BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT
(Includes revisions adopted by Member Plans through their November 21, 2014 meeting)**

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Shield Plan, known as _____ ("Plan" or "Sponsoring Plan"), which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, Plan and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name");

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with: (i) health care plans and related services, as defined in BCBSA's License Agreement with Plan, and administering the non-health portion of workers' compensation insurance, and (ii) underwriting the indemnity portion of workers' compensation insurance, provided that Controlled Affiliate's total premium revenue comprises less than 15 percent of the Sponsoring Plan's net subscription revenue.

This grant of rights is non-exclusive and is limited to the Service Area served by the Plan. Controlled Affiliate may use the Licensed Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Service Area under any name or mark; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

Amended as of September 19, 2014

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report or reports to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that the Sponsoring Plan has:

(1) The legal authority directly or indirectly through wholly-owned subsidiaries:

(a) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and

(b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan does not concur; and

(c) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

(i) change its legal and/or trade names;

(ii) change the geographic area in which it operates;

(iii) change any of the type(s) of businesses in which it engages;

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- (iv) create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business;
- (v) sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced;
- (vi) make any loans or advances except in the ordinary course of business;
- (vii) enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate);
- (viii) conduct any business other than under the Licensed Marks and Name;
- (ix) take any action that Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plans directly or indirectly through wholly owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate.

Or

- (2) The legal authority directly or indirectly through wholly-owned subsidiaries;
- (a) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof and to:
 - (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; and
 - (c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate.

Or

- (3) With respect to a Controlled Affiliate that is 100% controlled by Plans including the Sponsoring Plan and which offers solely Medicaid products and services, the legal authority together with such other Plans:

Amended as of September 19, 2014

- (a) to select all members of the Controlled Affiliate's governing body; and
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate; and
- (c) to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such control and ownership by Plans must be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License attached hereto as Exhibit B.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within its Service Area may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Service Area the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. If Controlled Affiliate meets the standards of 2E(1) but not 2E(2) above and any of Controlled Affiliate's advertising or promotional material is reasonably determined by BCBSA and/or the Plan to be in contravention of rules and regulations governing the use of the Licensed Marks and Name, Controlled Affiliate shall for ninety (90) days thereafter obtain prior approval from BCBSA of advertising and promotional efforts using the Licensed Marks and Name, approval or disapproval thereof to be forthcoming within five (5) business days of receipt of same by BCBSA or its designee. In all advertising and promotional efforts, Controlled Affiliate shall observe the Service Area limitations applicable to Plan.

E. Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this Agreement, Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name.

Amended as of September 19, 2014

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify Plan and Plan shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and Plan hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to: (i) Controlled Affiliate's rendering of services under the Licensed Marks and Name; or (ii) the activities of any hospital, medical group, clinic or other provider of health services that is owned or controlled directly or indirectly by Plan or Controlled Affiliate.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) the Plan ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Cross License Agreement the Plan ceases to be authorized to use the Licensed Names and Marks in the geographic area served by the Controlled Affiliate provided, however, that if the Controlled Affiliate is serving more than one State or portions thereof, the termination of this Agreement shall be limited to the State(s) or portions thereof in which the Plan's license to use the Licensed Marks and Names is terminated. By not appealing or challenging such regulatory action within the time prescribed by law or regulation, and in any event no later than 120 days after such action is taken, a Plan shall be deemed to have exhausted its rights to appeal or challenge, and automatic termination shall proceed.

Amended as of June 21, 2012

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Plan or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Plan advising of the specific matters at issue and granting the Plan an opportunity to be heard and to present its response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) for a Smaller Controlled Affiliate (as defined in Exhibit A), failure to comply with any of the applicable requirements of Standards 2, 3, 4, 5 or 7 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(e); or (6) failure by a Controlled Affiliate that meets the standards of 2E(1) but not 2E(2) above to obtain BCBSA's written consent to a change in the identity of any owner, in the extent of ownership, or in the identity of any person or entity with the authority to select or appoint members or board members, provided that as to publicly traded Controlled Affiliates this provision shall apply only if the change affects a person or entity that owns at least 5% of the Controlled Affiliate's stock before or after the change; or (7) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans, any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Plan shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between BCBSA, the Plan and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Controlled Affiliate shall no longer comply with item 2(E) above;
- (2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or
- (3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(e)(3)(vii) and (viii) of this Agreement.

Amended as of March 18, 2004

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(b) hereof, or in the event the Controlled Affiliate is a Larger Controlled Affiliate (as defined in Exhibit A), upon termination of this Agreement, the provisions of Paragraph 7.G. shall not apply and the following provisions shall apply, except that, in the event of a partial termination of this Agreement pursuant to Paragraph 7(B)(ii) of this Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the geographic area for which the Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA, subject to any conflicting state law and state regulatory requirements. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for payment to BCBSA of an amount equal to the Re-Establishment Fee (described below) multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any other Plan is permitted by BCBSA to use marks or names licensed by BCBSA in the Service Area established by this Agreement, the Re-Establishment Fee shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates and the denominator of which is the total number of Licensed Enrollees in the Service Area.

Amended as of June 16, 2005

The Re-Establishment Fee shall be indexed to a base fee of \$80. The Re-Establishment Fee through December 31, 2005 shall be \$80. The Re-Establishment Fee for calendar years after December 31, 2005 shall be adjusted on January 1 of each calendar year up to and including January 1, 2010 and shall be the base fee multiplied by 100% plus the cumulative percentage increase or decrease in the Plans' gross administrative expense (standard BCBSA definition) per Licensed Enrollee since December 31, 2004. The adjustment shall end on January 1, 2011, at which time the Re-Establishment Fee shall be fixed at the then-current amount and no longer automatically adjusted. For example, if the Plans' gross administrative expense per Licensed Enrollee was \$278.60, \$285.00 and \$290.00 for calendar year end 2004, 2005 and 2006, respectively, the January 1, 2007 Re-Establishment Fee would be \$83.27 (100% of base fee plus \$1.84 for calendar year 2005 and \$1.43 for calendar year 2006. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Plan or any other Licensed Controlled Affiliates of the Plan to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this sub paragraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. At least 50% of the Re-Establishment Fee shall be awarded to the Plan (or Plans) that receive the new license(s) for the service area(s) at issue; provided, however, that such award shall not become due or payable until all disputes, if any, regarding the amount of and BCBSA's right to such Re-Establishment Fee have been finally resolved; and provided further that the award shall be based on the final amount actually received by BCBSA. The Board of Directors shall adopt a resolution which it may amend from time to time that shall govern BCBSA's use of its portion of the award. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Plan or its other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.M. and any cost associated with reestablishing the Service Area, including any payments made by BCBSA to a Plan or Plans (or their Licensed Controlled Affiliates) for purposes of replacing the Controlled Affiliate.

Amended as June 16, 2005

(4) BCBSA shall have the right to examine and audit and/or hire at terminated entity's expense a third party auditor to examine and audit the books and records of the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan to verify compliance with this paragraph 7.H.

(5) Subsequent to termination of this Agreement, the terminated entity and its affiliates, agents, and employees shall have an ongoing and continuing obligation to protect all BCBSA and Blue Licensee data that was acquired or accessed during the period this Agreement was in force, including but not limited to all confidential processes, pricing, provider, discount and other strategic and competitively sensitive information ("Blue Information") from disclosure, and shall not, either alone or with another entity, disclose such Blue Information or use it in any manner to compete without the express written permission of BCBSA.

(6) As to a breach of 7.H.(1), (2), (3), (4) or (5) the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. This Agreement shall remain in effect until terminated by the Controlled Affiliate or the Plan upon not less than eighteen (18) months written notice to the Association or upon a shorter notice period approved by BCBSA in writing at its sole discretion, or until terminated as otherwise provided herein. The Plan's right to terminate without cause upon such notice is unfettered and may be exercised in the Plan's sole discretion.

J. In the event the Controlled Affiliate is a Smaller Controlled Affiliate (as defined in Exhibit A), the Controlled Affiliate agrees to be jointly liable for the amount described in H.3. and M. hereof upon termination of the BCBSA license agreement of any Larger Controlled Affiliate of the Plan.

K. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless the Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of the Plan's license agreement upon the required 6 month written notice.

L. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

M. In the event that the Plan has more than 50 percent voting control of the Controlled Affiliate under Paragraph 2(E)(2) above and is a Larger Controlled Affiliate (as defined in Exhibit A), then the vote called for in Paragraphs 7(C) and 7(D) above shall require the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans.

Amended September 19, 2014

N. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Plan, and any other Licensed Controlled Affiliates of the Plan shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between them or between or among either of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit C.

10. JOINT VENTURE

Nothing contained in the Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

Amended as of September 19, 2014

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

Amended as of June 16, 2005

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15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: _____

Date: _____

Plan:

By: _____

Date: _____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: _____

Date: _____

EXHIBIT A

CONTROLLED AFFILIATE LICENSE STANDARDS

November 2014

PREAMBLE

For purposes of definition:

A "smaller Controlled Affiliate:" (1) comprises less than fifteen percent (15%) of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed);* or (2) underwrites the indemnity portion of workers' compensation insurance and has total premium revenue less than 15 percent of the Sponsoring Plan's net subscription revenue.

A "larger Controlled Affiliate" comprises fifteen percent (15%) or more of Sponsoring Plan's and its licensed Controlled Affiliates' total member enrollment (as reported on the BCBSA Quarterly Enrollment Report, excluding rider and freestanding coverage, and treating an entity seeking licensure as licensed.)*

Changes in Controlled Affiliate status:

If **any** Controlled Affiliate's status changes regarding: its Plan ownership level, its risk acceptance or direct delivery of medical care, the Controlled Affiliate shall notify BCBSA within thirty (30) days of such occurrence in writing and come into compliance with the applicable standards within six (6) months.

If a smaller Controlled Affiliate's health and workers' compensation administration business reaches or surpasses fifteen percent (15%) of the total member enrollment of the Sponsoring Plan and licensed Controlled Affiliates, the Controlled Affiliate shall:

Amended as of September 19, 2014

EXHIBIT A (continued)

1. Within thirty (30) days, notify BCBSA of this fact in writing, including evidence that the Controlled Affiliate meets the minimum liquidity and capital (BCBSA "Health Risk-Based Capital (HRBC)" as defined by the NAIC and state-established minimum reserve) requirements of the larger Controlled Affiliate Financial Responsibility standard; and
2. Within six (6) months after reaching or surpassing the fifteen percent (15%) threshold, demonstrate compliance with all license requirements for a larger Controlled Affiliate.

If a Controlled Affiliate that underwrites the indemnity portion of workers' compensation insurance receives a change in rating or proposed change in rating, the Controlled Affiliate shall notify BCBSA within 30 days of notification by the external rating agency.

*For purposes of this calculation,

The numerator equals:

Applicant Controlled Affiliate's member enrollment, as defined in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

The denominator equals:

Numerator PLUS Sponsoring Plan and all other licensed Controlled Affiliates' member enrollment, as reported in BCBSA's Quarterly Enrollment Report (excluding rider and freestanding coverage).

Amended as of September 19, 2014

EXHIBIT A (continued)

STANDARDS FOR LICENSED CONTROLLED AFFILIATES

Each licensed controlled affiliate shall be subject to certain standards as determined below:

1. What percent of the licensed controlled affiliate is controlled by the Sponsoring Plan and other Plans?

More than 50% by Sponsoring Plan ↓ Standard 1A, 4	50% by Sponsoring Plan ↓ Standard 1B, 4	100% Plan control but less than 50% Sponsoring Plan Control and its offers solely Medicaid products and services ↓ Standard 1(C)
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IN ADDITION,

2. Is risk being assumed?

	Yes ↓		No ↓	
Controlled Affiliate underwrites any indemnity portion of workers' compensation insurance ↓ Standards 7A-7E, 11	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance ↓ Standard 2 (Guidelines 1.1,1.2) and Standard 11	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates, and does not underwrite the indemnity portion of workers' compensation insurance ↓ Standard 6H	Controlled Affiliate comprises < 15% of total member enrollment of Sponsoring Plan and its licensed affiliates ↓ Standard 2 (Guidelines 1.1,1.3) and Standard 11	Controlled Affiliate comprises ≥ 15% of total member enrollment of Sponsoring Plan and its licensed affiliates ↓ Standard 6H

IN ADDITION,

3. Is medical care being directly provided?

Yes ↓ Standard 3A	No ↓ Standard 3B
-------------------------	------------------------

IN ADDITION,

4. If the controlled affiliate has health or workers' compensation administration business, does such business comprise 15% or more of the total member enrollment of Plan and its licensed controlled affiliates?

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

Standard 1 - Organization and Governance

1A.) The Standard for more than 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA, Sponsoring Plan"), has the legal authority, directly or indirectly through wholly-owned subsidiaries: 1) to select members of the Controlled Affiliate's governing body having more than 50% voting control thereof; and 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; and 3) to exercise control over the policy and operations of the Controlled Affiliate. In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own more than 50% of any for-profit Controlled Affiliate.

1B.) The Standard for 50% Plan control is:

A Controlled Affiliate shall be organized and operated in such a manner that a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA, (the "Sponsoring Plan"), has the legal authority, directly or indirectly through wholly-owned subsidiaries:

- 1) to select members of the Controlled Affiliate's governing body having not less than 50% voting control thereof; and
- 2) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Sponsoring Plan do not concur; and
- 3) to exercise control over the policy and operations of the Controlled Affiliate at least equal to that exercised by persons or entities (jointly or individually) other than the Sponsoring Plan.

Amended September 19, 2014

EXHIBIT A (continued)

Notwithstanding anything to the contrary in 1) through 3) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by the Sponsoring Plan before the Controlled Affiliate can:

- o change the geographic area in which it operates
- o change its legal and/or trade names
- o change any of the types of businesses in which it engages
- o create, or become liable for by way of guarantee, any indebtedness, other than indebtedness arising in the ordinary course of business
- o sell any assets, except for sales in the ordinary course of business or sales of equipment no longer useful or being replaced
- o make any loans or advances except in the ordinary course of business
- o enter into any arrangement or agreement with any party directly or indirectly affiliated with any of the owners or persons or entities with the authority to select or appoint members or board members of the Controlled Affiliate, other than the Sponsoring Plan or other Plans (excluding owners of stock holdings of under 5% in a publicly traded Controlled Affiliate)
- o conduct any business other than under the Licensed Marks and Name
- o take any action that the Sponsoring Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Sponsoring Plan directly or indirectly through wholly-owned subsidiaries shall own at least 50% of any for-profit Controlled Affiliate.

1C.) The Standard for 100% Plan control but less than 50% Sponsoring Plan Control:

A Controlled Affiliate shall be organized and operated in such a manner that (i) it offers solely Medicaid products and services; and (ii) a Plan authorized to use the Licensed Marks in the Service Area of the Controlled Affiliate pursuant to the separate Primary License Agreement with BCBSA (the "Sponsoring Plan,") has the legal authority together with Other Plans:

Amended September 19, 2014

- 1) to select all members of the Controlled Affiliate's governing body; and
- 2)to prevent any change in the articles of incorporation, bylaws, or other establishing or governing documents of the Controlled Affiliate; and
- 3)to exercise control over the policy and operations of the Controlled Affiliate.

In addition, the Sponsoring Plan and such other Plans shall own 100% of any for-profit Controlled Affiliate, with the Sponsoring Plan and such other Plans each having an ownership interest. Such 100% control and ownership by Plans shall be direct or, if indirect, solely through affiliates that are licensed to use marks owned by BCBSA. Further, the Sponsoring Plan and such other Plans shall execute the Addendum to Controlled Affiliate License.

Amended September 19, 2014

EXHIBIT A (continued)

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers. If a risk-assuming Controlled Affiliate ceases operations for any reason, Blue Cross and/or Blue Cross Plan coverage will be offered to all Controlled Affiliate subscribers without exclusions, limitations or conditions based on health status. If a nonrisk-assuming Controlled Affiliate ceases operations for any reason, Sponsoring Plan will provide for services to its customers.

The requirements of the preceding two sentences shall apply to all lines of business unless a line of business is specially exempted from the requirement(s) by the BCBSA Board of Directors.

Standard 3 - State Licensure/Certification

3A.)The Standard for a Controlled Affiliate that employs, owns or contracts on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification for its medical care providers to operate under applicable state laws.

3B.)The Standard for a Controlled Affiliate that does not employ, own or contract on a substantially exclusive basis for medical services is:

A Controlled Affiliate shall maintain unimpaired licensure or certification to operate under applicable state laws.

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of 1) the structure of the Blue Cross and Blue Shield System; and 2) the independent nature of every licensee; and 3) the Controlled Affiliate's financial condition.

Amended as of September 19, 2014

EXHIBIT A (continued)

Standard 5 - Reports and Records for Certain Smaller Controlled Affiliates

For a smaller Controlled Affiliate that does not underwrite the indemnity portion of workers' compensation insurance, the Standard is:

A Controlled Affiliate and/or its Sponsoring licensed Plan shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Other Standards for Larger Controlled Affiliates

Standards 6(A) - (I) that follow apply to larger Controlled Affiliates.

Standard 6(A): Board of Directors

A Controlled Affiliate Governing Board shall act in the interest of its Corporation in providing cost-effective health care services to its customers. A Controlled Affiliate shall maintain a governing Board, which shall control the Controlled Affiliate, composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Standard 6(B): Responsiveness to Customers

A Controlled Affiliate shall be operated in a manner responsive to customer needs and requirements.

Standard 6(C): Participation in National Programs

A Controlled Affiliate shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the licensees and ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's Service Area.

Amended as of September 19, 2014

EXHIBIT A (continued)

Such programs are applicable to licensees, and include:

1. BlueCard Program;
2. Inter-Plan Teleprocessing System (ITS);
3. National Account Programs;
4. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
5. Inter-Plan Medicare Advantage Program.

Standard 6(D): Financial Performance Requirements

In addition to requirements under the national programs listed in Standard 6C: Participation in National Programs, a Controlled Affiliate shall take such action as required to ensure its financial performance in programs and contracts of an inter-licensee nature or where BCBSA is a party.

Standard 6(E): Cooperation with Plan Performance Response Process

A Controlled Affiliate shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Plan Performance Response Process and in addressing Controlled Affiliate performance problems identified thereunder.

Standard 6(F): Independent Financial Rating

A Controlled Affiliate shall obtain a rating of its financial strength from an independent rating agency approved by BCBSA's Board of Directors for such purpose.

Standard 6(G): Local and National Best Efforts

Notwithstanding any other provision in the Plan's License Agreement with BCBSA or in this License Agreement, during each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Shield Mark.

Standard 6(H): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Amended as of November 21, 2014

EXHIBIT A (continued)

Standard 6(I): Reports and Records

A Controlled Affiliate shall furnish to BCBSA on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between BCBSA and Controlled Affiliate. Such reports and records are the following:

- A) BCBSA Controlled Affiliate Licensure Information Request; and
- B) Biennial trade name and service mark usage material, including disclosure material; and
- C) Changes in the ownership and governance of the Controlled Affiliate, including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, or changes in the identity of the Controlled Affiliate's Principal Officers, and changes in risk acceptance, contract growth, or direct delivery of medical care; and
- D) Semi-annual "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), and

Amended as of November 17, 2011

EXHIBIT A (continued)

Standard 6(J): Control by Unlicensed Entities Prohibited

No Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled Affiliate thereof to obtain control of the Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Standard 7 - Other Standards for Risk-Assuming Workers' Compensation Controlled Affiliates

Standards 7(A) - (E) that follow apply to Controlled Affiliates that underwrite the indemnity portion of workers' compensation insurance.

Standard 7 (A): Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 7(B): Reports and Records

A Controlled Affiliate shall furnish, on a timely and accurate basis, reports and records relating to compliance with these Standards and the License Agreements between BCBSA and the Controlled Affiliate. Such reports and records are the following:

- A. BCBSA Controlled Affiliate Licensure Information Request; and
- B. Biennial trade name and service mark usage materials, including disclosure materials; and
- C. Annual Certified Audit Report, Annual Statement as filed with the State Insurance Department (with all attachments), Annual NAIC's Risk-Based Capital Worksheets for Property and Casualty Insurers; and
- D. Quarterly Estimated Risk-Based Capital for Property and Casualty Insurers, Insurance Department Examination Report; and

Amended as of November 17, 2011

EXHIBIT A (continued)

- E. Notification of all changes and proposed changes to independent ratings within 30 days of receipt and submission of a copy of all rating reports; and
- F. Changes in the ownership and governance of the Controlled Affiliate including changes in its charter, articles of incorporation, or bylaws, changes in a Controlled Affiliate's Board composition, Plan control, state license status, operating area, the Controlled Affiliate's Principal Officers or direct delivery of medical care.

Standard 7(C): Loss Prevention

A Controlled Affiliate shall apply loss prevention protocol to both new and existing business.

Standard 7(D): Claims Administration

A Controlled Affiliate shall maintain an effective claims administration process that includes all the necessary functions to assure prompt and proper resolution of medical and indemnity claims.

Standard 7(E): Disability and Provider Management

A Controlled Affiliate shall arrange for the provision of appropriate and necessary medical and rehabilitative services to facilitate early intervention by medical professionals and timely and appropriate return to work.

Amended as of November 16, 2000

EXHIBIT A (continued)

Standard 8 - Cooperation with Controlled Affiliate License Performance Response Process Protocol

A Controlled Affiliate and its Sponsoring Plan shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Controlled Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing Controlled Affiliate compliance problems identified thereunder.

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

A smaller controlled affiliate that formerly was a Primary Licensee shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of November 21, 2014

EXHIBIT A (continued)

Standard 9(A) - Participation in National Programs by Smaller Controlled Affiliates that were former Primary Licensees

C. Reporting requirements include:

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

Amended as of June 13, 2002

Exhibit A (continued)

Standard 9(B) - Participation in National Programs by Smaller Controlled Affiliates

A smaller controlled affiliate shall participate in national programs in accordance with BlueCard and other relevant Policies and Provisions shall effectively and efficiently participate in national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area and be subject to certain relevant financial and reporting requirements.

A. National program requirements include:

- BlueCard Program;
- Inter-Plan Teleprocessing System (ITS);
- National Account Programs.

B. Financial Requirements include:

- Standard 6(D): Financial Performance Requirements and Standard 6(H): Financial Responsibility; or
- A financial guarantee covering the Controlled Affiliate's Inter-Plan Programs obligations in a form, and from a guarantor, acceptable to BCBSA.

Amended as of June 20, 2013

EXHIBIT A (continued)

Standard 10 - Participation in Inter-Plan Medicare Advantage Program

A smaller controlled affiliate for which this standard applies pursuant to the Preamble section of Exhibit A of the Controlled Affiliate License Agreement shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the controlled affiliate's service area.

National program requirements include:

- A. Inter-Plan Medicare Advantage Program.

Standard 11: Participation in Master Business Associate Agreement by Smaller Controlled Affiliate Licensees

Effective April 14, 2003, all smaller controlled affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of September 19, 2014

EXHIBIT B

ADDENDUM TO CONTROLLED AFFILIATE LICENSE TO BE EXECUTED BY CONTROLLED AFFILIATES LICENSED UNDER CONTROLLED AFFILIATE LICENSE STANDARD 1C.

ADDENDUM TO CONTROLLED AFFILIATE LICENSE

This Addendum is made to that certain Blue Cross Controlled Affiliate License Agreement executed by and among Blue Cross and Blue Shield Association ("Licensor"), _____ ("Controlled Affiliate Licensee") and _____ ("Sponsoring Plan") dated the ____ day of _____, _____ ("Agreement"). The parties to this Addendum are Licensor, Controlled Affiliate Licensee, Sponsoring Plan, and the undersigned other Plans ("Other Plans"). This Addendum is made and shall be deemed effective as of the date of the Agreement.

WHEREAS, the Sponsoring Plan asserts that it can serve the Medicaid market in its Service Area more efficiently and with less risk though a Medicaid enterprise jointly owned and controlled with other Plans than through a wholly owned and controlled Medicaid enterprise;

WHEREAS, in such circumstance Controlled Affiliate License Standard 1C. permits the licensing of a Controlled Affiliate that is less than 50% owned and controlled by the Sponsoring Plan but which is 100% owned and controlled by Plans including the Sponsoring Plan, subject to certain conditions;

WHEREAS, one such condition is that the Sponsoring Plan and all such other owning and controlling Plans enter into this Addendum.;

NOW THEREFORE, for good and valuable consideration, including the promises and covenants set forth herein, the parties agree as follows:

1. The Sponsoring Plan shall participate operationally in Controlled Affiliate's business that is conducted under the Licensed Marks. The parties understand that participation may take many forms, one of which should be providing a network of providers in the Service Area of the Controlled Affiliate for the Medicaid services being offered under the Agreement and being involved in network development and provider relations.
2. Each of the Other Plans agrees that (i) it will cooperate fully with the Sponsoring Plan and BCBSA as needed to enable Sponsoring Plan and Controlled Affiliate Licensee to meet their obligations to Licensor under the Agreement and all associated rules and regulations of Licensor, including the Brand Regulations, (ii) it will not take any action, either individually or jointly with any of the Other Plans, that would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement, and (iii) it will not fail

to take any action, either individually or jointly with any of the Other Plans, where such failure would cause Sponsoring Plan or Controlled Affiliate Licensee to violate the Agreement.

3. Each of the Other Plans acknowledges that it has reviewed the Agreement and understands that Sponsoring Plan has the right to terminate the Agreement without cause upon notice as provided in Paragraph 7 of the Agreement, and that such right is unfettered and may be exercised by Sponsoring Plan in its sole discretion.

WHEREFORE, by signing below the parties agree to be bound to the terms stated herein.

BLUE CROSS BLUE SHIELD ASSOCIATION

By: _____

[Controlled Affiliate Licensee]

By: _____

[Sponsoring Plan]

By: _____

[Other Plan 1]

By: _____

[Other Plan 2]

By: _____

Amended as of September 19, 2014

EXHIBIT C
ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENT

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

FOR RISK PRODUCTS:

For Controlled Affiliates not underwriting the indemnity portion of workers' compensation insurance:

An amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For Controlled Affiliates underwriting the indemnity portion of workers' compensation insurance:

An amount equal to 0.35 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus, an annual fee of \$5,000 per license for a Controlled Affiliate subject to Standard 7.

Amended as of September, 19, 2014

EXHIBIT C (continued)

FOR NONRISK PRODUCTS:

For third-party administrative business, an amount equal to its pro rata share of Sponsoring Plan's dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on health care plans and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by Sponsoring Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

For non-third party administrative business (e.g., case management, provider networks, etc.), an amount equal to 0.24 percent of the gross revenue per annum of Controlled Affiliate arising from products using the marks; plus:

- 1) An annual fee of \$5,000 per license for a Controlled Affiliate subject to Standard 6 D.
- 2) An annual fee of \$2,000 per license for all other Controlled Affiliates.

The foregoing shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® License are issued to the same Controlled Affiliate. In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Amended as of September 19, 2014

EXHIBIT 1A

**CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO LIFE INSURANCE COMPANIES
(Includes revisions adopted by Member Plans through their November 21, 2014 meeting)**

This agreement by and among Blue Cross and Blue Shield Association ("BCBSA")
_____("Controlled Affiliate"), a Controlled Affiliate of the Blue Shield Plan(s), known as
_____("Plan").

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, the Plan and the Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name");

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Controlled Affiliate the exclusive right to use the licensed Marks and Names in connection with and only in connection with those life insurance and related services authorized by applicable state law, other than health care plans and related services (as defined in the Plan's License Agreements with BCBSA) which services are not separately licensed to Controlled Affiliate by BCBSA, in the Service Area served by the Plan, except that BCBSA reserves the right to use the Licensed Marks and Name in said Service Area, and except to the extent that said Service Area may overlap the area or areas served by one or more other licensed Blue Shield Plans as of the date of this License as to which overlapping areas the rights hereby granted are non-exclusive as to such other Plan or Plans and their respective Licensed Controlled Affiliates only. Controlled Affiliate cannot use the Licensed Marks or Name outside the Service Area or in its legal or trade name; provided, however, that if and only for so long as Controlled Affiliate also holds a Blue Shield Affiliate License Agreement applicable to health care plans and related services, Controlled Affiliate may use the Licensed Marks and Name in its legal and trade name according to the terms of such license agreement.

Amended as of June 12, 2003

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in relation to the sale, marketing and rendering of authorized products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A as it may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees that Plan and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by Plan or by BCBSA) a report to Plan and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner that it is subject to the bona fide control of a Plan or Plans. Absent written approval by BCBSA of an alternative method of control, bona fide control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Controlled Affiliate's governing body having not less than 51% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Plan or Plans shall own at least 51% of any for-profit Controlled Affiliate. If the Controlled Affiliate is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items (a) and (c) above, proxies representing 51% of the votes at any meeting of the policyholders and shall demonstrate that there is no reason to believe this such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

3. SERVICE MARK USE

Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks, and shall comply with such rules (applicable to all Controlled Affiliates licensed to use the Marks) relative to service mark use, as are issued from time-to-time by BCBSA. If there is any public reference to the affiliation between the Plan and the Controlled Affiliate, all of the Controlled Affiliate's licensed services in the Service Area of the Plan shall be rendered under the Licensed Marks. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the option of Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENTS

Controlled Affiliate shall promptly notify Plan and BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Controlled Affiliate shall not be entitled to require Plan or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to Plan and BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate hereby agrees to save, defend, indemnify and hold Plan and BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Controlled Affiliate's rendering of health care services under the Licensed Marks.

7. LICENSE TERM

The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods upon evidence satisfactory to the Plan and BCBSA that Controlled Affiliate meets the then applicable quality control standards, unless one of the parties hereto notifies the other party of the termination hereof at least sixty (60) days prior to expiration of any license period.

This Agreement may be terminated by the Plan or by BCBSA for cause at any time provided that Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Controlled Affiliate's failure to abide by the quality control provisions of Paragraph 2, above, shall be considered a proper ground for cancellation of this Agreement.

This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- A. Controlled Affiliate shall no longer comply with Standard No. 1 (Organization and Governance) of Exhibit A or, following an opportunity to cure, with the remaining quality control provisions of Exhibit A, as it may be amended from time-to-time; or
- B. Plan ceases to be authorized to use the Licensed Marks; or
- C. Appropriate dues for Controlled Affiliate pursuant to item 8 hereof, which are the royalties for this License Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks including any use in its trade name.

In the event of any disagreement between Plan and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of the Blue Cross and Blue Shield Association and provide instruction on how the customer can contact the Blue Cross and Blue Shield Association or a designated licensee to obtain further information on securing coverage. The written notification required by this paragraph shall be in writing and in a form approved by the Association. The Association shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. DUES

Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

▲ An annual fee of five thousand dollars (\$5,000) per license, plus

▲ .05% of gross revenue per year from branded group products, plus

▲ .5% of gross revenue per year from branded individual products plus

▲ .14% of gross revenue per year from branded individual annuity products.

The foregoing percentages shall be reduced by one-half where both a BLUE CROSS® and BLUE SHIELD® license are issued to the same entity. In the event that any License period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Plan will promptly and timely transmit to BCBSA all dues owed by Controlled Affiliate as determined by the above formula and if Plan shall fail to do so, Controlled Affiliate shall pay such dues directly.

Amended as of November 20, 1997

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between Plan and Controlled Affiliate or between either and BCBSA.

9A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

10. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

Amended as of June 16, 2005

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(The next page is page 5)

11. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by a writing executed by all parties.

12. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way effect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

13. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: _

Date: _

Controlled Affiliate

By: _

Date: _

Plan

By: _

Date: _

EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES
Page 1 of 2

PREAMBLE

The standards for licensing Life Insurance Companies (Life and Health Insurance companies, as defined by state statute) are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote of all Plans. Each Licensed Plan is required to use a standard controlled affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Life Insurance Company maintains compliance with the license standards.

An organization meeting the following standards shall be eligible for a license to use the Licensed Marks within the service area of its sponsoring Licensed Plan to the extent and the manner authorized under the Controlled Affiliate License applicable to Life Insurance Companies and the principal license to the Plan.

Standard 1 - Organization and Governance

The LIC shall be organized and operated in such a manner that it is controlled by a licensed Plan or Plans which have, directly or indirectly: 1) not less than 51% of the voting control of the LIC; and 2) the legal ability to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the LIC with which it does not concur; and 3) operational control of the LIC.

If the LIC is a mutual company, the Plan or its designee(s) shall have and maintain, in lieu of the requirements of items 1 and 2 above, proxies representing at least 51% of the votes at any policyholder meeting and shall demonstrate that there is no reason to believe such proxies shall be revoked by sufficient policyholders to reduce such percentage below 51%.

Standard 2 - State Licensure

The LIC must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life and health insurance company in each state in which the LIC does business.

Standard 3 - Records and Examination

The LIC and its sponsoring licensed Plan(s) shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the LIC as may be required in order to establish compliance with the license agreement.

EXHIBIT A
CONTROLLED AFFILIATE LICENSE STANDARDS
LIFE INSURANCE COMPANIES
Page 2 of 2

LIC and its sponsoring licensed Plan(s) shall permit BCBSA to examine the affairs of the LIC and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the sponsoring Plan(s).

Standard 4 - Mediation

The LIC and its sponsoring Plan(s) shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed controlled affiliate, a licensed Plan or BCBSA.

Standard 5 - Financial Responsibility

The LIC shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with Affiliate License Performance Response Process Protocol

The LIC and its Sponsoring Plan(s) shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of the Affiliate License Performance Response Process Protocol (ALPRPP) and in addressing LIC compliance problems identified thereunder.

**CONTROLLED AFFILIATE
TRADEMARK LICENSE AGREEMENT
FOR LIFE AND DISABILITY INSURANCE PRODUCTS**

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____, ("Life and Disability Controlled Affiliate") which is a company offering life and disability insurance products owned and controlled by _____, _____, _____ (individually, "Sponsoring Plan" and when referred to collectively, "Sponsoring Plans").

Whereas, BCBSA is the owner of the BLUE CROSS and BLUE SHIELD word and design service marks and any derivatives thereof ("Licensed Marks");

Whereas, each Sponsoring Plan is licensed separately by BCBSA to use one or more of the Licensed Marks in a particular Service Area;

Whereas, the Sponsoring Plans and the Life and Disability Controlled Affiliate desire that the latter be entitled to use the appropriate Licensed Marks in connection with life and disability insurance products in some or all of such Sponsoring Plans' Service Areas and in the Service Areas of other Regular Member Plans, as defined in the BCBSA By-laws, ("Blue Plans") consistent with the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

A. Subject to the terms and conditions of this Agreement, BCBSA hereby grants to the Life and Disability Controlled Affiliate the limited right to use the Licensed Marks in connection with and only in connection with the following life and disability insurance products authorized by state law: (1) Group: Term Life, Long Term Disability, Whole Life, Benefit Life, Universal Life; (2) Individual: Term Life, Whole Life, Dependent Life, Spouse Life; (3) Other: Disability Income, Short Term Disability, Long Term Disability, Income Replacement; and (4) such other life and disability products approved by BCBSA in writing ("Licensed Products") in the Service Areas served by the Sponsoring Plans or in the Service Area or Areas of one or more other licensed Blue Plans, provided that such Blue Plans have consented to such use as authorized by this Agreement. Life and Disability Controlled Affiliate may not use the Licensed Marks in its legal or trade name.

B. Notwithstanding that the license granted to Life and Disability Controlled Affiliate is a license to use all of the Licensed Marks, Life and Disability Controlled Affiliate may only use those of the Licensed Marks in the Service Area of a Sponsoring Plan or other consenting Blue Plan as described below that such Plan is authorized to use as a Blue Plan pursuant to its separate license agreements with BCBSA.

C. Life and Disability Controlled Affiliate may use the Licensed Marks in the Service Areas of Sponsoring Plans or in the Service Area of a Blue Plan that is not a signatory to this Agreement only after such Sponsoring Plan(s) or non-signatory Blue Plan consents to such use by executing a written consent in substantially the same form as the Consent Agreement attached as Exhibit B.

D. The following provisions apply with respect to Consent Agreements once such agreements have been fully and properly executed:

(1) All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in the Service Area of Sponsoring Plan or consenting Blue Plan (hereinafter, such consenting Sponsoring Plan or consenting Blue Plan collectively referred to "Consenting Plan(s)") must clearly identify the Consenting Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");

(2) To the extent the Consenting Plan has separate divisions or other Affiliates that use the Licensed Marks in distinct geographic areas within its Service Area, consent obtained under this Agreement may be limited to one or more of such specific geographic areas as specified by the Consenting Plan in its signed Consent Agreement. For purposes of this entire Agreement, all references to the Service Area of a Sponsoring Plan, Blue Plan or Consenting Plan may include the entire Service Area or a distinct geographic area within such Service Area as specified in this Section 1 D (2);

(3) Where BCBSA has licensed two or more Blue Plans to use the same Licensed Marks in the same Service Area, in addition to the requirements set forth in Section D (1) above, the sales, marketing and advertising materials referenced in such section above must be communicated to the Consenting Plan's existing and prospective accounts through or with the approval of such Consenting Plan, and the personnel of such Consenting Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the Consenting Plan;

(4) Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the Consenting Plan has been granted by BCBSA the license to use under its Blue Plan license agreements (for example, if a Consenting Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).

(5) If a Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless BCBSA and the Consenting Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

2. QUALITY CONTROL

A. Life and Disability Controlled Affiliate agrees to use the Licensed Marks only in relation to the sale, marketing and administration of the Licensed Products and further agrees to be bound by the conditions regarding quality control shown in Exhibit A and the Guidelines to Administer the Standards for Trademark License Agreement for Life and Disability Insurance Products attached thereto.

B. Life and Disability Controlled Affiliate agrees that BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Life and Disability Controlled Affiliate's rendering of service and use of the Licensed Marks.

C. Life and Disability Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by BCBSA) a report to BCBSA demonstrating Life and Disability Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of Exhibit A.

D. As used herein, a Life and Disability Controlled Affiliate is defined as: An entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance

thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

3. SERVICE MARK USE

Life and Disability Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and shall ensure all uses of the Licensed Marks comply with the BCBSA Brand Regulations, as amended by BCBSA from time to time. Life and Disability Controlled Affiliate recognizes and agrees that all use of the Licensed Marks by Life and Disability Controlled Affiliate shall inure to the benefit of BCBSA.

4. SUBLICENSING AND ASSIGNMENT

The license hereby granted to Life and Disability Controlled Affiliate to use the Licensed Marks is and shall be personal to Life and Disability Controlled Affiliate and shall not be assignable by any act of the Life and Disability Controlled Affiliate, directly or indirectly, without the written consent of BCBSA. Said license shall not be assignable by operation of law, nor shall Life and Disability Controlled Affiliate mortgage or part with possession or control of this license or any right hereunder, and the Life and Disability Controlled Affiliate shall have no right to grant any sublicense to use the Licensed Marks.

5. INFRINGEMENTS

Life and Disability Controlled Affiliate shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off which may occur in relation to the Licensed Marks. Life and Disability Controlled Affiliate shall not be entitled to require BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Life and Disability Controlled Affiliate agrees to render to BCBSA, free of charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks by BCBSA. BCBSA shall have sole control of the defense and resolution of any claim of infringement brought or threatened by others.

6. LIABILITY INDEMNIFICATION

Life and Disability Controlled Affiliate hereby agrees to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description which may arise as a result of Life and Disability Controlled Affiliate's conduct.

7. LICENSE TERM

A. The license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods, unless either BCBSA or Life and Disability Controlled Affiliate notifies the other party in writing of the termination hereof at least sixty (60) days prior to expiration of any license period.

B. This Agreement may be terminated by BCBSA for cause at any time provided that Life and Disability Controlled Affiliate has been given a reasonable opportunity to cure and shall not effect such a cure within thirty (30) days of receiving written notice of the intent to terminate (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period). By way of example and not for purposes of limitation, Life and Disability Controlled Affiliate's failure to abide by the conditions regarding use of the Licensed Marks set forth in Section 1 of this Agreement or the quality control provisions of Section 2 (other than with respect to Section 2 D which is subject to immediate termination as stated in Section 7 C (1) below) shall be considered proper grounds for termination of this Agreement.

C. This Agreement and all of Life and Disability Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

(1) Life and Disability Controlled Affiliate shall no longer comply with Section 2 D (or Standard No. 1 (Organization and Governance) of Exhibit A); or

(2) Any Sponsoring Plan ceases to be authorized to use the Licensed Marks; or

(3) Appropriate fees for Life and Disability Controlled Affiliate pursuant to Section 8 of this Agreement are more than sixty (60) days in arrears to BCBSA.

Upon termination of this Agreement for cause or otherwise, Life and Disability Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks.

In the event of any disagreement between Life and Disability Controlled Affiliate and BCBSA as to whether grounds exist for termination or as to any other term or condition hereof, the decision of BCBSA shall control, subject to provisions for mediation or mandatory dispute resolution in effect between the parties.

Upon termination of this Agreement, Licensed Life and Disability Controlled Affiliate shall immediately notify all of its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

8. ROYALTIES

Life and Disability Controlled Affiliate will pay to BCBSA a fee for this license in accordance with the following formula:

- An annual fee of five thousand dollars (\$5,000) per license, plus
- .05% of gross revenue per year from group products sold under the Licensed Marks, plus
- .5% of gross revenue per year from individual products sold under the Licensed Marks

In the event that any license period is greater or less than one (1) year, any amounts due shall be prorated. Royalties under this formula will be calculated, billed and paid in arrears.

Life and Disability Controlled Affiliate will promptly and timely transmit to BCBSA all fees owed by Life and Disability Controlled Affiliate as determined by the above formula.

9. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between any Sponsoring Plan and Life and Disability Controlled Affiliate or between among them and/or BCBSA.

10. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the

Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with 0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by: (a) a writing signed by all parties; or (b) a writing approved by the affirmative vote of three-fourths of the Blue Plans and three-fourths of the total then current weighted vote of all the Blue Plans as officially recorded by the BCBSA Corporate Secretary. Upon such adoption by the Blue Plans, this Agreement and all other Trademark License Agreements for Life and Disability Insurance Products then in effect shall simultaneously be amended.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such finding shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of the Life and Disability Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed, effective as of the date of last signature written below.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: _

Date: _

Life and Disability Controlled Affiliate:

By: _

Date: _

Sponsoring Plan:

By: ____

Date: _

Name: _____

Sponsoring Plan:

By: ____

Date: _

Name: _____

[Add other Sponsoring Plans as necessary]

EXHIBIT A

LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS

Page 1 of 2

Standard 1 - Organization and Governance

Any Life and Disability Controlled Affiliate licensed under the Trademark License Agreement for Life and Disability Insurance Products ("licensee") shall be organized and operated in such a manner that it is an entity organized and operated in such a manner that it is 100% owned and controlled by Sponsoring Plans. Absent written approval by BCBSA of an alternative method of control, control shall mean the legal authority, directly or indirectly through wholly-owned subsidiaries: (a) to select members of the Life and Disability Controlled Affiliate's governing body having not less than 100% voting control thereof; (b) to exercise operational control with respect to the governance thereof; and (c) to prevent any change in its articles of incorporation, bylaws or other governing documents deemed inappropriate. In addition, a Sponsoring Plan or Plans shall own at least 100% of any for profit Life and Disability Controlled Affiliate.

Standard 2 - State Licensure

The licensee must maintain unimpaired licensure or certificate of authority to operate under applicable state laws as a life company in each state in which the licensee does business.

Standard 3 - Records and Examination

The licensee shall maintain and furnish, on a timely and accurate basis, such records and reports regarding the licensee as may be required in order to establish compliance with the Agreement. The licensee shall permit BCBSA to examine the affairs of the licensee and shall agree that BCBSA's board may submit a written report to the chief executive officer(s) and the board(s) of directors of the Sponsoring Plan(s).

Standard 4 - Mediation

The licensee, its Sponsoring Plan(s) and all consenting Blue Plans shall agree to use the then-current BCBSA mediation and mandatory dispute resolution processes, in lieu of a legal action between or among another licensed Life and Disability Controlled Affiliate, a Sponsoring Plan and or consenting Blue Plan or BCBSA.

EXHIBIT A
LICENSE STANDARDS APPLICABLE TO TRADEMARK LICENSE
AGREEMENT FOR LIFE AND DISABILITY INSURANCE PRODUCTS
Page 2 of 2

Standard 5 - Financial Responsibility

The licensee shall maintain adequate financial resources to protect its customers and meet its business obligations.

Standard 6 - Cooperation with BCBSA Governance

The licensee shall cooperate with BCBSA's Board of Directors and its Brand Enhancement & Protection Committee in the administration of and in addressing licensee compliance problems that may be identified in connection with the operation or administration of the Trademark License Agreement for Life and Disability Insurance Products.

EXHIBIT B

CONSENT AGREEMENT

This Consent Agreement is made and entered into by and among the undersigned Blue Plan, and _____ ("Life and Disability Controlled Affiliate"), and the Blue Cross and Blue Shield Association ("BCBSA") and shall be deemed effective on _____ ("Effective Date").

Whereas, BCBSA owns the Blue Cross and Blue Shield word and design service marks and any derivative mark thereof (the "Brands");

Whereas, the undersigned Blue Plan is licensed to use one or more of the Brands within a specific geographic area ("Service Area");

Whereas Life and Disability Controlled Affiliate is licensed by BCBSA to use one or more of the Brands to offer life and disability insurance products ("Products") as defined and authorized in the Trademark License Agreement for Life and Disability Insurance Products ("Life and Disability License Agreement");

Whereas neither the Blue Plan nor its affiliates offer the Products under any of the Brands in such Blue Plan's Service Area or portion thereof where Blue Plan has consented to sale of the Products by Life and Disability Controlled Affiliate; and

Whereas BCBSA and the undersigned Blue Plan desire to consent to Life and Disability Controlled Affiliate's use of the Brands in Blue Plan's Service Area consistent with the terms of the Life and Disability License Agreement and this Consent Agreement.

Now, therefore, in consideration of the obligations and conditions stated in this Agreement, Blue Plan, Life and Disability Controlled Affiliate and BCBSA agree as follows:

1. Life and Disability Controlled Affiliate may market, sell, administer and underwrite the Products in Blue Plan's Service Area under the Brands licensed to Blue Plan in such Service Area subject to the terms of this Consent Agreement, the Life and Disability License Agreement and Blue Plan's license agreement(s) with BCBSA. Life and Disability Controlled Affiliate's rights under the Brands to offer the Products under the Brands are limited to offering the Products only under the Brand(s) licensed to the consenting Blue Plan.
2. Life and Disability Controlled Affiliate shall work with the undersigned Blue Plan to develop a written sales and marketing agreement that identifies the relationship between it and Blue Plan for the sales,

marketing and customer service for the Products. The term of the sales and marketing agreement shall be the same as the term of this Consent Agreement.

3. All sales, marketing and advertising materials developed by and proposed for use by Life and Disability Controlled Affiliate in a consenting Blue Plan's Service Area must clearly identify the consenting Blue Plan (for example, a statement on such materials that reads "This product is offered with the cooperation of Blue Cross and/or Blue Shield of [Geography]");
4. Life and Disability Controlled Affiliate may use the Brands to sell the Products in the following Service Area or portion thereof as designated by Blue Plan:

5. If two or more Blue Plans to use the same Licensed Marks in the same Service Area, Life and Disability Controlled Affiliate shall work with the consenting Blue Plan in the following manner: (a) the sales, marketing and advertising materials must be communicated to the consenting Blue Plan's existing and prospective accounts through or with the approval of such Blue Plan, and (b) the personnel of such Blue Plan must actively participate in all sales and marketing activities conducted by Life and Disability Controlled Affiliate in the same Service Area, including participating in meetings (whether in-person or via telephone, video or internet conference) with both existing and prospective accounts of the consenting Blue Plan;
6. Life and Disability Controlled Affiliate shall be entitled to use in a Service Area only those Licensed Marks that the consenting Blue Plan has been granted by BCBSA the license to use under its license agreement (for example, if a consenting Blue Plan is licensed to use only the Blue Cross Marks in its Service Area, the materials used by Life and Disability Controlled Affiliate in that Service Area may only contain or reference the Blue Cross Marks and not the Blue Shield Marks).
7. If this Consent Agreement is terminated, Life and Disability Controlled Affiliate shall, unless each BCBSA and the Blue Plan agree in their sole discretion to a phase out in writing, immediately (i) cease all use of the Licensed Marks, including in connection with any and all sales and marketing of the Licensed Products in the Service Area where consent has been terminated, and (ii) notify its customers that it is no longer a licensee of BCBSA and provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in form approved by BCBSA.

8. The term of this Consent Agreement shall be one year from the Effective Date. Unless either Blue Plan or Life and Disability Controlled Affiliate provides the other party with written notice of its desire not to renew this Consent Agreement at least 60 days prior to expiration of the term or any extended term or unless terminated as provided in Paragraph 9 below, this Consent Agreement shall automatically renew for subsequent one year periods.
9. This Consent Agreement may be terminated as follows:
 - A. Upon mutual written consent of Life and Disability Controlled Affiliate and Blue Plan;
 - B. By Blue Plan or Life and Disability Controlled Affiliate upon 60 days advance written notice to the non-terminating party and BCBSA; or
 - C. By Blue Plan immediately if Life and Disability Controlled Affiliate does not comply with this Consent Agreement or the sales protocol agreement.
10. This Consent Agreement shall automatically terminate if Blue Plan's primary licensee agreement terminates for any reason or if the Life and Disability License Agreement terminates for any reason.

Agreed and Accepted by:

[Blue Plan]:

By: _____

Title: _____

BLUE CROSS AND BLUE SHIELD ASSOCIATION:

By: _____

Title: _____

LIFE AND DISABILITY CONTROLLED AFFILIATE:

By: _____

Title: _____

Exhibit 1B
BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS
(Adopted by Member Plans at their November 21, 2014)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Advantage PPO products in geographic regions designated by CMS (hereafter "regional MAPPO products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name") to offer regional MAPPO products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional MAPPO products and related services.

This grant of rights is non-exclusive and is limited to the following states: _____ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

(3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:

- (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
- (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
- (c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional MAPPO products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Shield License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking

appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Controlled Affiliate shall no longer comply with item 2(E) above;
- (2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Shield License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to \$25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such

geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with

0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: _____

Date: _____

Controlling Plan:

By: _____

Date: _____

Controlling Plan:

By: _____

Date: _____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: _____

Date: _____

EXHIBIT A

**CONTROLLED AFFILIATE LICENSE STANDARDS
APPLICABLE TO REGIONAL MEDICARE
ADVANTAGE PPO PRODUCTS
November 2014**

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Advantage PPO Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
- (2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
- (3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:
 - (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
 - (b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
 - (c) exercise control over the policy and operations of the Controlled Affiliate; and

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

- a. the structure of the Blue Cross and Blue Shield System; and
- b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Shield Marks.

Standard 7 - Participation in Certain National Programs

A Controlled Affiliate shall effectively and efficiently participate in certain national programs from time to time as may be adopted by Member Plans for the purposes of providing ease of claims processing for customers receiving benefits outside of the Controlled Affiliate's service area.

National program requirements include:

- a. Inter-Plan Teleprocessing System (ITS); and
- b. Inter-Plan Medicare Advantage Program.

Standard 8 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

Amended as of November 15, 2007

EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE ADVANTAGE PPO PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional MAPPO products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

Exhibit 1C

BLUE SHIELD
CONTROLLED AFFILIATE LICENSE AGREEMENT
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS
(Adopted by Member Plans at their November 21, 2014)

This Agreement by and among Blue Cross and Blue Shield Association ("BCBSA") and _____ ("Controlled Affiliate"), a Controlled Affiliate of the Blue Cross Plan(s), known as _____ ("Controlling Plans"), each of which is also a Party signatory hereto.

WHEREAS, BCBSA is the owner of the BLUE SHIELD and BLUE SHIELD Design service marks;

WHEREAS, under the Medicare Modernization Act, companies may apply to and be awarded a contract by the Centers for Medicare and Medicaid Services ("CMS") to offer Medicare Part D Prescription Drug Plan products in geographic regions designated by CMS (hereafter "regional PDP products").

WHEREAS, some of the CMS-designated regions include the Service Areas, or portions thereof, of more than one Plan.

WHEREAS, the Controlling Plans and Controlled Affiliate desire that the latter be entitled to use the BLUE SHIELD and BLUE SHIELD Design service marks (collectively the "Licensed Marks") as service marks and be entitled to use the term BLUE SHIELD in a trade name ("Licensed Name") to offer regional PDP products in a region that includes the Service Areas, or portions thereof, of more than one Controlling Plan;

NOW THEREFORE, in consideration of the foregoing and the mutual agreements hereinafter set forth and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereby agree as follows:

1. GRANT OF LICENSE

Subject to the terms and conditions of this Agreement, BCBSA hereby grants to Controlled Affiliate the right to use the Licensed Marks and Name in connection with, and only in connection with the sale, marketing and administration of regional PDP products and related services.

This grant of rights is non-exclusive and is limited to the following states: _____ (the "Region"). Controlled Affiliate may use the Licensed

Marks and Name in its legal name on the following conditions: (i) the legal name must be approved in advance, in writing, by BCBSA; (ii) Controlled Affiliate shall not do business outside the Region under any name or mark except business conducted in the Service Area of a Controlling Plan provided that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks and Name in connection with health care plans and related services in the Service Area of such Controlling Plan; and (iii) Controlled Affiliate shall not use the Licensed Marks and Name, or any derivative thereof, as part of any name or symbol used to identify itself in any securities market. Controlled Affiliate may use the Licensed Marks and Name in its Trade Name only with the prior, written, consent of BCBSA.

2. QUALITY CONTROL

A. Controlled Affiliate agrees to use the Licensed Marks and Name only in connection with the licensed services and further agrees to be bound by the conditions regarding quality control shown in attached Exhibit A as they may be amended by BCBSA from time-to-time.

B. Controlled Affiliate agrees to comply with all applicable federal, state and local laws.

C. Controlled Affiliate agrees that it will provide on an annual basis (or more often if reasonably required by the Controlling Plans or by BCBSA) a report or reports to the Controlling Plans and BCBSA demonstrating Controlled Affiliate's compliance with the requirements of this Agreement including but not limited to the quality control provisions of this paragraph and the attached Exhibit A.

D. Controlled Affiliate agrees that the Controlling Plans and/or BCBSA may, from time-to-time, upon reasonable notice, review and inspect the manner and method of Controlled Affiliate's rendering of service and use of the Licensed Marks and Name.

E. As used herein, a Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

(1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;

(2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and

- (3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:
- (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
 - (b) to prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
 - (c) to exercise control over the policy and operations of the Controlled Affiliate; and

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

3. SERVICE MARK USE

A. Controlled Affiliate recognizes the importance of a comprehensive national network of independent BCBSA licensees which are committed to strengthening the Licensed Marks and Name. The Controlled Affiliate further recognizes that its actions within the Region may affect the value of the Licensed Marks and Name nationwide.

B. Controlled Affiliate shall at all times make proper service mark use of the Licensed Marks and Name, including but not limited to use of such symbols or words as BCBSA shall specify to protect the Licensed Marks and Name and shall comply with such rules (generally applicable to Controlled Affiliates licensed to use the Licensed Marks and Name) relative to service mark use, as are issued from time-to-time by BCBSA. Controlled Affiliate recognizes and agrees that all use of the Licensed Marks and Name by Controlled Affiliate shall inure to the benefit of BCBSA.

C. Controlled Affiliate may not directly or indirectly use the Licensed Marks and Name in a manner that transfers or is intended to transfer in the Region the goodwill associated therewith to another mark or name, nor may Controlled Affiliate engage in activity that may dilute or tarnish the unique value of the Licensed Marks and Name.

D. Controlled Affiliate shall use its best efforts to promote and build the value of the Licensed Marks and Name in connection with the sale, marketing and administration of regional PDP products and related services.

4. SUBLICENSING AND ASSIGNMENT

Controlled Affiliate shall not, directly or indirectly, sublicense, transfer, hypothecate, sell, encumber or mortgage, by operation of law or otherwise, the rights granted hereunder and any such act shall be voidable at the sole option of any Controlling Plan or BCBSA. This Agreement and all rights and duties hereunder are personal to Controlled Affiliate.

5. INFRINGEMENT

Controlled Affiliate shall promptly notify the Controlling Plans and the Controlling Plans shall promptly notify BCBSA of any suspected acts of infringement, unfair competition or passing off that may occur in relation to the Licensed Marks and Name. Controlled Affiliate shall not be entitled to require the Controlling Plans or BCBSA to take any actions or institute any proceedings to prevent infringement, unfair competition or passing off by third parties. Controlled Affiliate agrees to render to the Controlling Plans and BCBSA, without charge, all reasonable assistance in connection with any matter pertaining to the protection of the Licensed Marks and Name by BCBSA.

6. LIABILITY INDEMNIFICATION

Controlled Affiliate and the Controlling Plans hereby agree to save, defend, indemnify and hold BCBSA harmless from and against all claims, damages, liabilities and costs of every kind, nature and description (except those arising solely as a result of BCBSA's negligence) that may arise as a result of or related to Controlled Affiliate's rendering of services under the Licensed Marks and Name.

7. LICENSE TERM

A. Except as otherwise provided herein, the license granted by this Agreement shall remain in effect for a period of one (1) year and shall be automatically extended for additional one (1) year periods unless terminated pursuant to the provisions herein.

B. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that: (i) any one of the Controlling Plans ceases to be authorized to use the Licensed Marks and Name; or (ii) pursuant to Paragraph 15(a)(x) of the Blue Shield License Agreement any one of the Controlling Plans ceases to be authorized to use the Licensed Names and Marks in the Region.

C. Notwithstanding any other provision of this Agreement, this license to use the Licensed Marks and Name may be forthwith terminated by the Controlling Plans or the affirmative vote of the majority of the Board of Directors of BCBSA present and voting at a special meeting expressly called by BCBSA for the purpose on ten (10) days written notice to the Controlling Plans advising of the specific matters at issue and granting the Controlling Plans an opportunity to be heard and to present their response to the Board for: (1) failure to comply with any applicable minimum capital or liquidity requirement under the quality control standards of this

Agreement; or (2) failure to comply with the "Organization and Governance" quality control standard of this Agreement; or (3) impending financial insolvency; or (4) failure to comply with any of the applicable requirements of Standards 2, 3, 4, or 5 of attached Exhibit A; or (5) the pendency of any action instituted against the Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business or seeking the declaration or establishment of a trust for any of its property or business, unless this Controlled Affiliate License Agreement has been earlier terminated under paragraph 7(E); or (6) such other reason as is determined in good faith immediately and irreparably to threaten the integrity and reputation of BCBSA, the Plans (including the Controlling Plans), any other licensee including Controlled Affiliate and/or the Licensed Marks and Name.

D. Except as otherwise provided in Paragraphs 7(B), 7(C) or 7(E) herein, should Controlled Affiliate fail to comply with the provisions of this Agreement and not cure such failure within thirty (30) days of receiving written notice thereof (or commence a cure within such thirty day period and continue diligent efforts to complete the cure if such curing cannot reasonably be completed within such thirty day period) BCBSA or the Controlling Plans shall have the right to issue a notice that the Controlled Affiliate is in a state of noncompliance. If a state of noncompliance as aforesaid is undisputed by the Controlled Affiliate or is found to exist by a mandatory dispute resolution panel and is uncured as provided above, BCBSA shall have the right to seek judicial enforcement of the Agreement or to issue a notice of termination thereof. Notwithstanding any other provisions of this Agreement, any disputes as to the termination of this License pursuant to Paragraphs 7(B), 7(C) or 7(E) of this Agreement shall not be subject to mediation and mandatory dispute resolution. All other disputes between or among BCBSA, any of the Controlling Plans and/or Controlled Affiliate shall be submitted promptly to mediation and mandatory dispute resolution. The mandatory dispute resolution panel shall have authority to issue orders for specific performance and assess monetary penalties. Except, however, as provided in Paragraphs 7(B) and 7(E) of this Agreement, this license to use the Licensed Marks and Name may not be finally terminated for any reason without the affirmative vote of a majority of the present and voting members of the Board of Directors of BCBSA.

E. This Agreement and all of Controlled Affiliate's rights hereunder shall immediately terminate without any further action by any party or entity in the event that:

- (1) Controlled Affiliate shall no longer comply with item 2(E) above;
- (2) Appropriate dues, royalties and other payments for Controlled Affiliate pursuant to paragraph 9 hereof, which are the royalties for this License Agreement, are more than sixty (60) days in arrears to BCBSA; or

(3) Any of the following events occur: (i) a voluntary petition shall be filed by Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief, or (ii) an involuntary petition or proceeding shall be filed against Controlled Affiliate seeking bankruptcy, reorganization, arrangement with creditors or other relief under the bankruptcy laws of the United States or any other law governing insolvency or debtor relief and such petition or proceeding is consented to or acquiesced in by Controlled Affiliate or is not dismissed within sixty (60) days of the date upon which the petition or other document commencing the proceeding is served upon the Controlled Affiliate, or (iii) an order for relief is entered against Controlled Affiliate in any case under the bankruptcy laws of the United States, or Controlled Affiliate is adjudged bankrupt or insolvent as those terms are defined in the Uniform Commercial Code as enacted in the State of Illinois by any court of competent jurisdiction, or (iv) Controlled Affiliate makes a general assignment of its assets for the benefit of creditors, or (v) any government or any government official, office, agency, branch, or unit assumes control of Controlled Affiliate or delinquency proceedings (voluntary or involuntary) are instituted, or (vi) an action is brought by Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business, or (vii) an action is instituted by any governmental entity or officer against Controlled Affiliate seeking its dissolution or liquidation of its assets or seeking the appointment of a trustee, interim trustee, receiver or other custodian for any of its property or business and such action is consented to or acquiesced in by Controlled Affiliate or is not dismissed within one hundred thirty (130) days of the date upon which the pleading or other document commencing the action is served upon the Controlled Affiliate, provided that if the action is stayed or its prosecution is enjoined, the one hundred thirty (130) day period is tolled for the duration of the stay or injunction, and provided further, that the Association's Board of Directors may toll or extend the 130 day period at any time prior to its expiration, or (viii) a trustee, interim trustee, receiver or other custodian for any of Controlled Affiliate's property or business is appointed or the Controlled Affiliate is ordered dissolved or liquidated. Notwithstanding any other provision of this Agreement, a declaration or a request for declaration of the existence of a trust over any of the Controlled Affiliate's property or business shall not in itself be deemed to constitute or seek appointment of a trustee, interim trustee, receiver or other custodian for purposes of subparagraphs 7(E)(3)(vii) and (viii) of this Agreement.

F. Upon termination of this Agreement for cause or otherwise, Controlled Affiliate agrees that it shall immediately discontinue all use of the Licensed Marks and Name, including any use in its trade name, except to the extent that it continues to be authorized to use the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan.

G. Upon termination of this Agreement, Controlled Affiliate shall immediately notify all of its customers to whom it provides products or services under the Licensed Marks pursuant to this Agreement that it is no longer a licensee of BCBSA and, if directed by the Association's Board of Directors, shall provide instruction on how the customer can contact BCBSA or a designated licensee to obtain further information on securing coverage. The notification required by this paragraph shall be in writing and in a form approved by BCBSA. The BCBSA shall have the right to audit the terminated entity's books and records to verify compliance with this paragraph.

H. In the event this Agreement terminates pursuant to 7(B) hereof, upon termination of this Agreement the provisions of Paragraph 7(G) shall not apply and the following provisions shall apply, except that, in the event that Controlled Affiliate is separately licensed by BCBSA to use the Licensed Marks in the Service Area of a Controlling Plan and termination of this Agreement is due to a partial termination of such Controlling Plan's license pursuant to Paragraph 15(a)(x)(ii) of the Blue Shield License Agreement, the notices, national account listing, payment, and audit right listed below shall be applicable solely with respect to the Region and the geographic area for which the Controlling Plan's license to use the Licensed Names and Marks is terminated:

(1) The Controlled Affiliate shall send a notice through the U.S. mails, with first class postage affixed, to all individual and group customers, providers, brokers and agents of products or services sold, marketed, underwritten or administered by the Controlled Affiliate under the Licensed Marks and Name. The form and content of the notice shall be specified by BCBSA and shall, at a minimum, notify the recipient of the termination of the license, the consequences thereof, and instructions for obtaining alternate products or services licensed by BCBSA. This notice shall be mailed within 15 days after termination.

(2) The Controlled Affiliate shall deliver to BCBSA within five days of a request by BCBSA a listing of national accounts in which the Controlled Affiliate is involved (in a control, participating or servicing capacity), identifying the national account and the Controlled Affiliate's role therein.

(3) Unless the cause of termination is an event respecting BCBSA stated in paragraph 15(a) or (b) of the Plan's license agreement with BCBSA to use the Licensed Marks and Name, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for payment to BCBSA of an amount equal to \$25 multiplied by the number of Licensed Enrollees of the Controlled Affiliate; provided that if any Plan other than a Controlling Plan is permitted by BCBSA to use marks or names licensed by BCBSA in a geographic area in the Region, the payment for Licensed Enrollees in such

geographic area shall be multiplied by a fraction, the numerator of which is the number of Licensed Enrollees of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans in such geographic area and the denominator of which is the total number of Licensed Enrollees in such geographic area. Licensed Enrollee means each and every person and covered dependent who is enrolled as an individual or member of a group receiving products or services sold, marketed or administered under marks or names licensed by BCBSA as determined at the earlier of (i) the end of the last fiscal year of the terminated entity which ended prior to termination or (ii) the fiscal year which ended before any transactions causing the termination began. Notwithstanding the foregoing, the amount payable pursuant to this subparagraph H. (3) shall be due only to the extent that, in BCBSA's opinion, it does not cause the net worth of the Controlled Affiliate, the Controlling Plans or any other Licensed Controlled Affiliates of the Controlling Plans to fall below 100% of the Health Risk-Based Capital formula, or its equivalent under any successor formula, as set forth in the applicable financial responsibility standards established by BCBSA (provided such equivalent is approved for purposes of this subparagraph by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans); measured as of the date of termination, and adjusted for the value of any transactions not made in the ordinary course of business. This payment shall not be due in connection with transactions exclusively by or among Plans (including the Controlling Plans) or their affiliates, including reorganizations, combinations or mergers, where the BCBSA Board of Directors determines that the license termination does not result in a material diminution in the number of Licensed Enrollees or the extent of their coverage. In the event that the Controlled Affiliate's license is reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, BCBSA shall reimburse the Controlled Affiliate (and/or the Controlling Plans or their other Licensed Controlled Affiliates, as the case may be) for payments made under this subparagraph 7.H.(3) only to the extent that such payments exceed the amounts due to BCBSA pursuant to paragraph 7.K. and any costs associated with reestablishing the terminated Controlling Plan's Service Area or the Region, including any payments made by BCBSA to a Plan or Plans (including the other Controlling Plans), or their Licensed Controlled Affiliates, for purposes of replacing the Controlled Affiliate.

(4) BCBSA shall have the right to audit the books and records of the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans to verify compliance with this paragraph 7.H.

(5) As to a breach of 7.H.(1), (2), (3) or (4), the parties agree that the obligations are immediately enforceable in a court of competent jurisdiction. As to a breach of 7.H.(1), (2) or (4) by the Controlled Affiliate, the parties agree there is no adequate remedy at law and BCBSA is entitled to obtain specific performance.

I. BCBSA shall be entitled to enjoin the Controlled Affiliate or any related party in a court of competent jurisdiction from entry into any transaction which would result in a termination of this Agreement unless a Controlling Plan's license from BCBSA to use the Licensed Marks and Names has been terminated pursuant to 10(d) of such Controlling Plan's license agreement upon the required 6 month written notice.

J. BCBSA acknowledges that it is not the owner of assets of the Controlled Affiliate.

K. In the event this Agreement terminates and is subsequently reinstated by BCBSA or is deemed to have remained in effect without interruption by a court of competent jurisdiction, the Controlled Affiliate, the Controlling Plans, and any other Licensed Controlled Affiliates of the Controlling Plans shall be jointly liable for reimbursing BCBSA the reasonable costs incurred by BCBSA in connection with the termination and the reinstatement or court action, and any associated legal proceedings, including but not limited to: outside legal fees, consulting fees, public relations fees, advertising costs, and costs incurred to develop, lease or establish an interim provider network. Any amount due to BCBSA under this subparagraph may be waived in whole or in part by the BCBSA Board of Directors in its sole discretion.

8. DISPUTE RESOLUTION

The parties agree that any disputes between or among them or between or among any of them and one or more Plans or Controlled Affiliates of Plans that use in any manner the Blue Shield and Blue Shield Marks and Name are subject to the Mediation and Mandatory Dispute Resolution process attached to and made a part of each Controlling Plan's License from BCBSA to use the Licensed Marks and Name as Exhibit 5 as amended from time-to-time, which documents are incorporated herein by reference as though fully set forth herein.

9. LICENSE FEE

Controlled Affiliate will pay to BCBSA a fee for this License determined pursuant to the formula(s) set forth in Exhibit B.

10. JOINT VENTURE

Nothing contained in this Agreement shall be construed as creating a joint venture, partnership, agency or employment relationship between the Controlling Plans and Controlled Affiliate or between either and BCBSA.

11. NOTICES AND CORRESPONDENCE

Notices regarding the subject matter of this Agreement or breach or termination thereof shall be in writing and shall be addressed in duplicate to the last known address of each other party, marked respectively to the attention of its President and, if any, its General Counsel.

12. COMPLETE AGREEMENT

This Agreement contains the complete understandings of the parties in relation to the subject matter hereof. This Agreement may only be amended by the affirmative vote of three-fourths of the Plans and three-fourths of the total then current weighted vote of all the Plans as officially recorded by the BCBSA Corporate Secretary.

13. SEVERABILITY

If any term of this Agreement is held to be unlawful by a court of competent jurisdiction, such findings shall in no way affect the remaining obligations of the parties hereunder and the court may substitute a lawful term or condition for any unlawful term or condition so long as the effect of such substitution is to provide the parties with the benefits of this Agreement.

14. NONWAIVER

No waiver by BCBSA of any breach or default in performance on the part of Controlled Affiliate or any other licensee of any of the terms, covenants or conditions of this Agreement shall constitute a waiver of any subsequent breach or default in performance of said terms, covenants or conditions.

14A. VOTING

For all provisions of this Agreement referring to voting, the term 'Plans' shall mean all entities licensed under the Blue Cross License Agreement and/or the Blue Shield License Agreement, and in all votes of the Plans under this Agreement the Plans shall vote together. For weighted votes of the Plans, the Plan shall have a number of votes equal to the number of weighted votes (if any) that it holds as a Blue Cross Plan plus the number of weighted votes (if any) that it holds as a Blue Shield Plan. For all other votes of the Plans, the Plan shall have one vote. For all questions requiring an affirmative three-fourths weighted vote of the Plans, the requirement shall be deemed satisfied with a lesser weighted vote unless the greater of: (i) 6/52 or more of the Plans (rounded to the nearest whole number, with

0.5 or multiples thereof being rounded to the next higher whole number) fail to cast weighted votes in favor of the question; or (ii) three (3) of the Plans fail to cast weighted votes in favor of the question. Notwithstanding the foregoing provision, if there are thirty-nine (39) Plans, the requirement of an affirmative three-fourths weighted vote shall be deemed satisfied with a lesser weighted vote unless four (4) or more Plans fail to cast weighted votes in favor of the question.

15. GOVERNING LAW

This Agreement shall be governed by, and construed and interpreted in accordance with, the laws of the State of Illinois.

16. HEADINGS

The headings inserted in this agreement are for convenience only and shall have no bearing on the interpretation hereof.

IN WITNESS WHEREOF, the parties have caused this License Agreement to be executed and effective as of the date of last signature written below.

Controlled Affiliate:

By: _____

Date: _____

Controlling Plan:

By: _____

Date: _____

Controlling Plan:

By: _____

Date: _____

BLUE CROSS AND BLUE SHIELD ASSOCIATION

By: _____

Date: _____

EXHIBIT A

**CONTROLLED AFFILIATE LICENSE STANDARDS
APPLICABLE TO REGIONAL MEDICARE
PART D PRESCRIPTION DRUG PLAN PRODUCTS
November 2014**

PREAMBLE

The standards for licensing Controlled Affiliates for Medicare Part D Prescription Drug Plan Products are established by BCBSA and are subject to change from time-to-time upon the affirmative vote of three-fourths (3/4) of the Plans and three-fourths (3/4) of the total weighted vote. Each Controlling Plan is required to use a standard Controlled Affiliate license form provided by BCBSA and to cooperate fully in assuring that the licensed Controlled Affiliate maintains compliance with the license standards.

Standard 1 - Organization and Governance

A Controlled Affiliate is defined as an entity organized and operated in such a manner, that it meets the following requirements:

- (1) Controlled Affiliate is owned or controlled by two or more Controlling Plans;
- (2) Each Controlling Plan is authorized pursuant to a separate Blue Shield License Agreement to use the Licensed Marks in a geographic area in the Region and every geographic area in the Region is so licensed to at least one of the Controlling Plans; and
- (3) The Controlling Plans must have the legal authority directly or indirectly through wholly-owned subsidiaries:
 - (a) to select members of the Controlled Affiliate's governing body having not less than 100% voting control thereof;
 - (b) prevent any change in the articles of incorporation, bylaws or other establishing or governing documents of the Controlled Affiliate with which the Controlling Plans do not concur;
 - (c) exercise control over the policy and operations of the Controlled Affiliate; and

EXHIBIT A (continued)

Notwithstanding anything to the contrary in (a) through (c) hereof, the Controlled Affiliate's establishing or governing documents must also require written approval by each of the Controlling Plans before the Controlled Affiliate can:

- (i) change its legal and/or trade names;
- (ii) change the geographic area in which it operates (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iii) change any of the type(s) of businesses in which it engages (except such approval shall not be required with respect to business of the Controlled Affiliate conducted under the Licensed Marks within the Service Area of one of the Controlling Plans pursuant to a separate controlled affiliate license agreement with BCBSA sponsored by such Controlling Plan);
- (iv) take any action that any Controlling Plan or BCBSA reasonably believes will adversely affect the Licensed Marks and Name.

In addition, the Controlling Plans directly or indirectly through wholly-owned subsidiaries shall own 100% of any for-profit Controlled Affiliate.

Standard 2 - Financial Responsibility

A Controlled Affiliate shall be operated in a manner that provides reasonable financial assurance that it can fulfill all of its contractual obligations to its customers.

Standard 3 - State Licensure/Certification

A Controlled Affiliate shall maintain appropriate and unimpaired licensure and certifications.

EXHIBIT A (continued)

Standard 4 - Certain Disclosures

A Controlled Affiliate shall make adequate disclosure in contracting with third parties and in disseminating public statements of:

- a. the structure of the Blue Cross and Blue Shield System; and
- b. the independent nature of every licensee.

Standard 5 - Reports and Records for Controlled Affiliates

A Controlled Affiliate and/or its Controlling Plans shall furnish, on a timely and accurate basis, reports and records relating to these Standards and the License Agreements between BCBSA and Controlled Affiliate.

Standard 6 - Best Efforts

During each year, a Controlled Affiliate shall use its best efforts to promote and build the value of the Blue Shield Marks.

Standard 7 - Participation in Master Business Associate Agreement

Controlled Affiliates shall comply with the terms of the Business Associate Agreement for Blue Cross and Blue Shield Licensees to the extent they perform the functions of a business associate or subcontractor to a business associate, as defined by the Business Associate Agreement.

EXHIBIT B

**ROYALTY FORMULA FOR SECTION 9 OF THE
CONTROLLED AFFILIATE LICENSE AGREEMENTS
APPLICABLE TO REGIONAL MEDICARE PART D PRESCRIPTION DRUG PLAN PRODUCTS**

Controlled Affiliate will pay BCBSA a fee for this license in accordance with the following formula:

An amount equal to its pro rata share of each Controlling Plan dues payable to BCBSA computed with the addition of the Controlled Affiliate's members using the Marks on regional PDP products and related services as reported on the Quarterly Enrollment Report with BCBSA. The payment by each Controlling Plan of its dues to BCBSA, including that portion described in this paragraph, will satisfy the requirement of this paragraph, and no separate payment will be necessary.

Amended as of June 14, 2007

EXHIBIT 2

Membership Standards

Page 1 of 5

Preamble

The Membership Standards apply to all organizations seeking to become or to continue as Regular Members of the Blue Cross and Blue Shield Association. Any organization seeking to become a Regular Member must be found to be in substantial compliance with all Membership Standards at the time membership is granted and the organization must be found to be in substantial compliance with all Membership Standards for a period of two (2) years preceding the date of its application. If Membership is sought by an entity which controls or is controlled by one or more Plans, such compliance shall be determined on the basis of compliance by such Plan or Plans.

The Regular Member Plans shall have authority to interpret these Standards.

A Regular Member Plan that operates as a "Shell Holding Company" is defined as an entity that assumes no underwriting risk and has less than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) and less than 5% of the consolidated enterprise net general and administrative expenses.

A Regular Member Plan that operates as a "Hybrid Holding Company" is defined as an entity that assumes no underwriting risk and has either more than 1% of the consolidated enterprise assets (excludes investments in subsidiaries) or more than 5% of the consolidated enterprise net general and administrative expenses.

StandardA Plan shall maintain a governing Board, which shall control the Plan and ensure that the Plan follows appropriate practices of corporate governance. A Plan's Board shall not be controlled by any special interest group, shall make an annual determination that a majority of its directors are independent, and shall act in the best interest of its Corporation and its customers. The Board shall be composed of a majority of persons other than providers of health care services, who shall be known as public members. A public member shall not be an employee of or have a financial interest in a health care provider, nor be a member of a profession which provides health care services.

Amended as of March 15, 2007

EXHIBIT 2

Membership Standards

Page 2 of 5

StandardA Plan shall furnish to the Association on a timely and accurate basis reports and records relating to compliance with these Standards and the License Agreements between the Association and the Plans. Such reports and records are the following:

- A. BCBSA Membership Information Request;
 - B. Biennial trade name and service mark usage material, including disclosure material under Standard 7;
 - C. Changes in the governance of the Plan, including changes in a Plan's Charter, Articles of Incorporation, or Bylaws, changes in a Plan's Board composition, or changes in the identity of the Plan's Principal Officers;
 - D. Quarterly Financial Report, Semi-annual "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC, Annual Budget, Annual Certified Audit Report, Insurance Department Examination Report, Annual Statement filed with State Insurance Department (with all attachments), Plan, Subsidiary and Affiliate Report; and
- Plans that are a Shell Holding Company as defined in the Preamble hereto are required to furnish only a calendar year-end "Health Risk-Based Capital (HRBC) Report" as defined by the NAIC.

Amended as of November 17, 2011

EXHIBIT 2

Membership Standards

Page 3 of 5

E. Quarterly Enrollment Report, Quarterly Member Touchpoint Measures Index (MTM) through 12/31/2011, and Semi-annual MTM Index starting 1/1/2012 and thereafter.

•For purposes of MTM reporting only, a Plan shall file a separate MTM report for each Geographic Market.

Standard A Plan shall be operated in a manner that provides reasonable financial assurance that it can fulfill its contractual obligations to its customers.

Standard 4:A Plan shall be operated in a manner responsive to customer needs and requirements.

StandardA Plan shall effectively and efficiently participate in each national program as from time to time may be adopted by the Member Plans for the purposes of providing portability of membership between the Plans and ease of claims processing for customers receiving benefits outside of the Plan's Service Area.

Such programs are applicable to Blue Cross and Blue Shield Plans, and include:

- A. Inter-Plan Teleprocessing System (ITS);
- B. BlueCard Program;
- C. National Account Programs;
- D. Business Associate Agreement for Blue Cross and Blue Shield Licensees, effective April 14, 2003; and
- E. Inter-Plan Medicare Advantage Program.

Amended as of November 21, 2014

EXHIBIT 2

Membership Standards

Page 4 of 5

StandardIn addition to requirements under the national programs listed in Standard 5: Participation in National Programs, a Plan
6: shall take such action as required to ensure its financial performance in programs and contracts of an inter-Plan nature or where the Association is a party.

StandardA Plan shall make adequate disclosure in contracting with third parties and in disseminating public statements of (i) the
7: structure of the Blue Cross and Blue Shield System, (ii) the independent nature of every Plan, and (iii) the Plan's financial condition.

StandardA Plan shall cooperate with the Association's Board of Directors and its Brand Enhancement & Protection Committee in
8: the administration of the Plan Performance Response Process and in addressing Plan performance problems identified thereunder.

StandardA Plan shall obtain a rating of its financial strength from an independent rating agency approved by the Association's
9: Board of Directors for such purpose.

StandardNotwithstanding any other provision in this License Agreement, during each year, a Plan and its Controlled Affiliate(s)
10: engaged in providing licensable services (excluding Life Insurance and Charitable Foundation Services) shall use their best efforts to promote and build the value of the Blue Shield Marks.

StandardNeither a Plan nor any Larger Controlled Affiliate shall cause or permit an entity other than a Plan or a Licensed Controlled
11: Affiliate thereof to obtain control of the Plan or Larger Controlled Affiliate or to acquire a substantial portion of its assets related to licensable services.

Amended as of June 16, 2005

EXHIBIT 2

Membership Standards

Page 5 of 5

StandardNo provider network, or portion thereof, shall be rented or otherwise made available to a National Competitor if the
12: Licensed Marks or Names are used in any way with such network.

A provider network may be rented or otherwise made available, provided there is no
use of the Licensed Marks or Names with respect to the network being rented.

Amended as of March 18, 2004

EXHIBIT 3

**GUIDELINES WITH RESPECT TO USE OF
LICENSED NAME AND MARKS IN CONNECTION WITH NATIONAL ACCOUNTS**

Page 1 of 3

1. The strength of the Blue Cross/Blue Shield National Accounts mechanism, and the continued provision of cost effective, quality health care benefits to National Accounts, are predicated on locally managed provider networks coordinated on a national scale in a manner consistent with effective service to National Account customers and consistent with the preservation of the integrity of the Blue Cross/Blue Shield system and the Licensed Marks. These guidelines shall be interpreted in keeping with such ends.
2. A National Account is an entity with employee and/or retiree locations in more than one Plan's Service Area. Unless otherwise agreed, a National Account is deemed located in the Service Area in which the corporate headquarters of the National Account is located. A local plant, office or division headquarters of an entity may be deemed a separate National Account when that local plant, office or division headquarters 1) has employee locations in more than one Service Area, and 2) has independent health benefit decision-making authority for the employees working at such local plant, office or division headquarters and for employees working at other locations outside the Service Area. In such a case, the local plant, office or division headquarters is a National Account that is deemed located in the Service Area in which such local plant, office or division headquarters is located. The Control Plan of a National Account is the Plan in whose Service Area the National Account is located. A participating ("Par") Plan is a Plan in whose Service Area the National Account has employee and/or retiree locations, but in which the National Account is not located. In the event that a National Account parent company consolidates health benefit-decision making for itself and its wholly-owned subsidiary companies, the parent company and the subsidiary companies shall be considered one National Account. The Control Plan for such a National Account shall be the Plan in whose Service Area the parent company headquarters is located.
3. The National Account Guidelines enunciated herein below shall be applicable only with respect to the business of new National Accounts acquired after January 1, 1991.
4. Control Plans shall utilize National Account identification cards complying with then currently effective BCBSA graphic standards in connection with all National Accounts business to facilitate administration thereof, to minimize subscriber and provider confusion, and to reflect a commitment to cooperation among Plans.

Amended as of June 12, 2003

Exhibit 3

Page 2 of 3

5. Disputes among Plans and/or BCBSA as to the interpretation or implementation of these Guidelines or as to other National Accounts issues shall be submitted to mediation and mandatory dispute resolution as provided in the License Agreement. For two years from the effective date of the License Agreement, however, such disputes shall be subject to mediation only, with the results of such mediation to be collected and reported in order to establish more definitive operating parameters for National Accounts business and to serve as ground rules for future binding dispute resolution.

6. The Control Plan may use the BlueCard Program (as defined by IPPC) to deliver benefits to employees and non-Medicare eligible retirees in a Participating Plan's service area if an alternative arrangement with the Participating Plan cannot be negotiated. The Participating Plan's minimum servicing requirement for those employees and non-Medicare retirees in its service area is to deliver benefits using the BlueCard Program. Account delivery is subject to the policies, provisions and procedures of the BlueCard Program.

7. For provider payments in a Participating Plan's area (on non-BlueCard claims), payment to the provider may be made by the Participating Plan or the Control Plan at the Participating Plan's option. If the Participating Plan elects to pay the provider, it may not withhold payment of a claim verified by the Control Plan or its designated processor, and payment must be in conformity with service criteria established by the Board of Directors of BCBSA (or an authorized committee thereof) to assure prompt payment, good service and minimum confusion with providers and subscribers. The Control Plan, at the Participating Plan's request, will also assure that measures are taken to protect the confidentiality of the data pertaining to provider reimbursement levels and profiles.

Amended as of June 14, 1996

Exhibit 3

Page 3 of 3

8. The Control Plan, in its financial agreements with a National Account, is expected to reasonably reflect the aggregate amount of differentials passed along to the Control Plan by all Participating Plans in a National Account.
9. Other than in contracting with health care providers or soliciting such contracts in areas contiguous to a Plan's Service Area in order to serve its subscribers or those of its licensed Controlled Affiliate residing or working in its Service Area, a Control Plan may not use the Licensed Marks and/or Name, as a tag line or otherwise, to negotiate directly with providers outside its Service Area.

Amended as of March 13, 2003

EXHIBIT 4

GOVERNMENT PROGRAMS AND CERTAIN OTHER USES

Page 1 of 14

1. A Plan and its licensed Controlled Affiliate may use the Licensed Marks and Name in bidding on and executing a contract to serve a Government Program, and in thereafter communicating with the Government concerning the Program. With respect, however, to such contracts entered into after the 1st day of January, 1991, the Licensed Marks and Name will not be used in communications or transactions with beneficiaries or providers in the Government Program located outside a Plan's Service Area, unless the Plan can demonstrate to the satisfaction of BCBSA's governing body that such a restriction on use of the Licensed Marks and Name will jeopardize its ability to procure the contract for the Government Program. As to both existing and future contracts for Government Programs, Plans will discontinue use of the Licensed Marks and Name as to beneficiaries and Providers outside their Service Area as expeditiously as circumstances reasonably permit. Effective January 1, 1995, except as provided in the first sentence above, all use by a Plan of the Licensed Marks and Name in Government Programs outside of the Plan's Service Area shall be discontinued. Incidental communications outside a Plan's Service Area with resident or former resident beneficiaries of the Plan, and other categories of necessary incidental communications approved by BCBSA, are not prohibited. For purposes of this Paragraph 1, the term "Government Programs" shall mean Medicare Part A, Medicare Part B and other non-risk government programs.
2. In connection with activity otherwise in furtherance of the License Agreement, a Plan and its Controlled Affiliates that are licensed to use the Licensed Marks and Name in its Service Area pursuant to the Controlled Affiliate License Agreements authorized in clauses a) through c) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Plan's Service Area in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:
 - 2.1 Common Business Communications
 - a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);
 - b. distributing business cards other than in marketing and selling;
 - c. advertising in publications or electronic media solely to persons for employment;

Amended as of June 19, 2014

EXHIBIT 4

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2.2 Marketing Spillover

a. advertising in print, electronic or other media which serve, as a substantial market, the Service Area of the Plan or licensed Controlled Affiliate, provided that no Plan or Controlled Affiliate may advertise outside its Service Area on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Service Area;

b. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Plan's Service Area or that of a licensed Controlled Affiliate;

2.3 Provider Contracting

a. contracting with health care providers or soliciting such contracts in areas contiguous to the Plan's Service Area in order to serve its subscribers or those of such licensed Controlled Affiliates residing or working in its service area;

b. issuing a small sign containing the legal name or trade name of the Plan or such licensed Controlled Affiliates for display by a provider to identify the latter as a participating provider of the Plan or Controlled Affiliate;

c. negotiating rates with a health care provider for services to a specific member, provided that all of the following conditions are met:

(1) the health care provider does not have a contract, applicable to the services rendered or to be rendered, with the Licensee (or any of the Licensees in the case of overlapping Service Areas) in whose Service Area the health care provider is located; and

(2) the Plan or Controlled Affiliate reasonably determines that the member did/does not have a reasonable opportunity to access a participating provider whose contract applies to the services rendered or to be rendered; and

(3) at least one of the following circumstances exists:

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EXHIBIT 4

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- (i) the member received emergency services and the Plan or Controlled Affiliate knows or reasonably anticipates that the charges on the claim will meet or exceed \$5,000; or
 - (ii) a provider, in consultation pre- or post- treatment with the Plan or Controlled Affiliate, makes/made a treatment recommendation or referral to a non-par provider or to a par provider whose contract does not apply to the services to be rendered; or
 - (iii) the member inadvertently accessed a non-par provider or non-contracted services in the course of receiving services from a par provider (e.g., the member sees a non-par consulting specialist in a participating hospital); and
 - (4) the Licensee (and in the case of overlapping Service Areas, all of the Licensees) in whose Service Area the health care provider is located consent(s) in advance.
- d. contracting with a pharmacy management organization ("Pharmacy Intermediary") to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;

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EXHIBIT 4

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- e. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided that (1) the Plan and the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Plan's Service Area, and (2) neither the Plan's or the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Plan's Service Area;
 - f. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;
 - g. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for all of the Plan's or licensed Controlled Affiliate's members nationwide, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;
 - h. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Plan's Service Area;
 - i. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Plan's Service Area;
 - j. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Plan's Service Area;
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EXHIBIT 4

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- k. contracting with a company that operates provider sites in the Plan's Service Area, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Plan's Service Area;
 - l. contracting with a company that makes health care professionals available in the Plan's Service Area (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Plan's Service Area.
- 2.4 Services to National Accounts
- a. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee (as those terms are defined in the Inter-Plan Programs Policies and Provisions ("IP Policies")) to offer Blue-branded Health Coverage to the National Account, offering Blue-branded Health and Wellness Programs to all members of the National Account, including members who have not enrolled in the Blue-branded Health Coverage ("non-Blue Health Coverage members"), provided that:
 - (i) the Plan and/or licensed Controlled Affiliate has no contact or interaction with providers outside of the Plan's Service Area regarding such non-Blue Health Coverage members, except as specifically provided in the IP Policies; and
 - (ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not offer Blue-branded Health and Wellness Programs to any employees working at such local plant, office or division without the consent of such other Licensee; and
 - (iii) if the Plan and/or licensed Controlled Affiliate provides an information card to the non-Blue Health Coverage members, the card may not display the Symbols in the masthead, must contain a prominent disclosure conveying that it is not a health insurance card, and otherwise must be designed so that it is dissimilar to a Blue member identification card.

Amended as of June 19, 2014

EXHIBIT 4

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For purposes of this subparagraph a, the following definitions apply:

“Health and Wellness Program” shall mean a program that includes at least one of the following elements or a related element:

- Health Risk Assessment and/or Preventive Screenings
- Exercise and Fitness Programs
- Health and Wellness Events (e.g., attendance at a health fair, a 5K walk)
- Nutrition and Weight Management
- Health Education (e.g., smoking cessation classes)
- Prenatal and Parenting Education
- Disease or Chronic Condition Management

The above listing is intended to represent examples of the types of programs that may be offered, and other programs, including those offered through different media such as the internet or telephonically, may also be deemed Health and Wellness programs.

“Health Coverage” shall mean providing or administering medical, surgical, hospital, major medical, or catastrophic coverage, or any HMO, PPO, POS or other managed care plan for the foregoing services.

Amended as of June 19, 2014

EXHIBIT 4

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2.4 Services to National Accounts (continued)

- b. in conjunction with contracting with a National Account as Control Licensee or Alternate Control Licensee to offer Blue-branded Health Coverage to the National Account, performing the Eligibility and Enrollment functions of HR administration for all benefit plans offered by the National Account to its members, including benefit plans that are not underwritten or administered by the Plan, provided that:
 - (i) in performing such functions, the Plan and/or licensed Controlled Affiliate does not use the Brands in any communications with health care providers outside of the Plan's Service Area, and otherwise limits its use of the Brands outside of the Service Area to communications with the account's members, the other benefit plan providers with which the account has contracted and other reasonably necessary communications to perform such functions; and
 - (ii) if in accordance with IP Policies another Licensee is soliciting or servicing under the Brands a local plant, office or division of the account that is outside of the Plan's Service Area, the Plan and/or licensed Controlled Affiliate may not perform Eligibility and Enrollment functions for employees working at such local plant, office or division without the consent of such other Licensee;

For purposes of this subparagraph b, the following definitions apply:

"Health Coverage" has the meaning set forth in subparagraph 2.4.a.

Amended as of June 19, 2014

EXHIBIT 4

Page 8 of 14

“Eligibility” means services that manage the account’s eligibility data and determine or process determinations relating to eligibility for benefit plans offered by the account to its employees, including such services as:

- monitoring and auditing data to ensure that only entitled individuals are enrolled in each such benefit plan;
- review of eligibility documentation (e.g. marriage licenses, birth certificates, student status verification letters, employment records);
- identification of key member segments such as over-age dependents, part-time employees, employees reaching certain milestones (e.g. Medicare-eligible, retirees);
- termination of coverage for those individuals found to be ineligible for coverage under a benefit plan, and, if applicable, generation of a COBRA event; and
- management of “hour-banking” for union environments in which union members can bank hours to remain eligible for benefits.

“Enrollment” means services that enroll eligible individuals and their spouses/dependents or terminate or change their enrollment in the account’s benefit plans on an ongoing basis and during open enrollment periods, including such services as:

- the coordination of each step in open enrollment process from project planning and system set-up to the generation of confirmation statements;
- ongoing enrollment support for new hires and changes due to life events and work status adjustments;
- evidence of insurability (EOI) administration for life and disability coverage;
- transmission of eligibility/enrollment information to the account’s benefit plan providers;
- review and reconciliation of error reports received from the account’s benefit plan providers; and
- transmission of information to the account’s payroll system (e.g., benefit deductions, employee demographic data).

Amended as of November 18, 2010

EXHIBIT 4

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2.5 Knowledge Sharing

- a. submitting scholarly articles authored or co-authored by the Plan or Controlled Affiliate or its respective employees for publication in peer-reviewed journals;
- b. permitting an internal representative of the Plan or Controlled Affiliate (e.g., officer, employee) to speak or present at a conference or symposium for which the event sponsor will issue communications that will identify the Plan's or Controlled Affiliate's representative as a participant, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;

2.6 Other Uses

- a. entering into a license agreement between and among BCBSA, the Plan and a debit card issuer located outside the Plan's Service Area, and entering into a corresponding operating agreement or agreements, in order to offer a debit card bearing the Licensed Marks and Name to eligible persons as defined by the aforementioned license agreement;
- b. appearing in communications issued by an independent third party to recognize outstanding performance of the Plan or Controlled Affiliate or a member of the Plan's or Controlled Affiliate's senior management as part of an established program of the third party for which the Plan has provided information to be considered for the recognition, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;
- c. to identify itself as being a joint sponsor of an event, program or activity along with other Plans or such Plans' licensed Controlled Affiliates, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;
- d. hosting meetings or events in Washington, D.C. related to policy and business issues in the Plan's Service Area, or hosting events in conjunction with the assemblies or conventions of national political parties, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time;

Amended as of June 19, 2014

EXHIBIT 4

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- e. permitting an affiliate that is not licensed to use the Licensed Marks to identify its corporate relationship with the Plan, provided that such use complies with regulations of general application specifically prescribed by BCBSA from time to time.

3. In connection with activity otherwise in furtherance of the License Agreement, a Controlled Affiliate that is licensed to use the Licensed Marks and Name pursuant to a Controlled Affiliate License Agreement authorized in clauses d) or e) of Paragraph 2 of the Plan's License Agreement with BCBSA may use the Licensed Marks and Name outside the Region (as that term is defined in such respective Controlled Affiliate License Agreements) in the following circumstances which are deemed legitimate and necessary and not likely to cause consumer confusion:

- a. sending letterhead, envelopes, and similar items solely for administrative purposes (e.g., not for purposes of marketing, advertising, promoting, selling or soliciting the sale of health care plans and related services);
- b. distributing business cards other than in marketing and selling;
- c. contracting with health care providers or soliciting such contracts in areas contiguous to the Region in order to serve its subscribers residing in the Region, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans in connection with such contracting unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;
- d. issuing a small sign containing the legal name or trade name of the Controlled Affiliate for display by a provider to identify the latter as a participating provider of the Controlled Affiliate, provided that the Controlled Affiliate may not use the names of any of its Controlling Plans on such signs unless the provider is located in a geographic area that is also contiguous to such Controlling Plan's Service Area;
- e. advertising in publications or electronic media solely to persons for employment;

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- f. advertising in print, electronic or other media which serve, as a substantial market, the Region, provided that the Controlled Affiliate may not advertise outside its Region on the national broadcast and cable networks and that advertisements in national print media are limited to the smallest regional edition encompassing the Region, and provided further that any such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to advertise in such media;
- g. advertising by direct mail where the addressee's zip code plus 4 includes, at least in part, the Region, provided that such advertising by the Controlled Affiliate may not reference the name of any of its Controlling Plans unless the respective Controlling Plan is authorized under paragraph 2 of this Exhibit 4 to send direct mail to such zip code plus 4.
- h. [Intentionally left blank, pending review by the Inter-Plan Programs Committee of the applicability of the case management rule to such Controlled Affiliates.]
- i. contracting with a pharmacy management organization ("Pharmacy Intermediary") to gain access to a national or regional pharmacy network to provide self-administered prescription drugs to deliver a pharmacy benefit for the Controlled Affiliate's regional Medicare Advantage PPO or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective Controlled Affiliate License Agreements, provided, however, that the Pharmacy Intermediary may not use the Licensed Marks or Name in contracting with the pharmacy providers in such network;
- j. contracting with the corporate owner of a national or regional retail pharmacy chain to gain access to the pharmacies in the chain to provide self-administered prescription drugs to deliver a pharmacy benefit to the Controlled Affiliate's regional Medicare Advantage PPO
or regional Medicare Part D Prescription Drug members enrolled under the Licensed Marks pursuant to such respective
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Controlled Affiliate License Agreements, provided that (1) the Controlled Affiliate may not contract directly with pharmacists or pharmacy stores outside the Region, and (2) neither the Controlled Affiliate's name nor the Licensed Marks or Name may be posted or otherwise displayed at or by any pharmacy store outside the Region;

k. contracting with a dental management organization ("Dental Intermediary") to gain access to a national or regional dental network to deliver a routine dental benefit for the Controlled Affiliate's regional Medicare Advantage PPO members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Dental Intermediary may not use the Licensed Marks or Name in contracting with the dental providers in such network;

l. contracting with a vision management organization ("Vision Intermediary") to gain access to a national or regional vision network to deliver a routine vision benefit for the Controlled Affiliate's regional Medicare Advantage members enrolled under the Licensed Marks pursuant to such Controlled Affiliate License Agreement, provided, however, that the Vision Intermediary may not use the Licensed Marks or Name in contracting with the vision providers in such network;

m. contracting with an independent clinical laboratory for analysis and clinical assessment of specimens that are collected within the Controlled Affiliate's Region;

n. contracting with a durable medical equipment or home medical equipment company for durable medical equipment and supplies and home medical equipment and supplies that are shipped to a location within the Controlled Affiliate's Region;

o. contracting with a specialty pharmaceutical company for non-routine biological therapeutics that are ordered by a health care professional located within the Region;

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- p. contracting with a company that operates provider sites in the Region, provided that the contract is solely for services rendered at a site (e.g., hospital, mobile van) that is within the Region;
 - q. contracting with a company that makes health care professionals available in the Region (e.g., traveling home health nurse), provided that the contract is solely for services rendered by health care professionals who are located within the Region.
4. BCBSA shall retain the right to use the Licensed Marks in conjunction with the Federal Employee Program and with any other national offering made to federal employees pursuant to the Federal Employees Health Benefits Program (FEHBP), including the right to license such use to its vendors, but only in the following manner.
- a. the Licensed Marks may only be used by BCBSA with the term "Federal Employee Program", "Federal", "FEP", or similar language identifying the program as a benefit program for federal employees;
 - b. the Licensed Marks may not be used by BCBSA with the name(s) of a specific Plan or Plans and;
 - c. any use by BCBSA in conjunction with a new national FEHBP program proposed after the enactment of this amendment will require the approval of the BCBSA Board of Directors.

Amended as of March 16, 2006

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5. Where required by applicable state or local law or regulation, a Plan or its licensed Controlled Affiliate may submit documents that contain the Brands to, and file forms that contain the Brands with, state or local regulators in a state not included in its Service Area, provided that it gives reasonable advance notice to the local Plan of its intent to submit such documents or file such forms. Notwithstanding, in no event may a Plan or its licensed Controlled Affiliate use the Brands to register, or to obtain or maintain a license, a certificate of authority, or an equivalent document authorizing it to act as a risk-bearing entity or third party administrator in a state not included in its Service Area. If the local Plan advises BCBSA that it believes its License Agreement has been or would be violated by any submission or filing, BCBSA shall determine whether such submission or filing is required by state or local law or regulation and violates the License Agreement, subject to the Plan's or licensed Controlled Affiliate's rights to obtain an independent review of such determination under Paragraph 9(a) and Exhibit 5 of its License Agreement or Paragraph 8 of the Controlled Affiliate License. For purposes of this paragraph, "local Plan" is defined as each Plan whose Service Area includes all or part of the state in which the foregoing applicable state or local law or regulation has been enacted.

Amended as of November 18, 2010

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MEDIATION AND MANDATORY DISPUTE RESOLUTION (MMDR) RULES

The Blue Cross and Blue Shield Plans ("Plans") and the Blue Cross Blue Shield Association ("BCBSA") recognize and acknowledge that the Blue Cross and Blue Shield system is a unique nonprofit and for-profit system offering cost effective health care financing and services. The Plans and BCBSA desire to utilize Mediation and Mandatory Dispute Resolution ("MMDR") to avoid expensive and time-consuming litigation that may otherwise occur in the federal and state judicial systems. Even MMDR should be viewed, however, as methods of last resort, all other procedures for dispute resolution having failed. Except as otherwise provided in the License Agreements, the Plans, their Controlled Affiliates and BCBSA agree to submit all disputes to MMDR pursuant to these Rules and in lieu of litigation.

1. Initiation of Proceedings

A. Pre-MMDR Efforts

Before filing a Complaint to invoke the MMDR process, the CEO of a complaining party, or his/her designated representative, shall undertake good faith efforts with the other side(s) to try to resolve any dispute.

B. Complaint

To commence a proceeding, the complaining party (or parties) shall provide by certified mail, return receipt requested, a written Complaint to the BCBSA Corporate Secretary (which shall also constitute service on BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) named therein. The Complaint shall contain:

- i. identification of the complaining party (or parties) requesting the proceeding;
- ii. identification of the respondent(s);
- iii. identification of any other persons or entities who are interested in a resolution of the dispute;
- iv. a full statement describing the nature of the dispute;
- v. identification of all of the issues that are being submitted for resolution;

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- vi. the remedy sought;
- vii. a statement as to whether the complaining party (or parties) elect(s) first to pursue Mediation;
- viii. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor; and
- ix. a statement signed by the CEO of the complaining party affirming that the CEO has undertaken efforts, or has directed efforts to be undertaken, to resolve the dispute before resorting to the MMDR process.

The complaining party (or parties) shall file and serve with the Complaint copies of all documents which the party (or parties) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

C. Answer

Within twenty (20) days after receipt of the Complaint, each respondent shall serve on BCBSA and on the complaining party (or parties):

- i. a full Answer to the aforesaid Complaint;
- ii. a statement of any Counterclaims against the complaining party (or parties), providing with respect thereto the information specified in Paragraph 1.B., above;
- iii. a statement as to whether the respondent elects to first pursue Mediation; and
- iv. any request, if applicable, that the matter be handled on an expedited basis and the reasons therefor.

The respondent(s) shall file and serve with the Answer or by the date of the Initial Conference set forth in Paragraph 3.C., below, copies of all documents which the respondent(s) intend(s) to offer at the Arbitration Hearing and a statement identifying the witnesses the party (or parties) intend(s) to present at the Hearing, along with a summary of each witness' expected testimony.

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D. Reply To Counterclaim

Within ten (10) days after receipt of any Counterclaim, the complaining party (or parties) shall serve on BCBSA and on the responding party (or parties) a Reply to the Counterclaim. Such Reply must provide the same information required by Paragraph 1.C., above.

2. Mediation

To facilitate the mediation of disputes between or among BCBSA, the Plans and/or their Controlled Affiliates, the BCBSA Board has provided for Mediation under these Rules. Mediation may be pursued in lieu of or in an effort to obviate the Mandatory Dispute Resolution process, and all parties are strongly urged, but not required, to exhaust the mediation procedure provided for herein. In the event any party refuses to proceed with Mediation, the parties shall proceed immediately to Mandatory Dispute Resolution, as provided in Section 3.

A. Selection of Mediators

If all parties agree to pursue Mediation, they shall promptly attempt to agree upon: (i) the number of mediators desired, not to exceed three mediators; and (ii) the selection of experienced mediator(s) from an independent entity to mediate all disputes set forth in the Complaint and Answer (and Counterclaim and Reply, if any). In the event the parties are unable to agree upon the selection or number of mediators, both within five (5) days of the service of the Answer or Reply to Counterclaim, whichever is later, the BCBSA Corporate Secretary shall immediately refer the matter to a nationally recognized professional ADR organization (such as CPR or JAMS) for mediation by a single mediator to be selected by the ADR organization.

B. Binding Decision

Before the Mediation Hearing described below, the BCBSA Corporate Secretary shall contact the parties to determine whether they wish to be bound by any recommendation of the selected mediator(s) for resolution of the disputes. If all wish to be bound, the Corporate Secretary will send appropriate documentation to them for their signatures before the Mediation Hearing begins.

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C. Mediation Procedure

The Mediator(s) shall apply the mediation procedures and processes provided for herein (not the rules of the ADR organization with which they are affiliated) and shall promptly advise the parties of a scheduled Mediation Hearing date. Unless a party requests an expedited procedure, or unless all parties to the proceeding agree to one or more extensions of time, the Mediation Hearing set forth below shall be completed within forty (40) days of BCBSA's receipt of the Complaint. The selected mediator(s), unless the parties otherwise agree, shall adhere to the following procedure:

- i. Each party must be represented by its CEO or other representative who has been delegated full authority to resolve the dispute. However, parties may send additional representatives as they see fit.
- ii. Each party will be given one-half hour to present its case, beginning with the complaining party (or parties), followed by the other party or parties. The parties are free to structure their presentations as they see fit, using oral statements or direct examination of witnesses. However, neither cross-examination nor questioning of opposing representatives will be permitted. At the close of each presentation, the selected mediator(s) will be given an opportunity to ask questions of the presenters and witnesses. All parties must be present throughout the Mediation Hearing. The selected mediator(s) may extend the time allowed for each party's presentation at the Mediation Hearing. The selected mediator(s) may meet in executive session, outside the presence of the parties, or may meet with the parties separately, to discuss the controversy.
- iii. After the close of the presentations, the parties will attempt to negotiate a settlement of the dispute. If the parties desire, the selected mediators, or any one or more of the selected mediator(s), will sit in on the negotiations.

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- iv. After the close of the presentations, the selected mediator(s) may meet privately to agree upon a recommendation for resolution of the dispute which would be submitted to the parties for their consideration and approval. If the parties have previously agreed to be bound by the results of this procedure, this recommendation shall be binding upon the parties.
- v. The purpose of the Mediation Hearing is to assist the parties to settle their grievances short of mandatory dispute resolution. As a result, the Mediation Hearing has been designed to be as informal as possible. Rules of evidence shall not apply. There will be no transcript of the proceedings, and no party may make a tape recording of the Mediation Hearing.
- vi. In order to facilitate a free and open discussion, the Mediation proceeding shall remain confidential. A "Stipulation to Confidentiality" which prohibits future use of settlement offers, all position papers or other statements furnished to the selected mediator(s), and decisions or recommendations in any Mediation proceeding shall be executed by each party.
- vii. Upon request of the selected mediator(s), or one of the parties, BCBSA staff may also submit documentation at any time during the proceedings.

D. Notice of Termination of Mediation

If the Mediation cannot be completed within the prescribed or agreed time period due to the lack of cooperation of any party, as determined by the selected mediator(s), or if the Mediation does not result in a final resolution of all disputes at the Mediation Hearing or within ten (10) days after the Mediation Hearing, any party or any one of the selected mediator(s) shall so notify the BCBSA Corporate Secretary, who shall promptly issue a Notice of Termination of Mediation to all parties, to the selected mediator(s), and to the MDR Administrator. Such notice shall serve to bring the Mediation to an end and to initiate Mandatory Dispute Resolution. Upon agreement of all parties and the mediator(s), the Mediation process may continue at the same time the MDR process is invoked. In such case, the Notice of Termination of Mediation described above serves to initiate the MDR proceeding, but does not terminate mediation proceedings, which may proceed simultaneous with the MDR proceeding.

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3. Mandatory Dispute Resolution (MDR)

If any party elects not to first pursue Mediation, or if a Notice of Termination of Mediation is issued as set forth in Paragraph 2.D., above, then the unresolved disputes set forth in any Complaint and Answer (and Counterclaim and Reply, if any) shall be subject to mandatory binding arbitration (herein referred to as "MDR").

A. MDR Administrator

The Administrator for purposes of Mandatory Arbitration shall be an independent nationally recognized entity such as CPR or JAMS, specializing in alternative dispute resolution. In the event the parties pursued Mediation with CPR, JAMS or a similar organization, that organization also shall serve as the MDR Administrator, unless all parties notify the BCBSA Corporate Secretary in writing within two (2) days of receiving the Notice of Termination of Mediation that they wish to pursue MDR with another nationally recognized organization serving as MDR Administrator.

In the event the parties (i) did not pursue Mediation, (ii) pursued mediation with a Mediator not affiliated with an ADR organization that offers a panel of arbitrators, or (iii) all parties that pursued Mediation notified the BCBSA Corporate Secretary that they wish to have an MDR Administrator that is different from the organization with which their mediator was affiliated, they shall promptly attempt to agree on a nationally recognized ADR entity that supplies a panel of arbitrators. If they reach such agreement within five (5) days of the Notice of Termination of Mediation or receipt of the Answer or Reply to Counterclaim (whichever is later), the parties shall promptly inform the BCBSA Corporate Secretary of their agreed upon ADR organization. In the event the parties are unable to reach agreement on an MDR Administrator within that timeframe, the BCBSA Corporate Secretary shall immediately refer the matter to CPR, JAMS or a similar organization for MDR.

Any person who served as a Mediator shall not serve as an arbitrator for the same or similar dispute for purposes of MDR.

B. Rules for MDR

The rules controlling all aspects of MDR shall be exclusively those provided for herein. The rules promulgated or otherwise used by the MDR Administrator organization shall not apply.

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C. Initial Conference

Within seven (7) days after a Notice of Termination has issued, or the matter has otherwise been referred to an MDR Administrator, or within five (5) days after the time for filing and serving the Answer or Reply to any Counterclaim (whichever is later) if the parties elect first not to mediate, the parties shall confer with the Administrator to discuss selecting a dispute resolution panel ("the Panel"). This conference (the "Initial Conference") may be by telephone. The parties are encouraged to agree to the composition of the Panel and to present that agreement to the Administrator at the Initial Conference. If the parties do not agree on the composition of the Panel by the time of the Initial Conference, or by any extension thereof agreed to by all parties and the Administrator, then the Panel Selection Process set forth in subparagraph D, below, shall be followed.

D. Panel Selection Process

The Administrator shall designate, prior to the Initial Conference, at least seven potential arbitrators. Each party shall be permitted to strike any designee for cause and the Administrator shall determine the sufficiency thereof in its sole discretion. The Administrator will designate a replacement for any designee so stricken. Each party shall then be permitted one peremptory strike from the list of designees. The Administrator shall set the dates for exercising all strikes, which shall be set to encourage the prompt selection of arbitrators.

After the parties exercise any designee strikes for cause and their peremptory strike against any designee of their choice, the parties shall each rank the remaining panel members in order of preference and provide the Administrator, without serving on any other party, their ranked list. The Administrator shall not disclose any party's ranked list to members of the panel or to other parties.

From the remaining designees, and after considering opportunities to maximize, so far as possible, the collectively stated arbitrator preferences provided by the parties on their ranked lists, the Administrator shall select a three member Panel. The Panel Selection Process shall be completed no later than ten (10) days after the Initial Conference.

Each Arbitrator shall be compensated at his or her normal hourly rate or, in the absence of an established rate, at a reasonable hourly rate to be promptly fixed by the Administrator for all time spent in connection with the proceedings and shall be reimbursed for any travel and other reasonable expenses.

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E. Duties Of The Arbitrators

The Panel shall promptly designate a Presiding Arbitrator for the purposes reflected below, but shall retain the power to review and modify any ruling or other action of said Presiding Arbitrator. Each Arbitrator shall be an independent Arbitrator, shall be governed by the Code of Ethics for Arbitrators in Commercial Disputes, and shall at or prior to the commencement of any Arbitration Hearing take an oath to that effect. Each Arbitrator shall promptly disclose in writing to the Panel and to the parties any circumstances, whenever arising, that might cause doubt as to such Arbitrator's compliance, or ability to comply, with said Code of Ethics, and, absent resignation by such Arbitrator, the remaining Arbitrators shall determine in their sole discretion whether the circumstances so disclosed constitute grounds for disqualification and for replacement. With respect to such circumstances arising or coming to the attention of a party after an Arbitrator's selection, a party may likewise request the Arbitrator's resignation or a determination as to disqualification by the remaining Arbitrators. With respect to a sole Arbitrator, the determination as to disqualification shall be made by the Administrator.

There shall be no ex parte communication between the parties or their counsel and any member of the Panel.

F. Panel's Jurisdiction And Authority

The Panel's jurisdiction and authority shall extend to all disputes between or among the Plans, their Controlled Affiliates, and/or BCBSA, except for those disputes excepted from these MMDR procedures as set forth in the License Agreements.

With the exception of punitive or treble damages, the Panel shall have full authority to award the relief it deems appropriate to resolve the parties' disputes, including monetary awards and injunctions, mandatory or prohibitory. The Panel has no authority to award punitive or treble damages except that the Panel may allocate or assess responsibility for punitive or treble damages assessed by another tribunal. Subject to the above limitations, the Panel may, by way of example, but not of limitation:

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- i. interpret or construe the meaning of any terms, phrase or provision in any license between BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.
- ii. determine whether BCBSA, a Plan or a Controlled Affiliate has violated the terms or conditions of any license between the BCBSA and a Plan or a Controlled Affiliate relating to the use of the BLUE CROSS® or BLUE SHIELD® service marks.
- iii. decide challenges as to its own jurisdiction.
- iv. issue such orders for interim relief as it deems appropriate pending Hearing and Award in any Arbitration.

It is understood that the Panel is expected to resolve issues based on governing principles of law, preserving to the maximum extent legally possible the continued integrity of the Licensed Marks and the BLUE CROSS/BLUE SHIELD system. The Panel shall apply federal law to all issues which, if asserted in the United States District Court, would give rise to federal question jurisdiction, 28 U.S.C. § 1331. The Panel shall apply Illinois law to all issues involving interpretation, performance or construction of any License Agreement or Controlled Affiliate License Agreement unless the agreement otherwise provides. As to other issues, the Panel shall choose the applicable law based on conflicts of law principles of the State of Illinois.

G. Administrative Conference

Within five (5) days of the Panel being selected, the Presiding Arbitrator shall confer with the parties and the other members of the Panel and shall schedule, in writing, a conference in which the parties and the Panel shall participate (the "Administrative Conference"). The Administrative Conference shall take place no later than fifteen (15) days after the Panel is selected. At the Administrative Conference the parties and the Panel shall discuss the scheduling of the Arbitration Hearing and any other matter appropriate to be considered, including but not limited to: any written discovery in the form of requests for production of documents or requests to admit facts; the identity of any witness whose deposition a party may desire and a showing of exceptional good cause for the taking

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of any such deposition; the desirability of bifurcation or other separation of the issues; the need for and the type of record of conferences and hearings, including the need for transcripts; the need for expert witnesses and how expert testimony should be presented; the appropriateness of motions to dismiss and/or for full or partial summary judgment; consideration of stipulations; the desirability of presenting any direct testimony in writing; and the necessity for any on-site inspection by the Panel. If the parties agree, the Administrative Conference may be by telephone.

H. Discovery

- i. ***Requests for Production of Documents:*** All requests for the production of documents must be served no later than five (5) days after the date of the Initial Conference. Within twenty (20) days after receipt of a request for production of documents, a party shall (a) serve responses and objections to the request, (b) produce all responsive, non-privileged documents to the requesting party, and (c) to the extent any responsive documents are withheld on the grounds of attorney-client privilege or work product, produce a log identifying such documents in the manner specified in Fed. R. Civ. P. 26(b)(5). If, after reviewing a privilege log, the requesting party believes attorney-client privilege or work product protection was improperly claimed by the producing party with respect to any document, the requesting party may ask the Presiding Arbitrator to conduct an in-camera inspection of the same. With respect to documentary and other discovery produced in any MDR proceeding by BCBSA, the fact that a party's CEO or other senior officers may serve on the BCBSA Board of Directors, BCBSA Board Committees or other BCBSA work groups, task forces and the like, shall not be a basis for defeating an otherwise valid claim of attorney-client privilege or work product protection over such documentary or other discovery materials by BCBSA.
- ii. ***Requests for Admissions:*** Requests for Admissions may be served up to twenty-one (21) days prior to the discovery cut-off set by the Presiding Arbitrator. A party served with Requests For Admissions must respond within twenty (20) days of receipt of said request. The good faith use of and response to Requests for Admissions is encouraged, and the Panel shall have full discretion, with reference to the Federal Rules of Civil Procedure, in awarding appropriate sanctions with respect to abuse of the procedure.

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- iii. **Depositions:** As a general rule, the parties will not be permitted to take party or non-party deposition testimony for discovery purposes. The Presiding Arbitrator, in his or her sole discretion, shall have the authority to permit a party to take such deposition testimony upon a showing of exceptional good cause. The parties will be permitted to take de bene esse deposition testimony to the fullest extent permitted by law of any witness who cannot be compelled to testify at the Arbitration Hearing. No deposition, for discovery purposes or otherwise, shall exceed three (3) hours, excluding objections and colloquy of counsel. Depositions may be recorded in any manner recognized by the Federal Rules of Civil Procedure and the parties shall specify in each notice of deposition or request for permission to take deposition testimony the manner in which such deposition shall be recorded.
- iv. **Expert witness(es):** If a party intends to present the testimony of an expert witness during the oral hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)(B) ten (10) days prior to the discovery cut-off set by the Presiding Arbitrator. If a party intends to present the testimony of a rebuttal expert witness during the Arbitration Hearing, it shall provide all other parties with a written statement setting forth the information required to be provided by Fed. R. Civ. P. 26(a)(2)(B) within twenty (20) days after the date on which the written statement of the expert witness whose testimony is to be rebutted was produced.
- v. **Discovery cut-off:** The Presiding Arbitrator shall determine the date on which the discovery period will end, but the discovery period shall not exceed thirty (30) days from the date of the Administrative Conference without the agreement of all parties.

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vi. ***Additional discovery:*** Any additional discovery will be at the discretion of the Presiding Arbitrator.

vii. ***Discovery Disputes:*** Any discovery disputes shall be raised by motion to the Presiding Arbitrator, who is authorized to resolve all such disputes, and whose resolution will be binding on the parties unless modified by the Arbitration Panel. Prior to raising any discovery dispute with the Presiding Arbitrator, the parties shall meet and confer, telephonically or in person, in an attempt to resolve or narrow the dispute. If a party refuses to comply with a decision resolving a discovery dispute, the Panel, in keeping with Fed. R. Civ. P. 37, may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for resolution adversely to that party.

viii. ***Extensions:*** The time for responding to discovery requests may be extended by the Presiding Arbitrator for good and sufficient cause shown. Any request for such an extension shall be made in writing.

I. Panel Suggested Settlement/Mediation

At any point during the proceedings, the Panel at the request of any party or on its own initiative, may suggest that the parties explore settlement and that they do so at or before the conclusion of the Arbitration Hearing, and the Panel shall give such assistance in settlement negotiations as the parties may request and the Panel may deem appropriate. Alternatively, the Panel may direct the parties to endeavor to mediate their disputes as provided above, or to explore a mini-trial proceeding, or to have an independent party render a neutral evaluation of the parties' respective positions. The Panel shall enter such sanctions as it deems appropriate with respect to any party failing to pursue in good faith such Mediation or other alternate dispute resolution methods.

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J. Subpoenas on Third Parties

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq.*, and subject to Paragraph 3.G(iii) above, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan or any officer, employee or director of a third party Blue Plan, to compel deposition testimony or the production of documents, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena.

K. Arbitration Hearing

An Arbitration Hearing will be held within thirty (30) days after the Administrative Conference if no discovery is taken, or within thirty (30) days after the close of discovery, unless all parties and the Panel agree to extend the Arbitration Hearing date, or unless the parties agree in writing to waive the Arbitration Hearing. The parties may mutually agree on the location of the Arbitration Hearing. If the parties fail to agree, the Arbitration Hearing shall be held in Chicago, Illinois, or at such other location determined by the Presiding Arbitrator to be most convenient to the participants. The Panel will determine the date(s) and time(s) of the Arbitration Hearing(s) after consultation with all parties and shall provide reasonable notice thereof to all parties or their representatives.

L. Arbitration Hearing Memoranda

Twenty (20) days prior to the Arbitration Hearing, each party shall submit to the other party (or parties) and to the Panel an Arbitration Hearing Memorandum which sets forth the applicable law and any argument as to any relevant issue. The Arbitration Hearing Memorandum will supplement, and not repeat, the allegations, information and documents contained in or with the Complaint, Answer, Counterclaim and Reply, if any. Ten (10) days prior to the Arbitration Hearing, each party shall submit to each other party a list of all expert and fact witnesses (but not including rebuttal fact witness) that such party intends to have testify at the Arbitration Hearing and a brief summary of the testimony each such witness is expected to give. In addition, no later than five (5) days prior to the Arbitration, each party may submit to each other party and to the Panel a Response Arbitration Hearing Memorandum which sets forth any response to another party's Arbitration Hearing Memorandum.

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M. Notice For Testimony

Ten (10) days prior to the Arbitration Hearing, any party may serve a Notice on any other party (or parties) requesting the attendance at the Arbitration Hearing of any officer, employee or director of the other party (or parties) for the purpose of providing noncumulative testimony. If a party fails to produce one of its officers, employees or directors whose noncumulative testimony during the Arbitration Hearing is reasonably requested by an adverse party, the Panel may refuse to allow that party to support or oppose designated claims or defenses, prohibit that party from introducing designated matters into evidence or, in extreme cases, decide an issue submitted for mandatory dispute resolution adversely to that party; provided, however, that a party may refuse to produce a director to testify if, within two (2) days of receiving a notice requesting the attendance of such director at the Arbitration Hearing, the party agrees to make the director available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. This Rule may not be used for the purpose of burdening or harassing any party, and the Presiding Arbitrator may impose such orders as are appropriate so as to prevent or remedy any such burden or harassment.

Pursuant to, and consistent with, the Federal Arbitration Act, 9 U.S.C. § 9 *et seq.*, twenty (20) days or more prior to the Arbitration Hearing, a party may request the issuance of a subpoena on any third party, including but not limited to any third party Blue Plan, BCBSA or any officer, employee or director of a third party Blue Plan or BCBSA for the purpose of providing noncumulative testimony at the Arbitration Hearing, and, if good and sufficient cause is shown, the Panel shall issue such a subpoena; provided however, that a director of a third party Blue Plan or BCBSA may refuse to testify if, within two (2) days of receiving a subpoena requesting the attendance of such director at the Arbitration Hearing, the director agrees to make him/herself available for a de bene esse deposition at a mutually convenient time at any location within fifty (50) miles of the director's primary residence chosen by the party requesting the director's testimony. Each Blue Plan agrees to waive, on its own behalf and on behalf of its directors and officers, any objection it otherwise might have to any such subpoena based on service, venue or extraterritoriality.

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N. Arbitration Hearing Procedures

- i. **Attendance at Arbitration Hearing:** Any person having a direct interest in the proceeding is entitled to attend the Arbitration Hearing. The Presiding Arbitrator shall otherwise have the power to require the exclusion of any witness, other than a party or other essential person, during the testimony of any other witness. It shall be discretionary with the Presiding Arbitrator to determine the propriety of the attendance of any other person.
- ii. **Confidentiality:** The Panel and all parties shall maintain the privacy of the Arbitration Proceeding. The parties and the Panel shall treat the Arbitration Hearing and any discovery or other proceedings or events related thereto, including any award resulting therefrom, as confidential except as otherwise necessary in connection with a judicial challenge to or enforcement of an award or unless otherwise required by law.
- iii. **Stenographic Record:** Any party, or if the parties do not object, the Panel, may request that a stenographic or other record be made of any Arbitration Hearing or portion thereof. The costs of the recording and/or of preparing the transcript shall be borne by the requesting party and by any party who receives a copy thereof. If the Panel requests a recording and/or a transcript, the costs thereof shall be borne equally by the parties.
- iv. **Oaths:** The Panel may require witnesses to testify under oath or affirmation administered by any duly qualified person and, if requested by any party, shall do so.
- v. **Order of Arbitration Hearing:** An Arbitration Hearing shall be opened by the recording of the date, time, and place of the Arbitration Hearing, and the presence of the Panel, the parties, and their representatives, if any. The Panel may, at the beginning of the Arbitration Hearing, ask for statements clarifying the issues involved.

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Unless otherwise agreed, the complaining party (or parties) shall then present evidence to support their claim(s). The respondent(s) shall then present evidence supporting their defenses and Counterclaims, if any. The complaining party (or parties) shall then present evidence supporting defenses to the Counterclaims, if any, and rebuttal.

Witnesses for each party shall submit to questions by adverse parties and/or the Panel.

The Panel has the discretion to vary these procedures, but shall afford a full and equal opportunity to all parties for the presentation of any material and relevant evidence.

vi. **Evidence:** The parties may offer such evidence as is relevant and material to the dispute and shall produce such evidence as the Panel may deem necessary to an understanding and resolution of the dispute. Unless good cause is shown, as determined by the Panel or agreed to by all other parties, no party shall be permitted to offer evidence at the Arbitration Hearing which was not disclosed prior to the Arbitration Hearing by that party. The Panel may receive and consider the evidence of witnesses by affidavit upon such terms as the Panel deems appropriate.

The Panel shall be the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence, other than enforcement of the attorney-client privilege and the work product protection, shall not be necessary. The Federal Rules of Evidence shall be considered by the Panel in conducting the Arbitration Hearing but those rules shall not be controlling. All evidence shall be taken in the presence of the Panel and all of the parties, except where any party is in default or has waived the right to be present.

Settlement offers by any party in connection with Mediation or MDR proceedings, decisions or recommendations of the selected mediators, and a party's position papers or statements furnished to the selected mediators shall not be admissible evidence or considered by the Panel without the consent of all parties.

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- vii. ***Closing of Arbitration Hearing:*** The Presiding Arbitrator shall specifically inquire of all parties whether they have any further proofs to offer or witnesses to be heard. Upon receiving negative replies or if he or she is satisfied that the record is complete, the Presiding Arbitrator shall declare the Arbitration Hearing closed with an appropriate notation made on the record. Subject to being reopened as provided below, the time within which the Panel is required to make the award shall commence to run, in the absence of contrary agreement by the parties, upon the closing of the Arbitration Hearing.

With respect to complex disputes, the Panel may, in its sole discretion, defer the closing of the Arbitration Hearing for a period of up to thirty (30) days after the presentation of proofs in order to permit the parties to submit post-hearing briefs and argument, as the Panel deems appropriate, prior to making an award.

For good cause, the Arbitration Hearing may be reopened for up to thirty (30) days on the Panel's initiative, or upon application of a party, at any time before the award is made

O. Awards

An Award must be in writing and shall be made promptly by the Panel and, unless otherwise agreed by the parties or specified by law, no later than thirty (30) days from the date of closing the Arbitration Hearing. If all parties so request, the Award shall contain findings of fact and conclusions of law. The Award, and all other rulings and determinations by the Panel, may be by a majority vote.

Parties shall accept as legal delivery of the Award the placing of the Award or a true copy thereof in the mail addressed to a party or its representative at its last known address or personal service of the Award on a party or its representative.

Awards are binding only on the parties to the Arbitration and are not binding on any non-parties to the Arbitration and may not be used or cited as precedent in any other proceeding.

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After the expiration of twenty (20) days from initial delivery, the Award (with corrections, if any) shall be final and binding on the parties, and the parties shall undertake to carry out the Award without delay.

Proceedings to confirm, modify or vacate an Award shall be conducted in conformity with and controlled by the Federal Arbitration Act. 9 U.S.C. § 1, *et seq.*

P. Return of Documents

Within sixty (60) days after the Award and the conclusion of any judicial proceedings with respect thereto, each party and the Panel shall return any documents produced by any other party, including all copies thereof. If a party receives a discovery request in any other proceeding which would require it to produce any documents produced to it by any other party in a proceeding hereunder, it shall not produce such documents without first notifying the producing party and giving said party reasonable time to respond, if appropriate, to the discovery request.

4. Miscellaneous

A. Expedited Procedures

Any party to a Mediation may direct a request for an expedited Mediation Hearing to the Chairman of the Mediation Committee, to the selected Mediators, and to all other parties at any time. The Chairman of the Mediation Committee, or at his or her direction, the then selected Mediators, shall grant any request which is supported by good and sufficient reasons. If such a request is granted, the Mediation shall be completed within as short a period as practicable, as determined by the Chairman of the Mediation Committee or, at his or her direction, the then selected Mediators.

Any party to an Arbitration may direct a request for expedited proceedings to the Administrator, to the Panel, and to all other parties at any time. The Administrator, or the Presiding Arbitrator if the Panel has been selected, shall grant any such request which is supported by good and sufficient reasons. If such a request is granted, the Arbitration shall be completed within as short a time as practicable, as determined by the Administrator and/or the Presiding Arbitrator.

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B. Temporary or Preliminary Injunctive Relief

Any party may seek temporary or preliminary injunctive relief with the filing of a Complaint or at any time thereafter. If such relief is sought prior to the time that an Arbitration Panel has been selected, then the Administrator shall select a single Arbitrator who is a lawyer who has no interest in the subject matter of the dispute, and no connection to any of the parties, to hear and determine the request for temporary or preliminary injunction. If such relief is sought after the time that an Arbitration Panel has been selected, then the Arbitration Panel will hear and determine the request. The request for temporary or preliminary injunctive relief will be determined with reference to the temporary or preliminary injunction standards set forth in Fed. R. Civ. P. 65.

C. Defaults and Proceedings in the Absence of a Party

Whenever a party fails to comply with the MDR Rules in a manner deemed material by the Panel, the Panel shall fix a reasonable time for compliance and, if the party does not comply within said period, the Panel may enter an Order of default or afford such other relief as it deems appropriate. Arbitration may proceed in the event of a default or in the absence of any party who, after due notice, fails to be present or fails to obtain an extension. An Award shall not be made solely on the default or absence of a party, but the Panel shall require the party who is present to submit such evidence as the Panel may require for the making of findings, determinations, conclusions, and Awards.

D. Notice

Each party shall be deemed to have consented that any papers, notices, or process necessary or proper for the initiation or continuation of a proceeding under these rules or for any court action in connection therewith may be served on a party by mail addressed to the party or its representative at its last known address or by personal service, in or outside the state where the MDR proceeding is to be held.

The Corporate Secretary and the parties may also use facsimile transmission, telex, telegram, or other written forms of electronic communication to give the notices required by these rules.

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E. Expenses

The expenses of witnesses shall be paid by the party causing or requesting the appearance of such witnesses. All expenses of the MDR proceeding, including compensation, required travel and other reasonable expenses of the Panel, and the cost of any proof produced at the direct request of the Panel, shall be borne equally by the parties and shall be paid periodically on a timely basis, unless they agree otherwise or unless the Panel in the Award assesses such expenses, or any part thereof against any party (or parties). In exceptional cases, the Panel may award reasonable attorneys' fees as an item of expense, and the Panel shall promptly determine the amount of such fees based on affidavits or such other proofs as the Panel deems sufficient.

F. Disqualification or Disability of A Panel Member

In the event that any Arbitrator of a Panel with more than one Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the remaining Panel member(s):

- i. shall designate a replacement, subject to the right of any party to challenge such replacement for cause.
- ii. shall decide the extent to which previously held hearings shall be repeated.

If the remaining Panel members consider the proceedings to have progressed to a stage as to make replacement impracticable, the parties may agree, as an alternative to the recommencement of the Mandatory Dispute Resolution process, to resolution of the dispute by the remaining Panel members.

In the event that a single Arbitrator should become disqualified, resign, die, or refuse or be unable to perform or discharge his or her duties after the commencement of MDR but prior to the rendition of an Award, and the parties are unable to agree upon a replacement, the Administrator shall appoint a successor, subject to the right of any party to challenge such successor for cause, and the successor shall decide the extent to which previously held proceedings shall be repeated.

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G. Extensions of Time

Subject to the provisions of Paragraph 3.H.(viii), any time limit set forth in these Rules may be extended upon agreement of the parties and approval of: (1) the Mediator if the proceeding is then in Mediation; (2) the Administrator if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (3) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected.

H. Intervention

The Plans, their Controlled Affiliates, and BCBSA, to the extent subject to MMDR pursuant to their License Agreements, shall have the right to move to intervene in any pending Arbitration. A written motion for intervention shall be made to: (1) the Administrator, if the proceeding is in Arbitration, but no Arbitration Panel has been selected; or (2) the Arbitration Panel, if the proceeding is in Arbitration and the Arbitration Panel has been selected. The written motion for intervention shall be delivered to the BCBSA Corporate Secretary (which shall also constitute service on the BCBSA if it is a respondent) and to any Plan(s) and/or Controlled Affiliate(s) which are parties to the proceeding. Any party to the proceeding can submit written objections to the motion to intervene. The motion for intervention shall be granted upon good cause shown. Intervention also may be allowed by stipulation of the parties to the Arbitration proceeding. Intervention shall be allowed upon such terms as the Arbitration Panel decides.

I. BCBSA Assistance In Resolution of Disputes

The resources and personnel of the BCBSA may be requested by any member Plan at any time to try to resolve disputes with another Plan.

J. Neutral Evaluation

The parties can voluntarily agree at any time to have an independent party render a neutral evaluation of the parties' respective positions.

Amended as of September 20, 2007

EXHIBIT 5

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K. Recovery of Attorney Fees and Expenses

i. Motions to Compel

Notwithstanding any other provisions of these Rules, any Party subject to the License Agreements (for purposes of this Section K and all of its sub-sections only hereinafter referred to collectively and individually as a "Party") that initiates a court action or administrative proceeding solely to compel adherence to these Rules shall not be determined to have violated these Rules by initiating such action or proceeding.

ii. Recovery of Fees, Expenses and Costs

The Arbitration Panel may, in its sole discretion, award a Party its reasonable attorneys' fees, expenses and costs associated with a filing to compel adherence to these Rules and/or reasonable attorneys' fees, expenses and costs incurred in responding to an action filed in violation of these Rules; provided, however, that neither fees, expenses, nor costs shall be awarded by the Arbitration Panel if the Party from which the award is sought can demonstrate to the Arbitration panel, in its sole discretion, that it did not violate these Rules or that it had reasonable grounds for believing that its action did not violate these Rules.

iii. Requests for Reimbursement

For purposes of this Section K, any Party may request reimbursement of fees, expenses and/or costs by submitting said request in writing to the Arbitration Panel at any time before an award is delivered pursuant to Paragraph 3.O above, with a copy to the Party from which reimbursement is sought, explaining why it is entitled to such reimbursement. The Party from which reimbursement is sought shall have twenty (20) days to submit a response to such request to the Arbitration Panel with a copy to the Party seeking reimbursement.

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L. Calculation of Time and Deadlines

In computing any period of time prescribed or allowed under these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the period runs until the end of the next day which is not one of the aforementioned days. When the period of time prescribed is less than six (6) days, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation. As used in this rule, "legal holiday" includes New Year's Day, Martin Luther King, Jr. Day, Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day and any other day appointed as a holiday by the President or the Congress of the United States.

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Exhibit 21

<i>Legal Name</i>	<i>State</i>
American Imaging Management, Inc. (d/b/a AIM Specialty Health)	Illinois
AMERIGROUP Arizona, Inc.	Arizona
AMERIGROUP Community Care of New Mexico, Inc.	New Mexico
AMERIGROUP Corporation (d/b/a AMERIGROUP CORPORATION; AGP Corporation; AMGP; AMGP Corporation; AMGP Missouri, Inc.; Amerigroup)	Delaware
AMERIGROUP Florida, Inc. (d/b/a AMERIGROUP Community Care)	Florida
Amerigroup Insurance Company	Texas
Amerigroup Kansas, Inc.	Kansas
AMERIGROUP Louisiana, Inc. (d/b/a AMERIGROUP Community Care; Amerigroup Community Care)	Louisiana
AMERIGROUP Maryland, Inc. (d/b/a AMERIGROUP Community Care)	Maryland
AMERIGROUP Nevada, Inc. (d/b/a AMERIGROUP Community Care)	Nevada
AMERIGROUP New Jersey, Inc. (d/b/a AMERIGROUP Community Care)	New Jersey
AMERIGROUP New York, LLC (HealthPlus Amerigroup; HealthPlus, an Amerigroup Company; AMERIGROUP Community Care)	New York
AMERIGROUP Ohio, Inc. (d/b/a AMERIGROUP Community Care)	Ohio
AMERIGROUP Pennsylvania, Inc.	Pennsylvania
Amerigroup Services, Inc.	Virginia
AMERIGROUP Tennessee, Inc. (d/b/a AMERIGROUP Community Care)	Tennessee
AMERIGROUP Texas, Inc. (d/b/a AMERIGROUP Community Care)	Texas
AMERIGROUP Washington, Inc.	Washington
AMGP Georgia Managed Care Company, Inc. (d/b/a AMERIGROUP; AMERIGROUP Community Care; AMERIGROUP Georgia; AMGP Georgia)	Georgia
Anthem, Inc.	Indiana
Anthem Blue Cross Life and Health Insurance Company	California
Anthem Financial, Inc.	Delaware
Anthem Health Insurance Company of Nevada	Nevada
Anthem Health Plans of Kentucky, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Kentucky
Anthem Health Plans of Maine, Inc. (d/b/a Anthem Blue Cross and Blue Shield and Associated Hospital Service)	Maine
Anthem Health Plans of New Hampshire, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	New Hampshire
Anthem Health Plans of Virginia, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Virginia
Anthem Health Plans, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Connecticut
Anthem Holding Corp. (d/b/a Anthem Properties, Inc.)	Indiana
Anthem Insurance Companies, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Indiana
Anthem Kentucky Managed Care Plan, Inc. (d/b/a Anthem Blue Cross and Blue Shield Medicaid)	Kentucky
Anthem Life & Disability Insurance Company	New York - DOI
Anthem Life Insurance Company	Indiana
Anthem Southeast, Inc.	Indiana
Anthem UM Services, Inc.	Indiana
Anthem Workers' Compensation, LLC	Indiana
Arcus Enterprises, Inc.	Delaware
ARCUS HealthyLiving Services, Inc.	Indiana
Associated Group, Inc.	Indiana

<i>Legal Name</i>	<i>State</i>
ATH Holding Company, LLC	Indiana
Better Health, Inc.	Florida
Blue Cross and Blue Shield of Georgia, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Georgia
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (d/b/a Anthem Blue Cross and Blue Shield)	Georgia
Blue Cross Blue Shield of Wisconsin (d/b/a Anthem Blue Cross and Blue Shield)	Wisconsin
Blue Cross of California (d/b/a Anthem Blue Cross)	California
Blue Cross of California Partnership Plan, Inc.(d/b/a Anthem Blue Cross Partnership Plan)	California
CareMore Health Group, Inc.	Delaware
CareMore Health Plan	California
CareMore Health Plan of Arizona, Inc.	Arizona
CareMore Health Plan of Colorado, Inc.	Colorado
CareMore Health Plan of Georgia, Inc.	Georgia
CareMore Health Plan of Nevada	Nevada
CareMore Health Plan of Texas, Inc.	Texas
CareMore Health System	California
CareMore Holdings, Inc.	Delaware
CareMore IPA of New York, LLC	New York
CareMore Medical Management Company, a California Limited Partnership	California
CareMore Services Company, LLC	Indiana
CareMore, LLC	Indiana
Cerulean Companies, Inc.	Georgia
Claim Management Services, Inc.(d/b/a Anthem Blue Cross and Blue Shield)	Wisconsin
CMMC Holding Company, LLC	Delaware
Community Insurance Company (d/b/a Anthem Blue Cross and Blue Shield)	Ohio
CompCare Health Services Insurance Corporation (d/b/a Anthem Blue Cross and Blue Shield)	Wisconsin
Crossroads Acquisition Corp.	Delaware
DeCare Analytics, LLC	Minnesota
DeCare Dental Health International, LLC	Minnesota
DeCare Dental Insurance Ireland, Ltd.	Ireland
DeCare Dental Networks, LLC	Minnesota
DeCare Dental, LLC	Minnesota
DeCare Operations Ireland, Limited	Ireland
DeCare Systems Ireland, Limited	Ireland
Designated Agent Company, Inc. (d/b/a Access Insurance Agency, Inc.)	Kentucky
EHC Benefits Agency, Inc.	New York
Empire HealthChoice Assurance, Inc. (d/b/a Empire Blue Cross; Empire Blue Cross Blue Shield)	New York - DOI
Empire HealthChoice HMO, Inc. (d/b/a Empire Blue Cross HMO; Empire Blue Cross Blue Shield HMO)	New York
Forty-Four Forty-Four Forest Park Redevelopment Corporation	Missouri
Golden West Health Plan, Inc.	California
Government Health Services, L.L.C.	Wisconsin
Greater Georgia Life Insurance Company (d/b/a Anthem Life)	Georgia
Health Core, Inc.	Delaware
Health Management Corporation (d/b/a LiveHealth Online; HMC of Virginia; Health Management of Virginia)	New York

<i>Legal Name</i>	<i>State</i>
Health Ventures Partner, L.L.C.	Illinois
HealthKeepers, Inc.	Virginia
HealthLink HMO, Inc. (d/b/a HealthLink HMO)	Missouri
HealthLink, Inc.	Illinois
Healthy Alliance Life Insurance Company (d/b/a Anthem Blue Cross and Blue Shield)	Missouri
HMO Colorado, Inc. (d/b/a HMO Colorado; HMO Nevada)	Colorado
HMO Missouri, Inc. (d/b/a Amerigroup Missouri; Anthem Blue Cross and Blue Shield)	Missouri
Imaging Management Holdings, LLC	Delaware
Imaging Providers of Texas	Texas
Matthew Thomson Health Plan, Inc.	New Hampshire
Meridian Resource Company, LLC	Wisconsin
National Government Services, Inc. (d/b/a NGS of Indiana)	Indiana
National Telehealth Network, LLC	Delaware
OneNation Insurance Company (d/b/a Anthem Alliance Health Insurance Company)	Indiana
Park Square Holdings, Inc.	California
Park Square I, Inc.	California
Park Square II, Inc.	California
PHP Holdings, Inc.	Florida
R & P Realty, Inc.	Missouri
Resolution Health, Inc.	Delaware
RightCHOICE Managed Care, Inc. (d/b/a RightCHOICE Benefit Administrators; Anthem Blue Cross and Blue Shield)	Delaware
Rocky Mountain Hospital and Medical Service, Inc.(d/b/a Anthem Blue Cross and Blue Shield)	Colorado
SellCore, Inc. (d/b/a SellCore Insurance Services, Inc.)	Delaware
Simply Healthcare Holdings, Inc.	Florida
Simply Healthcare Plans, Inc. (d/b/a Clear Health Alliance)	Florida
Southeast Services, Inc.	Virginia
State Sponsored Business UM Services, Inc.	Indiana
The Anthem Companies of California, Inc.	California
The Anthem Companies, Inc.	Indiana
TrustSolutions, LLC	Wisconsin
UNICARE Health Plan of Kansas, Inc.	Kansas
UNICARE Health Plan of West Virginia, Inc.	West Virginia
UNICARE Health Plans of Texas, Inc.	Texas
UNICARE Illinois Services, Inc.	Illinois
UniCare Life & Health Insurance Company	Indiana
UNICARE National Services, Inc.	Delaware
UniCare Specialty Services, Inc.	Delaware
UtiliMED IPA, Inc.	New York
WellPoint Acquisition, LLC	Indiana
WellPoint Behavioral Health, Inc.	Delaware
WellPoint California Services, Inc.	Delaware
WellPoint Dental Services, Inc.	Delaware
WellPoint Holding Corp.	Delaware
WellPoint Information Technology Services, Inc.	California
WellPoint Insurance Services, Inc.	Hawaii

<i>Legal Name</i>	<i>State</i>
WellPoint Military Care Corporation	Indiana
WellPoint Partnership Plan, LLC	Illinois
WPMI (Shanghai) Enterprise Service Co., Ltd.	China
WPMI, LLC	Delaware

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the following Registration Statements:

- Form S-8 No. 333-73516 and Form S-8 No. 333-110503 pertaining to the Anthem 2001 Stock Incentive Plan;
- Form S-8 No. 333-84906 and Form S-8 No. 333-129334 pertaining to the Anthem 401(k) Plan;
- Form S-8 No. 333-159830 pertaining to the Anthem Incentive Compensation Plan;
- Form S-8 No. 333-156099 pertaining to the Anthem, Inc. Employee Stock Purchase Plan;
- Form S-8 No. 333-185675 pertaining to the AMERIGROUP Corporation 2009 Equity Incentive Plan; and
- Form S-3 No. 333-200749 pertaining to the Anthem, Inc. automatic shelf registration

of our report dated February 24, 2015, with respect to the consolidated financial statements and schedule of Anthem, Inc., and the effectiveness of internal control over financial reporting of Anthem, Inc., included in its Annual Report (Form 10-K) for the year ended December 31, 2014.

/S/ ERNST & YOUNG LLP
Indianapolis, Indiana
February 24, 2015

Exhibit 31.1

**CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, Joseph R. Swedish, certify that:

1. I have reviewed this report on Form 10-K of Anthem, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):
 - a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 24, 2015

/s/ JOSEPH R. SWEDISH

Chief Executive Officer

Exhibit 31.2

**CERTIFICATION PURSUANT TO
RULE 13a-14(a) AND RULE 15d-14(a) OF THE EXCHANGE ACT RULES,
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002**

I, Wayne S. DeVeydt, certify that:

1. I have reviewed this report on Form 10-K of Anthem, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - a) designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - b) designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - c) evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - d) disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent function):
 - a) all significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - b) any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 24, 2015

/s/ WAYNE S. DEVEYDT

Executive Vice President and
Chief Financial Officer

Exhibit 32.1

**CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report of Anthem, Inc. (the "Company") on Form 10-K for the period ended December 31, 2014 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Joseph R. Swedish, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

- (1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
- (2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ JOSEPH R. SWEDISH

Joseph R. Swedish
Chief Executive Officer
February 24, 2015

Exhibit 32.2

**CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Annual Report of Anthem, Inc. (the "Company") on Form 10-K for the period ended December 31, 2014 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Wayne S. DeVeydt, Executive Vice President and Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to § 906 of the Sarbanes-Oxley Act of 2002, that:

- (1) The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
- (2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ WAYNE S. DEVEYDT

Wayne S. DeVeydt
Executive Vice President and Chief Financial Officer
February 24, 2015

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Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

All Lines of Business

Dollars in 000's

	2018												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2018
0. Members													-
1. Member Months													-
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	357,183	357,519	357,909	1,072,611
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	-	-	-	-	-	-	-	-	-	-	-	-	-
3. Fee for Service	-	-	-	-	-	-	-	-	-	-	-	-	-
4. Risk Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-
5. Change in Unearned Premium Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	8,882	8,892	8,901	26,675
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	366,065	366,410	366,811	1,099,286
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	230,719	222,335	222,299	675,352
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	35,433	30,944	30,362	96,739
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	66,701	62,356	63,618	192,676
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	3,676	3,681	3,685	11,042
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	336,529	319,316	319,964	975,809
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	336,529	319,316	319,964	975,809
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	8,393	8,371	8,388	25,152
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	25,364	24,943	24,726	75,034
16b. ACA Risk Adjustment User Fee Paid	-	-	-	-	-	-	-	-	-	-	-	-	-
17. Increase in Reserves for Accident and Health Contacts	-	-	-	-	-	-	-	-	-	-	-	-	-
18. Aggregate Write-Ins for Other Income or Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	370,286	352,630	353,078	1,075,994
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	(4,221)	13,781	13,733	23,292
21. Net Investment Income Earned	-	-	-	-	-	-	-	-	-	790	790	790	2,370
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	(1,270)	5,391	5,373	9,495
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	5,523	5,530	5,536	16,589
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(7,685)	3,650	3,613	(422)

Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

All Lines of Business

Dollars in 000's

	2019												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2019
0. Members													-
1. Member Months													-
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	363,635	364,218	364,888	365,758	366,414	368,603	367,949	368,638	369,183	378,429	378,772	379,174	4,435,659
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	-	-	-	-	-	-	-	-	-	-	-	-	-
3. Fee for Service	-	-	-	-	-	-	-	-	-	-	-	-	-
4. Risk Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-
5. Change in Unearned Premium Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-
6. ACA Health Insurer Fee Subsidy Premium	9,001	9,011	9,021	9,031	9,041	9,050	9,060	9,070	9,080	9,358	9,368	9,378	109,470
7. Total (L2a,b+L3+L4+L5+L6)	372,636	373,229	373,909	374,789	375,455	377,654	377,009	377,708	378,263	387,787	388,140	388,552	4,545,130
Hospital and Medical:													
8. Hospital/Medical Benefits	235,571	217,103	234,146	230,027	237,620	227,864	234,593	239,647	230,566	247,589	239,595	239,545	2,813,865
9. Other Benefits & Professional Services	32,205	27,480	30,278	29,775	30,538	28,473	29,686	30,236	28,772	32,345	30,547	30,436	360,771
10. Prescription Drugs	68,364	59,939	65,387	62,217	64,104	59,676	61,894	63,774	58,982	68,847	64,287	65,574	763,046
11. Expanded Benefits	3,689	3,693	3,698	3,702	3,706	3,711	3,715	3,719	3,724	3,728	3,732	3,737	44,555
12. Subtotal (L8+L9+L10+L11)	339,829	308,215	333,509	325,721	335,969	319,723	329,887	337,376	322,044	352,510	338,162	339,292	3,982,236
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	339,829	308,215	333,509	325,721	335,969	319,723	329,887	337,376	322,044	352,510	338,162	339,292	3,982,236
15. Claims Adjustment Expenses	8,435	8,444	8,454	8,463	8,473	8,482	8,491	8,501	8,510	8,738	8,748	8,758	102,496
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	23,693	23,334	23,931	23,908	24,264	24,300	24,260	24,421	25,212	26,929	26,488	26,248	296,987
16b. ACA Risk Adjustment User Fee Paid	-	-	-	-	-	-	-	-	-	-	-	-	-
17. Increase in Reserves for Accident and Health Contacts	-	-	-	-	-	-	-	-	-	-	-	-	-
18. Aggregate Write-Ins for Other Income or Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	371,957	339,993	365,894	358,092	368,705	352,505	362,639	370,298	355,766	388,177	373,398	374,297	4,381,720
20. Net Underwriting Gain or Loss (L7 -L19)	679	33,236	8,015	16,697	6,750	25,149	14,370	7,410	22,497	(390)	14,742	14,255	163,410
21. Net Investment Income Earned	790	790	790	790	790	790	790	790	790	790	790	790	9,479
22. Federal Income Taxes	543	12,589	3,258	6,470	2,790	9,597	5,609	3,034	8,616	148	5,747	5,567	63,969
23. Health Insurance Provider Fee	5,585	5,591	5,597	5,603	5,609	5,615	5,621	5,627	5,633	5,806	5,812	5,818	67,915
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(4,659)	15,845	(49)	5,414	(859)	10,726	3,930	(461)	9,037	(5,554)	3,973	3,660	41,005

Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

All Lines of Business

Dollars in 000's

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members													-
1. Member Months													-
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	382,518	383,136	383,850	384,778	385,476	387,829	387,111	387,844	388,421	398,187	398,545	398,969	4,666,663
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	-	-	-	-	-	-	-	-	-	-	-	-	-
3. Fee for Service	-	-	-	-	-	-	-	-	-	-	-	-	-
4. Risk Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-
5. Change in Unearned Premium Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-
6. ACA Health Insurer Fee Subsidy Premium	9,403	9,413	9,423	9,433	9,443	9,454	9,464	9,474	9,485	9,778	9,788	9,799	114,357
7. Total (L2a,b+L3+L4+L5+L6)	391,920	392,549	393,273	394,211	394,919	397,282	396,575	397,318	397,906	407,964	408,334	408,768	4,781,020
Hospital and Medical:													
8. Hospital/Medical Benefits	247,249	228,043	245,768	241,509	249,442	239,286	246,321	251,619	242,150	259,974	251,648	251,558	2,954,566
9. Other Benefits & Professional Services	32,498	27,897	32,270	30,830	31,933	30,015	31,512	32,118	30,463	33,937	32,443	32,558	378,475
10. Prescription Drugs	72,084	63,205	68,949	65,611	67,606	62,943	65,286	67,261	62,195	72,605	67,787	69,141	804,672
11. Expanded Benefits	3,741	3,745	3,750	3,754	3,759	3,763	3,767	3,772	3,776	3,781	3,785	3,789	45,183
12. Subtotal (L8+L9+L10+L11)	355,573	322,891	350,737	341,704	352,738	336,007	346,887	354,769	338,585	370,296	355,663	357,046	4,182,897
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	355,573	322,891	350,737	341,704	352,738	336,007	346,887	354,769	338,585	370,296	355,663	357,046	4,182,897
15. Claims Adjustment Expenses	8,785	8,795	8,805	8,814	8,824	8,834	8,844	8,854	8,864	9,102	9,112	9,123	106,756
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	25,021	24,625	25,273	25,243	25,628	25,662	25,614	25,786	26,644	28,497	28,007	27,732	313,733
16b. ACA Risk Adjustment User Fee Paid	-	-	-	-	-	-	-	-	-	-	-	-	-
17. Increase in Reserves for Accident and Health Contacts	-	-	-	-	-	-	-	-	-	-	-	-	-
18. Aggregate Write-Ins for Other Income or Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	389,379	356,311	384,814	375,762	387,190	370,503	381,345	389,409	374,093	407,896	392,783	393,901	4,603,385
20. Net Underwriting Gain or Loss (L7 -L19)	2,541	36,238	8,458	18,450	7,729	26,779	15,230	7,910	23,813	69	15,551	14,867	177,635
21. Net Investment Income Earned	790	790	790	790	790	790	790	790	790	790	790	790	9,479
22. Federal Income Taxes	1,233	13,700	3,422	7,119	3,152	10,201	5,927	3,219	9,103	318	6,046	5,793	69,232
23. Health Insurance Provider Fee	5,833	5,840	5,846	5,852	5,859	5,865	5,871	5,878	5,884	6,066	6,073	6,079	70,947
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(3,735)	17,488	(20)	6,269	(492)	11,503	4,221	(397)	9,616	(5,525)	4,222	3,784	46,935

Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

All Lines of Business

Dollars in 000's

	2021												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2021
0. Members													-
1. Member Months													-
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	403,139	403,796	404,555	405,546	406,288	408,818	408,031	408,812	409,424	419,737	420,113	420,559	4,918,819
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	-	-	-	-	-	-	-	-	-	-	-	-	-
3. Fee for Service	-	-	-	-	-	-	-	-	-	-	-	-	-
4. Risk Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-
5. Change in Unearned Premium Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-
6. ACA Health Insurer Fee Subsidy Premium	9,843	9,853	9,864	9,875	9,886	9,896	9,907	9,918	9,929	10,238	10,249	10,260	119,718
7. Total (L2a,b+L3+L4+L5+L6)	412,982	413,649	414,419	415,421	416,174	418,714	417,938	418,730	419,352	429,975	430,363	430,819	5,038,537
Hospital and Medical:													
8. Hospital/Medical Benefits	260,183	240,206	258,645	254,240	262,531	251,957	259,315	264,870	254,995	273,659	264,985	264,854	3,110,439
9. Other Benefits & Professional Services	34,210	29,382	33,993	32,621	33,929	31,831	32,934	33,926	32,154	35,986	34,312	34,298	399,576
10. Prescription Drugs	76,015	66,655	72,711	69,196	71,305	66,395	68,871	70,945	65,590	76,574	71,484	72,908	848,650
11. Expanded Benefits	3,794	3,798	3,803	3,807	3,812	3,816	3,820	3,825	3,829	3,834	3,838	3,843	45,819
12. Subtotal (L8+L9+L10+L11)	374,201	340,041	369,152	359,865	371,576	354,000	364,941	373,565	356,569	390,053	374,620	375,902	4,404,485
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	374,201	340,041	369,152	359,865	371,576	354,000	364,941	373,565	356,569	390,053	374,620	375,902	4,404,485
15. Claims Adjustment Expenses	9,174	9,185	9,195	9,205	9,215	9,226	9,236	9,246	9,256	9,530	9,541	9,551	111,561
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	26,498	26,060	26,765	26,728	27,144	27,177	27,120	27,302	28,235	30,280	29,736	29,424	332,468
16b. ACA Risk Adjustment User Fee Paid	-	-	-	-	-	-	-	-	-	-	-	-	-
17. Increase in Reserves for Accident and Health Contacts	-	-	-	-	-	-	-	-	-	-	-	-	-
18. Aggregate Write-Ins for Other Income or Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	409,874	375,286	405,112	395,798	407,935	390,402	401,296	410,113	394,060	429,864	413,897	414,878	4,848,514
20. Net Underwriting Gain or Loss (L7 -L19)	3,108	38,363	9,307	19,624	8,238	28,312	16,642	8,616	25,292	112	16,466	15,941	190,023
21. Net Investment Income Earned	790	790	790	790	790	790	790	790	790	790	790	790	9,479
22. Federal Income Taxes	1,442	14,487	3,736	7,553	3,340	10,768	6,450	3,480	9,650	334	6,385	6,191	73,816
23. Health Insurance Provider Fee	6,106	6,113	6,120	6,126	6,133	6,140	6,146	6,153	6,160	6,352	6,359	6,365	74,273
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(3,651)	18,553	242	6,734	(445)	12,195	4,836	(227)	10,272	(5,784)	4,512	4,175	51,413

	2018											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Admitted Assets												
1. Bonds										379,598	380,388	381,178
2. Stock												
3. Real Estate/Mortgage Investments												
4. Cash/Cash Equivalents										185,716	192,554	280,856
5. Health Insurers Provider Fee (from AHCA)										64,502	73,393	0
6. Affiliated Receivables												
7. Affiliated Investments												
8. Aggregate Write-Ins for Invested Assets												
9. Aggregate Write-Ins for Other Than Invested Assets - ACA Risk Adjustment Receivable												
10. Amounts Recoverable from Reinsurers												
11. Other Assets										96,155	99,780	103,408
12. Total Assets(L1+L2+L3+L4+L5+L6+L7+L8+L9+L10+L11)	0	0	0	0	0	0	0	0	0	725,970	746,115	765,442
Liabilities												
13. Net Claims Unpaid (Accident and Health Policies)										213,566	220,074	225,546
14. Unpaid Claims Adjustment Expenses										6,748	6,954	7,127
15a. Aggregate Health Policy Reserves (Excluding ACA Risk Adjustment Payable and MLR Rebate)										46,248	46,248	46,248
15b. Aggregate Health Policy Reserves - ACA Risk Adjustment Payable												
15c. Aggregate Health Claim Reserves										31,717	31,717	31,717
16. Premiums Received in Advanced										0	0	0
17. General Expenses Due or Accrued										7,156	7,037	6,976
18. Ceded Reinsurance Payable												
19. Payable to Parents, Subsidiaries & Affiliates										5,814	6,597	7,376
20. Aggregate Write-Ins for Other Liabilities - Health Insurer Fee (Payable This Year)										-11,065	-5,536	0
21. Other Liabilities										81,981	85,569	89,384
22. Total Liabilities (L13+L14+L15a,b,c+L16+L17+L18+L19+L20+L21)	0	0	0	0	0	0	0	0	0	382,165	398,660	414,373
Capital and Surplus												
23. Aggregate Write-Ins for Special Surplus Funds - Health Insurer Fee (Payable Next Year)										51,650	51,650	51,650
24. Capital Stock												
25. Gross Paid In and Contributed Surplus										86,894	86,894	86,894
26. Surplus Notes										0	0	0
27. Unassigned Surplus										205,262	208,911	212,525
28. Other Items(elaborate)												
29. Total Capital and Surplus(L23+L24+L25+L26+L27+L28)	0	0	0	0	0	0	0	0	0	343,806	347,456	351,069

	2019											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Admitted Assets												
1. Bonds	396,473	397,263	398,053	398,843	399,633	400,423	401,213	402,003	402,793	403,583	404,373	405,162
2. Stock												
3. Real Estate/Mortgage Investments												
4. Cash/Cash Equivalents	336,811	345,973	358,197	341,822	344,275	354,741	348,336	348,816	288,945	257,185	258,346	368,701
5. Health Insurers Provider Fee (from AHCA)	9,001	18,013	27,034	36,065	45,105	54,156	63,216	72,286	81,366	90,724	100,092	0
6. Affiliated Receivables												
7. Affiliated Investments												
8. Aggregate Write-Ins for Invested Assets												
9. Aggregate Write-Ins for Other Than Invested Assets - ACA Risk Adjustment Receivable												
10. Amounts Recoverable from Reinsurers												
11. Other Assets	78,400	82,092	85,791	89,500	93,214	96,951	100,682	104,419	108,162	111,999	115,839	119,683
12. Total Assets(L1+L2+L3+L4+L5+L6+L7+L8+L9+L10+L11)	820,685	843,340	869,075	866,229	882,228	906,271	913,447	927,525	881,266	863,491	878,650	893,546
Liabilities												
13. Net Claims Unpaid (Accident and Health Policies)	303,475	289,359	292,183	291,856	293,491	292,162	292,510	293,607	292,939	295,125	295,749	296,352
14. Unpaid Claims Adjustment Expenses	9,589	9,143	9,232	9,222	9,274	9,232	9,243	9,277	9,256	9,325	9,345	9,364
15a. Aggregate Health Policy Reserves (Excluding ACA Risk Adjustment Payable and MLR Rebate)	46,248	46,248	46,248	46,248	46,248	46,248	46,248	46,248	46,248	46,248	46,248	46,248
15b. Aggregate Health Policy Reserves - ACA Risk Adjustment Payable												
15c. Aggregate Health Claim Reserves	31,717	31,717	31,717	31,717	31,717	31,717	31,717	31,717	31,717	31,717	31,717	31,717
16. Premiums Received in Advanced	0	0	0	0	0	0	0	0	0	0	0	0
17. General Expenses Due or Accrued	6,684	6,583	6,751	6,745	6,845	6,856	6,844	6,890	7,113	7,597	7,473	7,405
18. Ceded Reinsurance Payable												
19. Payable to Parents, Subsidiaries & Affiliates	1,297	2,580	3,888	4,503	5,649	6,796	6,808	7,796	8,807	7,841	8,681	9,514
20. Aggregate Write-Ins for Other Liabilities - Health Insurer Fee (Payable This Year)	5,585	11,175	16,772	22,374	27,983	33,598	39,219	44,846	-17,436	-11,630	-5,818	0
21. Other Liabilities	69,680	84,280	100,078	85,943	94,259	102,174	99,439	106,187	112,627	92,827	96,842	100,872
22. Total Liabilities (L13+L14+L15a,b,c+L16+L17+L18+L19+L20+L21)	474,275	481,085	506,869	498,609	515,466	528,783	532,028	546,568	491,272	479,050	490,236	501,473
Capital and Surplus												
23. Aggregate Write-Ins for Special Surplus Funds - Health Insurer Fee (Payable Next Year)	67,915	67,915	67,915	67,915	67,915	67,915	67,915	67,915	67,915	67,915	67,915	67,915
24. Capital Stock												
25. Gross Paid In and Contributed Surplus	86,894	86,894	86,894	86,894	86,894	86,894	86,894	86,894	86,894	86,894	86,894	86,894
26. Surplus Notes	0	0	0	0	0	0	0	0	0	0	0	0
27. Unassigned Surplus	191,600	207,446	207,396	212,811	211,952	222,679	226,609	226,147	235,185	229,631	233,604	237,264
28. Other Items(elaborate)												
29. Total Capital and Surplus(L23+L24+L25+L26+L27+L28)	346,410	362,255	362,206	367,620	366,762	377,488	381,418	380,957	389,994	384,440	388,413	392,074

	2020											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Admitted Assets												
1. Bonds	405,952	406,742	407,532	408,322	409,112	409,902	410,692	411,482	412,272	413,062	413,852	414,642
2. Stock												
3. Real Estate/Mortgage Investments												
4. Cash/Cash Equivalents	384,609	395,329	375,299	375,001	380,276	389,646	386,250	386,824	324,894	297,196	298,739	414,059
5. Health Insurers Provider Fee (from AHCA)	9,403	18,815	28,238	37,671	47,115	56,569	66,033	75,507	84,992	94,769	104,558	0
6. Affiliated Receivables												
7. Affiliated Investments												
8. Aggregate Write-Ins for Invested Assets												
9. Aggregate Write-Ins for Other Than Invested Assets - ACA Risk Adjustment Receivable												
10. Amounts Recoverable from Reinsurers												
11. Other Assets	78,591	82,475	86,367	90,268	94,176	98,108	102,033	105,965	109,903	113,939	117,980	122,025
12. Total Assets(L1+L2+L3+L4+L5+L6+L7+L8+L9+L10+L11)	878,555	903,362	897,436	911,262	930,679	954,225	965,008	979,778	932,060	918,966	935,128	950,726
Liabilities												
13. Net Claims Unpaid (Accident and Health Policies)	317,535	302,942	306,367	306,063	307,851	306,553	307,013	308,239	307,586	309,896	310,598	311,285
14. Unpaid Claims Adjustment Expenses	10,034	9,572	9,681	9,671	12,159	9,687	9,701	9,740	9,719	9,792	9,814	9,836
15a. Aggregate Health Policy Reserves (Excluding ACA Risk Adjustment Payable and MLR Rebate)	46,248	46,248	46,248	46,248	46,248	46,248	46,248	46,248	46,248	46,248	46,248	46,248
15b. Aggregate Health Policy Reserves - ACA Risk Adjustment Payable												
15c. Aggregate Health Claim Reserves	31,717	31,717	31,717	31,717	31,717	31,717	31,717	31,717	31,717	31,717	31,717	31,717
16. Premiums Received in Advanced	0	0	0	0	0	0	0	0	0	0	0	0
17. General Expenses Due or Accrued	7,059	6,947	7,130	7,122	7,230	7,240	7,226	7,275	7,517	8,040	7,901	7,824
18. Ceded Reinsurance Payable												
19. Payable to Parents, Subsidiaries & Affiliates	1,365	2,714	4,090	4,738	5,943	7,151	7,163	8,202	9,267	8,253	9,137	10,015
20. Aggregate Write-Ins for Other Liabilities - Health Insurer Fee (Payable This Year)	5,833	11,673	17,519	23,371	29,230	35,095	40,967	46,844	-18,218	-12,152	-6,079	0
21. Other Liabilities	70,425	85,721	68,877	70,257	78,716	87,448	87,664	94,601	101,697	86,171	90,568	94,792
22. Total Liabilities (L13+L14+L15a,b,c+L16+L17+L18+L19+L20+L21)	490,216	497,534	491,629	499,186	519,095	531,138	537,699	552,866	495,533	487,965	499,904	511,717
Capital and Surplus												
23. Aggregate Write-Ins for Special Surplus Funds - Health Insurer Fee (Payable Next Year)	70,947	70,947	70,947	70,947	70,947	70,947	70,947	70,947	70,947	70,947	70,947	70,947
24. Capital Stock												
25. Gross Paid In and Contributed Surplus	86,894	86,894	86,894	86,894	86,894	86,894	86,894	86,894	86,894	86,894	86,894	86,894
26. Surplus Notes	0	0	0	0	0	0	0	0	0	0	0	0
27. Unassigned Surplus	230,498	247,986	247,966	254,235	253,743	265,246	269,467	269,070	278,686	273,161	277,383	281,168
28. Other Items(elaborate)												
29. Total Capital and Surplus(L23+L24+L25+L26+L27+L28)	388,339	405,827	405,807	412,076	411,584	423,087	427,308	426,911	436,527	431,002	435,224	439,009

	2021											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Admitted Assets												
1. Bonds	415,432	416,222	417,012	417,802	418,592	419,381	420,171	420,961	421,751	422,541	423,331	424,121
2. Stock												
3. Real Estate/Mortgage Investments												
4. Cash/Cash Equivalents	440,308	451,910	466,347	449,219	452,683	464,856	458,446	459,474	394,582	360,013	361,589	482,580
5. Health Insurers Provider Fee (from AHCA)	9,843	19,696	29,560	39,435	49,321	59,217	69,124	79,042	88,971	99,209	109,458	0
6. Affiliated Receivables												
7. Affiliated Investments												
8. Aggregate Write-Ins for Invested Assets												
9. Aggregate Write-Ins for Other Than Invested Assets - ACA Risk Adjustment Receivable												
10. Amounts Recoverable from Reinsurers												
11. Other Assets	78,800	82,894	86,995	91,107	95,226	99,371	103,507	107,652	111,803	116,058	120,318	124,581
12. Total Assets(L1+L2+L3+L4+L5+L6+L7+L8+L9+L10+L11)	944,383	970,722	999,914	997,563	1,015,822	1,042,826	1,051,249	1,067,129	1,017,106	997,821	1,014,695	1,031,282
Liabilities												
13. Net Claims Unpaid (Accident and Health Policies)	334,170	318,917	322,499	322,216	324,138	322,803	323,246	324,540	323,861	326,307	327,056	327,776
14. Unpaid Claims Adjustment Expenses	10,559	10,077	10,190	10,181	10,242	10,200	10,214	10,255	10,233	10,311	10,334	10,357
15a. Aggregate Health Policy Reserves (Excluding ACA Risk Adjustment Payable and MLR Rebate)	46,248	46,248	46,248	46,248	46,248	46,248	46,248	46,248	46,248	46,248	46,248	46,248
15b. Aggregate Health Policy Reserves - ACA Risk Adjustment Payable												
15c. Aggregate Health Claim Reserves	31,717	31,717	31,717	31,717	31,717	31,717	31,717	31,717	31,717	31,717	31,717	31,717
16. Premiums Received in Advanced	0	0	0	0	0	0	0	0	0	0	0	0
17. General Expenses Due or Accrued	7,476	7,352	7,551	7,541	7,658	7,667	7,651	7,703	7,966	8,543	8,389	8,301
18. Ceded Reinsurance Payable												
19. Payable to Parents, Subsidiaries & Affiliates	1,440	2,863	4,315	4,998	6,271	7,545	7,558	8,654	9,779	8,712	9,647	10,575
20. Aggregate Write-Ins for Other Liabilities - Health Insurer Fee (Payable This Year)	6,106	12,220	18,339	24,466	30,599	36,738	42,885	49,038	-19,076	-12,724	-6,365	0
21. Other Liabilities	71,308	87,415	104,902	89,309	98,507	107,270	104,258	111,729	118,860	96,973	101,422	105,886
22. Total Liabilities (L13+L14+L15a,b,c+L16+L17+L18+L19+L20+L21)	509,025	516,810	545,761	536,676	555,380	570,189	573,776	589,884	529,589	516,087	528,448	540,860
Capital and Surplus												
23. Aggregate Write-Ins for Special Surplus Funds - Health Insurer Fee (Payable Next Year)	74,273	74,273	74,273	74,273	74,273	74,273	74,273	74,273	74,273	74,273	74,273	74,273
24. Capital Stock												
25. Gross Paid In and Contributed Surplus	86,894	86,894	86,894	86,894	86,894	86,894	86,894	86,894	86,894	86,894	86,894	86,894
26. Surplus Notes	0	0	0	0	0	0	0	0	0	0	0	0
27. Unassigned Surplus	274,191	292,745	292,986	299,720	299,275	311,470	316,306	316,079	326,351	320,567	325,080	329,255
28. Other Items(elaborate)												
29. Total Capital and Surplus(L23+L24+L25+L26+L27+L28)	435,358	453,912	454,153	460,887	460,442	472,637	477,473	477,246	487,518	481,734	486,247	490,422

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Cash From Operations													
1. Premiums Collected Net of Reinsurance	0	0	0	0	0	0	0	0	0	357,183	357,519	440,204	1,154,906
2. Benefits Paid	0	0	0	0	0	0	0	0	0	336,529	319,316	319,964	975,809
3. Underwriting Expenses Paid	0	0	0	0	0	0	0	0	0	33,758	33,314	33,115	100,187
4. Total Cash From Underwriting (L1-L2-L3)	0	0	0	0	0	0	0	0	0	-13,104	4,889	87,126	78,911
5. Net Investment Income	0	0	0	0	0	0	0	0	0	790	790	790	2,370
6. Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Dividends to Policyholders	0	0	0	0	0	0	0	0	0	0	0	0	0
8. Federal and Foreign Income Taxes (Paid) Recovered	0	0	0	0	0	0	0	0	0	1,270	-5,391	-5,373	-9,495
9. Health Insurers Provider Fee	0												16,589
10. Net Cash From Operations (L4+L5+L6-L7+L8-L9)	0	0	0	0	0	0	0	0	-16,589	-11,045	288	82,542	55,197
Cash From Investments													
11. Net Cash from Investments	0	0	0	0	0	0	0	0	0	0	0	0	0
Cash From Financing and Misc Sources													
12. Capital and paid in Surplus													0
13. Surplus Notes													0
14. Borrowed Funds													0
15. Dividends													0
16. Other Cash Provided (Applied)										4,020	6,551	5,759	-148,178
17. Net Cash from Financing and Misc Sources (L12+L13+L14-L15+L16)	0	0	0	0	0	0	0	0	0	4,020	6,551	5,759	-148,178

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Cash From Operations													
1. Premiums Collected Net of Reinsurance	363,635	364,218	364,888	365,758	366,414	368,603	367,949	368,638	369,183	378,429	378,772	488,645	4,545,130
2. Benefits Paid	339,829	308,215	333,509	325,721	335,969	319,723	329,887	337,376	322,044	352,510	338,162	339,292	3,982,236
3. Underwriting Expenses Paid	32,128	31,779	32,384	32,371	32,736	32,782	32,751	32,922	33,722	35,667	35,235	35,005	399,483
4. Total Cash From Underwriting (L1-L2-L3)	-8,323	24,224	-1,006	7,667	-2,290	16,098	5,310	-1,661	13,417	-9,748	5,374	114,348	163,410
5. Net Investment Income	790	790	790	790	790	790	790	790	790	790	790	790	9,479
6. Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Dividends to Policyholders	0	0	0	0	0	0	0	0	0	0	0	0	0
8. Federal and Foreign Income Taxes (Paid) Recovered	-543	-12,589	-3,258	-6,470	-2,790	-9,597	-5,609	-3,034	-8,616	-148	-5,747	-5,567	-63,969
9. Health Insurers Provider Fee									67,915				67,915
10. Net Cash From Operations (L4+L5+L6-L7+L8-L9)	-8,076	12,425	-3,474	1,986	-4,290	7,291	491	-3,904	-62,325	-9,106	417	109,571	41,005
Cash From Investments													
11. Net Cash from Investments	0	0	0	0	0	0	0	0	0	0	0	0	0
Cash From Financing and Misc Sources													
12. Capital and paid in Surplus													0
13. Surplus Notes													0
14. Borrowed Funds													0
15. Dividends													0
16. Other Cash Provided (Applied)	64,031	-3,263	15,698	-18,361	6,744	3,175	-6,896	4,385	2,453	-22,653	744	784	46,840
17. Net Cash from Financing and Misc Sources (L12+L13+L14-L15+L16)	64,031	-3,263	15,698	-18,361	6,744	3,175	-6,896	4,385	2,453	-22,653	744	784	46,840

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Cash From Operations													
1. Premiums Collected Net of Reinsurance	382,518	383,136	383,850	384,778	385,476	387,829	387,111	387,844	388,421	398,187	398,545	513,326	4,781,020
2. Benefits Paid	355,573	322,891	350,737	341,704	352,738	336,007	346,887	354,769	338,585	370,296	355,663	357,046	4,182,897
3. Underwriting Expenses Paid	33,806	33,420	34,077	34,057	34,452	34,496	34,458	34,640	35,508	37,600	37,119	36,855	420,489
4. Total Cash From Underwriting (L1-L2-L3)	-6,861	26,825	-965	9,016	-1,715	17,325	5,766	-1,565	14,328	-9,709	5,763	119,425	177,635
5. Net Investment Income	790	790	790	790	790	790	790	790	790	790	790	790	9,479
6. Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Dividends to Policyholders	0	0	0	0	0	0	0	0	0	0	0	0	0
8. Federal and Foreign Income Taxes (Paid) Recovered	-1,233	-13,700	-3,422	-7,119	-3,152	-10,201	-5,927	-3,219	-9,103	-318	-6,046	-5,793	-69,232
9. Health Insurers Provider Fee									70,947				70,947
10. Net Cash From Operations (L4+L5+L6-L7+L8-L9)	-7,304	13,915	-3,597	2,688	-4,077	7,915	628	-3,993	-64,932	-9,237	507	114,422	46,935
Cash From Investments													
11. Net Cash from Investments	0	0	0	0	0	0	0	0	0	0	0	0	0
Cash From Financing and Misc Sources													
12. Capital and paid in Surplus													0
13. Surplus Notes													0
14. Borrowed Funds													0
15. Dividends													0
16. Other Cash Provided (Applied)	23,212	-3,195	-16,433	-2,986	9,352	1,456	-4,025	4,567	3,002	-18,462	1,036	899	-1,577
17. Net Cash from Financing and Misc Sources (L12+L13+L14-L15+L16)	23,212	-3,195	-16,433	-2,986	9,352	1,456	-4,025	4,567	3,002	-18,462	1,036	899	-1,577

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
Cash From Operations													
1. Premiums Collected Net of Reinsurance	403,139	403,796	404,555	405,546	406,288	408,818	408,031	408,812	409,424	419,737	420,113	540,277	5,038,537
2. Benefits Paid	374,201	340,041	369,152	359,865	371,576	354,000	364,941	373,565	356,569	390,053	374,620	375,902	4,404,485
3. Underwriting Expenses Paid	35,672	35,245	35,959	35,933	36,359	36,402	36,355	36,548	37,491	39,810	39,277	38,976	444,029
4. Total Cash From Underwriting (L1-L2-L3)	-6,734	28,510	-557	9,749	-1,647	18,416	6,735	-1,301	15,364	-10,126	6,216	125,399	190,023
5. Net Investment Income	790	790	790	790	790	790	790	790	790	790	790	790	9,479
6. Other Income	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Dividends to Policyholders	0	0	0	0	0	0	0	0	0	0	0	0	0
8. Federal and Foreign Income Taxes (Paid) Recovered	-1,442	-14,487	-3,736	-7,553	-3,340	-10,768	-6,450	-3,480	-9,650	-334	-6,385	-6,191	-73,816
9. Health Insurers Provider Fee									74,273				74,273
10. Net Cash From Operations (L4+L5+L6-L7+L8-L9)	-7,387	14,813	-3,503	2,986	-4,198	8,438	1,075	-3,992	-67,770	-9,670	622	119,998	51,413
Cash From Investments													
11. Net Cash from Investments	0	0	0	0	0	0	0	0	0	0	0	0	0
Cash From Financing and Misc Sources													
12. Capital and paid in Surplus													0
13. Surplus Notes													0
14. Borrowed Funds													0
15. Dividends													0
16. Other Cash Provided (Applied)	33,636	-3,211	17,940	-20,113	7,662	3,735	-7,486	5,020	2,878	-24,899	954	993	17,107
17. Net Cash from Financing and Misc Sources (L12+L13+L14-L15+L16)	33,636	-3,211	17,940	-20,113	7,662	3,735	-7,486	5,020	2,878	-24,899	954	993	17,107

Total Consolidated Simply Healthcare Plans, Inc.
Pro-Forma Statutory Profit & Loss Statement (Florida Experience)
Florida Healthy Kids
Dollars in 000's

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members													-
1. Member Months													-
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	6,532	6,540	6,548	19,620
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	-	-	-	-	-	-	-	-	-	-	-	-	-
3. Fee for Service	-	-	-	-	-	-	-	-	-	-	-	-	-
4. Risk Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-
5. Change in Unearned Premium Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	209	209	209	628
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	6,741	6,749	6,757	20,248
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	4,057	3,740	3,691	11,488
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	-	-	-	-
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	1,410	1,382	1,421	4,213
11. Expanded Benefits													-
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	5,468	5,122	5,112	15,701
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	5,468	5,122	5,112	15,701
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	365	333	342	1,040
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	831	808	799	2,438
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	6,664	6,262	6,252	19,179
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	77	487	505	1,069
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	29	180	187	396
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	143	143	143	429
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(94)	164	175	244

Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

Florida Healthy Kids

Dollars in 000's

	2019												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2019
0. Members													-
1. Member Months													-
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	9,583	9,583	9,583	9,583	9,583	9,583	9,583	9,583	9,583	9,583	9,583	9,583	114,990
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	-	-	-	-	-	-	-	-	-	-	-	-	-
3. Fee for Service	-	-	-	-	-	-	-	-	-	-	-	-	-
4. Risk Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-
5. Change in Unearned Premium Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-
6. ACA Health Insurer Fee Subsidy Premium	300	300	300	300	300	300	300	300	300	300	300	300	3,596
7. Total (L2a,b+L3+L4+L5+L6)	9,882	9,882	9,882	9,882	9,882	9,882	9,882	9,882	9,882	9,882	9,882	9,882	118,586
Hospital and Medical:													
8. Hospital/Medical Benefits	9,071	9,071	9,071	9,071	9,071	9,071	9,071	9,071	9,071	9,071	9,071	9,071	108,849
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	-	-	-	-
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	-	-	-	-
12. Subtotal (L8+L9+L10+L11)	9,071	9,071	9,071	9,071	9,071	9,071	9,071	9,071	9,071	9,071	9,071	9,071	108,849
Less:													
13. Reinsurance Recoveries	-	-	-	-	-	-	-	-	-	-	-	-	-
14. Total Hospital and Medical (L12 -L13)	9,071	9,071	9,071	9,071	9,071	9,071	9,071	9,071	9,071	9,071	9,071	9,071	108,849
15. Claims Adjustment Expenses	379	379	379	379	379	379	379	379	379	379	379	379	4,544
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	975	975	975	975	975	975	975	975	975	975	975	975	11,696
16b. ACA Risk Adjustment User Fee Paid	-	-	-	-	-	-	-	-	-	-	-	-	-
17. Increase in Reserves for Accident and Health Contacts	-	-	-	-	-	-	-	-	-	-	-	-	-
18. Aggregate Write-Ins for Other Income or Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	10,424	10,424	10,424	10,424	10,424	10,424	10,424	10,424	10,424	10,424	10,424	10,424	125,089
20. Net Underwriting Gain or Loss (L7 -L19)	(542)	(542)	(542)	(542)	(542)	(542)	(542)	(542)	(542)	(542)	(542)	(542)	(6,503)
21. Net Investment Income Earned	-	-	-	-	-	-	-	-	-	-	-	-	-
22. Federal Income Taxes	(201)	(201)	(201)	(201)	(201)	(201)	(201)	(201)	(201)	(201)	(201)	(201)	(2,406)
23. Health Insurance Provider Fee	186	186	186	186	186	186	186	186	186	186	186	186	2,231
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(527)	(527)	(527)	(527)	(527)	(527)	(527)	(527)	(527)	(527)	(527)	(527)	(6,328)

Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

Florida Healthy Kids

Dollars in 000's

	2020												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2020
0. Members													-
1. Member Months													-
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	10,031	10,031	10,031	10,031	10,031	10,031	10,031	10,031	10,031	10,031	10,031	10,031	120,377
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	-	-	-	-	-	-	-	-	-	-	-	-	-
3. Fee for Service	-	-	-	-	-	-	-	-	-	-	-	-	-
4. Risk Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-
5. Change in Unearned Premium Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-
6. ACA Health Insurer Fee Subsidy Premium	314	314	314	314	314	314	314	314	314	314	314	314	3,764
7. Total (L2a,b+L3+L4+L5+L6)	10,345	10,345	10,345	10,345	10,345	10,345	10,345	10,345	10,345	10,345	10,345	10,345	124,141
Hospital and Medical:													
8. Hospital/Medical Benefits	9,496	9,496	9,496	9,496	9,496	9,496	9,496	9,496	9,496	9,496	9,496	9,496	113,948
9. Other Benefits & Professional Services													-
10. Prescription Drugs													-
11. Expanded Benefits													-
12. Subtotal (L8+L9+L10+L11)	9,496	9,496	9,496	9,496	9,496	9,496	9,496	9,496	9,496	9,496	9,496	9,496	113,948
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	9,496	9,496	9,496	9,496	9,496	9,496	9,496	9,496	9,496	9,496	9,496	9,496	113,948
15. Claims Adjustment Expenses	396	396	396	396	396	396	396	396	396	396	396	396	4,757
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	1,019	1,019	1,019	1,019	1,019	1,019	1,019	1,019	1,019	1,019	1,019	1,019	12,231
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	10,911	10,911	10,911	10,911	10,911	10,911	10,911	10,911	10,911	10,911	10,911	10,911	130,936
20. Net Underwriting Gain or Loss (L7 -L19)	(566)	(566)	(566)	(566)	(566)	(566)	(566)	(566)	(566)	(566)	(566)	(566)	(6,795)
21. Net Investment Income Earned													-
22. Federal Income Taxes	(210)	(210)	(210)	(210)	(210)	(210)	(210)	(210)	(210)	(210)	(210)	(210)	(2,514)
23. Health Insurance Provider Fee	195	195	195	195	195	195	195	195	195	195	195	195	2,335
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(551)	(551)	(551)	(551)	(551)	(551)	(551)	(551)	(551)	(551)	(551)	(551)	(6,616)

Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

Florida Healthy Kids

Dollars in 000's

	2021												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2021
0. Members													-
1. Member Months													-
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	11,087	11,087	11,087	11,087	11,087	11,087	11,087	11,087	11,087	11,087	11,087	11,087	133,041
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	-	-	-	-	-	-	-	-	-	-	-	-	-
3. Fee for Service	-	-	-	-	-	-	-	-	-	-	-	-	-
4. Risk Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-
5. Change in Unearned Premium Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-
6. ACA Health Insurer Fee Subsidy Premium	347	347	347	347	347	347	347	347	347	347	347	347	4,160
7. Total (L2a,b+L3+L4+L5+L6)	11,433	11,433	11,433	11,433	11,433	11,433	11,433	11,433	11,433	11,433	11,433	11,433	137,202
Hospital and Medical:													
8. Hospital/Medical Benefits	10,495	10,495	10,495	10,495	10,495	10,495	10,495	10,495	10,495	10,495	10,495	10,495	125,936
9. Other Benefits & Professional Services													-
10. Prescription Drugs													-
11. Expanded Benefits													-
12. Subtotal (L8+L9+L10+L11)	10,495	10,495	10,495	10,495	10,495	10,495	10,495	10,495	10,495	10,495	10,495	10,495	125,936
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	10,495	10,495	10,495	10,495	10,495	10,495	10,495	10,495	10,495	10,495	10,495	10,495	125,936
15. Claims Adjustment Expenses	438	438	438	438	438	438	438	438	438	438	438	438	5,257
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	1,124	1,124	1,124	1,124	1,124	1,124	1,124	1,124	1,124	1,124	1,124	1,124	13,490
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	12,057	12,057	12,057	12,057	12,057	12,057	12,057	12,057	12,057	12,057	12,057	12,057	144,683
20. Net Underwriting Gain or Loss (L7 -L19)	(623)	(623)	(623)	(623)	(623)	(623)	(623)	(623)	(623)	(623)	(623)	(623)	(7,482)
21. Net Investment Income Earned													-
22. Federal Income Taxes	(231)	(231)	(231)	(231)	(231)	(231)	(231)	(231)	(231)	(231)	(231)	(231)	(2,768)
23. Health Insurance Provider Fee	215	215	215	215	215	215	215	215	215	215	215	215	2,581
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(608)	(608)	(608)	(608)	(608)	(608)	(608)	(608)	(608)	(608)	(608)	(608)	(7,295)

Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

Medicare

Dollars in 000's

	2018												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2018
0. Members	-	-	-	-	-	-	-	-	-	-	-	-	-
1. Member Months	-	-	-	-	-	-	-	-	-	-	-	-	-
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	73,308	73,324	73,395	220,026
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	-	-	-	-	-	-	-	-	-	-	-	-	-
3. Fee for Service	-	-	-	-	-	-	-	-	-	-	-	-	-
4. Risk Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-
5. Change in Unearned Premium Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	-	-	-	-
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	73,308	73,324	73,395	220,026
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	62,342	62,126	62,254	186,722
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	-	-	-	-
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	-	-	-	-
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	62,342	62,126	62,254	186,722
Less:													
13. Reinsurance Recoveries	-	-	-	-	-	-	-	-	-	-	-	-	-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	62,342	62,126	62,254	186,722
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	9,375	8,961	8,735	27,071
16b. ACA Risk Adjustment User Fee Paid	-	-	-	-	-	-	-	-	-	-	-	-	-
17. Increase in Reserves for Accident and Health Contacts	-	-	-	-	-	-	-	-	-	-	-	-	-
18. Aggregate Write-Ins for Other Income or Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	71,718	71,087	70,989	213,793
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	1,590	2,237	2,406	6,233
21. Net Investment Income Earned	-	-	-	-	-	-	-	-	-	-	-	-	-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	588	828	890	2,306
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	-	-	-	-
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	1,002	1,409	1,516	3,927

Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

Medicare

Dollars in 000's

	2019												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2019
0. Members													-
1. Member Months													-
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	75,773	76,043	76,401	76,958	77,300	79,175	78,206	78,580	78,810	79,168	79,186	79,262	934,862
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	-	-	-	-	-	-	-	-	-	-	-	-	-
3. Fee for Service	-	-	-	-	-	-	-	-	-	-	-	-	-
4. Risk Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-
5. Change in Unearned Premium Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	-	-	-	-
7. Total (L2a,b+L3+L4+L5+L6)	75,773	76,043	76,401	76,958	77,300	79,175	78,206	78,580	78,810	79,168	79,186	79,262	934,862
Hospital and Medical:													
8. Hospital/Medical Benefits	63,365	63,826	63,941	64,475	65,192	65,902	66,910	67,260	67,385	67,702	67,889	68,000	791,847
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	-	-	-	-
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	-	-	-	-
12. Subtotal (L8+L9+L10+L11)	63,365	63,826	63,941	64,475	65,192	65,902	66,910	67,260	67,385	67,702	67,889	68,000	791,847
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	63,365	63,826	63,941	64,475	65,192	65,902	66,910	67,260	67,385	67,702	67,889	68,000	791,847
15. Claims Adjustment Expenses													-
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	7,508	7,132	7,710	7,669	8,007	8,026	7,968	8,112	8,884	10,173	9,713	9,455	100,358
16b. ACA Risk Adjustment User Fee Paid	-	-	-	-	-	-	-	-	-	-	-	-	-
17. Increase in Reserves for Accident and Health Contacts	-	-	-	-	-	-	-	-	-	-	-	-	-
18. Aggregate Write-Ins for Other Income or Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	70,874	70,958	71,651	72,145	73,199	73,927	74,878	75,372	76,269	77,876	77,602	77,455	892,205
20. Net Underwriting Gain or Loss (L7 -L19)	4,899	5,086	4,750	4,813	4,101	5,247	3,328	3,209	2,541	1,293	1,584	1,807	42,658
21. Net Investment Income Earned													-
22. Federal Income Taxes	1,813	1,882	1,758	1,781	1,517	1,942	1,231	1,187	940	478	586	669	15,783
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	-	-	-	-
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	3,087	3,204	2,993	3,032	2,584	3,306	2,097	2,021	1,601	814	998	1,138	26,874

Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

Medicare

Dollars in 000's

	2020												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2020
0. Members													-
1. Member Months													-
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	81,831	82,123	82,509	83,110	83,480	85,504	84,458	84,862	85,110	85,498	85,516	85,599	1,009,600
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	-	-	-	-	-	-	-	-	-	-	-	-	-
3. Fee for Service	-	-	-	-	-	-	-	-	-	-	-	-	-
4. Risk Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-
5. Change in Unearned Premium Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	-	-	-	-
7. Total (L2a,b+L3+L4+L5+L6)	81,831	82,123	82,509	83,110	83,480	85,504	84,458	84,862	85,110	85,498	85,516	85,599	1,009,600
Hospital and Medical:													
8. Hospital/Medical Benefits	68,180	68,675	68,799	69,374	70,145	70,909	71,993	72,370	72,505	72,847	73,047	73,167	852,013
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	-	-	-	-
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	-	-	-	-
12. Subtotal (L8+L9+L10+L11)	68,180	68,675	68,799	69,374	70,145	70,909	71,993	72,370	72,505	72,847	73,047	73,167	852,013
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	68,180	68,675	68,799	69,374	70,145	70,909	71,993	72,370	72,505	72,847	73,047	73,167	852,013
15. Claims Adjustment Expenses													-
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	8,165	7,750	8,380	8,332	8,698	8,714	8,647	8,800	9,640	11,044	10,535	10,241	108,946
16b. ACA Risk Adjustment User Fee Paid	-	-	-	-	-	-	-	-	-	-	-	-	-
17. Increase in Reserves for Accident and Health Contacts	-	-	-	-	-	-	-	-	-	-	-	-	-
18. Aggregate Write-Ins for Other Income or Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	76,345	76,426	77,179	77,706	78,843	79,623	80,641	81,170	82,145	83,891	83,582	83,408	960,959
20. Net Underwriting Gain or Loss (L7 -L19)	5,485	5,697	5,330	5,404	4,637	5,882	3,817	3,692	2,965	1,607	1,935	2,191	48,642
21. Net Investment Income Earned													-
22. Federal Income Taxes	2,030	2,108	1,972	2,000	1,716	2,176	1,412	1,366	1,097	595	716	811	17,997
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	-	-	-	-
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	3,456	3,589	3,358	3,405	2,921	3,705	2,405	2,326	1,868	1,012	1,219	1,380	30,644

Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

Medicare

Dollars in 000's

	2021												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2021
0. Members													-
1. Member Months													-
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	88,373	88,688	89,105	89,754	90,154	92,340	91,210	91,647	91,914	92,333	92,353	92,442	1,090,314
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)	-	-	-	-	-	-	-	-	-	-	-	-	-
3. Fee for Service	-	-	-	-	-	-	-	-	-	-	-	-	-
4. Risk Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-
5. Change in Unearned Premium Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	-	-	-	-
7. Total (L2a,b+L3+L4+L5+L6)	88,373	88,688	89,105	89,754	90,154	92,340	91,210	91,647	91,914	92,333	92,353	92,442	1,090,314
Hospital and Medical:													
8. Hospital/Medical Benefits	73,360	73,894	74,026	74,646	75,475	76,297	77,464	77,869	78,014	78,382	78,597	78,726	916,750
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	-	-	-	-
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	-	-	-	-
12. Subtotal (L8+L9+L10+L11)	73,360	73,894	74,026	74,646	75,475	76,297	77,464	77,869	78,014	78,382	78,597	78,726	916,750
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	73,360	73,894	74,026	74,646	75,475	76,297	77,464	77,869	78,014	78,382	78,597	78,726	916,750
15. Claims Adjustment Expenses													-
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	8,882	8,425	9,110	9,054	9,451	9,464	9,388	9,551	10,465	11,995	11,431	11,098	118,315
16b. ACA Risk Adjustment User Fee Paid	-	-	-	-	-	-	-	-	-	-	-	-	-
17. Increase in Reserves for Accident and Health Contacts	-	-	-	-	-	-	-	-	-	-	-	-	-
18. Aggregate Write-Ins for Other Income or Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	82,243	82,319	83,137	83,700	84,926	85,761	86,852	87,420	88,479	90,376	90,028	89,825	1,035,066
20. Net Underwriting Gain or Loss (L7 -L19)	6,130	6,369	5,968	6,055	5,228	6,579	4,358	4,227	3,436	1,957	2,325	2,617	55,248
21. Net Investment Income Earned													-
22. Federal Income Taxes	2,268	2,357	2,208	2,240	1,934	2,434	1,613	1,564	1,271	724	860	968	20,442
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	-	-	-	-
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	3,862	4,013	3,760	3,814	3,293	4,145	2,746	2,663	2,164	1,233	1,465	1,649	34,806

Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

Region 1-11 - Comprehensive and Specialty Plan

Dollars in 000's

	2018												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2018
0. Members	-	-	-	-	-	-	-	-	-	745,248	746,117	746,988	746,988
1. Member Months	-	-	-	-	-	-	-	-	-	745,248	1,491,365	2,238,352	2,238,352
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	277,343	277,655	277,967	832,965
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	8,673	8,682	8,692	26,047
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	286,016	286,337	286,659	859,012
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	164,319	156,469	156,353	477,142
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	35,433	30,944	30,362	96,739
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	65,291	60,974	62,198	188,463
11. Expanded Benefits										3,676	3,681	3,685	11,042
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	268,719	252,068	252,598	773,385
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	268,719	252,068	252,598	773,385
15. Claims Adjustment Expenses										8,028	8,037	8,047	24,112
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)										15,157	15,175	15,193	45,525
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	291,905	275,281	275,837	843,022
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	(5,889)	11,056	10,822	15,990
21. Net Investment Income Earned										790	790	790	2,370
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	(1,886)	4,383	4,296	6,793
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	5,380	5,387	5,393	16,160
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(8,593)	2,077	1,923	(4,593)
27. Prior Period Surplus		-	-	-	-	-	-	-	-	-	(8,593)	(6,516)	-
28. Net Income	-	-	-	-	-	-	-	-	-	(8,593)	2,077	1,923	(4,593)
29. Capital Increases	-	-	-	-	-	-	-	-	-	-	-	-	-
30. Other Increases (Decreases)	-	-	-	-	-	-	-	-	-	-	-	-	-
31. Dividends to Stockholders	-	-	-	-	-	-	-	-	-	-	-	-	-
32. End of Period Surplus (L27+L28+L29+L30-L31)	-	-	-	-	-	-	-	-	-	(8,593)	(6,516)	(4,593)	(4,593)
NOI as Percent of Revenue													-1.2%
NOI on the first 5% if the Total NOI is higher than 5%													-
NOI on the 5% - 10%, 50% will refund to the state													-
NOI on the > 10%, 100% will refund to the state													-
Total Refund to the State													-

Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance													Pro Forma Financial Statements
Total Consolidated Simply Healthcare Plans, Inc.													
Pro-Forma Statutory Profit & Loss Statement (Florida Experience)													
Region 1-11 - Comprehensive and Specialty Plan													
Dollars in 000's													
	2019												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2019
0. Members	747,859	748,732	749,605	750,480	751,355	752,232	753,109	753,988	754,868	755,748	756,630	757,513	757,513
1. Member Months	747,859	1,496,591	2,246,196	2,996,675	3,748,031	4,500,262	5,253,372	6,007,360	6,762,227	7,517,976	8,274,606	9,032,119	9,032,119
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	278,279	278,592	278,905	279,218	279,532	279,846	280,160	280,475	280,790	289,678	290,003	290,329	3,385,807
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	8,702	8,712	8,721	8,731	8,741	8,751	8,761	8,770	8,780	9,058	9,068	9,079	105,875
7. Total (L2a,b+L3+L4+L5+L6)	286,981	287,303	287,626	287,949	288,273	288,597	288,921	289,246	289,571	298,736	299,072	299,408	3,491,681
Hospital and Medical:													
8. Hospital/Medical Benefits	163,135	144,206	161,135	156,481	163,357	152,891	158,612	163,316	154,111	170,816	162,636	162,474	1,913,169
9. Other Benefits & Professional Services	32,205	27,480	30,278	29,775	30,538	28,473	29,686	30,236	28,772	32,345	30,547	30,436	360,771
10. Prescription Drugs	68,364	59,939	65,387	62,217	64,104	59,676	61,894	63,774	58,982	68,847	64,287	65,574	763,046
11. Expanded Benefits	3,689	3,693	3,698	3,702	3,706	3,711	3,715	3,719	3,724	3,728	3,732	3,737	44,555
12. Subtotal (L8+L9+L10+L11)	267,393	235,318	260,498	252,175	261,706	244,751	253,907	261,046	245,588	275,737	261,203	262,221	3,081,540
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	267,393	235,318	260,498	252,175	261,706	244,751	253,907	261,046	245,588	275,737	261,203	262,221	3,081,540
15. Claims Adjustment Expenses	8,056	8,066	8,075	8,084	8,094	8,103	8,113	8,122	8,132	8,359	8,369	8,379	97,953
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	15,210	15,228	15,246	15,264	15,282	15,299	15,317	15,335	15,353	15,781	15,800	15,818	184,933
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	290,660	258,612	283,819	275,523	285,081	268,153	277,337	284,503	269,073	299,877	285,371	286,418	3,364,426
20. Net Underwriting Gain or Loss (L7 -L19)	(3,679)	28,692	3,807	12,426	3,191	20,443	11,584	4,743	20,498	(1,141)	13,700	12,990	127,255
21. Net Investment Income Earned	790	790	790	790	790	790	790	790	790	790	790	790	9,479
22. Federal Income Taxes	(1,069)	10,908	1,701	4,890	1,473	7,856	4,578	2,047	7,877	(130)	5,361	5,099	50,592
23. Health Insurance Provider Fee	5,399	5,405	5,411	5,417	5,423	5,429	5,435	5,441	5,447	5,620	5,626	5,632	65,685
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(7,219)	13,169	(2,515)	2,909	(2,915)	7,948	2,361	(1,956)	7,964	(5,841)	3,503	3,049	20,458
27. Prior Period Surplus	(4,593)	(11,812)	1,357	(1,158)	1,752	(1,163)	6,785	9,146	7,190	15,154	9,313	12,816	(4,593)
28. Net Income	(7,219)	13,169	(2,515)	2,909	(2,915)	7,948	2,361	(1,956)	7,964	(5,841)	3,503	3,049	20,458
29. Capital Increases	-	-	-	-	-	-	-	-	-	-	-	-	-
30. Other Increases (Decreases)	-	-	-	-	-	-	-	-	-	-	-	-	-
31. Dividends to Stockholders	-	-	-	-	-	-	-	-	-	-	-	-	-
32. End of Period Surplus (L27+L28+L29+L30-L31)	(11,812)	1,357	(1,158)	1,752	(1,163)	6,785	9,146	7,190	15,154	9,313	12,816	15,865	15,865
NOI as Percent of Revenue													0.6%
NOI on the first 5% if the Total NOI is higher than 5%													-
NOI on the 5% - 10%, 50% will refund to the state													-
NOI on the > 10%, 100% will refund to the state													-
Total Refund to the State													-

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	758,397	759,281	760,167	761,054	761,942	762,831	763,721	764,612	765,504	766,397	767,291	768,186	768,186
1. Member Months	758,397	1,517,678	2,277,845	3,038,899	3,800,841	4,563,672	5,327,393	6,092,005	6,857,508	7,623,905	8,391,196	9,159,383	9,159,383
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	290,656	290,982	291,309	291,637	291,965	292,293	292,621	292,950	293,280	302,657	302,998	303,338	3,536,686
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	9,089	9,099	9,109	9,120	9,130	9,140	9,150	9,161	9,171	9,464	9,475	9,485	110,593
7. Total (L2a,b+L3+L4+L5+L6)	299,744	300,081	300,419	300,756	301,094	301,433	301,772	302,111	302,451	312,122	312,473	312,824	3,647,279
Hospital and Medical:													
8. Hospital/Medical Benefits	169,573	149,872	167,473	162,639	169,801	158,881	164,831	169,753	160,150	177,632	169,105	168,895	1,988,605
9. Other Benefits & Professional Services	32,498	27,897	32,270	30,830	31,933	30,015	31,512	32,118	30,463	33,937	32,443	32,558	378,475
10. Prescription Drugs	72,084	63,205	68,949	65,611	67,606	62,943	65,286	67,261	62,195	72,605	67,787	69,141	804,672
11. Expanded Benefits	3,741	3,745	3,750	3,754	3,759	3,763	3,767	3,772	3,776	3,781	3,785	3,789	45,183
12. Subtotal (L8+L9+L10+L11)	277,897	244,720	272,442	262,834	273,098	255,602	265,398	272,903	256,584	287,954	273,120	274,383	3,216,935
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	277,897	244,720	272,442	262,834	273,098	255,602	265,398	272,903	256,584	287,954	273,120	274,383	3,216,935
15. Claims Adjustment Expenses	8,389	8,398	8,408	8,418	8,428	8,438	8,448	8,457	8,467	8,706	8,716	8,726	101,999
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	15,837	15,855	15,874	15,892	15,911	15,929	15,948	15,966	15,985	16,434	16,453	16,472	192,556
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	302,122	268,974	296,724	287,145	297,436	279,969	289,793	297,327	281,036	313,094	298,290	299,582	3,511,491
20. Net Underwriting Gain or Loss (L7 -L19)	(2,378)	31,108	3,694	13,612	3,658	21,464	11,979	4,784	21,414	(972)	14,183	13,242	135,788
21. Net Investment Income Earned	790	790	790	790	790	790	790	790	790	790	790	790	9,479
22. Federal Income Taxes	(588)	11,802	1,659	5,329	1,646	8,234	4,724	2,062	8,215	(67)	5,540	5,192	53,749
23. Health Insurance Provider Fee	5,639	5,645	5,651	5,658	5,664	5,670	5,677	5,683	5,690	5,872	5,878	5,885	68,612
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(6,639)	14,450	(2,826)	3,415	(2,862)	8,349	2,367	(2,172)	8,299	(5,986)	3,555	2,955	22,907
27. Prior Period Surplus	15,865	9,226	23,676	20,850	24,265	21,404	29,753	32,120	29,949	38,248	32,261	35,816	15,865
28. Net Income	(6,639)	14,450	(2,826)	3,415	(2,862)	8,349	2,367	(2,172)	8,299	(5,986)	3,555	2,955	22,907
29. Capital Increases	-	-	-	-	-	-	-	-	-	-	-	-	-
30. Other Increases (Decreases)	-	-	-	-	-	-	-	-	-	-	-	-	-
31. Dividends to Stockholders	-	-	-	-	-	-	-	-	-	-	-	-	-
32. End of Period Surplus (L27+L28+L29+L30-L31)	9,226	23,676	20,850	24,265	21,404	29,753	32,120	29,949	38,248	32,261	35,816	38,772	38,772
NOI as Percent of Revenue													0.71%
NOI on the first 5% if the Total NOI is higher than 5%													-
NOI on the 5% - 10%, 50% will refund to the state													-
NOI on the > 10%, 100% will refund to the state													-
Total Refund to the State													-

Pro-Forma Statutory Profit & Loss Statement (Florida Experience)

Region 1-11 - Comprehensive and Specialty Plan

Dollars in 000's

	2021												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2021
0. Members	769,082	769,980	770,878	771,777	772,678	773,579	774,482	775,385	776,290	777,196	778,102	779,010	779,010
1. Member Months	769,082	1,539,062	2,309,940	3,081,718	3,854,396	4,627,975	5,402,457	6,177,842	6,954,132	7,731,328	8,509,430	9,288,440	9,288,440
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	303,680	304,021	304,363	304,705	305,048	305,391	305,734	306,078	306,423	316,318	316,674	317,030	3,695,464
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	9,496	9,507	9,517	9,528	9,539	9,550	9,560	9,571	9,582	9,891	9,902	9,914	115,558
7. Total (L2a,b+L3+L4+L5+L6)	313,176	313,528	313,880	314,233	314,587	314,941	315,295	315,649	316,004	326,209	326,576	326,944	3,811,022
Hospital and Medical:													
8. Hospital/Medical Benefits	176,328	155,817	174,124	169,100	176,561	165,165	171,357	176,506	166,486	184,783	175,893	175,633	2,067,753
9. Other Benefits & Professional Services	34,210	29,382	33,993	32,621	33,929	31,831	32,934	33,926	32,154	35,986	34,312	34,298	399,576
10. Prescription Drugs	76,015	66,655	72,711	69,196	71,305	66,395	68,871	70,945	65,590	76,574	71,484	72,908	848,650
11. Expanded Benefits	3,794	3,798	3,803	3,807	3,812	3,816	3,820	3,825	3,829	3,834	3,838	3,843	45,819
12. Subtotal (L8+L9+L10+L11)	290,346	255,653	284,631	274,724	285,607	267,208	276,983	285,201	268,060	301,177	285,527	286,681	3,361,799
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	290,346	255,653	284,631	274,724	285,607	267,208	276,983	285,201	268,060	301,177	285,527	286,681	3,361,799
15. Claims Adjustment Expenses	8,736	8,747	8,757	8,767	8,777	8,787	8,798	8,808	8,818	9,092	9,103	9,113	106,304
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	16,492	16,511	16,530	16,549	16,569	16,588	16,607	16,627	16,646	17,161	17,181	17,202	200,663
16b. ACA Risk Adjustmer User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	315,574	280,910	309,918	300,041	310,952	292,583	302,388	310,636	293,524	327,431	311,812	312,996	3,668,765
20. Net Underwriting Gain or Loss (L7 -L19)	(2,398)	32,618	3,963	14,193	3,634	22,357	12,907	5,013	22,480	(1,222)	14,764	13,947	142,257
21. Net Investment Income Earned	790	790	790	790	790	790	790	790	790	790	790	790	9,479
22. Federal Income Taxes	(595)	12,361	1,758	5,544	1,637	8,564	5,068	2,147	8,610	(160)	5,755	5,453	56,142
23. Health Insurance Provider Fee	5,891	5,898	5,905	5,911	5,918	5,925	5,931	5,938	5,945	6,137	6,143	6,150	71,692
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(6,905)	15,149	(2,911)	3,528	(3,131)	8,658	2,698	(2,282)	8,716	(6,408)	3,656	3,134	23,902
27. Prior Period Surplus	38,772	31,867	47,016	44,105	47,633	44,502	53,160	55,858	53,576	62,292	55,883	59,539	38,772
28. Net Income	(6,905)	15,149	(2,911)	3,528	(3,131)	8,658	2,698	(2,282)	8,716	(6,408)	3,656	3,134	23,902
29. Capital Increases	-	-	-	-	-	-	-	-	-	-	-	-	-
30. Other Increases (Decreases)	-	-	-	-	-	-	-	-	-	-	-	-	-
31. Dividends to Stockholders	-	-	-	-	-	-	-	-	-	-	-	-	-
32. End of Period Surplus (L27+L28+L29+L30-L31)	31,867	47,016	44,105	47,633	44,502	53,160	55,858	53,576	62,292	55,883	59,539	62,673	62,673

NOI as Percent of Revenue	0.7%
NOI on the first 5% if the Total NOI is higher than 5%	-
NOI on the 5% - 10%, 50% will refund to the state	-
NOI on the > 10%, 100% will refund to the state	-
Total Refund to the State	-

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	35,564	35,606	35,647	35,647
1. Member Months	-	-	-	-	-	-	-	-	-	35,564	71,170	106,818	106,818
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	10,949	10,961	10,973	32,883
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	342	343	343	1,028
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	11,291	11,304	11,316	33,911
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	6,883	6,548	6,533	19,964
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	1,718	1,216	1,124	4,057
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	2,332	2,199	2,251	6,782
11. Expanded Benefits										175	176	176	527
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	11,108	10,139	10,084	31,331
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	11,108	10,139	10,084	31,331
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	346	346	347	1,039
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	627	627	628	1,882
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	12,081	11,113	11,058	34,252
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	(789)	191	258	(340)
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	(292)	71	95	(126)
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	212	213	213	638
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(710)	(92)	(51)	(852)

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	35,689	35,731	35,772	35,814	35,856	35,898	35,940	35,982	36,024	36,066	36,108	36,150	36,150
1. Member Months	35,689	71,420	107,192	143,006	178,862	214,760	250,700	286,681	322,705	358,770	394,878	431,028	431,028
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	10,985	10,997	11,009	11,022	11,034	11,046	11,058	11,070	11,082	11,389	11,401	11,414	133,507
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	344	344	344	345	345	345	346	346	347	356	357	357	4,175
7. Total (L2a,b+L3+L4+L5+L6)	11,329	11,341	11,354	11,366	11,379	11,391	11,404	11,416	11,429	11,745	11,758	11,771	137,682
Hospital and Medical:													
8. Hospital/Medical Benefits	6,826	6,028	6,745	6,552	6,834	6,386	6,621	6,832	6,449	7,131	6,783	6,765	79,950
9. Other Benefits & Professional Services	1,274	960	1,014	1,037	1,012	917	981	963	932	1,076	977	952	12,095
10. Prescription Drugs	2,452	2,138	2,336	2,210	2,265	2,087	2,155	2,244	2,104	2,443	2,304	2,359	27,097
11. Expanded Benefits	176	176	176	177	177	177	177	177	178	178	178	178	2,126
12. Subtotal (L8+L9+L10+L11)	10,727	9,302	10,271	9,976	10,287	9,568	9,933	10,217	9,662	10,829	10,242	10,254	121,268
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	10,727	9,302	10,271	9,976	10,287	9,568	9,933	10,217	9,662	10,829	10,242	10,254	121,268
15. Claims Adjustment Expenses	347	348	348	348	349	349	350	350	350	359	359	360	4,217
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	629	629	630	631	632	632	633	634	635	650	651	652	7,638
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	11,703	10,279	11,249	10,955	11,268	10,550	10,916	11,201	10,647	11,838	11,253	11,265	133,123
20. Net Underwriting Gain or Loss (L7 -L19)	(374)	1,062	105	411	111	842	488	216	782	(93)	505	505	4,559
21. Net Investment Income Earned													-
22. Federal Income Taxes	(139)	393	39	152	41	311	180	80	289	(34)	187	187	1,687
23. Health Insurance Provider Fee	213	213	214	214	214	214	215	215	215	221	221	221	2,590
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(449)	456	(148)	45	(144)	316	93	(79)	278	(280)	97	97	282

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	36,192	36,234	36,276	36,319	36,361	36,404	36,446	36,489	36,531	36,574	36,616	36,659	36,659
1. Member Months	36,192	72,426	108,703	145,021	181,382	217,786	254,232	290,721	327,252	363,825	400,442	437,101	437,101
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	11,426	11,439	11,452	11,464	11,477	11,490	11,502	11,515	11,528	11,851	11,864	11,877	138,884
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	357	358	358	358	359	359	360	360	360	371	371	371	4,343
7. Total (L2a,b+L3+L4+L5+L6)	11,784	11,797	11,810	11,823	11,836	11,849	11,862	11,875	11,888	12,221	12,235	12,248	143,227
Hospital and Medical:													
8. Hospital/Medical Benefits	7,071	6,243	6,986	6,787	7,079	6,613	6,856	7,077	6,678	7,392	7,030	7,008	82,819
9. Other Benefits & Professional Services	1,127	847	1,128	1,015	1,033	971	1,075	1,061	1,007	1,113	1,072	1,084	12,534
10. Prescription Drugs	2,569	2,240	2,447	2,316	2,373	2,187	2,258	2,351	2,204	2,560	2,414	2,471	28,389
11. Expanded Benefits	179	179	179	179	179	180	180	180	180	180	181	181	2,156
12. Subtotal (L8+L9+L10+L11)	10,945	9,509	10,740	10,297	10,665	9,951	10,369	10,669	10,069	11,244	10,696	10,744	125,899
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	10,945	9,509	10,740	10,297	10,665	9,951	10,369	10,669	10,069	11,244	10,696	10,744	125,899
15. Claims Adjustment Expenses	360	361	361	361	362	362	363	363	364	373	373	373	4,376
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	652	653	654	655	655	656	657	658	659	675	675	676	7,926
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	11,958	10,523	11,755	11,313	11,682	10,970	11,388	11,690	11,091	12,292	11,744	11,794	138,200
20. Net Underwriting Gain or Loss (L7 -L19)	(174)	1,274	54	510	154	879	473	185	797	(71)	490	454	5,027
21. Net Investment Income Earned													-
22. Federal Income Taxes	(64)	471	20	189	57	325	175	68	295	(26)	181	168	1,860
23. Health Insurance Provider Fee	222	222	222	222	223	223	223	223	224	230	230	230	2,694
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(331)	581	(188)	99	(126)	331	75	(107)	278	(274)	79	56	472

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	36,702	36,745	36,788	36,830	36,873	36,916	36,960	37,003	37,046	37,089	37,132	37,176	37,176
1. Member Months	36,702	73,447	110,234	147,065	183,938	220,855	257,814	294,817	331,863	368,952	406,084	443,260	443,260
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	11,890	11,903	11,916	11,929	11,942	11,956	11,969	11,982	11,995	12,336	12,349	12,363	144,531
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	372	372	373	373	373	374	374	375	375	386	386	387	4,519
7. Total (L2a,b+L3+L4+L5+L6)	12,262	12,275	12,289	12,302	12,316	12,329	12,343	12,357	12,370	12,721	12,736	12,750	149,050
Hospital and Medical:													
8. Hospital/Medical Benefits	7,328	6,469	7,239	7,033	7,336	6,851	7,103	7,334	6,919	7,665	7,288	7,263	85,829
9. Other Benefits & Professional Services	1,187	893	1,192	1,091	1,136	1,058	1,095	1,136	1,072	1,212	1,151	1,144	13,367
10. Prescription Drugs	2,691	2,347	2,564	2,426	2,486	2,292	2,366	2,464	2,309	2,682	2,529	2,589	29,744
11. Expanded Benefits	181	181	181	182	182	182	182	183	183	183	183	183	2,187
12. Subtotal (L8+L9+L10+L11)	11,387	9,891	11,176	10,732	11,141	10,383	10,746	11,115	10,482	11,742	11,151	11,179	131,126
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	11,387	9,891	11,176	10,732	11,141	10,383	10,746	11,115	10,482	11,742	11,151	11,179	131,126
15. Claims Adjustment Expenses	374	374	375	375	376	376	376	377	377	388	389	389	4,546
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	677	678	679	679	680	681	682	683	683	703	704	704	8,233
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	12,438	10,943	12,230	11,787	12,197	11,440	11,804	12,175	11,543	12,833	12,243	12,272	143,905
20. Net Underwriting Gain or Loss (L7 -L19)	(177)	1,332	59	516	119	890	539	182	827	(111)	492	477	5,145
21. Net Investment Income Earned													-
22. Federal Income Taxes	(65)	493	22	191	44	329	199	67	306	(41)	182	177	1,904
23. Health Insurance Provider Fee	231	231	231	231	232	232	232	232	233	239	240	240	2,804
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(342)	608	(194)	93	(157)	329	107	(118)	288	(309)	71	61	438

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	36,076	36,118	36,160	36,160
1. Member Months	-	-	-	-	-	-	-	-	-	36,076	72,194	108,354	108,354
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	11,661	11,674	11,687	35,023
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	365	365	365	1,095
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	12,026	12,039	12,053	36,118
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	7,613	7,250	7,247	22,110
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	1,697	1,174	1,086	3,957
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	2,291	2,159	2,210	6,661
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	178	178	178	535
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	11,779	10,762	10,722	33,263
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	11,779	10,762	10,722	33,263
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	364	365	365	1,094
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	689	690	690	2,069
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	12,832	11,816	11,777	36,425
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	(806)	224	275	(307)
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	(298)	83	102	(114)
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	226	226	227	679
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(734)	(86)	(53)	(873)

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	36,202	36,244	36,287	36,329	36,371	36,414	36,456	36,499	36,541	36,584	36,627	36,670	36,670
1. Member Months	36,202	72,447	108,733	145,063	181,434	217,848	254,304	290,803	327,345	363,929	400,556	437,225	437,225
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	11,700	11,713	11,726	11,739	11,752	11,765	11,778	11,791	11,804	12,147	12,160	12,174	142,250
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	366	366	367	367	367	368	368	369	369	380	380	381	4,448
7. Total (L2a,b+L3+L4+L5+L6)	12,066	12,079	12,093	12,106	12,120	12,133	12,146	12,160	12,173	12,527	12,541	12,554	146,698
Hospital and Medical:													
8. Hospital/Medical Benefits	7,557	6,682	7,468	7,253	7,567	7,085	7,348	7,566	7,145	7,894	7,516	7,510	88,593
9. Other Benefits & Professional Services	1,230	914	960	981	956	866	935	910	875	1,015	921	905	11,469
10. Prescription Drugs	2,408	2,101	2,295	2,173	2,228	2,055	2,123	2,208	2,068	2,409	2,270	2,323	26,662
11. Expanded Benefits	179	179	179	179	179	180	180	180	180	180	181	181	2,157
12. Subtotal (L8+L9+L10+L11)	11,374	9,877	10,902	10,587	10,931	10,186	10,585	10,865	10,269	11,499	10,888	10,919	128,880
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	11,374	9,877	10,902	10,587	10,931	10,186	10,585	10,865	10,269	11,499	10,888	10,919	128,880
15. Claims Adjustment Expenses	365	366	366	367	367	367	368	368	369	379	380	380	4,442
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	691	692	693	694	694	695	696	697	698	717	718	719	8,405
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	12,430	10,934	11,961	11,647	11,993	11,249	11,649	11,930	11,335	12,595	11,985	12,018	141,727
20. Net Underwriting Gain or Loss (L7 -L19)	(364)	1,145	132	459	127	884	497	230	838	(68)	555	537	4,971
21. Net Investment Income Earned													-
22. Federal Income Taxes	(135)	424	49	170	47	327	184	85	310	(25)	206	199	1,839
23. Health Insurance Provider Fee	227	227	227	228	228	228	228	229	229	236	236	236	2,760
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(457)	494	(145)	62	(148)	329	85	(84)	299	(279)	114	102	372

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	36,712	36,755	36,798	36,841	36,884	36,927	36,970	37,013	37,056	37,100	37,143	37,186	37,186
1. Member Months	36,712	73,467	110,265	147,106	183,990	220,917	257,887	294,901	331,957	369,057	406,199	443,386	443,386
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	12,187	12,201	12,214	12,228	12,241	12,255	12,268	12,282	12,296	12,658	12,672	12,686	148,190
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	381	382	382	382	383	383	384	384	384	396	396	397	4,634
7. Total (L2a,b+L3+L4+L5+L6)	12,568	12,582	12,596	12,610	12,624	12,638	12,652	12,666	12,680	13,054	13,069	13,083	152,824
Hospital and Medical:													
8. Hospital/Medical Benefits	7,835	6,926	7,741	7,519	7,845	7,342	7,615	7,844	7,405	8,190	7,796	7,786	91,844
9. Other Benefits & Professional Services	1,072	799	1,076	963	982	922	1,029	1,009	954	1,055	1,017	1,036	11,913
10. Prescription Drugs	2,531	2,209	2,413	2,284	2,342	2,161	2,232	2,322	2,174	2,532	2,386	2,442	28,028
11. Expanded Benefits	181	181	182	182	182	182	182	183	183	183	183	183	2,187
12. Subtotal (L8+L9+L10+L11)	11,620	10,115	11,411	10,948	11,352	10,608	11,057	11,356	10,715	11,960	11,383	11,448	133,973
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	11,620	10,115	11,411	10,948	11,352	10,608	11,057	11,356	10,715	11,960	11,383	11,448	133,973
15. Claims Adjustment Expenses	380	381	381	382	382	383	383	384	384	395	395	396	4,626
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	720	721	721	722	723	724	725	726	726	747	748	749	8,751
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	12,720	11,216	12,514	12,052	12,457	11,714	12,165	12,465	11,826	13,102	12,526	12,592	147,350
20. Net Underwriting Gain or Loss (L7 -L19)	(151)	1,366	82	558	167	924	487	201	854	(48)	543	491	5,473
21. Net Investment Income Earned													-
22. Federal Income Taxes	(56)	505	30	207	62	342	180	74	316	(18)	201	182	2,025
23. Health Insurance Provider Fee	236	237	237	237	237	238	238	238	239	246	246	246	2,875
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(332)	624	(185)	114	(132)	344	69	(112)	300	(276)	96	63	573

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	37,230	37,273	37,317	37,360	37,404	37,447	37,491	37,535	37,578	37,622	37,666	37,710	37,710
1. Member Months	37,230	74,503	111,819	149,179	186,583	224,030	261,521	299,056	336,634	374,257	411,923	449,633	449,633
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	12,701	12,715	12,729	12,743	12,757	12,771	12,785	12,799	12,814	13,197	13,212	13,227	154,449
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	397	398	398	398	399	399	400	400	401	413	413	414	4,830
7. Total (L2a,b+L3+L4+L5+L6)	13,098	13,112	13,127	13,141	13,156	13,170	13,185	13,200	13,214	13,610	13,625	13,640	159,278
Hospital and Medical:													
8. Hospital/Medical Benefits	8,127	7,182	8,029	7,798	8,138	7,613	7,896	8,136	7,679	8,501	8,091	8,077	95,268
9. Other Benefits & Professional Services	1,133	847	1,140	1,039	1,083	1,012	1,049	1,083	1,022	1,157	1,100	1,098	12,763
10. Prescription Drugs	2,661	2,322	2,536	2,402	2,462	2,272	2,346	2,441	2,285	2,662	2,508	2,567	29,466
11. Expanded Benefits	184	184	184	184	185	185	185	185	185	186	186	186	2,218
12. Subtotal (L8+L9+L10+L11)	12,105	10,535	11,890	11,423	11,868	11,082	11,476	11,844	11,171	12,506	11,886	11,929	139,714
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	12,105	10,535	11,890	11,423	11,868	11,082	11,476	11,844	11,171	12,506	11,886	11,929	139,714
15. Claims Adjustment Expenses	396	397	397	398	398	399	399	399	400	412	412	413	4,820
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	750	750	751	752	753	754	755	756	757	779	780	781	9,117
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	13,251	11,682	13,038	12,573	13,019	12,234	12,630	13,000	12,327	13,697	13,078	13,122	153,651
20. Net Underwriting Gain or Loss (L7 -L19)	(153)	1,430	89	569	136	936	555	200	887	(87)	547	518	5,627
21. Net Investment Income Earned													-
22. Federal Income Taxes	(57)	529	33	210	50	346	205	74	328	(32)	202	192	2,082
23. Health Insurance Provider Fee	246	247	247	247	247	248	248	248	249	256	256	257	2,996
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(343)	654	(191)	111	(162)	342	102	(122)	310	(311)	88	70	549

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	51,033	51,093	51,152	51,152
1. Member Months	-	-	-	-	-	-	-	-	-	51,033	102,126	153,278	153,278
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	16,860	16,879	16,897	50,636
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	527	528	528	1,583
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	17,387	17,406	17,426	52,219
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	10,557	10,052	10,041	30,650
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	2,610	1,848	1,711	6,169
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	3,606	3,395	3,473	10,474
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	252	252	252	756
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	17,026	15,546	15,477	48,049
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	17,026	15,546	15,477	48,049
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	529	530	530	1,589
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	1,001	1,002	1,003	3,006
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	18,556	17,078	17,011	52,645
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	(1,169)	328	415	(425)
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	(432)	121	154	(157)
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	327	327	328	982
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(1,063)	(121)	(66)	(1,250)

	2019												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2019
0. Members	51,212	51,272	51,332	51,391	51,451	51,511	51,571	51,632	51,692	51,752	51,813	51,873	51,873
1. Member Months	51,212	102,484	153,815	205,207	256,658	308,169	359,741	411,372	463,064	514,817	566,629	618,502	618,502
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	16,916	16,935	16,954	16,973	16,992	17,011	17,030	17,049	17,068	17,550	17,569	17,589	205,637
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	529	530	530	531	531	532	533	533	534	549	549	550	6,430
7. Total (L2a,b+L3+L4+L5+L6)	17,445	17,465	17,484	17,504	17,523	17,543	17,563	17,582	17,602	18,098	18,119	18,139	212,067
Hospital and Medical:													
8. Hospital/Medical Benefits	10,480	9,262	10,351	10,052	10,494	9,819	10,187	10,491	9,898	10,947	10,421	10,406	122,808
9. Other Benefits & Professional Services	1,938	1,460	1,536	1,574	1,536	1,393	1,493	1,462	1,410	1,632	1,481	1,444	18,361
10. Prescription Drugs	3,789	3,308	3,612	3,421	3,510	3,240	3,348	3,480	3,254	3,780	3,558	3,640	41,940
11. Expanded Benefits	253	253	253	254	254	254	254	255	255	255	256	256	3,051
12. Subtotal (L8+L9+L10+L11)	16,460	14,283	15,752	15,300	15,794	14,706	15,282	15,688	14,817	16,615	15,715	15,746	186,160
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	16,460	14,283	15,752	15,300	15,794	14,706	15,282	15,688	14,817	16,615	15,715	15,746	186,160
15. Claims Adjustment Expenses	531	532	532	533	533	534	535	535	536	550	551	552	6,454
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	1,004	1,006	1,007	1,008	1,009	1,010	1,012	1,013	1,014	1,041	1,042	1,043	12,209
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	17,995	15,821	17,291	16,841	17,337	16,250	16,828	17,236	16,367	18,206	17,308	17,341	204,822
20. Net Underwriting Gain or Loss (L7 -L19)	(550)	1,644	193	663	186	1,293	734	346	1,235	(107)	810	798	7,245
21. Net Investment Income Earned													-
22. Federal Income Taxes	(203)	608	71	245	69	478	272	128	457	(40)	300	295	2,681
23. Health Insurance Provider Fee	328	329	329	329	330	330	330	331	331	340	341	341	3,989
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(675)	707	(207)	88	(212)	484	132	(113)	447	(408)	170	161	575

	2020												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2020
0. Members	51,934	51,994	52,055	52,116	52,176	52,237	52,298	52,359	52,420	52,481	52,543	52,604	52,604
1. Member Months	51,934	103,928	155,982	208,098	260,274	312,511	364,810	417,169	469,589	522,070	574,613	627,217	627,217
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	17,609	17,628	17,648	17,668	17,687	17,707	17,727	17,747	17,767	18,274	18,295	18,315	214,071
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	551	551	552	552	553	554	554	555	556	571	572	573	6,694
7. Total (L2a,b+L3+L4+L5+L6)	18,159	18,179	18,200	18,220	18,240	18,261	18,281	18,302	18,322	18,846	18,867	18,888	220,765
Hospital and Medical:													
8. Hospital/Medical Benefits	10,866	9,601	10,730	10,420	10,880	10,176	10,558	10,877	10,259	11,356	10,808	10,789	127,319
9. Other Benefits & Professional Services	1,711	1,284	1,709	1,547	1,572	1,475	1,634	1,608	1,525	1,684	1,623	1,644	19,014
10. Prescription Drugs	3,972	3,467	3,786	3,586	3,679	3,397	3,510	3,648	3,411	3,963	3,730	3,816	43,963
11. Expanded Benefits	256	256	257	257	257	258	258	258	259	259	259	259	3,094
12. Subtotal (L8+L9+L10+L11)	16,804	14,609	16,482	15,810	16,389	15,305	15,960	16,391	15,452	17,261	16,420	16,508	193,391
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	16,804	14,609	16,482	15,810	16,389	15,305	15,960	16,391	15,452	17,261	16,420	16,508	193,391
15. Claims Adjustment Expenses	552	553	553	554	555	555	556	557	557	572	573	574	6,712
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	1,044	1,046	1,047	1,048	1,049	1,051	1,052	1,053	1,054	1,082	1,084	1,085	12,695
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	18,401	16,207	18,083	17,413	17,993	16,911	17,567	18,000	17,064	18,916	18,076	18,167	212,798
20. Net Underwriting Gain or Loss (L7 -L19)	(242)	1,972	117	807	248	1,350	714	301	1,258	(70)	790	721	7,967
21. Net Investment Income Earned													-
22. Federal Income Taxes	(89)	730	43	299	92	499	264	111	466	(26)	292	267	2,948
23. Health Insurance Provider Fee	342	342	342	343	343	344	344	344	345	355	355	355	4,153
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(494)	900	(268)	166	(187)	507	106	(155)	448	(399)	143	99	866

	2021												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2021
0. Members	52,665	52,727	52,788	52,850	52,911	52,973	53,035	53,097	53,159	53,221	53,283	53,345	53,345
1. Member Months	52,665	105,392	158,180	211,030	263,942	316,915	369,950	423,047	476,206	529,426	582,709	636,055	636,055
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	18,336	18,356	18,377	18,397	18,418	18,438	18,459	18,479	18,500	19,035	19,056	19,078	222,929
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	573	574	575	575	576	577	577	578	579	595	596	597	6,971
7. Total (L2a,b+L3+L4+L5+L6)	18,909	18,930	18,951	18,972	18,994	19,015	19,036	19,057	19,079	19,630	19,652	19,674	229,900
Hospital and Medical:													
8. Hospital/Medical Benefits	11,270	9,956	11,128	10,807	11,285	10,551	10,947	11,281	10,637	11,784	11,214	11,191	132,052
9. Other Benefits & Professional Services	1,800	1,353	1,804	1,652	1,723	1,603	1,661	1,721	1,622	1,835	1,742	1,731	20,246
10. Prescription Drugs	4,163	3,635	3,969	3,759	3,857	3,561	3,679	3,824	3,575	4,154	3,910	4,000	46,085
11. Expanded Benefits	260	260	260	261	261	261	262	262	262	263	263	263	3,138
12. Subtotal (L8+L9+L10+L11)	17,493	15,204	17,161	16,479	17,125	15,977	16,549	17,088	16,096	18,035	17,128	17,185	201,521
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	17,493	15,204	17,161	16,479	17,125	15,977	16,549	17,088	16,096	18,035	17,128	17,185	201,521
15. Claims Adjustment Expenses	574	575	576	576	577	578	578	579	580	596	597	598	6,984
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	1,086	1,088	1,089	1,090	1,091	1,093	1,094	1,095	1,096	1,128	1,129	1,131	13,210
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	19,154	16,867	18,825	18,145	18,793	17,647	18,222	18,762	17,772	19,760	18,855	18,914	221,715
20. Net Underwriting Gain or Loss (L7 -L19)	(245)	2,063	126	827	200	1,368	814	295	1,307	(129)	798	761	8,185
21. Net Investment Income Earned													-
22. Federal Income Taxes	(91)	763	47	306	74	506	301	109	483	(48)	295	281	3,028
23. Health Insurance Provider Fee	356	356	357	357	357	358	358	359	359	369	370	370	4,325
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(510)	944	(277)	164	(231)	504	155	(173)	464	(451)	133	109	832

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	60,549	60,620	60,691	60,691
1. Member Months	-	-	-	-	-	-	-	-	-	60,549	121,170	181,860	181,860
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	19,467	19,489	19,510	58,466
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	609	609	610	1,828
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	20,076	20,098	20,120	60,294
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	12,525	11,919	11,896	36,341
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	3,246	2,344	2,187	7,776
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	3,632	3,426	3,508	10,567
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	299	299	299	897
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	19,702	17,988	17,891	55,581
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	19,702	17,988	17,891	55,581
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	615	616	616	1,847
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	1,163	1,165	1,166	3,495
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	21,480	19,769	19,673	60,922
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	(1,405)	329	447	(628)
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	(520)	122	165	(233)
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	378	378	378	1,134
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(1,263)	(171)	(97)	(1,530)

	2019												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2019
0. Members	60,762	60,833	60,904	60,975	61,046	61,117	61,188	61,260	61,331	61,403	61,474	61,546	61,546
1. Member Months	60,762	121,594	182,498	243,472	304,518	365,635	426,823	488,083	549,414	610,816	672,291	733,837	733,837
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	19,532	19,554	19,575	19,597	19,619	19,641	19,662	19,684	19,706	20,252	20,274	20,297	237,392
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	611	611	612	613	613	614	615	616	616	633	634	635	7,423
7. Total (L2a,b+L3+L4+L5+L6)	20,143	20,165	20,187	20,210	20,232	20,255	20,277	20,300	20,322	20,885	20,908	20,931	244,816
Hospital and Medical:													
8. Hospital/Medical Benefits	12,424	10,975	12,277	11,925	12,439	11,630	12,059	12,436	11,739	12,977	12,347	12,318	145,546
9. Other Benefits & Professional Services	2,448	1,863	1,987	2,013	1,985	1,794	1,911	1,897	1,818	2,085	1,906	1,873	23,579
10. Prescription Drugs	3,820	3,331	3,638	3,442	3,528	3,250	3,355	3,495	3,277	3,812	3,595	3,681	42,223
11. Expanded Benefits	300	300	300	301	301	301	302	302	303	303	303	304	3,620
12. Subtotal (L8+L9+L10+L11)	18,991	16,469	18,202	17,681	18,253	16,975	17,626	18,130	17,137	19,177	18,151	18,176	214,968
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	18,991	16,469	18,202	17,681	18,253	16,975	17,626	18,130	17,137	19,177	18,151	18,176	214,968
15. Claims Adjustment Expenses	617	618	619	619	620	621	621	622	623	639	640	641	7,500
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	1,168	1,169	1,170	1,172	1,173	1,174	1,176	1,177	1,178	1,209	1,210	1,212	14,188
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	20,776	18,256	19,991	19,472	20,046	18,770	19,424	19,929	18,938	21,025	20,002	20,029	236,656
20. Net Underwriting Gain or Loss (L7 -L19)	(633)	1,909	197	738	187	1,484	854	371	1,384	(140)	907	903	8,159
21. Net Investment Income Earned													-
22. Federal Income Taxes	(234)	706	73	273	69	549	316	137	512	(52)	335	334	3,019
23. Health Insurance Provider Fee	379	379	380	380	381	381	381	382	382	393	393	394	4,605
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(778)	824	(256)	85	(263)	554	156	(148)	490	(481)	178	175	535

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	61,618	61,690	61,762	61,834	61,906	61,978	62,050	62,123	62,195	62,268	62,340	62,413	62,413
1. Member Months	61,618	123,307	185,069	246,903	308,809	370,787	432,837	494,960	557,155	619,423	681,763	744,177	744,177
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	20,319	20,342	20,365	20,387	20,410	20,432	20,455	20,478	20,501	21,077	21,100	21,124	246,989
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	635	636	637	638	638	639	640	640	641	659	660	661	7,723
7. Total (L2a,b+L3+L4+L5+L6)	20,955	20,978	21,001	21,025	21,048	21,071	21,095	21,118	21,142	21,736	21,760	21,784	254,713
Hospital and Medical:													
8. Hospital/Medical Benefits	12,871	11,367	12,716	12,352	12,886	12,043	12,487	12,882	12,157	13,452	12,796	12,762	150,772
9. Other Benefits & Professional Services	2,180	1,672	2,181	1,972	2,023	1,892	2,083	2,075	1,956	2,166	2,077	2,097	24,372
10. Prescription Drugs	4,008	3,495	3,818	3,612	3,702	3,411	3,521	3,668	3,439	4,000	3,772	3,862	44,308
11. Expanded Benefits	304	304	305	305	305	306	306	306	307	307	308	308	3,671
12. Subtotal (L8+L9+L10+L11)	19,362	16,838	19,019	18,241	18,917	17,652	18,398	18,931	17,858	19,925	18,953	19,029	223,123
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	19,362	16,838	19,019	18,241	18,917	17,652	18,398	18,931	17,858	19,925	18,953	19,029	223,123
15. Claims Adjustment Expenses	641	642	643	644	644	645	646	647	647	664	665	666	7,794
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	1,213	1,215	1,216	1,218	1,219	1,220	1,222	1,223	1,225	1,257	1,258	1,259	14,744
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	21,217	18,695	20,878	20,102	20,780	19,517	20,265	20,801	19,730	21,846	20,876	20,954	245,662
20. Net Underwriting Gain or Loss (L7 -L19)	(262)	2,283	123	922	268	1,554	830	317	1,412	(110)	884	830	9,051
21. Net Investment Income Earned													-
22. Federal Income Taxes	(97)	845	46	341	99	575	307	117	522	(41)	327	307	3,349
23. Health Insurance Provider Fee	394	395	395	396	396	396	397	397	398	409	409	410	4,792
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(559)	1,044	(318)	186	(227)	583	126	(197)	492	(478)	148	113	911

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	62,486	62,559	62,632	62,705	62,778	62,851	62,925	62,998	63,072	63,145	63,219	63,293	63,293
1. Member Months	62,486	125,045	187,677	250,382	313,160	376,011	438,936	501,934	565,006	628,151	691,370	754,662	754,662
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	21,147	21,171	21,194	21,218	21,241	21,265	21,289	21,312	21,336	21,944	21,968	21,993	257,077
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	661	662	663	663	664	665	666	666	667	686	687	688	8,039
7. Total (L2a,b+L3+L4+L5+L6)	21,808	21,833	21,857	21,881	21,905	21,930	21,954	21,979	22,003	22,630	22,655	22,680	265,116
Hospital and Medical:													
8. Hospital/Medical Benefits	13,340	11,778	13,177	12,801	13,356	12,477	12,937	13,351	12,596	13,950	13,268	13,227	156,257
9. Other Benefits & Professional Services	2,287	1,757	2,294	2,115	2,203	2,052	2,124	2,201	2,077	2,340	2,222	2,209	25,880
10. Prescription Drugs	4,206	3,668	4,006	3,791	3,885	3,580	3,696	3,849	3,608	4,198	3,959	4,053	46,499
11. Expanded Benefits	308	309	309	309	310	310	310	311	311	311	312	312	3,723
12. Subtotal (L8+L9+L10+L11)	20,141	17,512	19,787	19,016	19,753	18,419	19,068	19,712	18,592	20,799	19,760	19,801	232,359
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	20,141	17,512	19,787	19,016	19,753	18,419	19,068	19,712	18,592	20,799	19,760	19,801	232,359
15. Claims Adjustment Expenses	667	667	668	669	670	671	671	672	673	692	693	694	8,106
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	1,261	1,262	1,264	1,265	1,267	1,268	1,270	1,271	1,273	1,309	1,310	1,312	15,333
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	22,068	19,442	21,719	20,950	21,689	20,358	21,009	21,655	20,538	22,800	21,763	21,807	255,798
20. Net Underwriting Gain or Loss (L7 -L19)	(260)	2,391	137	931	216	1,572	945	324	1,465	(170)	892	873	9,317
21. Net Investment Income Earned													-
22. Federal Income Taxes	(96)	885	51	345	80	582	350	120	542	(63)	330	323	3,447
23. Health Insurance Provider Fee	410	411	411	412	412	413	413	413	414	426	426	427	4,987
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(574)	1,096	(325)	175	(276)	578	183	(210)	509	(533)	136	124	883

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	69,626	69,707	69,788	69,788
1. Member Months	-	-	-	-	-	-	-	-	-	69,626	139,332	209,121	209,121
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	23,947	23,974	24,000	71,921
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	749	750	750	2,249
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	24,696	24,723	24,751	74,170
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	15,523	14,773	14,744	45,040
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	2,510	2,379	2,359	7,248
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	4,276	4,027	4,121	12,425
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	343	344	344	1,032
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	22,653	21,524	21,569	65,745
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	22,653	21,524	21,569	65,745
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	767	768	768	2,303
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	1,450	1,452	1,453	4,355
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	24,869	23,743	23,791	72,403
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	(174)	980	960	1,767
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	(64)	363	355	654
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	465	465	466	1,395
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(574)	153	139	(282)

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	69,870	69,951	70,033	70,114	70,196	70,278	70,360	70,442	70,524	70,607	70,689	70,771	70,771
1. Member Months	69,870	139,821	209,853	279,968	350,164	420,442	490,802	561,244	631,769	702,375	773,064	843,836	843,836
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	24,027	24,054	24,081	24,108	24,135	24,162	24,189	24,216	24,243	24,941	24,969	24,997	292,123
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	751	752	753	754	755	756	756	757	758	780	781	782	9,135
7. Total (L2a,b+L3+L4+L5+L6)	24,779	24,806	24,834	24,862	24,890	24,918	24,945	24,973	25,001	25,721	25,750	25,779	301,258
Hospital and Medical:													
8. Hospital/Medical Benefits	15,402	13,605	15,212	14,775	15,422	14,418	14,954	15,416	14,543	16,115	15,334	15,300	180,495
9. Other Benefits & Professional Services	2,481	2,182	2,449	2,382	2,482	2,305	2,387	2,479	2,336	2,641	2,504	2,483	29,112
10. Prescription Drugs	4,494	3,922	4,283	4,056	4,160	3,839	3,966	4,124	3,859	4,486	4,224	4,323	49,736
11. Expanded Benefits	345	345	345	346	346	347	347	347	348	348	349	349	4,163
12. Subtotal (L8+L9+L10+L11)	22,721	20,055	22,290	21,559	22,410	20,909	21,654	22,367	21,085	23,590	22,411	22,454	263,505
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	22,721	20,055	22,290	21,559	22,410	20,909	21,654	22,367	21,085	23,590	22,411	22,454	263,505
15. Claims Adjustment Expenses	769	770	771	772	773	774	775	776	777	798	799	799	9,352
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	1,455	1,457	1,459	1,460	1,462	1,464	1,465	1,467	1,469	1,508	1,510	1,512	17,688
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	24,946	22,282	24,520	23,791	24,645	23,146	23,894	24,610	23,331	25,896	24,720	24,766	290,546
20. Net Underwriting Gain or Loss (L7 -L19)	(167)	2,525	314	1,071	245	1,771	1,051	363	1,670	(175)	1,030	1,013	10,712
21. Net Investment Income Earned													-
22. Federal Income Taxes	(62)	934	116	396	91	655	389	134	618	(65)	381	375	3,963
23. Health Insurance Provider Fee	466	467	467	468	468	469	469	470	470	484	484	485	5,667
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(572)	1,124	(269)	207	(314)	647	193	(241)	582	(594)	165	153	1,081

	2020												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2020
0. Members	70,854	70,937	71,019	71,102	71,185	71,268	71,351	71,435	71,518	71,602	71,685	71,769	71,769
1. Member Months	70,854	141,791	212,810	283,913	355,098	426,366	497,718	569,152	640,670	712,272	783,957	855,726	855,726
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	25,025	25,053	25,081	25,109	25,137	25,165	25,193	25,222	25,250	25,985	26,014	26,044	304,278
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	783	783	784	785	786	787	788	789	790	813	813	814	9,515
7. Total (L2a,b+L3+L4+L5+L6)	25,807	25,836	25,865	25,894	25,923	25,952	25,981	26,010	26,039	26,798	26,828	26,858	313,793
Hospital and Medical:													
8. Hospital/Medical Benefits	15,988	14,120	15,789	15,335	16,008	14,961	15,518	16,001	15,092	16,735	15,922	15,882	187,350
9. Other Benefits & Professional Services	2,611	2,297	2,578	2,507	2,612	2,427	2,513	2,609	2,459	2,780	2,637	2,615	30,643
10. Prescription Drugs	4,714	4,114	4,493	4,255	4,364	4,028	4,161	4,327	4,048	4,706	4,431	4,534	52,174
11. Expanded Benefits	350	350	350	351	351	352	352	352	353	353	354	354	4,221
12. Subtotal (L8+L9+L10+L11)	23,662	20,881	23,210	22,448	23,335	21,767	22,543	23,290	21,951	24,575	23,343	23,385	274,388
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	23,662	20,881	23,210	22,448	23,335	21,767	22,543	23,290	21,951	24,575	23,343	23,385	274,388
15. Claims Adjustment Expenses	800	801	802	803	804	805	806	807	808	830	831	832	9,730
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	1,514	1,515	1,517	1,519	1,521	1,523	1,524	1,526	1,528	1,569	1,571	1,573	18,401
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	25,976	23,198	25,529	24,770	25,660	24,094	24,874	25,623	24,287	26,974	25,746	25,790	302,519
20. Net Underwriting Gain or Loss (L7 -L19)	(169)	2,639	336	1,124	263	1,858	1,108	388	1,753	(176)	1,082	1,068	11,274
21. Net Investment Income Earned													-
22. Federal Income Taxes	(62)	976	124	416	97	687	410	143	649	(65)	400	395	4,171
23. Health Insurance Provider Fee	485	486	487	487	488	488	489	489	490	504	505	505	5,903
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(592)	1,176	(275)	221	(322)	682	209	(245)	614	(615)	177	168	1,199

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	71,852	71,936	72,020	72,104	72,188	72,273	72,357	72,441	72,526	72,610	72,695	72,780	72,780
1. Member Months	71,852	143,789	215,809	287,913	360,101	432,374	504,731	577,172	649,698	722,308	795,003	867,783	867,783
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	26,073	26,102	26,131	26,160	26,190	26,219	26,248	26,278	26,307	27,082	27,113	27,143	317,045
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	815	816	817	818	819	820	821	822	823	847	848	849	9,914
7. Total (L2a,b+L3+L4+L5+L6)	26,888	26,918	26,948	26,978	27,009	27,039	27,069	27,099	27,130	27,929	27,960	27,992	326,959
Hospital and Medical:													
8. Hospital/Medical Benefits	16,602	14,660	16,393	15,922	16,623	15,531	16,109	16,615	15,667	17,386	16,539	16,493	194,540
9. Other Benefits & Professional Services	2,749	2,418	2,714	2,640	2,750	2,556	2,646	2,747	2,589	2,928	2,777	2,755	32,269
10. Prescription Drugs	4,945	4,316	4,713	4,464	4,578	4,226	4,365	4,539	4,246	4,937	4,648	4,756	54,733
11. Expanded Benefits	354	355	355	356	356	357	357	357	358	358	359	359	4,281
12. Subtotal (L8+L9+L10+L11)	24,650	21,749	24,176	23,382	24,307	22,668	23,478	24,259	22,860	25,609	24,323	24,363	285,823
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	24,650	21,749	24,176	23,382	24,307	22,668	23,478	24,259	22,860	25,609	24,323	24,363	285,823
15. Claims Adjustment Expenses	833	834	835	836	837	838	839	840	841	865	866	867	10,130
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	1,575	1,577	1,579	1,580	1,582	1,584	1,586	1,588	1,590	1,636	1,638	1,640	19,155
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	27,058	24,159	26,589	25,798	26,726	25,090	25,902	26,686	25,290	28,111	26,828	26,871	315,108
20. Net Underwriting Gain or Loss (L7 -L19)	(170)	2,759	359	1,181	283	1,949	1,167	413	1,839	(182)	1,133	1,121	11,851
21. Net Investment Income Earned													-
22. Federal Income Taxes	(63)	1,021	133	437	105	721	432	153	681	(67)	419	415	4,385
23. Health Insurance Provider Fee	506	506	507	508	508	509	509	510	510	525	526	527	6,151
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(613)	1,232	(281)	236	(330)	719	226	(250)	648	(640)	188	180	1,315

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	146,592	146,763	146,934	146,934
1. Member Months	-	-	-	-	-	-	-	-	-	146,592	293,354	440,288	440,288
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	40,726	40,771	40,816	122,314
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	1,274	1,275	1,276	3,825
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	42,000	42,046	42,093	126,139
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	25,707	24,416	24,272	74,395
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	4,326	4,091	4,035	12,451
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	7,762	7,322	7,498	22,582
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	723	724	725	2,172
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	38,517	36,553	36,530	111,599
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	38,517	36,553	36,530	111,599
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	1,388	1,389	1,391	4,168
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	2,626	2,629	2,633	7,888
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	42,531	40,572	40,553	123,656
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	(531)	1,475	1,540	2,483
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	(197)	546	570	919
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	790	791	792	2,373
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(1,125)	138	178	(809)

	2019												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2019
0. Members	147,105	147,277	147,449	147,621	147,793	147,965	148,138	148,311	148,484	148,657	148,831	149,004	149,004
1. Member Months	147,105	294,382	441,831	589,451	737,244	885,210	1,033,348	1,181,659	1,330,142	1,478,799	1,627,630	1,776,634	1,776,634
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	40,862	40,907	40,952	40,997	41,042	41,088	41,133	41,179	41,224	42,518	42,565	42,612	497,078
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	1,278	1,279	1,281	1,282	1,283	1,285	1,286	1,288	1,289	1,330	1,331	1,332	15,544
7. Total (L2a,b+L3+L4+L5+L6)	42,139	42,186	42,232	42,279	42,326	42,373	42,420	42,466	42,513	43,847	43,896	43,944	512,622
Hospital and Medical:													
8. Hospital/Medical Benefits	25,460	22,436	25,132	24,421	25,483	23,733	24,604	25,466	23,989	26,793	25,445	25,291	298,254
9. Other Benefits & Professional Services	4,266	3,740	4,209	4,096	4,265	3,943	4,079	4,259	4,006	4,546	4,300	4,242	49,951
10. Prescription Drugs	8,164	7,118	7,774	7,354	7,534	6,938	7,161	7,463	6,999	8,140	7,679	7,863	90,187
11. Expanded Benefits	726	727	727	728	729	730	731	732	732	733	734	735	8,764
12. Subtotal (L8+L9+L10+L11)	38,615	34,020	37,843	36,599	38,011	35,344	36,575	37,920	35,727	40,213	38,158	38,131	447,156
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	38,615	34,020	37,843	36,599	38,011	35,344	36,575	37,920	35,727	40,213	38,158	38,131	447,156
15. Claims Adjustment Expenses	1,393	1,394	1,396	1,398	1,399	1,401	1,402	1,404	1,406	1,442	1,444	1,446	16,924
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	2,636	2,639	2,642	2,645	2,648	2,651	2,654	2,657	2,660	2,729	2,732	2,735	32,029
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	42,644	38,053	41,880	40,641	42,058	39,396	40,632	41,981	39,793	44,384	42,335	42,312	496,109
20. Net Underwriting Gain or Loss (L7 -L19)	(504)	4,133	352	1,638	268	2,976	1,788	485	2,720	(537)	1,561	1,632	16,513
21. Net Investment Income Earned													-
22. Federal Income Taxes	(187)	1,529	130	606	99	1,101	661	180	1,006	(199)	578	604	6,110
23. Health Insurance Provider Fee	793	794	794	795	796	797	798	799	800	825	826	827	9,643
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(1,110)	1,810	(573)	237	(627)	1,078	328	(493)	914	(1,163)	158	201	760

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	149,178	149,352	149,526	149,701	149,875	150,050	150,225	150,401	150,576	150,752	150,928	151,104	151,104
1. Member Months	149,178	298,530	448,056	597,757	747,632	897,683	1,047,908	1,198,308	1,348,884	1,499,636	1,650,564	1,801,667	1,801,667
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	42,659	42,706	42,753	42,801	42,848	42,895	42,943	42,990	43,038	44,397	44,446	44,495	518,971
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	1,334	1,335	1,337	1,338	1,340	1,341	1,343	1,344	1,346	1,388	1,390	1,391	16,228
7. Total (L2a,b+L3+L4+L5+L6)	43,993	44,042	44,090	44,139	44,188	44,237	44,286	44,335	44,384	45,785	45,836	45,886	535,199
Hospital and Medical:													
8. Hospital/Medical Benefits	26,534	23,380	26,191	25,450	26,558	24,730	25,638	26,540	24,997	27,931	26,524	26,359	310,833
9. Other Benefits & Professional Services	4,484	3,932	4,424	4,305	4,483	4,145	4,289	4,477	4,212	4,780	4,521	4,461	52,513
10. Prescription Drugs	8,562	7,465	8,153	7,713	7,902	7,278	7,511	7,828	7,341	8,538	8,053	8,246	94,589
11. Expanded Benefits	736	737	738	738	739	740	741	742	743	744	745	745	8,888
12. Subtotal (L8+L9+L10+L11)	40,316	35,513	39,506	38,207	39,682	36,893	38,179	39,586	37,293	41,992	39,843	39,812	466,823
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	40,316	35,513	39,506	38,207	39,682	36,893	38,179	39,586	37,293	41,992	39,843	39,812	466,823
15. Claims Adjustment Expenses	1,447	1,449	1,451	1,452	1,454	1,456	1,457	1,459	1,461	1,499	1,501	1,502	17,588
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	2,739	2,742	2,745	2,748	2,751	2,755	2,758	2,761	2,764	2,836	2,839	2,843	33,282
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	44,502	39,704	43,702	42,407	43,888	41,104	42,394	43,807	41,518	46,327	44,183	44,157	517,693
20. Net Underwriting Gain or Loss (L7 -L19)	(509)	4,338	388	1,732	300	3,133	1,891	528	2,866	(542)	1,652	1,729	17,506
21. Net Investment Income Earned													-
22. Federal Income Taxes	(188)	1,605	144	641	111	1,159	700	195	1,060	(201)	611	640	6,477
23. Health Insurance Provider Fee	828	828	829	830	831	832	833	834	835	861	862	863	10,068
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(1,148)	1,904	(585)	261	(642)	1,142	358	(501)	971	(1,203)	179	226	961

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	151,280	151,456	151,633	151,810	151,987	152,164	152,342	152,520	152,698	152,876	153,054	153,233	153,233
1. Member Months	151,280	302,736	454,369	606,179	758,167	910,331	1,062,673	1,215,193	1,367,890	1,520,766	1,673,820	1,827,053	1,827,053
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	44,544	44,593	44,643	44,692	44,742	44,791	44,841	44,890	44,940	46,367	46,419	46,470	541,933
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	1,393	1,394	1,396	1,398	1,399	1,401	1,402	1,404	1,405	1,450	1,452	1,453	16,946
7. Total (L2a,b+L3+L4+L5+L6)	45,937	45,988	46,039	46,090	46,141	46,192	46,243	46,294	46,345	47,817	47,870	47,923	558,880
Hospital and Medical:													
8. Hospital/Medical Benefits	27,660	24,369	27,301	26,528	27,684	25,775	26,721	27,665	26,054	29,124	27,655	27,479	324,016
9. Other Benefits & Professional Services	4,714	4,134	4,652	4,527	4,714	4,359	4,510	4,707	4,429	5,026	4,755	4,693	55,221
10. Prescription Drugs	8,980	7,829	8,551	8,089	8,288	7,634	7,879	8,210	7,699	8,955	8,446	8,648	99,209
11. Expanded Benefits	746	747	748	749	750	751	751	752	753	754	755	756	9,013
12. Subtotal (L8+L9+L10+L11)	42,101	37,080	41,252	39,894	41,436	38,519	39,862	41,335	38,935	43,859	41,611	41,575	487,459
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	42,101	37,080	41,252	39,894	41,436	38,519	39,862	41,335	38,935	43,859	41,611	41,575	487,459
15. Claims Adjustment Expenses	1,504	1,506	1,508	1,509	1,511	1,513	1,515	1,516	1,518	1,566	1,568	1,570	18,306
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	2,846	2,849	2,853	2,856	2,859	2,863	2,866	2,869	2,873	2,964	2,967	2,971	34,636
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	46,451	41,435	45,612	44,259	45,806	42,894	44,243	45,721	43,326	48,389	46,146	46,116	540,400
20. Net Underwriting Gain or Loss (L7 -L19)	(514)	4,553	427	1,831	334	3,297	2,000	573	3,019	(572)	1,724	1,807	18,480
21. Net Investment Income Earned													-
22. Federal Income Taxes	(190)	1,684	158	677	124	1,220	740	212	1,117	(212)	638	669	6,837
23. Health Insurance Provider Fee	864	865	866	867	868	869	870	871	872	900	901	902	10,514
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(1,188)	2,003	(597)	286	(657)	1,208	390	(510)	1,030	(1,260)	186	237	1,129

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	85,555	85,655	85,755	85,755
1. Member Months	-	-	-	-	-	-	-	-	-	85,555	171,209	256,964	256,964
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	26,834	26,864	26,894	80,592
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	839	840	841	2,520
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	27,673	27,704	27,735	83,112
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	17,069	16,227	16,162	49,457
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	2,715	2,576	2,557	7,848
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	5,265	4,958	5,073	15,296
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	422	423	423	1,268
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	25,471	24,183	24,215	73,869
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	25,471	24,183	24,215	73,869
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	851	852	853	2,557
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	1,611	1,613	1,615	4,838
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	27,934	26,648	26,683	81,265
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	(261)	1,056	1,052	1,847
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	(96)	391	389	684
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	521	521	522	1,563
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(685)	144	141	(400)

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	85,855	85,955	86,055	86,155	86,256	86,357	86,457	86,558	86,659	86,760	86,862	86,963	86,963
1. Member Months	85,855	171,809	257,864	344,020	430,276	516,633	603,090	689,648	776,307	863,068	949,929	1,036,892	1,036,892
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	26,924	26,954	26,984	27,014	27,044	27,075	27,105	27,135	27,165	27,863	27,894	27,925	327,082
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	842	843	844	845	846	847	848	849	849	871	872	873	10,228
7. Total (L2a,b+L3+L4+L5+L6)	27,766	27,797	27,828	27,859	27,890	27,921	27,952	27,984	28,015	28,734	28,766	28,798	337,310
Hospital and Medical:													
8. Hospital/Medical Benefits	16,919	14,926	16,706	16,230	16,937	15,803	16,386	16,929	15,958	17,671	16,796	16,725	197,986
9. Other Benefits & Professional Services	2,687	2,365	2,651	2,577	2,688	2,500	2,590	2,686	2,528	2,847	2,702	2,682	31,503
10. Prescription Drugs	5,533	4,829	5,273	4,994	5,122	4,726	4,882	5,077	4,750	5,502	5,180	5,301	61,169
11. Expanded Benefits	424	424	425	425	425	426	426	427	427	428	428	429	5,115
12. Subtotal (L8+L9+L10+L11)	25,563	22,544	25,055	24,226	25,172	23,455	24,285	25,119	23,663	26,448	25,107	25,137	295,773
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	25,563	22,544	25,055	24,226	25,172	23,455	24,285	25,119	23,663	26,448	25,107	25,137	295,773
15. Claims Adjustment Expenses	854	855	856	857	858	859	860	861	862	882	883	884	10,374
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	1,617	1,618	1,620	1,622	1,624	1,626	1,628	1,630	1,632	1,668	1,670	1,672	19,628
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	28,034	25,018	27,531	26,706	27,655	25,940	26,774	27,610	26,157	28,998	27,660	27,693	325,775
20. Net Underwriting Gain or Loss (L7 -L19)	(268)	2,779	297	1,153	235	1,981	1,179	374	1,858	(264)	1,106	1,106	11,535
21. Net Investment Income Earned													-
22. Federal Income Taxes	(99)	1,028	110	427	87	733	436	138	687	(98)	409	409	4,268
23. Health Insurance Provider Fee	522	523	523	524	525	525	526	526	527	541	541	542	6,345
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(691)	1,228	(337)	203	(376)	723	217	(291)	643	(707)	156	155	922

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	87,064	87,166	87,268	87,369	87,471	87,573	87,676	87,778	87,880	87,983	88,085	88,188	88,188
1. Member Months	87,064	174,230	261,498	348,867	436,339	523,912	611,588	699,365	787,246	875,228	963,314	1,051,502	1,051,502
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	27,956	27,987	28,019	28,050	28,081	28,113	28,144	28,175	28,207	28,939	28,971	29,004	339,646
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	874	875	876	877	878	879	880	881	882	905	906	907	10,621
7. Total (L2a,b+L3+L4+L5+L6)	28,830	28,863	28,895	28,927	28,959	28,992	29,024	29,056	29,089	29,844	29,877	29,911	350,266
Hospital and Medical:													
8. Hospital/Medical Benefits	17,514	15,449	17,292	16,799	17,532	16,354	16,958	17,523	16,515	18,299	17,391	17,313	204,937
9. Other Benefits & Professional Services	2,818	2,480	2,780	2,703	2,819	2,622	2,717	2,817	2,652	2,987	2,835	2,815	33,045
10. Prescription Drugs	5,782	5,046	5,510	5,218	5,352	4,939	5,103	5,306	4,963	5,749	5,413	5,539	63,920
11. Expanded Benefits	429	430	430	431	431	432	432	433	434	434	435	435	5,187
12. Subtotal (L8+L9+L10+L11)	26,543	23,405	26,012	25,151	26,135	24,347	25,210	26,079	24,563	27,469	26,073	26,101	307,090
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	26,543	23,405	26,012	25,151	26,135	24,347	25,210	26,079	24,563	27,469	26,073	26,101	307,090
15. Claims Adjustment Expenses	885	886	887	888	889	890	891	892	893	913	914	916	10,744
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	1,674	1,676	1,678	1,680	1,682	1,684	1,686	1,688	1,690	1,728	1,730	1,732	20,327
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	29,102	25,967	28,577	27,719	28,706	26,921	27,787	28,659	27,146	30,110	28,718	28,749	338,162
20. Net Underwriting Gain or Loss (L7 -L19)	(272)	2,896	317	1,208	253	2,070	1,237	398	1,943	(266)	1,159	1,162	12,105
21. Net Investment Income Earned													-
22. Federal Income Taxes	(101)	1,071	117	447	94	766	458	147	719	(99)	429	430	4,479
23. Health Insurance Provider Fee	542	543	544	544	545	545	546	547	547	561	562	563	6,589
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(714)	1,281	(344)	217	(385)	759	233	(296)	677	(729)	168	169	1,037

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	88,291	88,394	88,497	88,600	88,704	88,807	88,911	89,015	89,119	89,222	89,327	89,431	89,431
1. Member Months	88,291	176,685	265,182	353,783	442,487	531,294	620,205	709,220	798,338	887,561	976,887	1,066,318	1,066,318
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	29,036	29,068	29,101	29,133	29,166	29,199	29,231	29,264	29,296	30,065	30,099	30,132	352,790
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	908	909	910	911	912	913	914	915	916	940	941	942	11,032
7. Total (L2a,b+L3+L4+L5+L6)	29,944	29,977	30,011	30,044	30,078	30,112	30,145	30,179	30,213	31,005	31,040	31,074	363,822
Hospital and Medical:													
8. Hospital/Medical Benefits	18,135	15,994	17,903	17,393	18,153	16,929	17,555	18,144	17,096	18,954	18,012	17,927	212,196
9. Other Benefits & Professional Services	2,957	2,603	2,917	2,836	2,958	2,752	2,852	2,955	2,783	3,135	2,975	2,956	34,679
10. Prescription Drugs	6,042	5,273	5,758	5,453	5,593	5,162	5,333	5,545	5,187	6,008	5,657	5,788	66,800
11. Expanded Benefits	436	436	437	437	438	438	439	439	440	440	441	441	5,260
12. Subtotal (L8+L9+L10+L11)	27,569	24,306	27,015	26,120	27,142	25,281	26,178	27,083	25,505	28,538	27,085	27,111	318,934
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	27,569	24,306	27,015	26,120	27,142	25,281	26,178	27,083	25,505	28,538	27,085	27,111	318,934
15. Claims Adjustment Expenses	917	918	919	920	921	922	923	924	925	949	951	952	11,139
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	1,734	1,736	1,738	1,740	1,742	1,744	1,746	1,748	1,750	1,796	1,798	1,800	21,073
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	30,220	26,959	29,671	28,780	29,805	27,947	28,847	29,756	28,181	31,283	29,834	29,863	351,147
20. Net Underwriting Gain or Loss (L7 -L19)	(276)	3,018	339	1,265	273	2,164	1,298	423	2,032	(278)	1,206	1,211	12,675
21. Net Investment Income Earned													-
22. Federal Income Taxes	(102)	1,117	126	468	101	801	480	157	752	(103)	446	448	4,690
23. Health Insurance Provider Fee	563	564	565	565	566	566	567	568	568	583	584	585	6,844
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(737)	1,337	(351)	232	(394)	797	251	(301)	712	(759)	176	179	1,141

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	11,389	11,403	11,416	11,416
1. Member Months	-	-	-	-	-	-	-	-	-	11,389	22,792	34,208	34,208
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	4,739	4,744	4,750	14,233
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	148	148	149	445
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	4,887	4,893	4,898	14,678
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	3,242	3,107	3,148	9,497
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	972	712	686	2,370
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	598	566	580	1,744
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	56	56	56	169
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	4,868	4,441	4,471	13,780
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	4,868	4,441	4,471	13,780
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	117	117	117	351
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	221	221	222	664
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	5,206	4,780	4,810	14,795
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	(319)	113	88	(118)
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	(118)	42	33	(44)
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	92	92	92	276
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(293)	(21)	(36)	(350)

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	11,429	11,443	11,456	11,469	11,483	11,496	11,510	11,523	11,536	11,550	11,563	11,577	11,577
1. Member Months	11,429	22,872	34,328	45,798	57,280	68,777	80,286	91,809	103,346	114,896	126,459	138,036	138,036
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	4,755	4,760	4,766	4,771	4,776	4,782	4,787	4,793	4,798	4,853	4,858	4,864	57,564
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	149	149	149	149	149	150	150	150	150	152	152	152	1,800
7. Total (L2a,b+L3+L4+L5+L6)	4,904	4,909	4,915	4,920	4,926	4,931	4,937	4,943	4,948	5,005	5,010	5,016	59,364
Hospital and Medical:													
8. Hospital/Medical Benefits	3,230	2,881	3,211	3,116	3,239	3,073	3,183	3,243	3,095	3,272	3,136	3,174	37,855
9. Other Benefits & Professional Services	723	567	629	624	626	581	626	617	586	665	622	636	7,504
10. Prescription Drugs	629	548	599	566	580	533	550	574	540	627	593	608	6,947
11. Expanded Benefits	56	56	57	57	57	57	57	57	57	57	57	57	681
12. Subtotal (L8+L9+L10+L11)	4,638	4,053	4,496	4,363	4,501	4,245	4,416	4,492	4,279	4,621	4,408	4,476	52,988
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	4,638	4,053	4,496	4,363	4,501	4,245	4,416	4,492	4,279	4,621	4,408	4,476	52,988
15. Claims Adjustment Expenses	117	117	118	118	118	118	118	118	118	122	122	122	1,426
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	222	222	223	223	223	223	224	224	224	230	230	231	2,698
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	4,978	4,393	4,836	4,704	4,842	4,586	4,758	4,834	4,622	4,972	4,760	4,828	57,112
20. Net Underwriting Gain or Loss (L7 -L19)	(74)	516	79	217	84	345	179	109	327	32	250	188	2,251
21. Net Investment Income Earned													-
22. Federal Income Taxes	(27)	191	29	80	31	128	66	40	121	12	93	70	833
23. Health Insurance Provider Fee	92	92	92	93	93	93	93	93	93	94	94	94	1,117
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(139)	233	(43)	44	(40)	125	20	(24)	113	(74)	63	24	302

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	11,590	11,604	11,617	11,631	11,645	11,658	11,672	11,685	11,699	11,713	11,726	11,740	11,740
1. Member Months	11,590	23,194	34,812	46,443	58,088	69,746	81,418	93,103	104,802	116,515	128,241	139,981	139,981
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	4,869	4,875	4,880	4,886	4,891	4,897	4,902	4,908	4,914	4,975	4,981	4,986	58,965
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	152	152	153	153	153	153	153	153	154	156	156	156	1,844
7. Total (L2a,b+L3+L4+L5+L6)	5,022	5,027	5,033	5,039	5,044	5,050	5,056	5,062	5,067	5,131	5,136	5,142	60,809
Hospital and Medical:													
8. Hospital/Medical Benefits	3,260	2,906	3,240	3,144	3,268	3,099	3,210	3,273	3,122	3,305	3,166	3,202	38,194
9. Other Benefits & Professional Services	689	562	701	635	659	628	679	675	641	715	686	706	7,975
10. Prescription Drugs	659	575	628	594	608	559	577	602	567	657	622	638	7,285
11. Expanded Benefits	57	57	57	57	57	58	58	58	58	58	58	58	691
12. Subtotal (L8+L9+L10+L11)	4,665	4,100	4,626	4,430	4,593	4,344	4,523	4,607	4,387	4,736	4,531	4,603	54,144
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	4,665	4,100	4,626	4,430	4,593	4,344	4,523	4,607	4,387	4,736	4,531	4,603	54,144
15. Claims Adjustment Expenses	122	122	122	122	123	123	123	123	123	127	127	127	1,483
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	231	231	231	232	232	232	232	233	233	239	240	240	2,806
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	5,018	4,453	4,980	4,784	4,947	4,699	4,878	4,962	4,743	5,101	4,898	4,970	58,434
20. Net Underwriting Gain or Loss (L7 -L19)	4	574	53	255	97	351	177	99	324	29	239	172	2,375
21. Net Investment Income Earned													-
22. Federal Income Taxes	1	212	20	94	36	130	66	37	120	11	88	64	879
23. Health Insurance Provider Fee	94	95	95	95	95	95	95	95	95	97	97	97	1,144
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(92)	267	(61)	66	(34)	126	17	(33)	109	(78)	54	12	352

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	11,754	11,767	11,781	11,795	11,809	11,822	11,836	11,850	11,864	11,878	11,892	11,905	11,905
1. Member Months	11,754	23,521	35,302	47,097	58,906	70,728	82,565	94,415	106,279	118,156	130,048	141,953	141,953
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	4,992	4,998	5,003	5,009	5,015	5,020	5,026	5,032	5,037	5,106	5,112	5,118	60,467
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	156	156	156	157	157	157	157	157	158	160	160	160	1,891
7. Total (L2a,b+L3+L4+L5+L6)	5,148	5,154	5,160	5,166	5,171	5,177	5,183	5,189	5,195	5,266	5,272	5,278	62,358
Hospital and Medical:													
8. Hospital/Medical Benefits	3,292	2,933	3,271	3,174	3,300	3,127	3,239	3,304	3,150	3,341	3,199	3,233	38,561
9. Other Benefits & Professional Services	737	603	750	698	725	688	712	726	694	778	746	757	8,614
10. Prescription Drugs	691	602	658	623	637	587	605	631	594	689	652	668	7,639
11. Expanded Benefits	58	58	58	58	58	58	58	58	59	59	59	59	700
12. Subtotal (L8+L9+L10+L11)	4,778	4,197	4,738	4,553	4,720	4,460	4,614	4,719	4,497	4,866	4,655	4,717	55,514
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	4,778	4,197	4,738	4,553	4,720	4,460	4,614	4,719	4,497	4,866	4,655	4,717	55,514
15. Claims Adjustment Expenses	127	127	127	127	128	128	128	128	128	130	130	130	1,538
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	240	240	241	241	241	242	242	242	242	246	246	246	2,909
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	5,145	4,565	5,105	4,921	5,089	4,829	4,984	5,089	4,867	5,242	5,031	5,093	59,962
20. Net Underwriting Gain or Loss (L7 -L19)	3	589	54	244	82	348	199	100	328	24	240	185	2,396
21. Net Investment Income Earned													-
22. Federal Income Taxes	1	218	20	90	30	129	74	37	121	9	89	68	887
23. Health Insurance Provider Fee	97	97	97	97	97	97	98	98	98	99	99	99	1,173
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(95)	274	(63)	57	(45)	122	28	(35)	109	(84)	52	17	337

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	20,801	20,825	20,849	20,849
1. Member Months	-	-	-	-	-	-	-	-	-	20,801	41,626	62,475	62,475
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	7,464	7,472	7,480	22,416
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	233	234	234	701
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	7,697	7,706	7,714	23,117
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	4,905	4,681	4,702	14,288
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	1,612	1,223	1,177	4,012
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	992	938	961	2,890
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	103	103	103	308
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	7,611	6,944	6,943	21,498
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	7,611	6,944	6,943	21,498
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	212	213	213	638
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	402	402	403	1,207
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	8,226	7,559	7,558	23,343
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	(529)	146	156	(227)
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	(196)	54	58	(84)
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	145	145	145	435
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(478)	(53)	(47)	(578)

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	20,874	20,898	20,922	20,947	20,971	20,996	21,020	21,045	21,069	21,094	21,119	21,143	21,143
1. Member Months	20,874	41,772	62,694	83,641	104,612	125,608	146,628	167,673	188,743	209,836	230,955	252,098	252,098
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	7,489	7,497	7,506	7,514	7,523	7,531	7,540	7,548	7,557	7,697	7,706	7,715	90,823
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	234	234	235	235	235	236	236	236	236	241	241	241	2,840
7. Total (L2a,b+L3+L4+L5+L6)	7,723	7,732	7,740	7,749	7,758	7,767	7,775	7,784	7,793	7,938	7,947	7,956	93,663
Hospital and Medical:													
8. Hospital/Medical Benefits	4,871	4,321	4,832	4,692	4,879	4,592	4,754	4,882	4,639	5,001	4,772	4,789	57,025
9. Other Benefits & Professional Services	1,252	993	1,097	1,089	1,094	1,009	1,070	1,070	1,021	1,153	1,079	1,092	13,018
10. Prescription Drugs	1,043	909	993	939	962	885	913	952	896	1,041	984	1,009	11,524
11. Expanded Benefits	103	103	103	103	103	104	104	104	104	104	104	104	1,244
12. Subtotal (L8+L9+L10+L11)	7,268	6,326	7,026	6,824	7,039	6,589	6,841	7,008	6,660	7,299	6,939	6,994	82,811
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	7,268	6,326	7,026	6,824	7,039	6,589	6,841	7,008	6,660	7,299	6,939	6,994	82,811
15. Claims Adjustment Expenses	213	213	214	214	214	214	215	215	215	221	221	222	2,592
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	403	404	404	405	405	406	406	407	407	418	419	419	4,903
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	7,884	6,943	7,644	7,442	7,658	7,209	7,461	7,629	7,282	7,939	7,579	7,635	90,306
20. Net Underwriting Gain or Loss (L7 -L19)	(161)	788	97	307	100	557	314	155	511	(1)	368	321	3,356
21. Net Investment Income Earned													-
22. Federal Income Taxes	(60)	292	36	114	37	206	116	57	189	(0)	136	119	1,242
23. Health Insurance Provider Fee	145	145	146	146	146	146	146	146	147	149	149	150	1,762
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(247)	351	(85)	48	(83)	205	52	(49)	175	(150)	82	53	353

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	21,168	21,193	21,217	21,242	21,267	21,292	21,316	21,341	21,366	21,391	21,416	21,441	21,441
1. Member Months	21,168	42,360	63,578	84,820	106,086	127,378	148,694	170,036	191,402	212,793	234,209	255,650	255,650
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	7,723	7,732	7,741	7,750	7,758	7,767	7,776	7,785	7,793	7,946	7,955	7,964	93,690
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	242	242	242	242	243	243	243	243	244	248	249	249	2,930
7. Total (L2a,b+L3+L4+L5+L6)	7,965	7,974	7,983	7,992	8,001	8,010	8,019	8,028	8,037	8,194	8,204	8,213	96,620
Hospital and Medical:													
8. Hospital/Medical Benefits	4,965	4,403	4,924	4,782	4,974	4,677	4,843	4,976	4,726	5,104	4,868	4,881	58,124
9. Other Benefits & Professional Services	1,191	973	1,203	1,095	1,138	1,078	1,161	1,166	1,105	1,232	1,179	1,201	13,723
10. Prescription Drugs	1,094	954	1,042	986	1,009	929	958	999	940	1,092	1,033	1,059	12,096
11. Expanded Benefits	104	105	105	105	105	105	105	105	105	106	106	106	1,261
12. Subtotal (L8+L9+L10+L11)	7,355	6,435	7,275	6,968	7,226	6,789	7,067	7,247	6,877	7,534	7,185	7,247	85,204
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	7,355	6,435	7,275	6,968	7,226	6,789	7,067	7,247	6,877	7,534	7,185	7,247	85,204
15. Claims Adjustment Expenses	222	222	222	223	223	223	224	224	224	230	231	231	2,699
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	420	420	421	421	422	422	423	423	424	436	436	437	5,105
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	7,996	7,077	7,918	7,612	7,870	7,435	7,714	7,894	7,525	8,200	7,852	7,915	93,008
20. Net Underwriting Gain or Loss (L7 -L19)	(32)	897	65	380	130	575	305	134	513	(5)	352	298	3,612
21. Net Investment Income Earned													-
22. Federal Income Taxes	(12)	332	24	141	48	213	113	50	190	(2)	130	110	1,336
23. Health Insurance Provider Fee	150	150	150	150	151	151	151	151	151	154	154	154	1,818
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(170)	415	(109)	89	(68)	212	42	(67)	172	(158)	67	33	458

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	21,466	21,491	21,516	21,541	21,566	21,592	21,617	21,642	21,667	21,693	21,718	21,743	21,743
1. Member Months	21,466	42,957	64,473	86,015	107,581	129,173	150,790	172,432	194,099	215,791	237,509	259,252	259,252
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	7,973	7,982	7,991	8,000	8,009	8,018	8,027	8,036	8,045	8,210	8,220	8,229	96,740
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	249	250	250	250	250	251	251	251	252	257	257	257	3,025
7. Total (L2a,b+L3+L4+L5+L6)	8,222	8,231	8,241	8,250	8,259	8,269	8,278	8,287	8,297	8,467	8,477	8,486	99,765
Hospital and Medical:													
8. Hospital/Medical Benefits	5,066	4,490	5,022	4,878	5,074	4,767	4,936	5,076	4,818	5,212	4,969	4,979	59,290
9. Other Benefits & Professional Services	1,265	1,038	1,280	1,198	1,243	1,174	1,214	1,244	1,187	1,330	1,272	1,283	14,727
10. Prescription Drugs	1,148	1,001	1,094	1,035	1,059	975	1,006	1,049	987	1,147	1,084	1,111	12,696
11. Expanded Benefits	106	106	106	106	106	107	107	107	107	107	107	107	1,279
12. Subtotal (L8+L9+L10+L11)	7,585	6,635	7,503	7,217	7,482	7,023	7,263	7,476	7,099	7,796	7,432	7,481	87,992
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	7,585	6,635	7,503	7,217	7,482	7,023	7,263	7,476	7,099	7,796	7,432	7,481	87,992
15. Claims Adjustment Expenses	231	231	232	232	232	233	233	233	233	238	238	239	2,806
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	437	438	438	439	439	440	440	441	441	450	451	452	5,307
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	8,254	7,304	8,173	7,888	8,154	7,696	7,936	8,150	7,774	8,484	8,122	8,171	96,105
20. Net Underwriting Gain or Loss (L7 -L19)	(31)	928	68	362	105	573	342	138	523	(17)	355	316	3,660
21. Net Investment Income Earned													-
22. Federal Income Taxes	(12)	343	25	134	39	212	126	51	193	(6)	131	117	1,354
23. Health Insurance Provider Fee	155	155	155	155	155	156	156	156	156	159	159	160	1,877
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(174)	430	(112)	73	(89)	205	60	(69)	173	(170)	64	39	429

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	78,920	79,012	79,105	79,105
1. Member Months	-	-	-	-	-	-	-	-	-	78,920	157,933	237,037	237,037
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	27,421	27,452	27,483	82,355
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	857	858	859	2,575
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	28,278	28,310	28,342	84,931
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	17,032	16,239	16,272	49,543
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	4,417	4,225	4,264	12,907
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	4,179	3,928	4,016	12,123
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	389	390	390	1,169
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	26,019	24,782	24,942	75,742
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	26,019	24,782	24,942	75,742
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	813	814	815	2,442
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	1,538	1,540	1,542	4,620
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	28,370	27,136	27,298	82,804
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	(91)	1,174	1,043	2,126
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	(34)	434	386	787
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	532	533	533	1,598
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(589)	207	124	(258)

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	79,197	79,289	79,382	79,474	79,567	79,660	79,753	79,846	79,939	80,032	80,126	80,219	80,219
1. Member Months	79,197	158,486	237,868	317,342	396,910	476,570	556,322	636,168	716,107	796,140	876,266	956,485	956,485
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	27,513	27,544	27,575	27,606	27,637	27,668	27,699	27,730	27,761	28,622	28,654	28,686	334,696
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	860	861	862	863	864	865	866	867	868	895	896	897	10,466
7. Total (L2a,b+L3+L4+L5+L6)	28,374	28,406	28,437	28,469	28,501	28,533	28,565	28,597	28,629	29,517	29,550	29,583	345,163
Hospital and Medical:													
8. Hospital/Medical Benefits	16,912	14,979	16,743	16,260	16,939	15,900	16,478	16,943	16,047	17,727	16,900	16,930	198,757
9. Other Benefits & Professional Services	4,394	3,909	4,365	4,238	4,403	4,162	4,308	4,407	4,200	4,639	4,437	4,478	51,939
10. Prescription Drugs	4,382	3,834	4,186	3,973	4,082	3,783	3,913	4,053	3,780	4,395	4,130	4,223	48,735
11. Expanded Benefits	391	391	392	392	393	393	393	394	394	395	395	396	4,718
12. Subtotal (L8+L9+L10+L11)	26,078	23,112	25,686	24,863	25,817	24,238	25,093	25,796	24,422	27,156	25,862	26,027	304,150
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	26,078	23,112	25,686	24,863	25,817	24,238	25,093	25,796	24,422	27,156	25,862	26,027	304,150
15. Claims Adjustment Expenses	816	817	818	819	820	821	822	823	824	846	847	848	9,919
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	1,544	1,545	1,547	1,549	1,551	1,553	1,554	1,556	1,558	1,601	1,603	1,605	18,765
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	28,438	25,474	28,051	27,231	28,187	26,611	27,469	28,175	26,803	29,603	28,312	28,480	332,834
20. Net Underwriting Gain or Loss (L7 -L19)	(64)	2,931	386	1,238	314	1,922	1,097	423	1,826	(86)	1,238	1,103	12,328
21. Net Investment Income Earned													-
22. Federal Income Taxes	(24)	1,085	143	458	116	711	406	156	676	(32)	458	408	4,562
23. Health Insurance Provider Fee	534	534	535	536	536	537	537	538	539	555	556	557	6,493
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(574)	1,312	(291)	245	(338)	674	153	(272)	612	(610)	224	139	1,274

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	80,313	80,406	80,500	80,594	80,688	80,782	80,877	80,971	81,065	81,160	81,255	81,350	81,350
1. Member Months	80,313	160,719	241,220	321,814	402,502	483,284	564,161	645,132	726,198	807,358	888,612	969,962	969,962
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	28,718	28,750	28,783	28,815	28,847	28,880	28,912	28,945	28,977	29,880	29,914	29,947	349,369
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	898	899	900	901	902	903	904	905	906	934	935	936	10,925
7. Total (L2a,b+L3+L4+L5+L6)	29,616	29,649	29,683	29,716	29,749	29,783	29,816	29,850	29,883	30,815	30,849	30,884	360,294
Hospital and Medical:													
8. Hospital/Medical Benefits	17,601	15,587	17,424	16,921	17,629	16,544	17,145	17,632	16,697	18,453	17,590	17,619	206,841
9. Other Benefits & Professional Services	4,614	4,105	4,583	4,451	4,623	4,371	4,524	4,628	4,411	4,872	4,660	4,704	54,546
10. Prescription Drugs	4,608	4,032	4,403	4,179	4,293	3,979	4,117	4,263	3,976	4,623	4,343	4,440	51,255
11. Expanded Benefits	396	397	397	398	398	398	399	399	400	400	401	401	4,785
12. Subtotal (L8+L9+L10+L11)	27,219	24,120	26,807	25,947	26,943	25,293	26,185	26,922	25,484	28,348	26,995	27,164	317,426
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	27,219	24,120	26,807	25,947	26,943	25,293	26,185	26,922	25,484	28,348	26,995	27,164	317,426
15. Claims Adjustment Expenses	849	850	851	852	853	854	855	856	857	881	882	883	10,325
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	1,607	1,608	1,610	1,612	1,614	1,616	1,618	1,620	1,622	1,666	1,668	1,670	19,531
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	29,675	26,578	29,268	28,412	29,411	27,763	28,658	29,398	27,962	30,895	29,545	29,718	347,283
20. Net Underwriting Gain or Loss (L7 -L19)	(58)	3,071	414	1,304	339	2,020	1,158	452	1,921	(81)	1,304	1,166	13,011
21. Net Investment Income Earned													-
22. Federal Income Taxes	(22)	1,136	153	483	125	747	428	167	711	(30)	483	432	4,814
23. Health Insurance Provider Fee	557	558	558	559	560	560	561	562	562	580	580	581	6,778
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(594)	1,377	(297)	263	(346)	712	169	(277)	648	(630)	241	154	1,419

	2021												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2021
0. Members	81,444	81,539	81,635	81,730	81,825	81,921	82,016	82,112	82,208	82,304	82,400	82,496	82,496
1. Member Months	81,444	162,984	244,618	326,348	408,173	490,094	572,110	654,222	736,430	818,733	901,133	983,629	983,629
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	29,981	30,015	30,048	30,082	30,116	30,150	30,184	30,218	30,252	31,199	31,234	31,270	364,748
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	938	939	940	941	942	943	944	945	946	976	977	978	11,406
7. Total (L2a,b+L3+L4+L5+L6)	30,919	30,953	30,988	31,023	31,058	31,093	31,127	31,162	31,197	32,175	32,211	32,247	376,154
Hospital and Medical:													
8. Hospital/Medical Benefits	18,321	16,222	18,135	17,612	18,349	17,217	17,843	18,352	17,377	19,212	18,312	18,338	215,290
9. Other Benefits & Professional Services	4,846	4,311	4,814	4,675	4,856	4,591	4,752	4,860	4,633	5,117	4,896	4,942	57,294
10. Prescription Drugs	4,846	4,240	4,630	4,395	4,516	4,186	4,331	4,484	4,181	4,862	4,568	4,670	53,908
11. Expanded Benefits	402	402	403	403	404	404	405	405	406	406	406	407	4,852
12. Subtotal (L8+L9+L10+L11)	28,414	25,176	27,982	27,084	28,125	26,398	27,331	28,102	26,597	29,597	28,182	28,357	331,344
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	28,414	25,176	27,982	27,084	28,125	26,398	27,331	28,102	26,597	29,597	28,182	28,357	331,344
15. Claims Adjustment Expenses	884	885	886	887	888	889	890	891	892	920	921	922	10,758
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	1,672	1,674	1,676	1,678	1,680	1,682	1,684	1,686	1,688	1,741	1,743	1,745	20,348
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	30,971	27,735	30,544	29,649	30,693	28,970	29,905	30,679	29,177	32,258	30,846	31,024	362,451
20. Net Underwriting Gain or Loss (L7 -L19)	(52)	3,218	444	1,373	365	2,123	1,223	484	2,021	(83)	1,365	1,224	13,703
21. Net Investment Income Earned													-
22. Federal Income Taxes	(19)	1,191	164	508	135	785	452	179	748	(31)	505	453	5,070
23. Health Insurance Provider Fee	582	582	583	584	584	585	586	586	587	605	606	607	7,076
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(615)	1,445	(303)	282	(355)	753	185	(282)	686	(658)	254	164	1,557

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	139,113	139,275	139,437	139,437
1. Member Months	-	-	-	-	-	-	-	-	-	139,113	278,388	417,825	417,825
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	58,368	58,434	58,501	175,303
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	1,825	1,827	1,829	5,482
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	60,193	60,262	60,330	180,785
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	35,676	33,989	34,003	103,668
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	8,601	8,211	8,252	25,064
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	10,745	10,037	10,239	31,022
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	686	687	688	2,061
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	55,708	52,925	53,183	161,815
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	55,708	52,925	53,183	161,815
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	1,595	1,596	1,598	4,789
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	3,015	3,019	3,022	9,057
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	60,318	57,540	57,803	175,662
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	(125)	2,722	2,527	5,123
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	(46)	1,007	935	1,896
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	1,132	1,134	1,135	3,401
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(1,211)	581	457	(173)

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	139,600	139,763	139,926	140,089	140,253	140,416	140,580	140,744	140,908	141,073	141,237	141,402	141,402
1. Member Months	139,600	279,363	419,289	559,378	699,631	840,048	980,628	1,121,372	1,262,280	1,403,353	1,544,591	1,685,993	1,685,993
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	58,567	58,634	58,700	58,767	58,833	58,900	58,967	59,034	59,101	61,013	61,082	61,152	712,750
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	1,831	1,833	1,836	1,838	1,840	1,842	1,844	1,846	1,848	1,908	1,910	1,912	22,288
7. Total (L2a,b+L3+L4+L5+L6)	60,398	60,467	60,536	60,604	60,673	60,742	60,811	60,880	60,949	62,921	62,992	63,064	735,038
Hospital and Medical:													
8. Hospital/Medical Benefits	35,439	31,347	35,006	33,989	35,489	33,251	34,505	35,486	33,492	37,195	35,435	35,445	416,079
9. Other Benefits & Professional Services	8,556	7,588	8,464	8,219	8,570	8,065	8,364	8,571	8,117	9,046	8,636	8,680	100,876
10. Prescription Drugs	11,248	9,864	10,761	10,241	10,552	9,825	10,190	10,498	9,712	11,291	10,546	10,759	125,487
11. Expanded Benefits	689	689	690	691	692	693	693	694	695	696	697	698	8,317
12. Subtotal (L8+L9+L10+L11)	55,931	49,488	54,921	53,140	55,302	51,834	53,752	55,250	52,016	58,228	55,314	55,581	650,758
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	55,931	49,488	54,921	53,140	55,302	51,834	53,752	55,250	52,016	58,228	55,314	55,581	650,758
15. Claims Adjustment Expenses	1,600	1,602	1,604	1,606	1,608	1,609	1,611	1,613	1,615	1,662	1,664	1,666	# 19,461
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	3,026	3,030	3,033	3,037	3,040	3,044	3,047	3,051	3,054	3,143	3,147	3,150	# 36,801
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	60,558	54,120	59,558	57,782	59,950	56,488	58,411	59,914	56,686	63,033	60,124	60,397	707,020
20. Net Underwriting Gain or Loss (L7 -L19)	(159)	6,347	977	2,822	723	4,254	2,400	967	4,264	(112)	2,868	2,666	28,018
21. Net Investment Income Earned													-
22. Federal Income Taxes	(59)	2,348	362	1,044	268	1,574	888	358	1,578	(41)	1,061	987	10,367
23. Health Insurance Provider Fee	1,136	1,137	1,139	1,140	1,141	1,143	1,144	1,145	1,147	1,184	1,185	1,186	13,827
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(1,236)	2,861	(523)	638	(686)	1,538	368	(536)	1,539	(1,254)	622	494	3,824

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	141,567	141,732	141,898	142,063	142,229	142,395	142,561	142,727	142,894	143,061	143,227	143,395	143,395
1. Member Months	141,567	283,299	425,197	567,260	709,489	851,884	994,445	1,137,172	1,280,066	1,423,127	1,566,354	1,709,749	1,709,749
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	61,221	61,291	61,360	61,430	61,500	61,569	61,639	61,709	61,779	63,786	63,858	63,931	745,073
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	1,914	1,917	1,919	1,921	1,923	1,925	1,927	1,930	1,932	1,995	1,997	1,999	23,299
7. Total (L2a,b+L3+L4+L5+L6)	63,135	63,207	63,279	63,351	63,423	63,495	63,567	63,639	63,711	65,780	65,855	65,930	768,372
Hospital and Medical:													
8. Hospital/Medical Benefits	36,947	32,678	36,493	35,434	36,998	34,661	35,968	36,995	34,912	38,784	36,946	36,952	433,770
9. Other Benefits & Professional Services	8,998	7,981	8,902	8,644	9,013	8,484	8,798	9,015	8,539	9,514	9,084	9,132	106,105
10. Prescription Drugs	11,819	10,365	11,308	10,761	11,089	10,326	10,710	11,032	10,205	11,865	11,082	11,305	131,867
11. Expanded Benefits	698	699	700	701	702	702	703	704	705	706	707	707	8,434
12. Subtotal (L8+L9+L10+L11)	58,463	51,724	57,404	55,540	57,802	54,174	56,180	57,746	54,361	60,869	57,819	58,096	680,177
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	58,463	51,724	57,404	55,540	57,802	54,174	56,180	57,746	54,361	60,869	57,819	58,096	680,177
15. Claims Adjustment Expenses	1,668	1,670	1,672	1,674	1,676	1,678	1,680	1,682	1,684	1,733	1,735	1,737	20,285
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	3,154	3,158	3,161	3,165	3,169	3,172	3,176	3,180	3,183	3,276	3,280	3,284	38,357
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	63,284	56,551	62,237	60,379	62,646	59,024	61,035	62,608	59,228	65,878	62,833	63,116	738,819
20. Net Underwriting Gain or Loss (L7 -L19)	(149)	6,656	1,042	2,972	777	4,471	2,532	1,031	4,483	(98)	3,022	2,813	29,553
21. Net Investment Income Earned													-
22. Federal Income Taxes	(55)	2,463	386	1,100	287	1,654	937	382	1,659	(36)	1,118	1,041	10,934
23. Health Insurance Provider Fee	1,188	1,189	1,190	1,192	1,193	1,194	1,196	1,197	1,199	1,237	1,239	1,240	14,454
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(1,282)	3,004	(534)	680	(704)	1,622	399	(547)	1,626	(1,299)	665	532	4,164

	2021												
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total 2021
0. Members	143,562	143,729	143,897	144,065	144,233	144,401	144,570	144,738	144,907	145,076	145,246	145,415	145,415
1. Member Months	143,562	287,291	431,188	575,253	719,486	863,887	1,008,457	1,153,195	1,298,102	1,443,179	1,588,424	1,733,839	1,733,839
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	64,003	64,076	64,149	64,222	64,295	64,368	64,441	64,514	64,587	66,693	66,769	66,844	778,960
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	2,001	2,004	2,006	2,008	2,011	2,013	2,015	2,017	2,020	2,085	2,088	2,090	24,358
7. Total (L2a,b+L3+L4+L5+L6)	66,005	66,080	66,155	66,230	66,305	66,381	66,456	66,531	66,607	68,778	68,856	68,935	803,319
Hospital and Medical:													
8. Hospital/Medical Benefits	38,524	34,071	38,049	36,944	38,577	36,136	37,499	38,573	36,398	40,446	38,527	38,529	452,274
9. Other Benefits & Professional Services	9,465	8,396	9,364	9,093	9,480	8,925	9,256	9,482	8,982	10,008	9,556	9,608	111,614
10. Prescription Drugs	12,420	10,892	11,883	11,309	11,654	10,853	11,257	11,595	10,725	12,470	11,646	11,879	138,582
11. Expanded Benefits	708	709	710	711	711	712	713	714	715	716	716	717	8,553
12. Subtotal (L8+L9+L10+L11)	61,117	54,067	60,006	58,057	60,423	56,626	58,725	60,365	56,820	63,639	60,445	60,733	711,023
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	61,117	54,067	60,006	58,057	60,423	56,626	58,725	60,365	56,820	63,639	60,445	60,733	711,023
15. Claims Adjustment Expenses	1,739	1,741	1,743	1,745	1,747	1,749	1,751	1,753	1,755	1,812	1,814	1,816	21,165
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	3,287	3,291	3,295	3,299	3,303	3,307	3,311	3,314	3,318	3,426	3,430	3,434	40,016
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	66,143	59,099	65,044	63,101	65,473	61,682	63,786	65,432	61,893	68,877	65,690	65,984	772,203
20. Net Underwriting Gain or Loss (L7 -L19)	(138)	6,980	1,111	3,129	833	4,699	2,670	1,100	4,714	(99)	3,167	2,951	31,115
21. Net Investment Income Earned													-
22. Federal Income Taxes	(51)	2,583	411	1,158	308	1,739	988	407	1,744	(37)	1,172	1,092	11,513
23. Health Insurance Provider Fee	1,242	1,243	1,244	1,246	1,247	1,249	1,250	1,252	1,253	1,294	1,295	1,297	15,112
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(1,329)	3,154	(545)	725	(723)	1,711	432	(559)	1,717	(1,356)	700	562	4,491

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	217	218	218	218
1. Member Months	-	-	-	-	-	-	-	-	-	217	435	653	653
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	493	493	494	1,479
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	15	15	15	46
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	508	509	509	1,526
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	121	116	117	353
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	13	14	14	41
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	345	317	321	984
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	1	1	1	3
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	480	447	453	1,380
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	480	447	453	1,380
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	7	7	7	22
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	14	14	14	42
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	502	469	474	1,444
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	6	40	35	82
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	2	15	13	30
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	10	10	10	29
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(6)	16	13	23

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	218	218	219	219	219	219	220	220	220	220	221	221	221
1. Member Months	218	436	655	874	1,093	1,312	1,531	1,751	1,971	2,192	2,412	2,633	2,633
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	494	495	495	496	497	497	498	498	499	525	526	527	6,047
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	15	15	15	16	16	16	16	16	16	16	16	16	189
7. Total (L2a,b+L3+L4+L5+L6)	510	510	511	512	512	513	513	514	514	542	542	543	6,236
Hospital and Medical:													
8. Hospital/Medical Benefits	121	108	119	115	122	115	120	121	113	129	123	124	1,429
9. Other Benefits & Professional Services	14	14	14	14	14	14	14	14	14	14	14	14	166
10. Prescription Drugs	359	317	346	332	345	326	340	345	312	368	338	343	4,071
11. Expanded Benefits	1	1	1	1	1	1	1	1	1	1	1	1	13
12. Subtotal (L8+L9+L10+L11)	495	440	479	461	481	455	475	481	440	512	477	483	5,679
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	495	440	479	461	481	455	475	481	440	512	477	483	5,679
15. Claims Adjustment Expenses	7	7	7	7	7	7	7	7	7	8	8	8	90
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	14	14	14	14	14	14	14	14	14	15	15	15	170
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	516	461	500	482	502	476	496	503	462	535	500	505	5,939
20. Net Underwriting Gain or Loss (L7 -L19)	(6)	49	11	29	10	36	17	11	53	7	43	38	297
21. Net Investment Income Earned													-
22. Federal Income Taxes	(2)	18	4	11	4	13	6	4	20	2	16	14	110
23. Health Insurance Provider Fee	10	10	10	10	10	10	10	10	10	10	10	10	117
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(14)	22	(3)	9	(3)	13	1	(3)	24	(6)	17	14	70

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	221	221	222	222	222	222	223	223	223	223	224	224	224
1. Member Months	221	442	664	886	1,108	1,330	1,553	1,776	1,999	2,223	2,446	2,670	2,670
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	527	528	528	529	530	530	531	531	532	560	561	562	6,450
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	16	17	17	17	17	17	17	17	17	18	18	18	202
7. Total (L2a,b+L3+L4+L5+L6)	544	544	545	546	546	547	547	548	549	578	579	579	6,651
Hospital and Medical:													
8. Hospital/Medical Benefits	129	115	126	122	130	122	128	129	121	137	132	133	1,524
9. Other Benefits & Professional Services	14	14	14	14	14	15	15	15	15	15	15	15	176
10. Prescription Drugs	383	339	369	354	368	348	363	368	333	393	361	366	4,343
11. Expanded Benefits	1	1	1	1	1	1	1	1	1	1	1	1	13
12. Subtotal (L8+L9+L10+L11)	528	469	511	492	513	485	506	513	469	547	509	515	6,056
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	528	469	511	492	513	485	506	513	469	547	509	515	6,056
15. Claims Adjustment Expenses	8	8	8	8	8	8	8	8	8	8	8	8	96
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	15	15	15	15	15	15	15	15	15	16	16	16	181
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	550	492	533	515	536	508	529	536	492	571	533	539	6,333
20. Net Underwriting Gain or Loss (L7 -L19)	(7)	53	12	31	11	39	18	12	56	7	46	40	318
21. Net Investment Income Earned													-
22. Federal Income Taxes	(3)	20	4	11	4	14	7	4	21	3	17	15	118
23. Health Insurance Provider Fee	10	10	10	10	10	10	10	10	10	11	11	11	125
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(15)	23	(3)	9	(4)	14	1	(3)	25	(6)	18	14	75

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	224	224	225	225	225	226	226	226	226	227	227	227	227
1. Member Months	224	449	673	898	1,124	1,349	1,575	1,801	2,027	2,254	2,481	2,708	2,708
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	562	563	564	564	565	566	566	567	568	598	598	599	6,879
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	18	18	18	18	18	18	18	18	18	19	19	19	215
7. Total (L2a,b+L3+L4+L5+L6)	580	581	581	582	583	583	584	585	585	616	617	618	7,094
Hospital and Medical:													
8. Hospital/Medical Benefits	138	122	135	131	138	130	136	138	129	146	140	141	1,625
9. Other Benefits & Professional Services	15	15	15	15	15	15	15	15	16	16	16	16	188
10. Prescription Drugs	409	361	393	377	392	371	387	393	355	419	385	390	4,633
11. Expanded Benefits	1	1	1	1	1	1	1	1	1	1	1	1	13
12. Subtotal (L8+L9+L10+L11)	563	500	545	525	547	518	540	547	501	583	543	549	6,459
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	563	500	545	525	547	518	540	547	501	583	543	549	6,459
15. Claims Adjustment Expenses	8	8	8	8	8	8	8	8	8	9	9	9	102
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	16	16	16	16	16	16	16	16	16	17	17	17	193
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	587	524	569	549	571	542	564	572	525	609	568	575	6,754
20. Net Underwriting Gain or Loss (L7 -L19)	(7)	56	13	33	11	41	19	13	60	8	49	43	340
21. Net Investment Income Earned													-
22. Federal Income Taxes	(3)	21	5	12	4	15	7	5	22	3	18	16	126
23. Health Insurance Provider Fee	11	11	11	11	11	11	11	11	11	12	12	12	133
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(15)	25	(3)	10	(4)	15	1	(3)	27	(7)	19	15	81

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	298	299	299	299
1. Member Months	-	-	-	-	-	-	-	-	-	298	597	896	896
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	752	753	754	2,259
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	24	24	24	71
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	775	776	777	2,329
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	200	192	194	586
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	17	17	17	51
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	514	473	479	1,466
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	1	1	1	4
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	733	683	691	2,108
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	733	683	691	2,108
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	11	11	11	34
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	21	21	21	64
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	766	715	724	2,205
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	10	61	53	124
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	4	23	20	46
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	15	15	15	44
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(8)	24	19	34

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	299	300	300	300	301	301	301	302	302	303	303	303	303
1. Member Months	299	599	899	1,200	1,500	1,802	2,103	2,405	2,707	3,010	3,313	3,616	3,616
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	755	755	756	757	758	759	760	761	762	802	803	804	9,232
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	24	24	24	24	24	24	24	24	24	25	25	25	289
7. Total (L2a,b+L3+L4+L5+L6)	778	779	780	781	782	783	784	785	785	827	828	829	9,521
Hospital and Medical:													
8. Hospital/Medical Benefits	201	179	197	191	202	190	199	201	188	214	205	207	2,372
9. Other Benefits & Professional Services	17	17	17	17	17	17	17	17	17	18	18	18	209
10. Prescription Drugs	535	473	515	494	514	486	507	514	465	549	504	511	6,068
11. Expanded Benefits	1	1	1	1	1	1	1	1	1	1	1	1	18
12. Subtotal (L8+L9+L10+L11)	755	670	731	704	734	694	725	734	672	782	729	738	8,668
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	755	670	731	704	734	694	725	734	672	782	729	738	8,668
15. Claims Adjustment Expenses	11	11	11	11	11	11	11	11	11	12	12	12	138
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	21	21	21	21	21	21	21	21	21	23	23	23	259
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	787	703	763	736	767	727	758	767	705	817	763	772	9,065
20. Net Underwriting Gain or Loss (L7 -L19)	(9)	76	17	45	15	56	26	17	80	11	65	57	456
21. Net Investment Income Earned													-
22. Federal Income Taxes	(3)	28	6	17	6	21	10	6	30	4	24	21	169
23. Health Insurance Provider Fee	15	15	15	15	15	15	15	15	15	16	16	16	179
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(20)	33	(4)	13	(5)	20	2	(4)	36	(9)	25	20	108

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	304	304	304	305	305	305	306	306	306	307	307	308	308
1. Member Months	304	608	912	1,217	1,522	1,827	2,133	2,439	2,745	3,052	3,359	3,667	3,667
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	805	806	807	808	809	810	810	811	812	855	856	857	9,847
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	25	25	25	25	25	25	25	25	25	27	27	27	308
7. Total (L2a,b+L3+L4+L5+L6)	830	831	832	833	834	835	836	837	838	882	883	884	10,155
Hospital and Medical:													
8. Hospital/Medical Benefits	214	190	210	203	215	203	212	215	201	228	218	220	2,530
9. Other Benefits & Professional Services	18	18	18	18	18	18	18	18	18	19	19	19	223
10. Prescription Drugs	571	505	549	527	548	518	541	549	497	585	538	545	6,474
11. Expanded Benefits	1	1	2	2	2	2	2	2	2	2	2	2	18
12. Subtotal (L8+L9+L10+L11)	805	715	779	751	783	741	773	783	717	834	777	787	9,245
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	805	715	779	751	783	741	773	783	717	834	777	787	9,245
15. Claims Adjustment Expenses	12	12	12	12	12	12	12	12	12	13	13	13	146
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	23	23	23	23	23	23	23	23	23	24	24	24	276
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	840	750	814	785	818	776	808	818	752	871	814	823	9,667
20. Net Underwriting Gain or Loss (L7 -L19)	(10)	81	18	48	16	59	28	19	86	11	69	61	487
21. Net Investment Income Earned													-
22. Federal Income Taxes	(4)	30	7	18	6	22	10	7	32	4	26	23	180
23. Health Insurance Provider Fee	16	16	16	16	16	16	16	16	16	17	17	17	191
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(22)	36	(4)	14	(5)	22	2	(4)	38	(9)	27	22	116

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	308	308	309	309	309	310	310	310	311	311	312	312	312
1. Member Months	308	616	925	1,234	1,543	1,853	2,163	2,473	2,784	3,095	3,407	3,718	3,718
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	858	859	860	861	862	863	864	865	866	912	914	915	10,503
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	27	27	27	27	27	27	27	27	27	29	29	29	328
7. Total (L2a,b+L3+L4+L5+L6)	885	886	887	888	889	890	891	893	894	941	942	943	10,831
Hospital and Medical:													
8. Hospital/Medical Benefits	229	203	224	217	229	216	226	229	214	243	233	235	2,698
9. Other Benefits & Professional Services	19	19	19	20	20	20	20	20	20	21	21	21	238
10. Prescription Drugs	609	538	586	563	585	553	577	585	530	625	574	582	6,906
11. Expanded Benefits	2	2	2	2	2	2	2	2	2	2	2	2	18
12. Subtotal (L8+L9+L10+L11)	859	763	831	800	835	790	825	835	765	890	829	839	9,861
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	859	763	831	800	835	790	825	835	765	890	829	839	9,861
15. Claims Adjustment Expenses	13	13	13	13	13	13	13	13	13	14	14	14	156
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	24	24	24	24	24	24	24	24	24	26	26	26	294
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	896	799	868	837	872	827	862	873	802	929	868	878	10,311
20. Net Underwriting Gain or Loss (L7 -L19)	(10)	87	19	51	18	63	30	20	92	12	74	65	521
21. Net Investment Income Earned													-
22. Federal Income Taxes	(4)	32	7	19	6	23	11	7	34	4	27	24	193
23. Health Insurance Provider Fee	17	17	17	17	17	17	17	17	17	18	18	18	204
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(23)	38	(4)	15	(6)	23	2	(4)	41	(10)	29	23	124

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	522	522	523	523
1. Member Months	-	-	-	-	-	-	-	-	-	522	1,044	1,567	1,567
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	1,349	1,351	1,353	4,053
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	42	42	42	127
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	1,392	1,393	1,395	4,180
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	332	318	321	971
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	56	56	56	168
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	924	849	861	2,635
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	3	3	3	8
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	1,315	1,226	1,240	3,781
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	1,315	1,226	1,240	3,781
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	20	20	20	61
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	38	38	38	114
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	1,373	1,284	1,299	3,956
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	19	109	96	224
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	7	40	36	83
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	26	26	26	79
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(15)	43	34	62

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	523	524	525	525	526	526	527	528	528	529	530	530	530
1. Member Months	523	1,047	1,572	2,097	2,623	3,150	3,677	4,205	4,733	5,262	5,791	6,322	6,322
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	1,354	1,356	1,357	1,359	1,360	1,362	1,364	1,365	1,367	1,439	1,441	1,443	16,567
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	42	42	42	42	43	43	43	43	43	45	45	45	518
7. Total (L2a,b+L3+L4+L5+L6)	1,396	1,398	1,400	1,401	1,403	1,405	1,406	1,408	1,409	1,484	1,486	1,488	17,085
Hospital and Medical:													
8. Hospital/Medical Benefits	333	296	326	316	334	315	330	334	311	354	339	342	3,931
9. Other Benefits & Professional Services	56	56	56	56	56	56	56	56	57	59	60	60	685
10. Prescription Drugs	962	850	926	888	923	873	912	924	836	986	906	919	10,904
11. Expanded Benefits	3	3	3	3	3	3	3	3	3	3	3	3	31
12. Subtotal (L8+L9+L10+L11)	1,354	1,205	1,310	1,263	1,316	1,247	1,300	1,317	1,207	1,402	1,307	1,323	15,551
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	1,354	1,205	1,310	1,263	1,316	1,247	1,300	1,317	1,207	1,402	1,307	1,323	15,551
15. Claims Adjustment Expenses	20	20	20	20	20	20	20	20	20	21	21	22	247
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	38	38	38	38	38	38	38	38	39	40	41	41	467
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	1,412	1,263	1,369	1,322	1,375	1,305	1,359	1,376	1,266	1,464	1,370	1,385	16,266
20. Net Underwriting Gain or Loss (L7 -L19)	(16)	135	31	80	28	99	47	32	144	20	117	103	819
21. Net Investment Income Earned													-
22. Federal Income Taxes	(6)	50	11	30	10	37	17	12	53	7	43	38	303
23. Health Insurance Provider Fee	26	26	26	26	26	26	26	26	27	28	28	28	321
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(36)	59	(7)	24	(9)	36	3	(6)	64	(15)	45	37	195

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	531	531	532	533	533	534	535	535	536	536	537	538	538
1. Member Months	531	1,062	1,594	2,127	2,660	3,194	3,729	4,264	4,800	5,336	5,873	6,411	6,411
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	1,444	1,446	1,448	1,449	1,451	1,453	1,454	1,456	1,458	1,535	1,537	1,539	17,671
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	45	45	45	45	45	45	45	46	46	48	48	48	553
7. Total (L2a,b+L3+L4+L5+L6)	1,490	1,491	1,493	1,495	1,496	1,498	1,500	1,502	1,503	1,583	1,585	1,587	18,223
Hospital and Medical:													
8. Hospital/Medical Benefits	355	316	348	337	356	336	352	356	332	378	362	365	4,192
9. Other Benefits & Professional Services	60	60	60	60	60	60	60	60	60	63	63	64	730
10. Prescription Drugs	1,026	907	987	948	985	931	972	986	892	1,052	967	980	11,633
11. Expanded Benefits	3	3	3	3	3	3	3	3	3	3	3	3	32
12. Subtotal (L8+L9+L10+L11)	1,444	1,285	1,398	1,347	1,404	1,330	1,387	1,405	1,287	1,496	1,395	1,411	16,587
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	1,444	1,285	1,398	1,347	1,404	1,330	1,387	1,405	1,287	1,496	1,395	1,411	16,587
15. Claims Adjustment Expenses	22	22	22	22	22	22	22	22	22	23	23	23	263
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	41	41	41	41	41	41	41	41	41	43	43	43	497
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	1,506	1,347	1,460	1,409	1,466	1,392	1,449	1,467	1,350	1,562	1,461	1,477	17,348
20. Net Underwriting Gain or Loss (L7 -L19)	(16)	144	33	85	30	106	50	34	153	21	124	110	876
21. Net Investment Income Earned													-
22. Federal Income Taxes	(6)	53	12	32	11	39	19	13	57	8	46	41	324
23. Health Insurance Provider Fee	28	28	28	28	28	28	28	28	28	30	30	30	343
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(38)	63	(7)	26	(9)	39	4	(7)	68	(16)	49	39	209

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	538	539	540	540	541	541	542	543	543	544	545	545	545
1. Member Months	538	1,077	1,617	2,157	2,698	3,239	3,781	4,324	4,867	5,411	5,956	6,501	6,501
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	1,541	1,542	1,544	1,546	1,548	1,550	1,551	1,553	1,555	1,638	1,639	1,641	18,848
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	48	48	48	48	48	48	49	49	49	51	51	51	589
7. Total (L2a,b+L3+L4+L5+L6)	1,589	1,591	1,592	1,594	1,596	1,598	1,600	1,602	1,604	1,689	1,691	1,693	19,438
Hospital and Medical:													
8. Hospital/Medical Benefits	379	337	371	359	380	358	375	380	354	403	386	389	4,471
9. Other Benefits & Professional Services	64	64	64	64	64	64	64	64	64	68	68	68	779
10. Prescription Drugs	1,095	968	1,053	1,011	1,051	993	1,037	1,052	952	1,122	1,031	1,045	12,411
11. Expanded Benefits	3	3	3	3	3	3	3	3	3	3	3	3	32
12. Subtotal (L8+L9+L10+L11)	1,540	1,371	1,491	1,437	1,497	1,418	1,479	1,498	1,373	1,596	1,487	1,505	17,692
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	1,540	1,371	1,491	1,437	1,497	1,418	1,479	1,498	1,373	1,596	1,487	1,505	17,692
15. Claims Adjustment Expenses	23	23	23	23	23	23	23	23	23	24	24	24	281
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	43	43	43	43	43	44	44	44	44	46	46	46	529
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	1,606	1,437	1,557	1,503	1,564	1,485	1,546	1,565	1,440	1,666	1,558	1,576	18,502
20. Net Underwriting Gain or Loss (L7 -L19)	(17)	154	35	91	32	113	54	37	164	23	133	117	935
21. Net Investment Income Earned													-
22. Federal Income Taxes	(6)	57	13	34	12	42	20	14	61	8	49	43	346
23. Health Insurance Provider Fee	30	30	30	30	30	30	30	30	30	32	32	32	366
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(41)	67	(8)	27	(10)	41	4	(7)	73	(17)	52	42	224

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	641	641	642	642
1. Member Months	-	-	-	-	-	-	-	-	-	641	1,282	1,924	1,924
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	1,817	1,819	1,821	5,457
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	57	57	57	171
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	1,874	1,876	1,878	5,628
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	526	504	508	1,538
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	162	98	76	336
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	1,163	1,068	1,083	3,314
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	3	3	3	9
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	1,854	1,673	1,670	5,197
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	1,854	1,673	1,670	5,197
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	27	27	27	82
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	51	51	51	154
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	1,932	1,752	1,748	5,433
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	(58)	124	130	195
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	(22)	46	48	72
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	35	35	35	106
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(72)	43	46	17

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	643	644	644	645	646	647	647	648	649	650	650	651	651
1. Member Months	643	1,286	1,931	2,576	3,221	3,868	4,515	5,163	5,812	6,461	7,112	7,763	7,763
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	1,823	1,825	1,828	1,830	1,832	1,834	1,836	1,838	1,840	1,938	1,940	1,943	22,307
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	57	57	57	57	57	57	57	57	58	61	61	61	698
7. Total (L2a,b+L3+L4+L5+L6)	1,880	1,882	1,885	1,887	1,889	1,891	1,893	1,896	1,898	1,999	2,001	2,003	23,004
Hospital and Medical:													
8. Hospital/Medical Benefits	528	469	516	500	529	499	522	529	493	561	537	542	6,226
9. Other Benefits & Professional Services	108	88	67	92	67	84	86	57	83	96	79	62	969
10. Prescription Drugs	1,210	1,069	1,164	1,117	1,161	1,097	1,146	1,162	1,052	1,240	1,140	1,155	13,714
11. Expanded Benefits	3	3	3	3	3	3	3	3	3	3	3	3	38
12. Subtotal (L8+L9+L10+L11)	1,849	1,630	1,750	1,712	1,761	1,684	1,758	1,751	1,631	1,900	1,759	1,763	20,947
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	1,849	1,630	1,750	1,712	1,761	1,684	1,758	1,751	1,631	1,900	1,759	1,763	20,947
15. Claims Adjustment Expenses	27	27	27	27	27	27	27	28	28	29	29	29	334
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	51	52	52	52	52	52	52	52	52	55	55	55	630
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	1,927	1,708	1,829	1,791	1,840	1,763	1,837	1,830	1,711	1,984	1,843	1,847	21,911
20. Net Underwriting Gain or Loss (L7 -L19)	(47)	174	55	95	49	128	57	65	187	15	158	157	1,094
21. Net Investment Income Earned													-
22. Federal Income Taxes	(17)	64	20	35	18	47	21	24	69	5	58	58	405
23. Health Insurance Provider Fee	35	35	35	35	36	36	36	36	36	38	38	38	433
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(65)	74	(1)	25	(5)	45	0	6	82	(28)	62	61	256

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	652	653	653	654	655	656	656	657	658	659	659	660	660
1. Member Months	652	1,304	1,958	2,612	3,267	3,922	4,579	5,236	5,894	6,553	7,212	7,872	7,872
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	1,945	1,947	1,949	1,952	1,954	1,956	1,958	1,961	1,963	2,067	2,070	2,072	23,793
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	61	61	61	61	61	61	61	61	61	65	65	65	744
7. Total (L2a,b+L3+L4+L5+L6)	2,006	2,008	2,010	2,013	2,015	2,017	2,020	2,022	2,024	2,132	2,134	2,137	24,537
Hospital and Medical:													
8. Hospital/Medical Benefits	563	500	551	533	565	532	557	564	526	598	573	578	6,640
9. Other Benefits & Professional Services	98	59	97	84	64	89	98	66	90	76	91	99	1,012
10. Prescription Drugs	1,290	1,141	1,242	1,192	1,238	1,171	1,223	1,240	1,122	1,323	1,216	1,232	14,630
11. Expanded Benefits	3	3	3	3	3	3	3	3	3	3	3	3	39
12. Subtotal (L8+L9+L10+L11)	1,955	1,703	1,893	1,813	1,871	1,795	1,881	1,873	1,741	2,001	1,883	1,913	22,321
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	1,955	1,703	1,893	1,813	1,871	1,795	1,881	1,873	1,741	2,001	1,883	1,913	22,321
15. Claims Adjustment Expenses	29	29	29	29	29	29	29	29	29	31	31	31	355
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	55	55	55	55	55	55	55	55	55	58	58	58	670
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	2,039	1,787	1,977	1,897	1,955	1,879	1,966	1,957	1,826	2,090	1,972	2,002	23,347
20. Net Underwriting Gain or Loss (L7 -L19)	(33)	221	34	116	60	138	54	65	199	42	162	135	1,191
21. Net Investment Income Earned													-
22. Federal Income Taxes	(12)	82	12	43	22	51	20	24	73	15	60	50	441
23. Health Insurance Provider Fee	38	38	38	38	38	38	38	38	38	40	40	40	462
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(59)	101	(17)	35	(0)	49	(4)	3	87	(14)	62	45	289

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	661	662	663	663	664	665	666	666	667	668	669	670	670
1. Member Months	661	1,323	1,985	2,649	3,313	3,978	4,643	5,310	5,977	6,645	7,314	7,983	7,983
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	2,074	2,077	2,079	2,082	2,084	2,086	2,089	2,091	2,094	2,205	2,207	2,210	25,379
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	65	65	65	65	65	65	65	65	65	69	69	69	794
7. Total (L2a,b+L3+L4+L5+L6)	2,139	2,142	2,144	2,147	2,149	2,152	2,154	2,157	2,159	2,274	2,276	2,279	26,172
Hospital and Medical:													
8. Hospital/Medical Benefits	601	533	587	569	602	568	594	601	561	638	611	617	7,082
9. Other Benefits & Professional Services	105	62	104	89	89	89	90	90	90	94	95	95	1,092
10. Prescription Drugs	1,377	1,217	1,325	1,272	1,321	1,249	1,305	1,323	1,197	1,412	1,297	1,315	15,608
11. Expanded Benefits	3	3	3	3	3	3	3	3	3	3	3	3	39
12. Subtotal (L8+L9+L10+L11)	2,086	1,815	2,020	1,933	2,016	1,909	1,992	2,017	1,851	2,148	2,006	2,029	23,821
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	2,086	1,815	2,020	1,933	2,016	1,909	1,992	2,017	1,851	2,148	2,006	2,029	23,821
15. Claims Adjustment Expenses	31	31	31	31	31	31	31	31	31	33	33	33	379
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	58	58	58	59	59	59	59	59	59	62	62	62	714
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	2,175	1,905	2,109	2,023	2,106	1,999	2,081	2,107	1,941	2,243	2,101	2,124	24,914
20. Net Underwriting Gain or Loss (L7 -L19)	(36)	237	35	124	44	153	73	50	218	31	175	155	1,258
21. Net Investment Income Earned													-
22. Federal Income Taxes	(13)	88	13	46	16	56	27	18	81	12	65	57	466
23. Health Insurance Provider Fee	40	40	40	40	40	40	41	41	41	43	43	43	492
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(63)	109	(18)	38	(13)	56	5	(9)	97	(23)	68	55	300

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	784	785	786	786
1. Member Months	-	-	-	-	-	-	-	-	-	784	1,569	2,354	2,354
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	1,896	1,898	1,900	5,694
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	59	59	59	178
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	1,955	1,957	1,960	5,872
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	511	489	494	1,495
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	67	67	67	202
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	1,264	1,161	1,177	3,603
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	4	4	4	12
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	1,846	1,722	1,743	5,311
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	1,846	1,722	1,743	5,311
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	29	29	29	86
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	54	54	54	163
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	1,929	1,805	1,826	5,561
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	26	152	133	311
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	10	56	49	115
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	37	37	37	110
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(20)	59	47	86

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	787	788	788	789	790	791	792	793	794	795	796	797	797
1. Member Months	787	1,574	2,363	3,152	3,942	4,734	5,526	6,319	7,113	7,908	8,704	9,501	9,501
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	1,902	1,905	1,907	1,909	1,911	1,913	1,916	1,918	1,920	2,022	2,024	2,027	23,274
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	59	60	60	60	60	60	60	60	60	63	63	63	728
7. Total (L2a,b+L3+L4+L5+L6)	1,962	1,964	1,966	1,969	1,971	1,973	1,976	1,978	1,980	2,085	2,088	2,090	24,002
Hospital and Medical:													
8. Hospital/Medical Benefits	513	456	502	486	514	485	508	514	480	545	522	527	6,051
9. Other Benefits & Professional Services	67	68	68	68	68	68	68	68	68	72	72	72	825
10. Prescription Drugs	1,315	1,163	1,266	1,215	1,262	1,193	1,246	1,264	1,144	1,349	1,239	1,256	14,911
11. Expanded Benefits	4	4	4	4	4	4	4	4	4	4	4	4	47
12. Subtotal (L8+L9+L10+L11)	1,899	1,690	1,839	1,773	1,848	1,750	1,826	1,849	1,696	1,969	1,837	1,859	21,834
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	1,899	1,690	1,839	1,773	1,848	1,750	1,826	1,849	1,696	1,969	1,837	1,859	21,834
15. Claims Adjustment Expenses	29	29	29	29	29	29	29	29	29	31	31	31	353
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	55	55	55	55	55	55	55	55	55	58	58	58	666
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	1,983	1,773	1,923	1,856	1,932	1,834	1,910	1,933	1,780	2,057	1,925	1,948	22,854
20. Net Underwriting Gain or Loss (L7 -L19)	(21)	191	44	112	39	139	66	45	200	28	162	142	1,148
21. Net Investment Income Earned													-
22. Federal Income Taxes	(8)	71	16	42	14	51	24	16	74	10	60	53	425
23. Health Insurance Provider Fee	37	37	37	37	37	37	37	37	37	39	39	39	452
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(50)	83	(10)	34	(12)	51	4	(9)	89	(22)	63	50	272

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	798	799	800	801	801	802	803	804	805	806	807	808	808
1. Member Months	798	1,596	2,396	3,197	3,998	4,800	5,604	6,408	7,213	8,019	8,827	9,635	9,635
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	2,029	2,031	2,034	2,036	2,039	2,041	2,043	2,046	2,048	2,157	2,159	2,162	24,824
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	63	64	64	64	64	64	64	64	64	67	68	68	776
7. Total (L2a,b+L3+L4+L5+L6)	2,093	2,095	2,097	2,100	2,102	2,105	2,107	2,110	2,112	2,224	2,227	2,229	25,601
Hospital and Medical:													
8. Hospital/Medical Benefits	547	486	536	519	548	518	541	548	512	581	557	562	6,454
9. Other Benefits & Professional Services	72	72	72	72	72	72	72	72	73	76	76	77	879
10. Prescription Drugs	1,403	1,240	1,350	1,296	1,347	1,273	1,330	1,348	1,220	1,439	1,322	1,340	15,908
11. Expanded Benefits	4	4	4	4	4	4	4	4	4	4	4	4	48
12. Subtotal (L8+L9+L10+L11)	2,026	1,802	1,962	1,891	1,971	1,867	1,947	1,972	1,808	2,100	1,959	1,983	23,288
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	2,026	1,802	1,962	1,891	1,971	1,867	1,947	1,972	1,808	2,100	1,959	1,983	23,288
15. Claims Adjustment Expenses	31	31	31	31	31	31	31	31	31	33	33	33	376
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	58	58	58	58	58	58	58	58	59	62	62	62	709
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	2,114	1,891	2,051	1,980	2,060	1,956	2,037	2,062	1,898	2,194	2,053	2,077	24,374
20. Net Underwriting Gain or Loss (L7 -L19)	(22)	204	47	120	42	149	70	48	214	30	173	152	1,227
21. Net Investment Income Earned													-
22. Federal Income Taxes	(8)	75	17	44	16	55	26	18	79	11	64	56	454
23. Health Insurance Provider Fee	39	39	39	40	40	40	40	40	40	42	42	42	482
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(53)	89	(10)	36	(13)	54	5	(10)	95	(23)	67	54	291

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	809	810	811	812	813	814	815	816	817	818	818	819	819
1. Member Months	809	1,619	2,430	3,242	4,054	4,868	5,683	6,498	7,315	8,132	8,951	9,770	9,770
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	2,164	2,167	2,169	2,172	2,174	2,177	2,179	2,182	2,184	2,300	2,303	2,306	26,478
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	68	68	68	68	68	68	68	68	68	72	72	72	828
7. Total (L2a,b+L3+L4+L5+L6)	2,232	2,235	2,237	2,240	2,242	2,245	2,248	2,250	2,253	2,372	2,375	2,378	27,306
Hospital and Medical:													
8. Hospital/Medical Benefits	583	518	571	553	585	552	577	584	546	620	594	600	6,883
9. Other Benefits & Professional Services	77	77	77	77	77	77	77	77	77	81	81	82	937
10. Prescription Drugs	1,497	1,323	1,440	1,383	1,437	1,358	1,419	1,438	1,302	1,535	1,410	1,430	16,971
11. Expanded Benefits	4	4	4	4	4	4	4	4	4	4	4	4	48
12. Subtotal (L8+L9+L10+L11)	2,161	1,922	2,092	2,017	2,102	1,991	2,077	2,104	1,929	2,240	2,090	2,115	24,840
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	2,161	1,922	2,092	2,017	2,102	1,991	2,077	2,104	1,929	2,240	2,090	2,115	24,840
15. Claims Adjustment Expenses	33	33	33	33	33	33	33	33	33	35	35	35	401
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	62	62	62	62	62	62	62	62	62	66	66	66	756
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	2,255	2,017	2,187	2,111	2,197	2,086	2,172	2,199	2,024	2,341	2,190	2,216	25,996
20. Net Underwriting Gain or Loss (L7 -L19)	(23)	218	50	128	45	159	75	51	228	32	185	162	1,310
21. Net Investment Income Earned													-
22. Federal Income Taxes	(9)	81	19	47	17	59	28	19	85	12	68	60	485
23. Health Insurance Provider Fee	42	42	42	42	42	42	42	42	42	45	45	45	514
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(57)	95	(11)	39	(14)	58	5	(10)	102	(25)	72	58	312

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	981	982	983	983
1. Member Months	-	-	-	-	-	-	-	-	-	981	1,963	2,947	2,947
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	3,140	3,144	3,147	9,431
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	98	98	98	295
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	3,238	3,242	3,246	9,726
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	895	858	866	2,619
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	110	110	110	331
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	2,049	1,883	1,909	5,840
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	5	5	5	15
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	3,059	2,856	2,890	8,805
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	3,059	2,856	2,890	8,805
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	47	47	47	140
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	88	88	88	264
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	3,194	2,990	3,025	9,209
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	44	252	221	517
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	16	93	82	191
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	61	61	61	183
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(33)	98	78	143

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	985	986	987	988	989	990	991	993	994	995	996	997	997
1. Member Months	985	1,970	2,957	3,945	4,934	5,925	6,916	7,909	8,903	9,898	10,894	11,891	11,891
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	3,151	3,155	3,158	3,162	3,166	3,169	3,173	3,177	3,181	3,350	3,353	3,357	38,552
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	99	99	99	99	99	99	99	99	99	105	105	105	1,206
7. Total (L2a,b+L3+L4+L5+L6)	3,250	3,253	3,257	3,261	3,265	3,269	3,272	3,276	3,280	3,454	3,458	3,462	39,758
Hospital and Medical:													
8. Hospital/Medical Benefits	898	798	880	852	901	850	889	900	841	955	915	924	10,605
9. Other Benefits & Professional Services	111	111	111	111	111	111	111	111	112	117	118	118	1,352
10. Prescription Drugs	2,132	1,885	2,052	1,969	2,046	1,934	2,021	2,048	1,854	2,186	2,008	2,036	24,171
11. Expanded Benefits	5	5	5	5	5	5	5	5	5	5	5	5	59
12. Subtotal (L8+L9+L10+L11)	3,146	2,798	3,047	2,937	3,063	2,901	3,026	3,065	2,811	3,263	3,046	3,083	36,186
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	3,146	2,798	3,047	2,937	3,063	2,901	3,026	3,065	2,811	3,263	3,046	3,083	36,186
15. Claims Adjustment Expenses	47	47	47	47	47	47	47	47	47	50	50	50	572
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	88	88	88	89	89	89	89	89	89	94	94	94	1,080
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	3,281	2,934	3,182	3,073	3,199	3,036	3,162	3,201	2,948	3,407	3,189	3,226	37,838
20. Net Underwriting Gain or Loss (L7 -L19)	(31)	320	75	188	66	232	110	75	332	48	269	236	1,920
21. Net Investment Income Earned													-
22. Federal Income Taxes	(11)	118	28	70	24	86	41	28	123	18	99	87	710
23. Health Insurance Provider Fee	61	61	61	61	61	61	62	62	62	65	65	65	748
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(81)	140	(14)	57	(20)	85	8	(14)	148	(35)	104	84	462

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	998	1,000	1,001	1,002	1,003	1,004	1,005	1,007	1,008	1,009	1,010	1,011	1,011
1. Member Months	998	1,998	2,999	4,001	5,004	6,008	7,014	8,020	9,028	10,037	11,047	12,059	12,059
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	3,361	3,365	3,369	3,373	3,377	3,381	3,385	3,389	3,393	3,573	3,577	3,581	41,122
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	105	105	105	105	106	106	106	106	106	112	112	112	1,286
7. Total (L2a,b+L3+L4+L5+L6)	3,466	3,470	3,474	3,478	3,482	3,486	3,491	3,495	3,499	3,685	3,689	3,693	42,408
Hospital and Medical:													
8. Hospital/Medical Benefits	958	852	938	909	961	907	949	960	897	1,019	976	985	11,311
9. Other Benefits & Professional Services	118	118	118	118	118	119	119	119	119	125	125	125	1,441
10. Prescription Drugs	2,274	2,011	2,189	2,101	2,183	2,063	2,156	2,185	1,978	2,332	2,143	2,172	25,786
11. Expanded Benefits	5	5	5	5	5	5	5	5	5	5	5	5	59
12. Subtotal (L8+L9+L10+L11)	3,355	2,985	3,250	3,133	3,267	3,094	3,228	3,269	2,999	3,481	3,249	3,288	38,598
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	3,355	2,985	3,250	3,133	3,267	3,094	3,228	3,269	2,999	3,481	3,249	3,288	38,598
15. Claims Adjustment Expenses	50	50	50	50	50	50	50	50	50	53	53	53	610
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	94	94	94	94	94	95	95	95	95	100	100	100	1,150
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	3,499	3,129	3,394	3,277	3,412	3,239	3,373	3,414	3,144	3,633	3,402	3,441	40,357
20. Net Underwriting Gain or Loss (L7 -L19)	(33)	341	80	201	71	248	118	80	355	51	287	252	2,051
21. Net Investment Income Earned													-
22. Federal Income Taxes	(12)	126	30	74	26	92	44	30	131	19	106	93	759
23. Health Insurance Provider Fee	65	65	65	65	66	66	66	66	66	69	69	69	798
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(86)	150	(15)	61	(21)	91	9	(15)	158	(37)	111	89	495

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	1,013	1,014	1,015	1,016	1,017	1,018	1,020	1,021	1,022	1,023	1,024	1,026	1,026
1. Member Months	1,013	2,026	3,041	4,057	5,074	6,093	7,113	8,133	9,155	10,179	11,203	12,229	12,229
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	3,585	3,589	3,594	3,598	3,602	3,606	3,610	3,615	3,619	3,811	3,815	3,820	43,864
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	112	112	112	113	113	113	113	113	113	119	119	119	1,372
7. Total (L2a,b+L3+L4+L5+L6)	3,697	3,702	3,706	3,710	3,715	3,719	3,723	3,728	3,732	3,930	3,935	3,939	45,235
Hospital and Medical:													
8. Hospital/Medical Benefits	1,022	908	1,001	969	1,025	967	1,012	1,024	957	1,086	1,041	1,051	12,064
9. Other Benefits & Professional Services	126	126	126	126	126	126	126	127	127	133	134	134	1,537
10. Prescription Drugs	2,426	2,145	2,335	2,241	2,329	2,201	2,300	2,331	2,110	2,488	2,286	2,317	27,509
11. Expanded Benefits	5	5	5	5	5	5	5	5	5	5	5	5	60
12. Subtotal (L8+L9+L10+L11)	3,579	3,184	3,467	3,342	3,485	3,300	3,443	3,487	3,198	3,713	3,465	3,507	41,170
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	3,579	3,184	3,467	3,342	3,485	3,300	3,443	3,487	3,198	3,713	3,465	3,507	41,170
15. Claims Adjustment Expenses	53	53	53	53	53	53	53	54	54	56	57	57	650
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	100	100	100	100	101	101	101	101	101	106	107	107	1,225
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	3,732	3,337	3,620	3,495	3,639	3,454	3,597	3,641	3,353	3,876	3,629	3,670	43,045
20. Net Underwriting Gain or Loss (L7 -L19)	(35)	364	86	215	76	265	126	86	379	54	306	269	2,191
21. Net Investment Income Earned													-
22. Federal Income Taxes	(13)	135	32	79	28	98	47	32	140	20	113	99	811
23. Health Insurance Provider Fee	70	70	70	70	70	70	70	70	70	74	74	74	851
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(92)	160	(16)	66	(22)	97	9	(16)	168	(40)	119	95	529

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	1,105	1,107	1,108	1,108
1. Member Months	-	-	-	-	-	-	-	-	-	1,105	2,212	3,320	3,320
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	3,207	3,211	3,215	9,633
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	100	100	101	301
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	3,308	3,311	3,315	9,934
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	870	833	841	2,544
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	121	121	122	364
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	2,128	1,955	1,982	6,065
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	5	5	5	16
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	3,125	2,915	2,950	8,990
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	3,125	2,915	2,950	8,990
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	48	48	48	144
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	90	90	90	271
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	3,263	3,054	3,089	9,405
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	45	258	227	529
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	17	95	84	196
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	62	62	62	187
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(34)	100	80	146

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	1,109	1,110	1,112	1,113	1,114	1,116	1,117	1,118	1,120	1,121	1,122	1,123	1,123
1. Member Months	1,109	2,220	3,331	4,444	5,559	6,674	7,791	8,910	10,029	11,150	12,272	13,396	13,396
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	3,218	3,222	3,226	3,230	3,233	3,237	3,241	3,245	3,248	3,421	3,425	3,429	39,376
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	101	101	101	101	101	101	101	101	102	107	107	107	1,231
7. Total (L2a,b+L3+L4+L5+L6)	3,319	3,323	3,327	3,331	3,335	3,338	3,342	3,346	3,350	3,528	3,532	3,536	40,607
Hospital and Medical:													
8. Hospital/Medical Benefits	873	775	854	828	875	826	864	874	816	928	889	897	10,299
9. Other Benefits & Professional Services	122	122	122	122	122	122	123	123	123	129	129	130	1,489
10. Prescription Drugs	2,214	1,957	2,131	2,045	2,125	2,009	2,098	2,127	1,925	2,270	2,086	2,115	25,102
11. Expanded Benefits	5	5	5	5	5	6	6	6	6	6	6	6	66
12. Subtotal (L8+L9+L10+L11)	3,214	2,860	3,113	3,000	3,128	2,962	3,090	3,130	2,870	3,333	3,110	3,147	36,957
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	3,214	2,860	3,113	3,000	3,128	2,962	3,090	3,130	2,870	3,333	3,110	3,147	36,957
15. Claims Adjustment Expenses	48	48	48	48	48	48	48	48	48	51	51	51	587
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	91	91	91	91	91	91	91	91	91	96	96	96	1,108
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	3,353	2,999	3,252	3,139	3,267	3,102	3,230	3,270	3,010	3,480	3,257	3,294	38,652
20. Net Underwriting Gain or Loss (L7 -L19)	(34)	324	75	191	67	237	112	76	340	48	275	242	1,955
21. Net Investment Income Earned													-
22. Federal Income Taxes	(12)	120	28	71	25	88	42	28	126	18	102	90	723
23. Health Insurance Provider Fee	62	63	63	63	63	63	63	63	63	66	66	67	764
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(84)	142	(15)	58	(20)	86	8	(15)	151	(36)	107	86	468

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	1,125	1,126	1,127	1,129	1,130	1,131	1,133	1,134	1,135	1,137	1,138	1,139	1,139
1. Member Months	1,125	2,251	3,378	4,507	5,637	6,768	7,901	9,035	10,170	11,307	12,445	13,584	13,584
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	3,433	3,437	3,441	3,445	3,449	3,453	3,457	3,461	3,465	3,649	3,653	3,657	42,000
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	107	107	108	108	108	108	108	108	108	114	114	114	1,313
7. Total (L2a,b+L3+L4+L5+L6)	3,540	3,544	3,548	3,553	3,557	3,561	3,565	3,569	3,573	3,763	3,767	3,772	43,313
Hospital and Medical:													
8. Hospital/Medical Benefits	931	827	911	883	934	881	921	932	871	989	948	957	10,985
9. Other Benefits & Professional Services	130	130	130	130	130	131	131	131	131	138	138	138	1,588
10. Prescription Drugs	2,362	2,088	2,273	2,182	2,267	2,143	2,239	2,270	2,054	2,422	2,225	2,256	26,780
11. Expanded Benefits	6	6	6	6	6	6	6	6	6	6	6	6	67
12. Subtotal (L8+L9+L10+L11)	3,428	3,051	3,320	3,200	3,336	3,160	3,296	3,338	3,061	3,555	3,317	3,356	39,419
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	3,428	3,051	3,320	3,200	3,336	3,160	3,296	3,338	3,061	3,555	3,317	3,356	39,419
15. Claims Adjustment Expenses	51	51	51	51	51	51	52	52	52	54	54	54	625
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	96	97	97	97	97	97	97	97	97	102	102	103	1,180
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	3,576	3,198	3,468	3,348	3,485	3,308	3,445	3,487	3,210	3,712	3,474	3,513	41,224
20. Net Underwriting Gain or Loss (L7 -L19)	(36)	346	81	204	72	253	120	82	363	52	294	258	2,089
21. Net Investment Income Earned													-
22. Federal Income Taxes	(13)	128	30	76	27	93	44	30	134	19	109	96	773
23. Health Insurance Provider Fee	67	67	67	67	67	67	67	67	67	71	71	71	815
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(89)	151	(16)	62	(22)	92	9	(16)	162	(38)	114	92	501

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	1,141	1,142	1,143	1,145	1,146	1,147	1,149	1,150	1,151	1,153	1,154	1,155	1,155
1. Member Months	1,141	2,283	3,426	4,571	5,717	6,864	8,012	9,162	10,314	11,466	12,620	13,776	13,776
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	3,662	3,666	3,670	3,674	3,679	3,683	3,687	3,692	3,696	3,892	3,897	3,901	44,799
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	115	115	115	115	115	115	115	115	116	122	122	122	1,401
7. Total (L2a,b+L3+L4+L5+L6)	3,776	3,781	3,785	3,789	3,794	3,798	3,803	3,807	3,811	4,014	4,018	4,023	46,199
Hospital and Medical:													
8. Hospital/Medical Benefits	993	882	972	941	996	939	983	995	929	1,055	1,011	1,020	11,716
9. Other Benefits & Professional Services	138	139	139	139	139	139	139	139	140	147	147	147	1,692
10. Prescription Drugs	2,520	2,228	2,425	2,327	2,418	2,286	2,388	2,421	2,191	2,584	2,374	2,407	28,569
11. Expanded Benefits	6	6	6	6	6	6	6	6	6	6	6	6	68
12. Subtotal (L8+L9+L10+L11)	3,657	3,254	3,541	3,413	3,559	3,370	3,516	3,561	3,265	3,792	3,538	3,580	42,045
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	3,657	3,254	3,541	3,413	3,559	3,370	3,516	3,561	3,265	3,792	3,538	3,580	42,045
15. Claims Adjustment Expenses	54	55	55	55	55	55	55	55	55	58	58	58	666
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	103	103	103	103	103	103	103	104	104	109	109	109	1,257
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	3,814	3,411	3,699	3,571	3,717	3,528	3,674	3,719	3,424	3,959	3,705	3,747	43,968
20. Net Underwriting Gain or Loss (L7 -L19)	(38)	369	86	218	77	270	128	88	388	55	314	276	2,231
21. Net Investment Income Earned													-
22. Federal Income Taxes	(14)	137	32	81	29	100	48	32	143	20	116	102	825
23. Health Insurance Provider Fee	71	71	71	71	71	71	72	72	72	76	76	76	869
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(95)	162	(17)	66	(23)	99	9	(16)	172	(41)	122	98	536

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	445	445	446	446
1. Member Months	-	-	-	-	-	-	-	-	-	445	890	1,335	1,335
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	1,081	1,082	1,083	3,246
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	34	34	34	102
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	1,115	1,116	1,117	3,348
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	228	218	220	666
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	34	34	35	103
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	788	724	734	2,247
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	2	2	2	7
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	1,053	979	991	3,022
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	1,053	979	991	3,022
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	17	17	17	50
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	31	31	31	94
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	1,101	1,027	1,039	3,166
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	14	89	78	182
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	5	33	29	67
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	21	21	21	63
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(12)	35	28	51

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	446	447	447	448	448	449	449	450	450	451	451	452	452
1. Member Months	446	893	1,340	1,787	2,236	2,684	3,133	3,583	4,033	4,484	4,936	5,387	5,387
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	1,085	1,086	1,087	1,088	1,090	1,091	1,092	1,093	1,095	1,153	1,154	1,156	13,269
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	34	34	34	34	34	34	34	34	34	36	36	36	415
7. Total (L2a,b+L3+L4+L5+L6)	1,118	1,120	1,121	1,122	1,124	1,125	1,126	1,128	1,129	1,189	1,190	1,192	13,684
Hospital and Medical:													
8. Hospital/Medical Benefits	229	203	223	216	229	216	226	229	213	243	232	234	2,694
9. Other Benefits & Professional Services	35	35	35	35	35	35	35	35	35	37	37	37	423
10. Prescription Drugs	820	725	789	758	787	744	777	788	713	841	773	783	9,298
11. Expanded Benefits	2	2	2	2	2	2	2	2	2	2	2	2	27
12. Subtotal (L8+L9+L10+L11)	1,085	965	1,049	1,011	1,053	997	1,040	1,054	964	1,123	1,044	1,057	12,442
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	1,085	965	1,049	1,011	1,053	997	1,040	1,054	964	1,123	1,044	1,057	12,442
15. Claims Adjustment Expenses	17	17	17	17	17	17	17	17	17	18	18	18	204
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	31	31	31	32	32	32	32	32	32	33	33	33	384
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	1,133	1,013	1,098	1,059	1,101	1,045	1,089	1,102	1,012	1,174	1,095	1,108	13,029
20. Net Underwriting Gain or Loss (L7 -L19)	(15)	107	23	63	22	80	38	25	117	15	95	84	655
21. Net Investment Income Earned													-
22. Federal Income Taxes	(6)	40	9	23	8	30	14	9	43	6	35	31	242
23. Health Insurance Provider Fee	21	21	21	21	21	21	21	21	21	22	22	22	257
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(30)	46	(6)	19	(7)	29	3	(5)	52	(13)	38	30	155

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	452	453	453	454	454	455	456	456	457	457	458	458	458
1. Member Months	452	905	1,359	1,813	2,267	2,722	3,178	3,634	4,090	4,547	5,005	5,463	5,463
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	1,157	1,158	1,160	1,161	1,162	1,164	1,165	1,166	1,168	1,230	1,231	1,233	14,153
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	36	36	36	36	36	36	36	36	37	38	38	39	443
7. Total (L2a,b+L3+L4+L5+L6)	1,193	1,194	1,196	1,197	1,199	1,200	1,201	1,203	1,204	1,268	1,270	1,271	14,596
Hospital and Medical:													
8. Hospital/Medical Benefits	244	216	238	231	244	230	241	244	227	259	248	250	2,873
9. Other Benefits & Professional Services	37	37	37	37	37	37	37	37	37	39	39	39	451
10. Prescription Drugs	875	773	842	808	840	794	829	841	761	897	824	836	9,920
11. Expanded Benefits	2	2	2	2	2	2	2	2	2	2	2	2	27
12. Subtotal (L8+L9+L10+L11)	1,158	1,029	1,119	1,078	1,123	1,063	1,110	1,124	1,028	1,198	1,114	1,127	13,270
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	1,158	1,029	1,119	1,078	1,123	1,063	1,110	1,124	1,028	1,198	1,114	1,127	13,270
15. Claims Adjustment Expenses	18	18	18	18	18	18	18	18	18	19	19	19	217
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	33	33	34	34	34	34	34	34	34	35	36	36	409
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	1,209	1,080	1,171	1,129	1,175	1,115	1,161	1,176	1,079	1,252	1,168	1,182	13,896
20. Net Underwriting Gain or Loss (L7 -L19)	(16)	114	25	68	24	85	40	27	125	16	102	90	700
21. Net Investment Income Earned													-
22. Federal Income Taxes	(6)	42	9	25	9	32	15	10	46	6	38	33	259
23. Health Insurance Provider Fee	22	22	22	23	23	23	23	23	23	24	24	24	275
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(32)	50	(7)	20	(8)	31	3	(6)	56	(14)	40	32	166

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	459	459	460	460	461	461	462	462	463	464	464	465	465
1. Member Months	459	918	1,378	1,838	2,299	2,760	3,222	3,685	4,148	4,612	5,076	5,540	5,540
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	1,234	1,235	1,237	1,238	1,240	1,241	1,243	1,244	1,245	1,312	1,313	1,315	15,096
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	39	39	39	39	39	39	39	39	39	41	41	41	472
7. Total (L2a,b+L3+L4+L5+L6)	1,273	1,274	1,275	1,277	1,278	1,280	1,281	1,283	1,284	1,353	1,354	1,356	15,568
Hospital and Medical:													
8. Hospital/Medical Benefits	260	231	254	246	261	246	257	260	243	276	264	267	3,064
9. Other Benefits & Professional Services	39	39	39	39	39	39	40	40	40	42	42	42	480
10. Prescription Drugs	933	825	898	862	896	847	885	897	812	957	879	891	10,583
11. Expanded Benefits	2	2	2	2	2	2	2	2	2	2	2	2	27
12. Subtotal (L8+L9+L10+L11)	1,235	1,097	1,194	1,150	1,198	1,134	1,183	1,199	1,096	1,277	1,188	1,202	14,154
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	1,235	1,097	1,194	1,150	1,198	1,134	1,183	1,199	1,096	1,277	1,188	1,202	14,154
15. Claims Adjustment Expenses	19	19	19	19	19	19	19	19	19	20	20	20	231
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	36	36	36	36	36	36	36	36	36	38	38	38	436
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	1,289	1,152	1,249	1,205	1,253	1,189	1,238	1,254	1,151	1,335	1,246	1,260	14,821
20. Net Underwriting Gain or Loss (L7 -L19)	(17)	122	27	72	26	91	43	29	133	17	108	96	748
21. Net Investment Income Earned													-
22. Federal Income Taxes	(6)	45	10	27	9	34	16	11	49	6	40	35	277
23. Health Insurance Provider Fee	24	24	24	24	24	24	24	24	24	25	25	26	293
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(35)	53	(7)	22	(8)	33	3	(6)	60	(14)	43	35	178

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	1,410	1,411	1,413	1,413
1. Member Months	-	-	-	-	-	-	-	-	-	1,410	2,821	4,234	4,234
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	3,681	3,685	3,690	11,056
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	115	115	115	346
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	3,796	3,801	3,805	11,402
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	960	919	926	2,805
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	127	127	127	381
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	2,495	2,292	2,324	7,110
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	7	7	7	21
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	3,589	3,345	3,384	10,317
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	3,589	3,345	3,384	10,317
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	55	55	55	165
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	104	104	104	311
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	3,747	3,504	3,543	10,794
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	49	297	262	608
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	18	110	97	225
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	71	71	72	214
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(41)	115	94	168

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	1,415	1,416	1,418	1,420	1,421	1,423	1,425	1,426	1,428	1,430	1,431	1,433	1,433
1. Member Months	1,415	2,831	4,249	5,668	7,089	8,512	9,937	11,363	12,791	14,220	15,651	17,084	17,084
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	3,694	3,698	3,702	3,707	3,711	3,715	3,720	3,724	3,728	3,926	3,931	3,936	45,192
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	116	116	116	116	116	116	116	116	117	123	123	123	1,413
7. Total (L2a,b+L3+L4+L5+L6)	3,809	3,814	3,818	3,823	3,827	3,832	3,836	3,840	3,845	4,049	4,054	4,059	46,606
Hospital and Medical:													
8. Hospital/Medical Benefits	963	855	942	912	966	910	952	965	899	1,024	980	988	11,355
9. Other Benefits & Professional Services	127	127	128	128	128	128	128	128	129	135	135	136	1,557
10. Prescription Drugs	2,595	2,294	2,498	2,397	2,491	2,355	2,460	2,494	2,257	2,661	2,445	2,479	29,427
11. Expanded Benefits	7	7	7	7	7	7	7	7	7	7	7	7	84
12. Subtotal (L8+L9+L10+L11)	3,693	3,284	3,574	3,444	3,592	3,400	3,547	3,594	3,291	3,828	3,568	3,609	42,424
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	3,693	3,284	3,574	3,444	3,592	3,400	3,547	3,594	3,291	3,828	3,568	3,609	42,424
15. Claims Adjustment Expenses	55	55	55	55	55	55	56	56	56	59	59	59	674
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	104	104	104	104	105	105	105	105	105	110	111	111	1,272
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	3,852	3,443	3,733	3,604	3,752	3,560	3,708	3,754	3,452	3,997	3,737	3,779	44,370
20. Net Underwriting Gain or Loss (L7 -L19)	(43)	371	85	219	75	272	128	86	393	53	317	280	2,236
21. Net Investment Income Earned													-
22. Federal Income Taxes	(16)	137	31	81	28	101	47	32	145	19	117	104	827
23. Health Insurance Provider Fee	72	72	72	72	72	72	72	72	72	76	76	76	877
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(99)	162	(18)	66	(24)	99	9	(18)	175	(43)	123	100	532

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	1,435	1,436	1,438	1,440	1,441	1,443	1,445	1,446	1,448	1,450	1,451	1,453	1,453
1. Member Months	1,435	2,871	4,309	5,748	7,189	8,632	10,077	11,523	12,971	14,421	15,872	17,325	17,325
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	3,940	3,945	3,949	3,954	3,958	3,963	3,968	3,972	3,977	4,188	4,193	4,198	48,205
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	123	123	123	124	124	124	124	124	124	131	131	131	1,507
7. Total (L2a,b+L3+L4+L5+L6)	4,063	4,068	4,073	4,077	4,082	4,087	4,092	4,096	4,101	4,319	4,324	4,329	49,712
Hospital and Medical:													
8. Hospital/Medical Benefits	1,028	912	1,004	973	1,030	970	1,016	1,029	958	1,092	1,045	1,054	12,112
9. Other Benefits & Professional Services	136	136	136	136	136	137	137	137	137	144	144	145	1,660
10. Prescription Drugs	2,769	2,448	2,665	2,558	2,657	2,512	2,624	2,661	2,408	2,839	2,609	2,644	31,393
11. Expanded Benefits	7	7	7	7	7	7	7	7	7	7	7	7	85
12. Subtotal (L8+L9+L10+L11)	3,939	3,502	3,812	3,674	3,831	3,626	3,784	3,833	3,510	4,083	3,806	3,850	45,250
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	3,939	3,502	3,812	3,674	3,831	3,626	3,784	3,833	3,510	4,083	3,806	3,850	45,250
15. Claims Adjustment Expenses	59	59	59	59	59	59	59	59	59	62	62	62	718
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	111	111	111	111	111	111	112	112	112	118	118	118	1,355
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	4,109	3,672	3,982	3,844	4,001	3,797	3,955	4,004	3,681	4,263	3,986	4,030	47,323
20. Net Underwriting Gain or Loss (L7 -L19)	(45)	396	91	234	81	290	137	92	420	56	338	299	2,389
21. Net Investment Income Earned													-
22. Federal Income Taxes	(17)	146	34	86	30	107	51	34	155	21	125	111	884
23. Health Insurance Provider Fee	76	77	77	77	77	77	77	77	77	81	81	81	935
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(105)	173	(19)	71	(26)	106	9	(19)	187	(46)	132	107	570

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	1,455	1,456	1,458	1,460	1,462	1,463	1,465	1,467	1,468	1,470	1,472	1,474	1,474
1. Member Months	1,455	2,911	4,369	5,829	7,291	8,754	10,219	11,685	13,154	14,624	16,096	17,569	17,569
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	4,203	4,208	4,213	4,217	4,222	4,227	4,232	4,237	4,242	4,467	4,473	4,478	51,419
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	131	132	132	132	132	132	132	132	133	140	140	140	1,608
7. Total (L2a,b+L3+L4+L5+L6)	4,334	4,339	4,344	4,349	4,354	4,359	4,364	4,370	4,375	4,607	4,612	4,618	53,027
Hospital and Medical:													
8. Hospital/Medical Benefits	1,096	973	1,071	1,038	1,099	1,035	1,083	1,097	1,022	1,165	1,115	1,124	12,918
9. Other Benefits & Professional Services	145	145	145	145	145	146	146	146	146	154	154	154	1,770
10. Prescription Drugs	2,954	2,611	2,843	2,728	2,835	2,680	2,800	2,838	2,569	3,029	2,783	2,821	33,491
11. Expanded Benefits	7	7	7	7	7	7	7	7	7	7	7	7	87
12. Subtotal (L8+L9+L10+L11)	4,202	3,736	4,066	3,918	4,086	3,868	4,036	4,089	3,744	4,355	4,059	4,106	48,266
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	4,202	3,736	4,066	3,918	4,086	3,868	4,036	4,089	3,744	4,355	4,059	4,106	48,266
15. Claims Adjustment Expenses	63	63	63	63	63	63	63	63	63	66	67	67	765
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	118	118	118	118	119	119	119	119	119	125	126	126	1,444
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	4,382	3,917	4,247	4,100	4,268	4,049	4,218	4,271	3,926	4,547	4,251	4,299	50,475
20. Net Underwriting Gain or Loss (L7 -L19)	(48)	423	97	250	87	310	147	99	448	60	361	319	2,552
21. Net Investment Income Earned													-
22. Federal Income Taxes	(18)	156	36	92	32	115	54	37	166	22	134	118	944
23. Health Insurance Provider Fee	82	82	82	82	82	82	82	82	82	87	87	87	998
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(112)	185	(20)	75	(27)	113	10	(20)	200	(49)	141	114	610

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	1,044	1,045	1,047	1,047
1. Member Months	-	-	-	-	-	-	-	-	-	1,044	2,090	3,136	3,136
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	3,311	3,315	3,319	9,946
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	104	104	104	311
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	3,415	3,419	3,423	10,257
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	895	857	865	2,618
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	89	89	89	267
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	2,238	2,056	2,085	6,379
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	5	5	5	15
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	3,228	3,008	3,044	9,280
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	3,228	3,008	3,044	9,280
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	49	49	49	148
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	93	93	93	280
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	3,370	3,151	3,187	9,707
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	45	268	236	549
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	17	99	87	203
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	64	64	64	193
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(36)	105	84	153

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	1,048	1,049	1,050	1,052	1,053	1,054	1,055	1,056	1,058	1,059	1,060	1,061	1,061
1. Member Months	1,048	2,097	3,147	4,199	5,252	6,306	7,361	8,417	9,475	10,534	11,594	12,656	12,656
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	3,323	3,327	3,331	3,334	3,338	3,342	3,346	3,350	3,354	3,532	3,536	3,540	40,654
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	104	104	104	104	104	105	105	105	105	110	111	111	1,271
7. Total (L2a,b+L3+L4+L5+L6)	3,427	3,431	3,435	3,439	3,443	3,447	3,451	3,455	3,459	3,643	3,647	3,651	41,925
Hospital and Medical:													
8. Hospital/Medical Benefits	898	798	879	851	901	850	889	900	840	955	915	923	10,598
9. Other Benefits & Professional Services	89	89	90	90	90	90	90	90	90	95	95	95	1,092
10. Prescription Drugs	2,328	2,058	2,241	2,151	2,235	2,113	2,207	2,237	2,025	2,388	2,194	2,224	26,400
11. Expanded Benefits	5	5	5	5	5	5	5	5	5	5	5	5	62
12. Subtotal (L8+L9+L10+L11)	3,321	2,951	3,215	3,097	3,231	3,057	3,191	3,232	2,960	3,443	3,208	3,247	38,153
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	3,321	2,951	3,215	3,097	3,231	3,057	3,191	3,232	2,960	3,443	3,208	3,247	38,153
15. Claims Adjustment Expenses	50	50	50	50	50	50	50	50	50	53	53	53	606
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	93	94	94	94	94	94	94	94	94	99	99	99	1,142
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	3,464	3,094	3,358	3,240	3,374	3,201	3,335	3,377	3,104	3,594	3,360	3,399	39,901
20. Net Underwriting Gain or Loss (L7 -L19)	(38)	337	77	198	69	246	116	78	355	48	286	252	2,025
21. Net Investment Income Earned													-
22. Federal Income Taxes	(14)	125	28	73	25	91	43	29	131	18	106	93	749
23. Health Insurance Provider Fee	64	65	65	65	65	65	65	65	65	69	69	69	789
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(88)	148	(16)	60	(22)	90	8	(16)	158	(38)	112	90	487

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	1,063	1,064	1,065	1,066	1,068	1,069	1,070	1,071	1,073	1,074	1,075	1,076	1,076
1. Member Months	1,063	2,127	3,192	4,258	5,326	6,394	7,465	8,536	9,609	10,682	11,757	12,834	12,834
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	3,544	3,549	3,553	3,557	3,561	3,565	3,569	3,573	3,578	3,768	3,772	3,776	43,365
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	111	111	111	111	111	111	112	112	112	118	118	118	1,356
7. Total (L2a,b+L3+L4+L5+L6)	3,655	3,660	3,664	3,668	3,672	3,677	3,681	3,685	3,689	3,885	3,890	3,894	44,721
Hospital and Medical:													
8. Hospital/Medical Benefits	958	851	938	908	961	906	948	960	896	1,019	975	984	11,304
9. Other Benefits & Professional Services	95	95	95	96	96	96	96	96	96	101	101	101	1,164
10. Prescription Drugs	2,484	2,196	2,391	2,295	2,384	2,254	2,354	2,387	2,160	2,547	2,340	2,372	28,164
11. Expanded Benefits	5	5	5	5	5	5	5	5	5	5	5	5	63
12. Subtotal (L8+L9+L10+L11)	3,543	3,148	3,429	3,303	3,446	3,261	3,404	3,448	3,157	3,672	3,422	3,463	40,696
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	3,543	3,148	3,429	3,303	3,446	3,261	3,404	3,448	3,157	3,672	3,422	3,463	40,696
15. Claims Adjustment Expenses	53	53	53	53	53	53	53	53	53	56	56	56	645
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	99	100	100	100	100	100	100	100	100	106	106	106	1,217
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	3,695	3,300	3,581	3,456	3,599	3,414	3,557	3,601	3,311	3,834	3,584	3,625	42,558
20. Net Underwriting Gain or Loss (L7 -L19)	(40)	360	82	212	73	263	124	84	379	52	306	269	2,163
21. Net Investment Income Earned													-
22. Federal Income Taxes	(15)	133	30	78	27	97	46	31	140	19	113	100	800
23. Health Insurance Provider Fee	69	69	69	69	69	69	69	69	69	73	73	73	841
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(94)	158	(17)	64	(23)	96	9	(17)	169	(41)	119	96	521

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	1,078	1,079	1,080	1,081	1,083	1,084	1,085	1,086	1,088	1,089	1,090	1,092	1,092
1. Member Months	1,078	2,156	3,237	4,318	5,401	6,485	7,570	8,656	9,744	10,833	11,923	13,015	13,015
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	3,781	3,785	3,790	3,794	3,798	3,803	3,807	3,812	3,816	4,019	4,024	4,028	46,256
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	118	118	119	119	119	119	119	119	119	126	126	126	1,446
7. Total (L2a,b+L3+L4+L5+L6)	3,899	3,904	3,908	3,913	3,917	3,922	3,926	3,931	3,935	4,145	4,149	4,154	47,702
Hospital and Medical:													
8. Hospital/Medical Benefits	1,022	908	1,000	969	1,025	966	1,011	1,024	955	1,086	1,040	1,050	12,057
9. Other Benefits & Professional Services	101	102	102	102	102	102	102	102	102	108	108	108	1,241
10. Prescription Drugs	2,650	2,343	2,550	2,448	2,543	2,404	2,512	2,546	2,304	2,717	2,497	2,531	30,046
11. Expanded Benefits	5	5	5	5	5	5	5	5	5	5	5	5	64
12. Subtotal (L8+L9+L10+L11)	3,779	3,357	3,657	3,524	3,676	3,478	3,630	3,678	3,367	3,917	3,650	3,694	43,409
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	3,779	3,357	3,657	3,524	3,676	3,478	3,630	3,678	3,367	3,917	3,650	3,694	43,409
15. Claims Adjustment Expenses	56	56	56	56	56	57	57	57	57	60	60	60	687
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	106	106	106	106	106	107	107	107	107	113	113	113	1,296
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	3,941	3,520	3,820	3,686	3,839	3,641	3,794	3,841	3,531	4,089	3,823	3,867	45,393
20. Net Underwriting Gain or Loss (L7 -L19)	(42)	384	88	226	79	280	133	90	404	55	326	287	2,310
21. Net Investment Income Earned													-
22. Federal Income Taxes	(16)	142	33	84	29	104	49	33	150	20	121	106	855
23. Health Insurance Provider Fee	73	73	74	74	74	74	74	74	74	78	78	78	897
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(100)	168	(18)	69	(24)	103	10	(18)	181	(43)	127	103	558

	2018												Total 2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	-	-	-	-	-	-	-	-	-	2,583	2,586	2,589	2,589
1. Member Months	-	-	-	-	-	-	-	-	-	2,583	5,169	7,758	7,758
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	-	-	-	-	-	-	-	-	-	8,180	8,190	8,199	24,570
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	-	-	-	-	-	-	-	-	-	256	256	256	768
7. Total (L2a,b+L3+L4+L5+L6)	-	-	-	-	-	-	-	-	-	8,436	8,446	8,456	25,338
Hospital and Medical:													
8. Hospital/Medical Benefits	-	-	-	-	-	-	-	-	-	2,049	1,963	1,981	5,993
9. Other Benefits & Professional Services	-	-	-	-	-	-	-	-	-	211	212	212	635
10. Prescription Drugs	-	-	-	-	-	-	-	-	-	5,703	5,240	5,312	16,255
11. Expanded Benefits	-	-	-	-	-	-	-	-	-	13	13	13	38
12. Subtotal (L8+L9+L10+L11)	-	-	-	-	-	-	-	-	-	7,976	7,427	7,517	22,921
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	-	-	-	-	-	-	-	-	-	7,976	7,427	7,517	22,921
15. Claims Adjustment Expenses	-	-	-	-	-	-	-	-	-	121	121	121	364
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	-	-	-	-	-	-	-	-	-	228	229	229	686
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	-	-	-	-	-	-	-	-	-	8,326	7,777	7,868	23,970
20. Net Underwriting Gain or Loss (L7 -L19)	-	-	-	-	-	-	-	-	-	110	669	588	1,368
21. Net Investment Income Earned													-
22. Federal Income Taxes	-	-	-	-	-	-	-	-	-	41	248	218	506
23. Health Insurance Provider Fee	-	-	-	-	-	-	-	-	-	159	159	159	477
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	-	-	-	-	-	-	-	-	-	(89)	263	212	385

	2019												Total 2019
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	2,592	2,595	2,598	2,601	2,604	2,607	2,610	2,613	2,616	2,619	2,622	2,626	2,626
1. Member Months	2,592	5,187	7,785	10,386	12,991	15,598	18,208	20,821	23,438	26,057	28,680	31,305	31,305
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	8,209	8,219	8,228	8,238	8,247	8,257	8,266	8,276	8,286	8,726	8,736	8,746	100,433
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	257	257	257	258	258	258	258	259	259	273	273	273	3,141
7. Total (L2a,b+L3+L4+L5+L6)	8,466	8,475	8,485	8,495	8,505	8,515	8,525	8,535	8,545	8,999	9,009	9,020	103,574
Hospital and Medical:													
8. Hospital/Medical Benefits	2,056	1,827	2,013	1,949	2,062	1,945	2,035	2,060	1,923	2,186	2,094	2,113	24,261
9. Other Benefits & Professional Services	212	212	213	213	213	213	214	214	214	225	226	226	2,595
10. Prescription Drugs	5,933	5,245	5,710	5,481	5,695	5,383	5,623	5,701	5,160	6,084	5,590	5,667	67,272
11. Expanded Benefits	13	13	13	13	13	13	13	13	13	13	13	13	154
12. Subtotal (L8+L9+L10+L11)	8,215	7,297	7,948	7,656	7,983	7,554	7,885	7,988	7,309	8,508	7,922	8,018	94,282
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	8,215	7,297	7,948	7,656	7,983	7,554	7,885	7,988	7,309	8,508	7,922	8,018	94,282
15. Claims Adjustment Expenses	122	122	122	122	122	122	122	123	123	129	129	129	1,486
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	229	229	230	230	230	231	231	231	231	243	244	244	2,803
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	8,565	7,648	8,299	8,007	8,335	7,907	8,238	8,341	7,663	8,880	8,295	8,392	98,572
20. Net Underwriting Gain or Loss (L7 -L19)	(100)	827	186	488	170	608	287	194	881	118	714	628	5,002
21. Net Investment Income Earned													-
22. Federal Income Taxes	(37)	306	69	180	63	225	106	72	326	44	264	232	1,851
23. Health Insurance Provider Fee	159	159	160	160	160	160	160	161	161	169	169	170	1,948
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(222)	362	(43)	147	(53)	223	20	(39)	395	(95)	281	226	1,203

	2020												Total 2020
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	2,629	2,632	2,635	2,638	2,641	2,644	2,647	2,650	2,653	2,656	2,659	2,663	2,663
1. Member Months	2,629	5,260	7,895	10,533	13,174	15,818	18,465	21,115	23,768	26,424	29,084	31,746	31,746
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	8,756	8,767	8,777	8,787	8,797	8,807	8,818	8,828	8,838	9,308	9,319	9,329	107,130
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	274	274	274	275	275	275	276	276	276	291	291	292	3,350
7. Total (L2a,b+L3+L4+L5+L6)	9,030	9,041	9,051	9,062	9,072	9,083	9,093	9,104	9,114	9,599	9,610	9,621	110,480
Hospital and Medical:													
8. Hospital/Medical Benefits	2,193	1,948	2,147	2,079	2,199	2,075	2,170	2,197	2,051	2,331	2,233	2,253	25,877
9. Other Benefits & Professional Services	226	226	227	227	227	227	228	228	228	240	241	241	2,766
10. Prescription Drugs	6,330	5,596	6,091	5,847	6,075	5,743	5,999	6,082	5,504	6,491	5,964	6,045	71,767
11. Expanded Benefits	13	13	13	13	13	13	13	13	13	13	13	13	157
12. Subtotal (L8+L9+L10+L11)	8,762	7,783	8,478	8,166	8,515	8,058	8,410	8,520	7,796	9,075	8,450	8,553	100,567
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	8,762	7,783	8,478	8,166	8,515	8,058	8,410	8,520	7,796	9,075	8,450	8,553	100,567
15. Claims Adjustment Expenses	129	130	130	130	130	130	130	131	131	137	138	138	1,583
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	244	244	245	245	245	246	246	246	246	259	259	260	2,986
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	9,136	8,157	8,852	8,541	8,890	8,434	8,787	8,897	8,173	9,472	8,847	8,950	105,136
20. Net Underwriting Gain or Loss (L7 -L19)	(106)	883	199	521	182	649	307	207	941	127	763	671	5,344
21. Net Investment Income Earned													-
22. Federal Income Taxes	(39)	327	74	193	67	240	113	77	348	47	282	248	1,977
23. Health Insurance Provider Fee	170	170	170	170	171	171	171	171	171	181	181	181	2,078
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(236)	386	(45)	158	(56)	238	22	(41)	421	(101)	300	242	1,288

	2021												Total 2021
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
0. Members	2,666	2,669	2,672	2,675	2,678	2,681	2,684	2,687	2,691	2,694	2,697	2,700	2,700
1. Member Months	2,666	5,334	8,006	10,681	13,359	16,040	18,725	21,412	24,103	26,797	29,493	32,194	32,194
2a. Net Premium Income (Excluding ACA Risk Adjustment Receivable)	9,340	9,351	9,362	9,373	9,384	9,395	9,406	9,417	9,428	9,929	9,940	9,952	114,275
2b. Net Premium Income - ACA Risk Adjustment Receivable (+)/Payable (-)													-
3. Fee for Service													-
4. Risk Revenue													-
5. Change in Unearned Premium Reserves													-
6. ACA Health Insurer Fee Subsidy Premium	292	292	293	293	293	294	294	294	295	310	311	311	3,573
7. Total (L2a,b+L3+L4+L5+L6)	9,632	9,644	9,655	9,666	9,677	9,688	9,700	9,711	9,722	10,239	10,251	10,263	117,848
Hospital and Medical:													
8. Hospital/Medical Benefits	2,340	2,078	2,290	2,218	2,346	2,213	2,315	2,343	2,187	2,487	2,382	2,404	27,601
9. Other Benefits & Professional Services	241	241	242	242	242	242	243	243	243	256	256	257	2,949
10. Prescription Drugs	6,753	5,970	6,498	6,237	6,481	6,127	6,400	6,489	5,872	6,924	6,362	6,449	76,563
11. Expanded Benefits	13	13	13	13	13	13	13	13	13	13	13	13	159
12. Subtotal (L8+L9+L10+L11)	9,346	8,302	9,043	8,710	9,082	8,595	8,971	9,088	8,316	9,680	9,013	9,123	107,271
Less:													
13. Reinsurance Recoveries													-
14. Total Hospital and Medical (L12 -L13)	9,346	8,302	9,043	8,710	9,082	8,595	8,971	9,088	8,316	9,680	9,013	9,123	107,271
15. Claims Adjustment Expenses	138	138	138	138	139	139	139	139	139	147	147	147	1,687
16a. General Admin Expenses (Excluding HIP Fee & User Fee Paid)	260	260	261	261	261	262	262	262	263	276	277	277	3,182
16b. ACA Risk Adjustment User Fee Paid													-
17. Increase in Reserves for Accident and Health Contacts													-
18. Aggregate Write-Ins for Other Income or Expenses													-
19. Total Underwriting Deductions (L14+L15+L16a,b+L17+L18)	9,745	8,701	9,442	9,110	9,482	8,995	9,372	9,489	8,718	10,103	9,437	9,547	112,141
20. Net Underwriting Gain or Loss (L7 -L19)	(112)	943	213	556	195	693	328	222	1,005	136	814	716	5,707
21. Net Investment Income Earned													-
22. Federal Income Taxes	(41)	349	79	206	72	256	121	82	372	50	301	265	2,112
23. Health Insurance Provider Fee	181	181	182	182	182	182	182	183	183	193	193	193	2,217
24. Net Realized Capital Gains (Losses)	-	-	-	-	-	-	-	-	-	-	-	-	-
25. Less Capital Gains Tax	-	-	-	-	-	-	-	-	-	-	-	-	-
26. Net Income or Loss (L20+L21-L22-L23+L24-L25)	(252)	413	(48)	169	(59)	254	24	(43)	450	(107)	320	258	1,379

Section C.4 - Surplus Account

Simply Healthcare Plans Inc., Better Health Inc., AMERIGROUP Florida, Inc. as of June 30, 2017 had a consolidated capital and surplus of \$264.6 million. The below chart projects a surplus requirement between \$67 and \$74 million over that three year projection period. At this time the Consolidated Simply Healthcare Plans, Inc. would be able to absorb the required increase with the excess currently on its balance sheet.

In the event the subsidiary can not meet the requirement the parent, Anthem, Inc., will fund the surplus amounts. As of June 30, 2017 the parent had \$4,521.2 million of cash and cash equivalents as stated in the 10-Q filed with the SEC. This balance is available for general corporate use to include investment in our business

Dollars in 000's

The greater of the below:

	<u>2019</u>	<u>2020</u>	<u>2021</u>
A flat amount of \$1.5 million	\$ 1,500	\$ 1,500	\$ 1,500
10% of total liabilities on Balance sheet	\$ 50,147	\$ 51,172	\$ 54,086

2% of annualized premiums - All Comprehensive and Specialty Regions Bid

	<u>2019</u>	<u>2020</u>	<u>2021</u>
Region 1	\$ 2,791	\$ 2,907	\$ 3,028
Region 2	3,030	3,161	3,299
Region 3	4,444	4,635	4,836
Region 4	5,194	5,416	5,649
Region 5	6,308	6,582	6,870
Region 6	10,713	11,202	11,716
Region 7	7,329	7,633	7,952
Region 8	1,417	1,462	1,511
Region 9	2,720	2,838	2,963
Region 10	7,507	7,855	8,220
Region 11	16,264	17,044	17,865
All Regions	<u>67,716</u>	<u>70,734</u>	<u>73,909</u>

2% of annualized premiums - All Lines of Business

	<u>\$ 88,713</u>	<u>\$ 93,333</u>	<u>\$ 98,376</u>
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Section C.4 - Insolvency Protection Account

Simply Healthcare Plans Inc., Better Health Inc., AMERIGROUP Florida, Inc. currently have Insolvency protection accounts established for their Medicaid contracts. Those accounts are valued at over \$53.2 million as of August 31, 2017.

We have estimated below that those accounts will need to be increased by \$14.5 million in the first 12 months of the contract.

In the event the subsidiary can not meet the requirement the parent, Anthem, Inc., will fund the surplus amounts. As of June 30, 2017 the parent had \$4,561.2 million of cash and cash equivalents as stated in the 10-Q filed with the SEC. This balance is available for general corporate use to include investment in our business

	Total Contract
[Dollars in 000's]	
Insolvency Protection Account as of August 31, 2017	\$ 53,211

Year 1: Projected 2% Annualized contract value - All Comprehensive and Specialty Regions Bid

	<u>2019</u>
Region 1	\$ 2,791
Region 2	3,030
Region 3	4,444
Region 4	5,194
Region 5	6,308
Region 6	10,713
Region 7	7,329
Region 8	1,417
Region 9	2,720
Region 10	7,507
Region 11	16,264
All Regions	<u>\$ 67,716</u>

Year 1 : Projected Increase to Insolvency account	<u>\$ 14,505</u>
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	<u>Jan-19</u>	<u>Feb-19</u>	<u>Mar-19</u>	<u>Apr-19</u>	<u>May-19</u>
5% of monthly Total capitation	\$ 18,182	\$ 18,211	\$ 18,244	\$ 18,288	\$ 18,321

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

RESPONDENT NAME: Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance

A. RESPONDENT BACKGROUND / EXPERIENCE

SRC# 1 – Managed Care Experience (Statewide):

The respondent, including respondent's parent, affiliate(s) and subsidiary(ies), shall provide a list of all current and/or recent (within five (5) years of the issue date of this solicitation (since July 14, 2012) contracts for managed care services (e.g. medical care, integrated medical and behavioral health services, transportation services and/or long-term services and support).

The respondent shall provide the following information for each identified contract:

- a. The Medicaid population served (such as TANF, ABD, dual eligible);
- b. The name and address of the client;
- c. The name of the contract;
- d. The specific start and end dates of the contract;
- e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services;
- f. The use of administrative and/or delegated subcontractor(s) and their scope of work;
- g. The annual contract amount (payment to the respondent) and annual claims payment amount;
- h. The scheduled and actual completion dates for contract implementation;
- i. The barriers encountered that hindered implementation (if applicable) and the resolutions;
- j. Accomplishments and achievements;
- k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid); and
- l. Whether the contract was capitated, FFS or other payment method.

In addition, the respondent shall describe its experience in delivering managed care services (e.g. medical care, integrated medical and behavioral health services, transportation services and/or long-term services and support), to Medicaid populations similar to the target population (such as TANF, ABD, dual eligible) identified in this solicitation.

For this SRC, the respondent may include experience provided by subcontractors for which the respondent was contractually responsible, if the respondent plans to use those same subcontractors for the SMMC program.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. Recognizing our unique opportunity to create a single, superior health plan that draws upon the combined strengths and 32 cumulative years of Florida Medicaid experience of our three managed care plans, we merged legacy Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup) into a single company that will operate as a comprehensive plan, across all regions. References to "Simply" throughout this response refer to

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

the newly merged organization, which is inclusive of the experience, results, and outcomes of all three of its legacy organizations. References to Clear Health are meant to highlight the targeted approaches and strategies, specific to our Specialty Plan offering, that we are bringing to bear for individuals with HIV/AIDS, based on our deep experience with this population. Clear Health will leverage all the capabilities of the combined Simply, while being laser-focused on its mission to bring the best possible care to our specialty plan members.

Our consolidated Florida health plan will continue under the consummate leadership of Ms. Lourdes Rivas, President and CEO. During her tenure at Clear Health, she has provided strong and visionary direction in a time of growth and change. She successfully focused the organization on priority initiatives: building a strong customer-centric focus, leading the development of Clear Health's strategic plan, and making sure that organizational goals are executed and target metrics achieved. She has been ably assisted by a combined management team with decades of collective experience that will continue to bring maturity, stability, and innovation to the health plan.

The integration of the strengths and capabilities of the three companies elevates our performance across all areas of operations and in the delivery of services to our enrollees (members), providers, and AHCA. As an organization we currently serve more than 630,000 members across Florida in Medicaid, Florida Healthy Kids (FHK), and Medicare Advantage programs, with a local high-touch, person-centered model, including more than 9,300 members in our HIV/AIDS specialty plan through Clear Health. We deliver managed care services in medical care, integrated medical and behavioral health services, dental, vision, pharmacy, long-term care, and transportation services to Florida Medicaid TANF, ABD, dual eligible, and Medicare populations.

Summaries of our three legacy organizations highlight the strengths each brings to the newly consolidated organization.

Legacy Simply, including D/B/A Clear Health Alliance

Simply has grown with the State as a proven performer demonstrated through several measures, including increased membership, improved satisfaction, and HEDIS scores to name a few. Since its inception in 2010, the health plan has doubled both its membership and its staffing as it expanded its MMA, specialty services, and Medicare Advantage footprint. We're extremely pleased that even as our membership expanded, member satisfaction remains high. According to 2017 CAHPS® data, we exceeded the 90th percentile in 16 measures for adults and the 75th percentile in seven measures for children, including "Rating of Health Plan" and "Rating of Health Care." In addition, Simply is currently a 4.5 star Medicare plan in Florida.

Simply also operates as a specialty plan for Medicaid recipients living with HIV/AIDS under the D/B/A Clear Health Alliance (Clear Health). In nearly all regions of the state, we provide managed care services to TANF, SSI and dual eligible populations with a diagnosis of HIV/AIDS. In our five years serving HIV/AIDS members, Clear Health has become a national model in providing managed medical assistance to individuals with a diagnosis of HIV/AIDS. We currently serve more than 9,300 members across Florida, and we are the largest HIV/AIDS specialty plan in the state and the nation. The consolidated organization will continue to do business as Clear Health for this population.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

In developing our HIV/AIDS specialty plan, we have tapped into the expertise of leaders in policy, research, care, and public education. Clear Health worked closely with the University of Miami, a renowned center of excellence in HIV/AIDS care and research. The University helped develop protocols for quality, compliance, and care, and provided an introduction to former NBA basketball star, Earvin “Magic” Johnson, who was so impressed by our commitment to not only the HIV/AIDS members, but also to the TANF, ABD, and dual eligible populations, that he became a plan spokesperson and an active participant in setting strategic direction for the program. Magic chairs Clear Health’s Strategic Advisory Group, which makes recommendations regarding improvements to quality, operations, and community partnerships in conjunction with our Member Advisory Committee and the broader HIV/AIDS community and research experts. He recently served as keynote speaker at the 17th Annual Center for AIDS Research Scientific Symposium. The symposium was sponsored by the University of Miami and organized by Dr. Margaret Fischl, a Clear Health provider and nationally renowned AIDS researcher. Through his direct input, leadership, and the efforts of the Magic Johnson Foundation, Magic has provided invaluable insight and an entrée to minority populations and communities that have historically been difficult to reach. Moreover, in his role as plan ambassador and community advocate, Magic visits with students in local schools, pastors in local churches, network providers, and our associates. In May of this year, he met with Florida lawmakers in Tallahassee, expressing support for our innovative efforts to serve Medicaid and Medicare members.

Legacy Better Health

Better Health initiated its partnership with the State through participation in a 2006 pilot reform project in Region 10. Better Health became the only Provider Service Network (PSN) to show achieved savings under reform and also became one of the largest PSNs in Broward County. Better Health accomplished this while also demonstrating improved outcomes. In addition, Better Health remaining committed to serving members in the county throughout the term of the Contract.

In 2012, Better Health, as a Managing Entity, brought education and managed care principles to MediPass providers in 31 rural counties serving Florida’s TANF, ABD, and dual eligible populations. We accomplished this through an administrative service agreement with AHCA providing enhanced case management services, utilization management, and prior authorization in counties with fewer than two managed care plans. Through this program, Better Health identified, recommended, and implemented cost saving initiatives in the MediPass program.

Legacy AMERIGROUP Florida (Amerigroup)

Amerigroup entered the Florida market through the acquisition of Physicians Healthcare Plans Inc. in 2003, and continues to be a trusted partner to AHCA and other State agencies serving Florida’s Medicaid, MMA, LTC and Florida Healthy Kids programs. It was one of the first health plans to implement and subsequently expand the Department of Elder Affairs’ (DOEA) Nursing Home Diversion Program, a predecessor to the current LTC program.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Amerigroup holds a commendable accreditation through NCQA and has among the highest HEDIS and CAHPS results in the state. Our consolidated health plan will build upon this exemplary performance. The Amerigroup philosophy has always been to support members across the full spectrum of physical health, behavioral health, and social needs, even if they are not the ultimate payer for services today. We will carry this philosophy forward with our combined organization.

Combining the Best of Three Plans

We are excited about the recent merger of these three high-performing managed care companies and the vast potential in consolidating the collective experience, expertise, and resources of these three companies as we move forward under the Simply brand. We seized this opportunity to carefully and methodically identify the best practices of each of our legacy organizations, seamlessly integrating programs and processes under a single leadership team. This thoughtful approach to combining our organizational strengths and resources resulted in a stronger and more effective organization serving the needs of our Florida members. We are confident this unification will bring many benefits including: financial and system efficiencies, best practices in integrated care delivery, and broad reach into the communities we serve. Ultimately, our aim is to continue to work and strengthen our partnership with AHCA, stakeholders, Florida communities, providers, subcontractors, and many others to further improve quality of life for our Florida Medicaid members while containing cost, improving health outcomes, and enhancing the patient experience.

Experience Delivering Managed Care throughout the Nation

We will continue to benefit from the national presence, best practices, and depth of experience across Medicaid and other state-sponsored programs through our ultimate parent company, Anthem, Inc. and its affiliates. Together with our affiliates, we serve approximately 6.5 million members in state-sponsored programs across 19 states and the District of Columbia. These affiliate health plans have coordinated acute, behavioral, and long term services and supports benefits for Medicaid and other state-sponsored health programs for more than 26 years.

Furthermore, Anthem has been a pioneer and innovator in providing integrated care solutions to individuals with specialized care and service needs, including those who are dually eligible for Medicare and Medicaid as well as frail adult populations residing in nursing facilities and in the community; members with intellectual or developmental disabilities; children in foster care; medically frail children; and members with serious mental illness and substance use disorders. Beyond this extensive state-sponsored program experience across all product lines, the Anthem family of health plans serves the healthcare needs of over 40 million Americans.

1. EXPERIENCE PROVIDING INTEGRATED MEDICAL AND BEHAVIORAL HEALTH SERVICES

Our organization has been providing integrated physical and behavioral health care in Florida since 2003. We integrate care because we have seen first-hand the impact that mental health and substance use conditions have on our members' physical health and their related ability to engage in the services and supports needed to meet their holistic needs. A unique tool that we utilize in connecting the dots between physical and behavioral health is our Case Management System. This tool is available to medical and behavioral health providers and Case Managers. It

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

provides access to near real-time member health information to maximize and facilitate care coordination and integrated care. We have received many compliments from providers, praising the uniqueness and innovation of this tool. As a result, we do not separate acute and primary care services from mental health, substance use disorder, and social services and supports.

For the last 14 years, we have coordinated the delivery of fully integrated physical and behavioral (mental health and substance use disorders) across all areas of our health plan, including case management, utilization management, information systems/health information technology, claims/encounter data, predictive modeling, and quality management functions. In addition, we use evidence-based practices from nationally-recognized organizations, such as the American Society of Addiction Medicine (ASAM) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Through our current contracts, including SMMC, FHK, and Medicare Advantage, we coordinate integrated physical and behavioral health care to more than 630,000 TANF, ABD, LTC, dual eligible, and Medicare members across 10 Florida regions, including more than 9,300 members in our HIV/AIDS specialty plan. Our model accounts for the differing needs of individuals based on risk: Low to Moderate, High Risk, and Highest Risk. Since 2010, Beacon Health Options has served as our behavioral health managed care subcontractor, supporting our care management process to offer seamless, holistic, and integrated care to our members.

We recognize that the care and treatment of individuals with HIV/AIDS is multi-dimensional and to be successful it is critical to partner inside and outside the health care community. We foster affiliations with community-based organizations with aligned goals for education, improved access to care and health outcomes, and reduction of HIV transmission, and we are committed to removing barriers to service. For example, we recently partnered with county health departments to improve adherence to preventive dental care among members less than 21 years of age. A mobile dental clinic will be used to improve access to these dental services.

As the needs of our members evolved, we adjusted our HIV/AIDS specialty care. For instance, we increased our nursing capacity as we continue to serve more and more members who are frail and aging, as well as individuals with associated co-morbidities and complex polypharmacy needs. Today, more than half of the current staff is comprised of nurses.

Further, our provider engagement model facilitates the delivery of high quality integrated care by delivering provider data solutions and performance reporting, high-touch face-to-face provider education and outreach. Our entire organization is involved with the providers on a daily basis to ensure their success and the best care for our members. This includes Clinical, Quality, Pharmacy, Customer Service, and our Management team. This type of comprehensive and integrated support helps providers to meet and exceed quality and performance targets, measure performance, and implement targeted interventions. We use a suite of data- and information-sharing tools to help providers understand and improve their performance. These tools include profile reports, which compare a provider's performance to peers and/or established benchmarks, as well as integrated data solutions, member dashboards, and provider scorecards that support our value-based purchasing (VBP) models and help providers improve performance and manage care more effectively.

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Lastly, we benefit from our working relationship with our affiliates through our ultimate parent company, Anthem, Inc. Together with these affiliates, we coordinate the delivery of integrated physical and behavioral health care to more than 5.6 million members in 19 markets. This care includes mental health, physical, pharmacy, and social services for more than 302,000 members with SMI conditions in 13 states, and substance use disorder services for more than 492,000 members in 19 states. Anthem is an industry leader supporting fully integrated physical and behavioral health care, and we continuously share best practices and lessons learned with Anthem and our affiliates to optimize our integrated care delivery model and services.

Notable accomplishments:

Our Clear Health member health outcomes demonstrate our effectiveness in building a care model that is reflective of our commitment to developing comprehensive, specialized care for individuals with HIV/AIDS:

- In 2014, we initiated an innovative CD4 program focused on improving medication regimen compliance for members with low CD4 counts. Of the 716 members tracked since program inception, 250 are actively in monitoring and intervention, and 178 have stabilized or improved.
- HEDIS measures continue to improve for our members. For the Comprehensive Diabetes Care (CDC) measure, we observed a 12.7% increase in HbA1c testing from 2016 to 2017, a 9% increase in diabetes retinal eye exams, and a 9.5% increase in medical attention for neuropathy. For the same time period, Clear Health fostered a 10.7% improvement in the Controlling Blood Pressure (CBP) measure, a 5.3% increase in Cervical Cancer Screening (CCS), and a 13.5% increase in Annual Dental Visits (ADV).
- Through an outreach partnership with Beacon Health Options, our behavioral health subcontractor, we increased behavioral health utilization among members. This resulted in reduced substance use disorder-related hospital admissions from approximately 14.0 admits per 1,000 members in January 2015 to less than 5.0 admits per 1,000 members in December 2016. We have also improved in the HEDIS measures related to follow-up visits 7 and 30 days after mental illness hospitalizations.

Similarly, we have achieved successful outcomes for members enrolled in our other programs:

- In HEDIS® 2017, Simply achieved 92.7 percent on the measure of Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia – exceeding the prior year's 90th percentile benchmark. Simply also surpassed the 90th percentile for Diabetes Monitoring for People with Diabetes and Schizophrenia. These measures demonstrate the extent to which people with behavioral health needs are being effectively managed for other chronic health conditions we know to be especially damaging in the population.
- Our Rising Star program focuses on continuity of care for members with serious physical and/or mental illness conditions through consistent collaboration and communication with providers who are already engaged with them. Through this provider, member, and payer collaboration, each member is assigned to a home hospital, home psychiatrist, and Case Manager to assure continuity of care. Program results demonstrate that caring for members at the same facility with the same providers promotes improved health, recovery, and more appropriate use of evidence-based practices and social supports. In the short amount of time this program has been in

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existence, we have already observed significant impact and expect continued results. For instance, in the first six months of the program, there has been a decrease of 24.5 percent of inpatient hospital spend.

- Our Internal Behavioral Health field-based Case Managers (CARES team) reside in the communities they serve, facilitating in-person interactions with members and neighborhood referrals to community-based services. Our primary focus is to engage all members in regular treatment as soon as possible with their PCP, as well as a primary behavioral health provider. This may include accompanying the member to the PCP visit. The CARES team often focuses on communication and coordination between providers to assure high quality integrated care for the member.

- Utilization Management and Case Management staff are trained to identify and refer members with co-occurring disorders to the appropriate treatment providers in the community including residential and detox services for pregnant women and outpatient substance use disorder and mental health services for all members. In addition, Case Management staff are required to complete a nine-module online training entitled, "Co-Occurring Disorders: A Training Series" developed by the University of South Florida and the Florida Department of Children and Families.

2. SUBCONTRACTORS' EXPERIENCE IN COORDINATING OR PROVIDING SERVICES TO MEDICAID RECIPIENTS

Clear Health views subcontractors as valued partners in delivering the highest quality services to enrollees (members), providers, and the Agency. Through a comprehensive vetting process, we select top-level qualified subcontractors who can best serve our members. Our subcontractors represent an extension of our plan. We build trusted, collaborative, accountable, and long-standing relationships with our subcontractors to coordinate the seamless delivery of services to our Florida members that meet or exceed AHCA requirements.

We monitor subcontractors to assure they meet or exceed Contract requirements as if we were performing the function ourselves. Our Subcontractor Oversight Program leverages a dedicated local health plan team supported by national subcontractor management resources. We will continue to maintain full responsibility for the services subcontractors deliver to our members. Our dedicated Florida-based Vendor Delegation Oversight Group (VDOG) oversees and monitors subcontractor performance. Led by Judi Peterson, our Staff Vice President of Operations and System Solutions, VDOG includes four full-time dedicated staff.

The VDOG team makes sure that all subcontractor agreements include detailed requirements and service level agreements (SLAs), set clear expectations of how we measure performance and the boundaries of what is acceptable, and specify the consequences for non-compliance. Our program enables us to continuously oversee and monitor subcontractor performance through daily collaboration, regular monitoring, and formalized auditing processes. The VDOG team has support from executive leadership and departments across our organization, including Provider Relations, Member Services, Compliance, Regulatory, Operations, Utilization Management, and Medical Management.

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Throughout the life of our Contract, Clear Health will retain sole responsibility for fulfilling SMMC Contract requirements and remain fully accountable for our subcontractors' performance. We will continue to oversee, monitor, supervise, and enforce Contract compliance, as well as promote frequent, open, and effective communication that emphasizes delivery of quality services to members.

Provided below is information about our current subcontractors, each of whom we vetted, have successfully partnered with for multiple years, and we intend to subcontract in the new Florida SMMC ITN.

Provision of Covered Services

Subcontractor: Audiology Distribution, LLC, D/B/A HearUSA, Inc. (HearUSA)

Service type: Audiology and hearing services

Experience serving Medicaid recipients: HearUSA has been administering Medicaid benefits for over 25 years. Today, it manages over 100 Medicaid plans in 11 states, covering in excess of 5 million lives. The company has significant experience and over two decades of institutional knowledge that it uses for benefit management, utilization, reporting, compliance, credentialing, and network development. HearUSA complies with state-specific Medicaid regulations and customizes benefit and implementation to meet the plan requirements. HearUSA is URAC accredited and HITRUST certified. HearUSA has experience with various types of Medicaid lines of business, including TANF, SSI and dual eligible populations.

Subcontractor: Beacon Health Options (Beacon) (previously known as PsychCare)

Service type: Behavioral health services

Experience serving Medicaid recipients: Beacon has been providing behavioral health managed care services for over 20 years. Simply has collaborated with Beacon since 2010, serving the complex behavioral health care needs of Florida Medicaid members, including TANF, ABD, IDD, seriously and persistently mentally ill (SPMI); children with severe emotional disturbance (SED), children in foster care, those struggling with substance use disorders; the chronically homeless; HIV/AIDS Special Needs Plans (SNPs); Programs for All Inclusive Care for the Elderly (PACE), and dual eligibles. Beacon manages behavioral health services as a subcontractor to 15 health plans, including Medicare, Medicaid, and CHIP programs in Florida. Currently, Beacon serves more than 14 million Medicaid managed care lives, including more than 900,000 ABD and SSI members nationwide.

Subcontractor: Chiro Alliance Corporation (CAC)

Service type: Chiropractic services

Experience serving Medicaid recipients: CAC has 7 years' experience serving Medicaid members and currently subcontracts across all of our Medicaid contracts. CAC contracts with 4 other MMA plans in Florida and provides chiropractic services to approximately 295,000 Medicare members in Florida and 583,000 Medicaid members nationwide.

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Subcontractor: DentaQuest of Florida, Inc. (DentaQuest)

Service type: Dental services

Experience serving Medicaid recipients: DentaQuest has been a mainstay in Florida's Medicaid system for the past 20 years. DentaQuest administers dental benefits on behalf of 2.1 million Floridians, including 1.3 million Medicaid recipients. Nationally, DentaQuest is the largest and most experienced Medicaid and CHIP dental benefits administrator, serving 20 million members across 30 states on behalf of nine state agencies and more than 100 health plans. We currently contracts with DentaQuest for our MMA and LTC services. DentaQuest's operational platform is designed to serve both Medicare and Medicaid populations, including TANF, CHIP, ABD, foster care, ACA, and LTC.

Subcontractor: Express Scripts, Inc. (ESI)

Service type: Pharmacy services

Experience serving Medicaid recipients: ESI has administered managed Medicaid and income-based health programs since 1995, serving various populations including but not limited to CHIP, TANF, ABD, SNP, IDD, foster care, and dual eligibles. As of September 2017, ESI manages over 7.5 million Medicaid enrollees across 24 states through 36 health plans including those eligible for TANF, SSI or who are dually eligible for Medicaid and Medicare. ESI currently contracts across all of our Medicaid plans.

Subcontractor: DentaQuest of Florida, Inc. D/B/A EyeQuest (EyeQuest)

Service type: Vision services

Experience serving Medicaid recipients: EyeQuest's operational platform is designed to serve the Medicaid populations, including TANF, CHIP, ABD, foster care, ACA, and LTC. EyeQuest currently serves 22 million Medicaid recipients, including 1.6 million in Medicaid vision. We currently contract with EyeQuest for MMA and LTC services in multiple regions for a population of approximately 345,000 members.

Subcontractor: Health Network One, Inc. (HN1)

Service type: Therapy services (dermatology, occupational, physical, and speech)

Experience serving Medicaid recipients: Since 2006, HN1 has provided services to Medicaid enrollees through various contracts with its health plan clients. Under these health plan contracts, HN1 has been delegating Claims, Utilization Management, Provider Contracting, and Provider Relations and Credentialing. Its Utilization Management and Credentialing services are NCQA certified. HN1 has 11 years of experience working with Medicaid plans servicing TANF, SSI and Dual populations. As of July 2017, HN1 and its affiliated companies are servicing 1.9 million Medicaid lives throughout Florida, Georgia, and New Jersey. HN1 currently contracts with five MMA plans in Florida, including ours.

Subcontractor: LogistiCare Solutions, LLC (LogistiCare)

Service type: Non-emergency transportation (NET) services

Experience serving Medicaid recipients: LogistiCare has more than 21 years of experience providing NET services for Medicaid and Medicare programs for managed care organizations and state governments. LogistiCare provides Medicaid services in 39 states and the District of Columbia and offers services to TANF, SSI, LTC, and Dual Eligible populations. Currently, Logisticare serves more than 250 customized NET programs and manages more than 69 million trips each year for 27 million members. In Florida, LogistiCare contracts with five MMA and four LTC plans, including ours.

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Subcontractor: MCT Express, Inc. (MCT Express)

Service type: NET services

Experience serving Medicaid recipients: MCT Express is a locally-owned transportation management company in Miami-Dade County which has been providing high quality NET services since 1995. They have extensive experience in providing transportation services to the medically fragile, disabled and elderly populations enrolled in Medicaid and Medicare Advantage organizations and healthcare facilities. MCT Express currently contracts with us for our MMA and Medicare Advantage plans, serving a membership of more than 160,000 in Regions 10 and 11.

Subcontractor: Ride2MD, Inc. (Ride2MD)

Service type: NET services

Experience serving Medicaid recipients: Ride2MD has been providing innovative Uber-like NET services to Florida Medicaid members since early 2016, which includes TANF, SSI, LTC, and Dual Eligible populations. The company is contracted with multiple MMA plans to provide ambulatory, wheelchair and stretcher services through a contracted, statewide network of transport companies. The management team of Ride2MD has combined over 30 years of Florida Medicaid experience. The founder of Ride2MD has significant experience on the payer side of Medicaid and managed NET brokers and transport providers across the state for over 200,000 Florida MMA and Specialty plan members. The compliance, network contracting, and credentialing team leadership has worked in Medicaid transportation for at least 15 years.

Administrative and/or Support Models

Subcontractor: AIM Specialty Health (AIM)

Service type: Utilization management, including radiology

Experience: AIM Specialty Health is a specialty benefits management company, focusing on tests and treatments in radiology, cardiology, medical and radiation oncology, specialty drugs, sleep medicine, musculoskeletal and pain management, and genetic testing. Founded in 1989, AIM works with 50 health plans supporting their diverse membership of more than 45 million lives, including 4.4 million Medicaid members. In Florida, AIM has 3 years of experience in providing radiology utilization management to our organization.

Subcontractor: Anthem, Inc. (Anthem)

Service type: Administrative/support services (for example, utilization management)

Experience serving Medicaid recipients: Anthem is a leading health benefits company in the United States. Through a broad portfolio of integrated healthcare plans and related services, Anthem delivers leading health benefit solutions to approximately 40 million medical members, including more than 6.5 million members in publicly-funded programs in 19 states and the District of Columbia. Anthem offers administrative and technical assistance to its affiliates, including assistance with claims processing, reporting, prevention of fraud, waste, and abuse, quality management, and utilization management.

3. BARRIERS TO IMPLEMENTATION AND CLEAR RESOLUTIONS

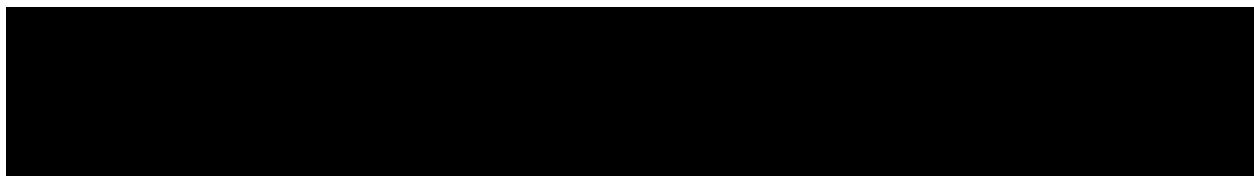


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[REDACTED]

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[REDACTED]

Evaluation Criteria:

1. The extent of the respondent's experience with providing integrated medical and behavioral health services.
2. The extent of the respondent's subcontractors' experience in coordinating or providing services to Medicaid recipients.
3. The extent to which the barriers to implementation experienced by the respondent have clear resolutions outlined.
4. The extent to which the respondent has listed accomplishments and achievements that are relevant to this solicitation.
5. The extent to which the respondent's Medicaid populations served are similar to the populations served by the SMMC program.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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SRC# 2 – Florida Experience (Regional):

The respondent shall provide documentation of the extent to which it has experience operating as a Florida Medicaid health plan in the region in which it plans to provide services or in any other region in the State of Florida. If applicable, the respondent shall provide the Agency Contract number and the regions of operation to show it has experience providing managed care services and/or LTC services in Florida. The respondent shall provide documentation of any Medicare Advantage Plan contracts for counties in the State of Florida.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Simply Healthcare Plans, Inc. (Simply) currently serves more than 630,000 members across the state in Medicaid, Florida Healthy Kids, and Medicare Advantage programs, with a local, high-touch, person-centered model including more than 9,300 Clear Health members. Eligible populations include ABD, TANF, Medikids, and Long-Term Care members. In addition, we serve foster children, medically complex children in the community and residing in nursing facilities, and statewide inpatient psychiatric program members. Services include integrated physical and behavioral health, dental, vision, long-term care, pharmacy, and non-emergency transportation.

For the SMMC ITN, Simply is proposing to establish a Comprehensive Plan (MMA and LTC) and Specialty Plan (HIV/AIDS) in all 11 Florida regions. Simply currently has a presence in every region except Region 4, which demonstrates our experience serving densely-populated urban areas and lesser-populated rural areas in the state. In all regions we serve, we coordinate the delivery of high-quality, integrated, person-centered, and culturally competent health care, with a focus on producing the Institute for Healthcare Improvement's Triple Aim of better health outcomes and improved member satisfaction at reduced per capita cost.

Provided below is information regarding our existing SMMC and Medicare Advantage contracts.

1. EXISTING SMMC CONTRACT(S) IN REGION 1

Simply, D/B/A Clear Health Alliance (Clear Health) has an SMMC Specialty contract (FP030) in Region 1 to provide managed medical assistance to individuals living with HIV/AIDS. The current contract term is February 8, 2014 through December 31, 2018. Within this contract, we coordinate member access to physical health, behavioral health, dental, vision, pharmacy, and transportation services.

We do not currently have an MMA or LTC contract in this region, but plan to offer MMA and LTC services as part of a Comprehensive Plan in all Florida regions, including Region 1, through this ITN.

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2. EXISTING SMMC CONTRACT(S) IN OTHER FLORIDA REGIONS

Simply coordinates care for Floridians through its MMA, LTC, Florida Healthy Kids, and HIV/AIDS Specialty plan (Clear Health) contracts in multiple regions throughout Florida. Outside Region 1, we have the following SMMC contracts:

Region 2: Specialty HIV/AIDS (FP030)
Region 3: Specialty HIV/AIDS (FP030)
Region 5: MMA (FP021), Specialty HIV/AIDS (FP030)
Region 6: MMA (FP013 and FP021), Specialty HIV/AIDS (FP030)
Region 7: MMA (FP021), Specialty HIV/AIDS (FP030)
Region 8: Specialty HIV/AIDS (FP030)
Region 9: Specialty HIV/AIDS (FP030)
Region 10: MMA (FP013), LTC (FP021), Specialty HIV/AIDS (FP030)
Region 11: MMA (FP018), MMA/LTC (FP021), Specialty HIV/AIDS (FP030)

3. EXISTING MEDICARE ADVANTAGE PLAN CONTRACT IN REGION 1

Simply does not currently operate a Medicare Advantage Plan in Region 1. However, we do operate Medicare Advantage Plans (Contract H5471) in Regions 5, 6, 7, 10, and 11, serving more than 40,000 members. Additionally, Simply has been approved by CMS to expand to Region 3 and Region 9 effective January 2018.

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Evaluation Criteria:

For the Managed Care Plan that is proposing to provide services under this solicitation, whether the respondent has:

- An existing SMMC Contract in that region;
- An existing SMMC Contract in another region in the State of Florida; or
- A Medicare Advantage Plan contract in that region.

Score: This section is worth a maximum of 30 raw points as outlined below.

1. 20 points if the respondent already has an SMMC Contract in the region that it plans to provide services (MMA, LTC and/or Specialty).
2. 10 points if the respondent has an SMMC Contract in other regions in the State.
3. 5 additional points will be awarded if the respondent has a comprehensive (MMA & LTC) SMMC Contract in the region that it plans to provide Medicaid services.
4. 5 additional points will be awarded if the plan has a Medicare Advantage Plan in the region that it plans to provide services.
5. 0 points will be awarded if the plan does not have an SMMC Contract in Florida or a Medicare Advantage Plan contract in the region.

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SRC# 3 – Statutorily Required Florida Presence (Statewide):

The respondent shall provide information regarding whether each operational function, as defined in Section 409.966(3)(c)3, Florida Statutes, will be based in the State of Florida, and the extent to which operational functions will be conducted by staff in-house or through contracted arrangements, located in the State of Florida. This includes:

- a. Specifying the location of where the respondent's corporate headquarters will be located (as defined by Section 409.966(3)(c)3, Florida Statutes);
- b. Indicating whether the respondent is a subsidiary of, or a joint venture with, any other entity whose principal office will not be located in the State of Florida; and
- c. Identifying the number of full-time staff, by operational function (as defined in Section 409.966(3)(c)3, Florida Statutes), that will be located in the State of Florida and out of state.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

Response:

As a local, community-based health plan, we proudly remain fully and solely responsible for meeting our obligation to fulfill Contract requirements. All members of Clear Health's leadership team are located in Florida, fully own the program, and make sure decisions regarding service delivery and administration are made locally – and are consistent with State goals. Additionally, responsibility for all performance and administrative functions ultimately resides with our local health plan.

1. LOCATION OF RESPONDENT'S CORPORATE HEADQUARTERS

Clear Health has always been located in Florida and is fully dedicated to serving Floridians. Our corporate headquarters is located at:

9250 West Flagler Street, Suite 600
Miami, FL 33174

To best serve members in our service locations throughout Florida, we also have offices in the following locations:

4200 West Cypress Street, Suite 900
Tampa, FL 33607

Royal Palm 1
1000 South Pine Island Road, Suite 900
Plantation, FL 33324

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200 West College Avenue
Tallahassee, FL 32301

2290 Lucien Way, Suite 210
Maitland, FL 32751

Simply D/B/A Clear Health is a subsidiary of our ultimate parent company, Anthem, Inc., whose corporate office is located at 120 Monument Circle, Indianapolis, IN 46204.

2. OPERATIONS FUNCTIONS TO BE PERFORMED IN FLORIDA

Clear Health attests that all the major specialty health plan operation functions listed in the ITN will be performed by Clear Health employees based in Florida. These functions are listed below and include full-time employee (FTE) counts for each function.

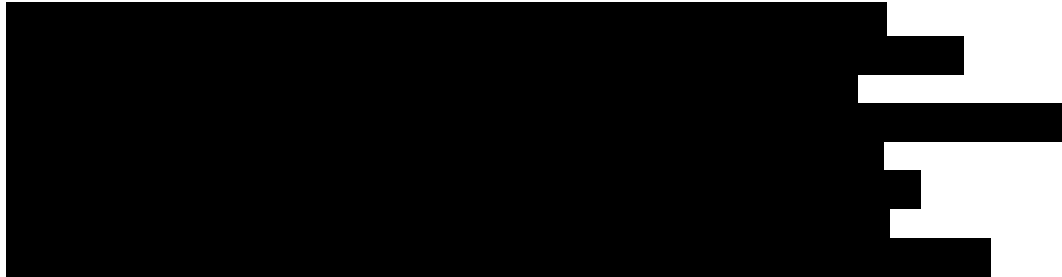
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Evaluation Criteria:

1. Whether the respondent's corporate headquarters will be located in Florida (it is not a subsidiary of or a joint venture with any other entity whose principal office will be located outside of Florida).
2. The extent to which operational functions (claims processing, enrollee/member services, provider relations, utilization and prior authorization, case management, disease management and quality functions, and finance and administration) will be performed in the State of Florida.

Score: This section is worth a maximum of 15 raw points. Each of the above components is worth a maximum of 5 points each as described below. 5 additional points will be awarded if respondent meets Items 1(a) and 2(a) below.

For Item 1:

- (a) 5 points for corporate headquarters in Florida and no parent or joint venture organization outside Florida;
- (b) 0 points if no relevant corporate headquarters in Florida.

For Item 2:

- (a) 5 points if all functions will be performed in Florida;
- (b) 4 points for 6-7 functions to be performed in Florida;
- (c) 3 points for 4-5 functions to be performed in Florida;
- (d) 2 points for 2-3 functions to be performed in Florida;
- (e) 1 point for 1 function to be performed in Florida;
- (f) 0 points for no functions to be performed in Florida;
- (g) 0 points if only community outreach, medical director and State administrative functions will be performed in Florida.

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SRC# 4 – Contract Performance (Statewide):

The respondent shall state whether, in the past five (5) years (since July 14, 2012), it has voluntarily terminated all or part of a managed care contract under which it provided health care services as the insurer; has had such a contract partially or fully terminated before the contract end date (with or without cause); has withdrawn from a contracted service area; or has requested a reduction of enrollment levels. If so, describe the contract; the month and year of the contract action; the reason(s) for the termination, withdrawal, or enrollment level reduction; the parties involved; and provide the name, address and telephone number of the client/other party. If the Contract was terminated based on the respondent's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination. Include information for the respondent as well as the respondent's affiliates and subsidiaries and its parent organization and that organizations' affiliates and subsidiaries.

Response:

For more than 14 years, Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health) has been one of the most successful local health plans in Florida and has continually adapted, tailoring solutions to assist the Florida Agency for Health Care Administration (AHCA) to meet its goals of improving the lives of Floridians by providing quality, cost-effective, and accessible health care solutions and programs. Our service to AHCA and to Florida communities precedes Medicaid reform in Florida, and we are thriving in the post-Medicaid reform era, now serving more than 630,000 members. In addition, Simply's ultimate parent organization, Anthem, Inc., is one of the nation's leading health benefits companies and has coordinated Medicaid and state-sponsored plan benefits for low-income populations for more than 26 years.

Together with Simply, our affiliate health plans, currently serve more than 6.5 million individuals across 19 states and the District of Columbia. Within each of these contracts, Simply and our affiliate health plans have been highly reliable and accountable sources of managed health care for a variety of populations. We have never had all or part of a managed care contract partially or fully terminated, as attested to below. We remain committed to a partnership with AHCA in serving Medicaid members throughout the state of Florida.

1. ENROLLMENT LEVEL REDUCTIONS OR VOLUNTARILY TERMINATION OF ALL OR PART OF A CONTRACT

Clear Health has not requested enrollment level reductions or voluntarily terminated all or part of a contract in the last five years. Additionally, neither our ultimate parent company, Anthem, Inc., nor our affiliate health plans administering Medicaid and other state-sponsored contracts, have requested enrollment level reductions or voluntarily terminated all or part of a contract in the last five years.

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2. TERMINATIONS DUE TO PERFORMANCE

Clear Health has not had a managed care contract terminated or not renewed by a state client for any reason, including performance, within the past five years. Additionally, within the past five years, none of the other managed care subsidiaries of our ultimate parent company, Anthem, Inc., nor our affiliated health plans administering Medicaid and other state-sponsored contracts, have had a state-sponsored health program contract terminated or not renewed for non-performance or poor performance.

3. TERMINATIONS FOR PERFORMANCE ISSUES RELATED TO PATIENT CARE

Clear Health has not had a managed care contract terminated or not renewed by a state client within the past five years for any reason, including the provision of patient care. Additionally, within the past five years, none of the other managed care subsidiaries of our ultimate parent, Anthem, Inc., nor our affiliate health plans administering Medicaid and other state-sponsored contracts, has had a state-sponsored health program contract terminated or not renewed for non-performance or poor performance for any reason, including the provision of patient care.

4. TERMINATIONS FOR PERFORMANCE ISSUES RELATED TO PROVIDER NETWORK MANAGEMENT, CLAIMS PROCESSING OR SOLVENCY CONCERNS.

Clear Health has not had a managed care contract terminated or not renewed by a state client within the past five years related to provider network management, claims processing, or solvency concerns. Additionally, none of the other managed care subsidiaries of our ultimate parent, Anthem, Inc., nor our affiliate health plans administering Medicaid and other state-sponsored contracts, has had a state-sponsored health program contract terminated or not renewed for non-performance or poor performance for any reason, including those related to provider network management, claims processing, or solvency concerns, within the past five years.

As requested by the Agency in its response to Vendors' questions – Question No. 431 - we provide additional information Anthem, Inc.'s commercial contracts:

Anthem, Inc.'s subsidiaries have more than 31 million medical members representing a 28 percent market share of the commercially insured population. Unlike contracts for state-sponsored business, commercial contracts typically have a one- or two-year contract term, and as is typical in the commercial market, these do not generally "terminate" outside of the normal course of such contract term. Rather, contracts generally continue through the defined end dates, and certain purchasers simply choose not to renew for subsequent terms, or enter into new contracts. As noted in our response, neither Simply nor any of our affiliates have had a state-sponsored contract terminated.

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Evaluation Criteria:

1. The extent to which the respondent or parent or subsidiary or affiliates have requested enrollment level reductions or voluntarily terminated all or part of a contract.
2. The extent to which the respondent or parent or subsidiary or affiliates has had contract(s) terminated due to performance.
3. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to patient care rather than administrative concerns (e.g., reporting timeliness).
4. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to provider network management, claims processing or solvency concerns.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each as described below.

For Item 1:

- (a) 5 points for no voluntary termination of all or part of a contract, no requests for enrollment level reduction and no service area withdrawals;
- (b) 0 points for any voluntary terminations, requests for enrollment level reductions, or service area withdrawals.

For Item 2:

- (a) 5 points for no involuntary terminations;
- (b) 0 points for any involuntary termination based on performance.

For Item 3:

- (a) 5 points for no contract terminations related to patient care;
- (b) 0 points if termination related to patient care.

For Item 4:

- (a) 5 points for no contract terminations related to provider network management, claims processing or solvency concerns;
- (b) 0 points if termination related to performance issues related to provider network management, claims processing or solvency concerns.

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B. Agency Goals

SRC# 5 – Disease Management (DM) Program (Statewide):

The respondent shall describe its proposed approach to implementation of specific disease management programs and how they will be used to advance the Agency's goals as stated in **Attachment A**, Instructions and Special Conditions, **Section A.**, Overview, **Sub-Section 15.**, Program Objectives and Goals, of this solicitation. The respondent's description shall include:

- a. A description of each proposed disease management program;
- b. A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level;
- c. A description of the evidence-based guidelines utilized in the approach;
- d. A description of how disease management programs are integrated with case management/care coordination programs; and
- e. A description of performance metrics used to evaluate the efficacy of the disease management program, including cost-savings, increase in treatment adherence, and measurement of the impact on potentially preventable events, including relevant experience to provide support for the use of the specific performance metrics.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Clear Health has been providing comprehensive disease management (DM) and case management services to Florida Medicaid managed care enrollees (members) living with HIV/AIDS and other co-morbidities since February 2012. Our comprehensive, evidence-based approach has been built based upon the Ryan White program and Medicare Special Needs Plan (SNP) model of care. It reduces acute episodes that may result in potentially preventable admissions, readmissions, and emergency department (ED) visits and improves quality of life for our members.

Clear Health was the first Managed Care Plan in Florida to exclusively serve the HIV/AIDS population, and we are the largest HIV/AIDS specialty plan in the state and in the nation. Our HIV/AIDS DM and Case Management program is very different than more traditional DM approaches. It is shaped by our extensive experience and expertise serving members with HIV/AIDS, and is delivered with heart by our dedicated team who knows the disease both professionally and personally. Our program aims to touch every member and is the foundation of our model of care. It:

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- Offers integrated case management and DM services to all our members to address the unique care coordination, access, and other challenges faced by persons living with HIV/AIDS
- Provides early identification, assessment, care planning, and education based on assessment of the member's health risks and other chronic conditions, review of progress towards goals, and outcome reviews
- Uses clinicians, with support of social workers as needed, to deliver HIV disease education, provide treatment adherence support, coordinate services and transportation, collaborate with local HIV/AIDS resources and community-based organizations, and monitor the member's condition according to evidence-based guidelines in partnership with the member's PCP (typically an infectious disease specialist) and HIV/AIDS specialists
- Has a dedicated Medical Director who has specific expertise treating our specialty population
- Collaboratively engages with Medical Directors in specialties such as behavioral health (BH), oncology, endocrinology and geriatrics through our parent company, Anthem
- Seamlessly integrates HIV/AIDS DM and case management with DM for other co-morbidities using our seven NCQA accredited DM programs and five additional DM programs designed to address common conditions in our membership

Due to our unique model and status as a HIV/AIDS specialty plan, this narrative outlines our overall HIV/AIDS DM and case management approach first. A description of our other DM programs, including the programs referenced in the ITN (cancer (oncology), diabetes, asthma, hypertension, BH, and substance abuse (substance use)), follows our HIV/AIDS DM and Case Management program description. Except for pregnancy and active cancer treatment, HIV/AIDS is the highest priority condition on our disease hierarchy, but we also holistically address other co-morbidities through a combination of NCQA-accredited and "home grown" DM programs tailored to the special needs of our membership.

1. INNOVATIVE AND EVIDENCE-BASED APPROACH FOR HIV/AIDS

Clear Health offers HIV/AIDS DM and case management services to all our members resulting in a higher rate of participation. Our comprehensive approach focuses on the whole health of the member and addresses common co-morbidities such as hypertension, substance use and mental health conditions. We assign every member participating in our HIV/AIDS DM and Case Management program a Case Manager (Managed Care Coordinator) knowledgeable in medical, BH, and social support service needs of persons living with HIV/AIDS. Many of our Managed Care Coordinators have dedicated their careers to improving the health of people living with HIV/AIDS, and all are very familiar with available local resources and the specialty providers who most frequently serve our members. In assigning members to a Managed Care Coordinator, we consider many factors including member preference as it relates to language (for example, English, Spanish, Creole), gender preference, age, cultural factors, and sexual orientation.

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**** RESULTS & SUCCESSES:** Our Managed Care Coordinators Receive High Marks from Members

In 2016, 93.83 percent of members reported they are always treated with respect and 97.52 percent of members reported they “agree” or “somewhat” agree that we answer all their questions.

We make monthly HIV/AIDS focused trainings, including those through the AIDS Education and Training Centers (AETC) available to our Managed Care Coordinators so they can network with available community resources and maintain up-to-date knowledge of the disease and best practices to treat the disease and support our members.

The program provides each member that consents to participate or opts-in with integrated DM and case management services, HIV disease education, treatment adherence support, coordination of transportation, and coordination of services for primary and specialty care. We assign members to HIV-experienced PCPs and refer them to HIV/AIDS trained and experienced specialists in our accessible network. Children and adolescents with HIV/AIDS are similarly assigned and referred to the appropriate qualified providers for care and treatment.

Our Managed Care Coordinators work with local HIV/AIDS service organizations such as Ryan White agencies and similar agencies or other community-based organizations that can assist members with non-Medicaid covered services such as food banks, legal or housing assistance, support groups/psychosocial counseling, clinical trials, and substance abuse-related programs designed to address the issues and concerns of persons living with HIV disease.

Management of our members’ comorbid conditions has become an increasingly important part of our HIV/AIDS DM and Case Management program. Our membership is aging as treatments have improved and more members are living longer with chronic conditions like hypertension. To better serve this evolving membership, we continue to expand our clinical team to fully address our members’ complex medical needs, BH conditions, and polypharmacy issues.

Managed Care Coordinators monitor our members’ conditions in close partnership with our providers. They monitor laboratory tests and results, utilization of services (for example, urgent care, ED, and hospital admissions and readmissions), and appropriate use of medication. They review pharmacy reports to monitor patient use of antiretroviral/antibiotic/antifungal drugs and other agents. Managed Care Coordinators communicate with members, their providers, and HIV/AIDS community agency case managers (if applicable) by phone, mail, and in-person. Members also have access to a 24-hour Nurse help line to consult with a clinician on potential non-emergency needs at any time.



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We measure the effectiveness of our HIV/AIDS DM and Case Management program using the following measures:

- Members identified with low CD4 count (< 200) that increase their CD4 count to > 200 within 12 months
- Members adhering to Highly Active Antiretroviral Therapy (HAART)
- Members who successfully meet their goals
- High member satisfaction with DM
- Members who accept referral for BH assessment and treatment who are identified for potential depression or other BH needs, but are not currently receiving treatment
- Members who are identified as smokers and would like assistance in quitting who accept referral to a Smoking Cessation program

As previously stated, our HIV/AIDS DM and Case Management program addresses co-morbidities that are secondary but integral to the successful management of HIV, including but not limited to diabetes, cardiovascular disease, and hypertension. Plans of care address co-morbidities according to member goals and objectives as needed. We follow standard clinical guidelines for each disease process, and special considerations for people diagnosed with HIV/AIDS, as appropriate. These programs are described in further detail below.

1.1. Innovative and Evidence-Based Approach for Managing Comorbid Conditions

Clear Health manages our members comorbid conditions by addressing gaps in care and coordination of service needs, improving member understanding of the disease process, and promoting self-management and member engagement. In addition to HIV/AIDS DM and case management, we offer 12 DM programs to address medical comorbid and behavioral health conditions. Seven of these programs are accredited by the NCQA, and all of the programs are seamlessly integrated in our HIV/AIDS DM approach. They are proactive and member-centered, and notable because of their persistent focus on closing gaps in care.

We realize our members must make significant changes to their lifestyles and daily living behaviors to successfully manage their comorbid chronic conditions. We drive positive outcomes by encouraging member education and self-care through motivational interviewing and as part of a holistic model that supports all of a member's behavioral, social, and physical health care needs. We engage the member, family, caregivers, providers, and others involved in the member's care

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to provide individualized services and interventions tailored to the member. We also leverage the analytic capabilities of our Case Management System to identify gaps in care and use this information to contact members and providers to encourage receipt of needed services.

Our DM programs address the comorbid conditions listed below. Conditions identified with an asterisk (*) represent our DM programs that are accredited by the NCQA.

- Alzheimer's/dementia
- Asthma*
- Bipolar Disorder (BH)
- Cancer (Active and Post-active Oncology and End of Life)
- Chronic obstructive pulmonary disease (COPD)*
- Congestive heart failure*
- Coronary artery disease*
- Diabetes*
- Hypertension
- Major depressive disorder* (BH)
- Schizophrenia* (BH)
- Substance use

All our DM programs, including HIV/AIDS DM and case management, support member behavioral, social, and physical healthcare needs by providing individualized services for members. This is accomplished through the use of comprehensive health assessments, disease stratification, and the development of tailored member interventions while working collaboratively with the member and provider. Our member-centric approach focuses on providing the tools and educational support necessary for members to effectively manage their health care needs.

All our DM programs, including HIV/AIDS DM and case management, include the following components:

- Well-defined disease algorithm
- Comprehensive population identification processes, supported by our proprietary risk stratification model
- Identification of gaps in care and outreach to address missed care opportunities in a timely fashion
- Evidence-based practice guidelines that are continuously reviewed and updated
- Collaborative practice models to include both the member's PCP and other providers
- Member self-management education, including prevention, behavior modification, and compliance
- Process and outcomes measurement, evaluation, and management

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Our DM programs, including HIV/AIDS DM and case management, are designed to:

- Identify members meeting the enrollment criteria for specific DM programs with stratification by severity and risk level
- Enhance engagement in DM programs
- Educate members about our DM programs
- Address comorbid conditions and consider the whole health of the member
- Improve the understanding of disease processes, including education based on member assessment of health risks and chronic conditions
- Address symptom management
- Address emotional issues of the caregiver as applicable
- Address behavioral management issues
- Medication Management and review to prevent adverse effect or interactions from contraindicated medications
- Reinforce evidence-based practice guidelines to promote members' informed decision-making
- Promote self-management through personalized member intervention
- Identification of, and linkage to, available community support services
- Improve member quality of life
- Address gaps in care and interface with member's PCP/specialist for care plan feedback and as needed for coordination of care
- Collaborate to develop member-centered goals and interventions so each member receives an individualized plan of care updated at least annually or sooner based on changes in member condition(s) or needs
- Support relationships between members and their providers and effective communication with providers
- Increase provider awareness of DM programs
- Reduce acute episodes requiring hospital admission, readmission, or ED visits
- Continuously assess the program with analysis for process improvement and member satisfaction

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According to the U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, health literacy is a critical component to effectively managing chronic conditions. “Choosing a healthy lifestyle, knowing how to seek medical care, and taking advantage of preventive measures require that people understand and use health information. The ability to obtain, process, and understand health information needed to make informed health decisions is known as health literacy.”

Our Managed Care Coordinators prioritize and address opportunities to improve health literacy. Through individualized planning, education, and goal setting, Managed Care Coordinators help fill knowledge deficits and enhance the member’s understanding regarding HIV/AIDS, CD4 and viral load, medical comorbidities and behavioral health conditions, complications, and the importance of preventive services, and meeting plan of care goals.

When we identify a comorbid condition, the member receives educational mailings which include general information about the member’s condition(s), tips for managing it, and how to avoid triggers or complications. Tobacco use is especially harmful for individuals living with HIV/AIDS and increases the risk of diseases such as lung cancer or even death. Because a sizable percentage of our members smoke (35 percent), we provide helpful resources and materials to help them quit. Our Managed Care Coordinators use these cessation tools as supplemental tools to reinforce the coaching they provide. They also refer members to our Quit Smoking and Using Tobacco Healthy Behaviors program.

Please see Table 5-1 in Attachment SRC# 5-1: DM Educational Materials for an inventory of our member outreach and educational materials. We developed these materials paying careful attention to reading level, clarity, simplicity, and cultural sensitivity to improve member understanding and health literacy. We update and add to these materials as dictated by advances in science, best practices, and available community resources.

When we send members educational materials and other communications by mail, we pay attention to maintaining confidentiality regarding our member’s condition. Our mailings use an alternative logo to protect the member’s privacy. The alternative logo does not include our full name or signature red ribbon, which many people associate with HIV/AIDS.

Members are prioritized for additional clinical outreach by Managed Care Coordinators according to risk levels. Our risk stratification approach is described in further detail below, and is based on our unique algorithm and inputs from a comprehensive health assessment, an HIV/AIDS Health Risk Assessment, and other information.

Our comprehensive health assessments capture a broad range of domains and information to determine member needs, interventions available to members, and how interventions should be targeted to members. The comprehensive health assessments identify:

- Condition-specific indicators, including compliance with HIV regimen and follow up care
- Preventive care activities
- Health behaviors (such as nutrition, physical activity, negative effects of tobacco, drug, or alcohol use)

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- Medical co-morbidities
- BH co-morbidities
- Depression screening
- Substance use and abuse
- Social, economic, self-care needs, ability, and desire to adhere to an available medical treatment plan
- Special needs (for example, hearing and vision impairment, language, cognitive defects, and physical limitations)
- Psychosocial needs:
 - Beliefs and concerns about the condition and treatment
 - Perceived barriers to meeting treatment requirements
 - Access, transportation, and barriers to obtaining treatment
 - Cultural, religious, and ethnic beliefs
 - Caregiver/family support
 - Social determinants of health

Comprehensive health assessments and disease stratification drive interventions which are then outlined in the member's plan of care. In the development of member interventions, the Managed Care Coordinator prioritizes special considerations for persons living with HIV/AIDS and addresses:

- Gaps in care
- BH needs
- Psychosocial needs
- Caregiver/family support needs
- Need for caregiver/family consent
- Housing needs/homelessness

Member interventions may include but are not limited to:

- Consultation with BH staff for BH needs, substance use disorder, or positive depression screening
- Assistance to obtain needed care (e.g., DME items such as walkers, wheelchairs, testing strips)
- Alternative forms of member materials to include TTDY, Braille, recorded materials, reading levels and other languages
- Social support systems when caregiver/family support is not available or is limited (such as community resources, including Ryan White funded programs)
- Encouraging family participation in education and plan of care goals

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Our comprehensive health assessments use branch logic to promote discussion and engage members in developing their plan of care. Managed Care Coordinators listen closely to members and identify patterns to determine how well the member understands their condition and makes decisions, discern their motivation, and facilitate a focus on solutions to reach the member's goals. When complete, the plan of care reflects the member's strengths and preferences. The Managed Care Coordinator assesses any member ambivalence and readiness for individual change, as well as barriers to achieving goals, before establishing interventions included in the plan of care.

A member's risk level determines the frequency of follow-up with our Managed Care Coordinators. Members with the highest needs are contacted more frequently than stable members who have resolved their gaps in care and have a self-care plan in place. However, we use these as guidelines only. The member can always request additional support or follow-up and our Managed Care Coordinators typically exceed the recommended frequency of contact based on the member's needs and unique situation. Assigned Managed Care Coordinators are available during business hours, Monday through Friday. When the Managed Care Coordinator is unavailable, the member can talk to a designated back-up Managed Care Coordinator for assistance. Additionally, members have access to an emergency back-up Managed Care Coordinator through an after-hours telephone line.

Through their Managed Care Coordinator, members have access to the full array of expertise within our organizational structure. Managed Care Coordinators collaborate with other team members, including BH Managed Care Coordinators and Medical Directors, through a variety of outlets to assure the member is receiving the best care possible. For example, Managed Care Coordinators may prepare and present their member's case at peer rounds for validation of the plan of care and to obtain suggestions to better manage the member. Rounds provide an opportunity to consult with Clear Health physicians, pharmacists, BH clinicians, nurses, social workers, and other members of the multi-disciplinary team (MDT) regarding medical management, medications, and suggested modifications to the plan of care. The team discusses innovative approaches to engage the member to commit to a plan of care and to set realistic goals. It also identifies community services and agencies that provide needed assistance or specific services.

1.a. Oncology DM

We encourage members to stay up-to-date on screenings such as mammograms and colonoscopies to increase the likelihood of early cancer detection and treatment. We also use programs such as our Quit Smoking and Using Tobacco Healthy Behaviors program to encourage behavioral change and reduce the incidence of modifiable risk factors.

Clear Health built our Oncology and End of Life Program using a comprehensive approach that begins with prevention and, for members with cancer, follows members through treatment to compassionate end-of-life support as needed. Our approach includes the following tiers:



- Active Engagement: We provide DM and case management for high-risk members in active cancer treatment.

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- **Post Active Engagement and Survivorship:** We provide information for follow up care and survivorship support to assist members through the post-treatment phase of their illness. This support helps members adjust to physical and emotional changes they may be experiencing, as well as anxiety about potential recurrence of the disease.
- **End of Life Support:** For our members with a terminal cancer diagnosis, we help coordinate services, and provide decision support for members and their families as they transition to hospice or palliative care.

Our DM programs are based on the hierarchy of disease. Cancer is the highest on the disease hierarchy, followed by HIV. This means that we place members in active cancer treatment in the Oncology and End of Life DM program, but we also holistically manage their HIV/AIDS condition and any other comorbidities. Of the members enrolled in our Oncology and End of Life DM program in 2016, 98.9 percent were actively engaged and working with a Managed Care Coordinator for goal setting and care planning.

Our Oncology and End of Life DM program provides members receiving active cancer treatment or post-active treatment case management and DM services from a local Managed Care Coordinator. An individualized plan of care is developed with the member and focuses on adherence to treatment plans, including medication management, monitoring symptoms, identifying when to seek medical attention, and identifying transportation support for PCP and specialty visits. Our Managed Care Coordinators encourage members to maintain a care journal, and monitor emotional side effects of the disease in both the member and any identified caregiver(s).



**** INNOVATION: Leveraging the American Cancer Society's Extensive Resources**

Our Managed Care Coordinators leverage the resources and community supports available locally and nationally, including online support groups and resources through the American Cancer Society Clinician's Portal. We help members through special access to the American Cancer Society's web portal, which connects members to many valuable resources such as lodging, breast cancer support, personal health manager, support groups, cleaning services and help with appearance-related side effects. **

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As needed for members in the late stages of cancer, Managed Care Coordinators also coordinate palliative and supportive care as part of their interactions with the member. If there are behavioral management issues or a positive depression screening, the Managed Care Coordinator refers the member to our BH Managed Care Coordinators who perform an additional assessment and, if indicated, connect the member to BH resources and supports in our provider network or in the member's community.

In addition to our standard DM program evaluation measures (for example, ED utilization, inpatient admissions, medication adherence), we measure the effectiveness of our Oncology and End of Life DM program in improving cancer management with the following measures:

- Members who successfully meet their goals
- Members in active treatment linked to the American Cancer Society
- High member satisfaction with DM
- Members who accept referral for BH assessment and treatment who are identified for potential depression or other BH needs, but are not currently receiving treatment
- Members who are identified as smokers and would like assistance in quitting who accept referral to a Smoking Cessation program

1.b. Diabetes DM

Diabetes is the sixth most frequent reason for outpatient visits for Clear Health members age 20 to 64 and the third for members age 65 and older.



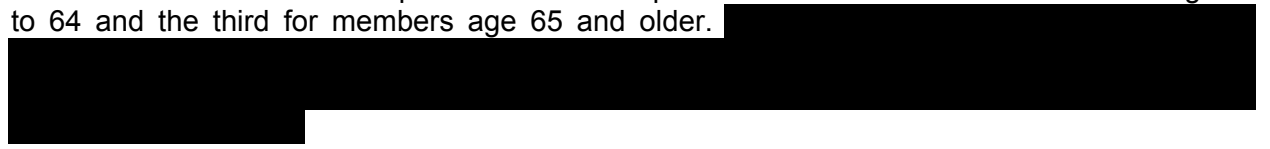


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[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

1.d. Hypertension DM

Hypertension is the number one comorbidity for Clear Health members. Although there is no evidence that HIV infection causes hypertension, HIV is associated with a higher incidence of hypertension. Our DM program for hypertension delivers targeted coaching and education about the disease, helps members understand food labels, and emphasizes the impact of healthy eating on their disease. Managed Care Coordinators assure members obtain a blood pressure monitor through their OTC benefits and encourage them to maintain a log of readings. They also emphasize the role tobacco use plays in worsening the member's condition, and [REDACTED]

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[REDACTED]

We measure the effectiveness of our Hypertension DM program with the following measures:

- Controlling blood pressure
- ED utilization
- Inpatient admissions
- Member adherence measures including medication adherence, plan of care adherence, and the member's perceived ability to self-manage

**** REAL STORY: Care Coordination and Disease Management Give Member Renewed Hope and Improved Health**

Reggie was diagnosed with HIV 10 years ago, and also has hypertension and hepatitis C. He was out of care for a long time after moving from Clearwater to Ocala. At age 62, Reggie was living in extreme poverty and isolation, often not eating for days. With no money for transportation, he was not getting care from a physician or taking his medications consistently for any of his conditions when he became our member.

When Lara, our Managed Care Coordinator, asked if he'd like to participate in our case management and hypertension disease management programs, Reggie was receptive. After talking with him, she realized his needs went beyond health care, and she arranged transportation for him to a local foodbank where he received food that same day for the month. She also paired him with a PCP and infectious disease specialist of his choosing close to his home and arranged for transportation to his appointments.

Reggie is continuing to take his medications and follow up with his doctors. He even took Lara up on her offer to participate in a smoking cessation program. She continues to monitor him – watching for signs of issues with his hypertension and viral load – and encourages him to live a healthy lifestyle. His tone of voice has changed markedly from worried to full of hope as he told Lara that, after many years, he had reconnected with his sister, Delores, who brings him food. Reggie calls Lara to ask questions sometimes, and the smile in his voice when he says a soft, "thank you," makes her smile too. ******

1.e. Mental Health (BH) DM

Many of our members have co-occurring BH conditions, and 34 percent have been diagnosed with severe mental illness (SMI). Integration of physical and BH health services is at the core of our BH DM program. We recently added many clinical and non-clinical Managed Care Coordinators with BH and substance use disorder training and experience to more holistically and effectively serve our population with highly complex physical and BH needs. We also use our Member Advisory Committee (MAC) meetings to identify unique barriers for HIV/AIDS members trying to access BH services so that we may better address those barriers.

[REDACTED]

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[REDACTED]

[REDACTED]

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[REDACTED]

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Clear Health is working to increase rates of BH screenings by PCPs. The presence of several BH and substance use diagnoses are known to be common among people living with HIV/AIDS. The relative frequency of these diagnoses in Florida appears lower than has been found in published studies, suggesting that members with BH and substance use conditions may not be getting screened and diagnosed, or are not being diagnosed accurately, and therefore are not being referred for services that could improve their quality of life and enhance the effectiveness of medical treatment. Our interventions focus on provider education regarding accurate coding and the DM and BH Case Management programs we offer, member education regarding the importance of discussing BH concerns with a provider, and system improvements to enhance internal reporting.

We measure the effectiveness of our Major Depressive Disorder DM program by monitoring the following measures:

- Antidepressant medication management (acute and continuation phase)
- ED utilization
- Inpatient admissions
- Member adherence measures including medication adherence, plan of care adherence, and the member's perceived ability to self-manage

**** RESULTS & SUCCESSES:** Clear Health Improves Antidepressant Medication Management
Our 2017 HEDIS score for anti-depressant medication management is 54.5 percent, which is above the 50th NCQA percentile and represents a five percent increase from 2016. ******

1.e.2. Schizophrenia DM (BH)



We measure the effectiveness of our Schizophrenia DM program with the following measures:

- Antipsychotic medication adherence
- Diabetes screening for people with schizophrenia
- ED utilization
- Inpatient admissions
- Member adherence measures including medication adherence, plan of care adherence, and the member's perceived ability to self-manage

**** RESULTS & SUCCESSES:** High Screening Rates for Diabetes
Members with schizophrenia are at an increased risk of diabetes, therefore screening and monitoring is very important to provide appropriate care. Our 2017 HEDIS rate for the Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication measure was 98.11, which is above the 90th percentile. ******

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1.e.3. Bipolar Disorder DM (BH)



We measure the effectiveness of our Bipolar DM program with the following measures:

- ED utilization
- Inpatient admissions
- Member adherence measures including medication adherence, plan of care adherence, and the member's perceived ability to self-manage

1.f. Substance Use and Abuse DM

Addiction is a preventable chronic, relapsing, treatable brain disease, for which we promote person-centered, evidence-based, integrated approaches to DM. We engage members with the goal of reducing harm, improving quality of life, and, ideally, helping members abstain from their addiction. We use motivational interviewing techniques informed by the evidence-based Stages of Change model to improve and maintain member engagement. We also involve family members and significant others in the member's plan of care, if the member agrees, to improve odds of sustaining recovery.

When a member with substance use concerns exhibits readiness to change his or her behaviors, the Managed Care Coordinator works closely with the BH Managed Care Coordinator, who identifies and refers the member to treatment services, including the Ryan White program for inpatient substance use treatment, guides the member through the process, and connects them with additional supports and services. To complement evidence-based substance use disorder treatment, the Managed Care Coordinator may also refer the member to a 12-step program or other peer mutual support group.

We measure the effectiveness of our substance use disorder DM program with the following measures:

- Initiation and engagement of alcohol and other drug dependence treatment
- ED utilization
- Inpatient admissions

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- Member adherence measures including medication adherence, plan of care adherence, and the member's perceived ability to self-manage by monitoring the initiation and engagement of alcohol and other drug dependence treatment measures

**** RESULTS & SUCCESSES:** Clear Health Engages Members in Alcohol Dependence Treatment

Our 2017 HEDIS score for Initiation and Engagement of Alcohol or Other Drug (AOD) Dependence Treatment: Initiation of AOD treatment is 43 percent, which exceeds the 50th NCQA percentile. ******

1.1. Other DM Programs

In addition to the DM programs outlined above, Clear Health offers DM programs for Alzheimer's/dementia; chronic heart failure; COPD; and coronary artery disease.

1.1.2. Alzheimer's/Dementia DM

Our members are at risk of experiencing a decline in mental processes, thinking, and cognitive functions as they age and/or their CD4 count falls. Additionally, the number of individuals living with Alzheimer's disease in Florida is growing, and nearly 12 percent of the population have been diagnosed with the disease. As our membership ages, we are also seeing more members with this disease. Alzheimer's and dementia patients can require 24-hour care, especially in later stages of the disease.

Our DM program for Alzheimer's/dementia supports members living with Alzheimer's and similar conditions and their caregivers. Managed Care Coordinators outreach to caregivers and deliver a clinical assessment of the caregiver's knowledge, ability, and willingness to support our member. The caregivers receive education and targeted coaching about caregiving, advance directives, home safety, and preventing falls. The Managed Care Coordinator may refer the caregiver to external resources such as Alzheimer's Association support groups, Florida Alzheimer's Disease Initiative (ADI), and online peer support programs.

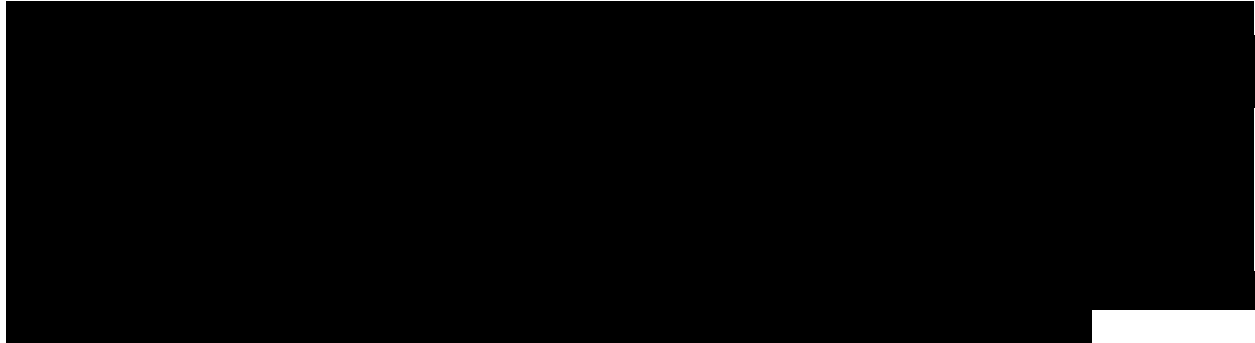


We measure the effectiveness of our Alzheimer's/Dementia DM program with the following measures:

- ED utilization
- Inpatient admissions
- Member adherence measures including medication adherence, plan of care adherence, and the member's perceived ability to self-manage

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1.1.3. Congestive Heart Failure DM



We measure the effectiveness of our congestive heart failure DM program with the following measures:

- Persistence of beta-blocker treatment after a heart attack
- Annual monitoring for patients on persistent medications – ACE or ARB
- Assessing tobacco use: total identified and participating
- Influenza vaccination
- Pneumococcal vaccination
- ED utilization
- Inpatient admissions
- Member adherence measures including medication adherence, plan of care adherence, ability to self-report, and member's perceived ability to self-manage

**** RESULTS & SUCCESSES:** Clear Health Performs in 95th Percentile for Annual Monitoring of Patients on ACE/ARB Medications

Our 2017 HEDIS score for Annual Monitoring for Patients on Persistent Medications – ACE or ARB is 98.4 percent, which is in the 95th NCQA percentile. ******

1.1.4. COPD DM

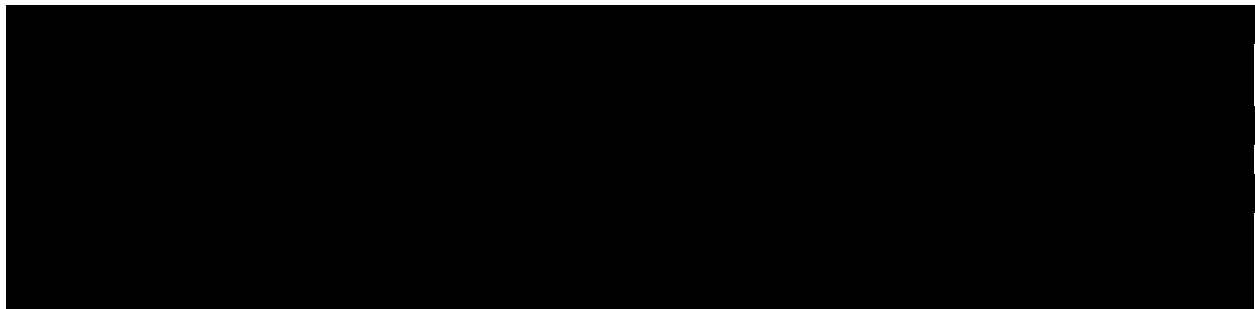




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We measure the effectiveness of our COPD DM program with the following measures:

- Pharmacotherapy management of COPD exacerbation: corticosteroid within 14 days
 - Pharmacotherapy management of COPD exacerbation: bronchodilator within 30 days
 - Assessing tobacco use: total identified and participating
- 
- 

- ED utilization
- Inpatient admissions
- Member adherence measures including medication adherence, plan of care adherence, and the member's perceived ability to self-manage

1.1.5. Coronary Artery Disease DM



We measure the effectiveness of our coronary artery disease DM program with the following measures:

- Persistence of beta-blocker treatment after a heart attack
- Annual monitoring for patients on persistent medications – ACE or ARB
- Assessing tobacco use: total identified and participating
- Influenza vaccination
- Pneumococcal vaccination

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- ED utilization
- Inpatient admissions
- Member adherence measures including medication adherence, plan of care adherence, ability to self-report, and the member's perceived ability to self-manage

1.2. Evidenced-based Programming

Each of our DM programs incorporate evidence-based clinical guidelines to dictate, guide, and design our case management approach to each DM program.

Our integrated DM programs support the practitioner-patient relationship and emphasize self-care to prevent condition exacerbation and complications using evidence-based clinical practice guidelines and member empowerment strategies intended to improve overall health. Our DM Clinical Guidelines are tools that help practitioners make decisions about appropriate health care for HIV/AIDS and managing co-occurring conditions.

Our HIV/AIDS DM and Case Management program is based on the following evidence-based guidelines: HIV/AIDS: U.S. Department of Health and Human Services (DHHS); Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents; and the Primary Care Guidelines for the Management of Persons Infected with Human Immunodeficiency Virus published by the Florida AIDS Education and Training Center (AETC).

Our other DM programs are founded on the following evidence-based guidelines:

- Cancer: National Comprehensive Cancer Network (NCCN); American Society of Clinical Oncology (ASCO); American Cancer Society (ACS); National Cancer Institute at the National Institutes of Health (NCI)
- Diabetes: Standards of Medical Care in Diabetes – 2017 (American Diabetes Association)
- Asthma: EPR 3: Guidelines of Asthma. July 2007; EP Report 3: Guidelines for the Diagnosis and Management of Asthma (NHLBI)
- Hypertension: The Fourth Report on the Diagnosis, Evaluation, and Treatment of High Blood Pressure in Children and Adolescents, U.S. Department of Health and Human Services National Institutes of Health National Heart, Lung, and Blood Institute; the Eighth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 8) (Report from the Panel Members Appointed to the Eighth Joint National Committee (JNC 8), Journal of the American Medical Association
- Behavioral Health (major depressive disorder, schizophrenia, bipolar disorder): Treatment of Patients with Major Depressive Disorder amended by the following Guideline Watch, October 2010 (American Psychiatric Association); Depression – The NICE Guideline on the Treatment and Management of Depression in Adults, 2010 (National Collaborating Centre for Mental Health, commissioned by the National Institute for Health and Clinical Excellence; Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders, June 2007 (American Academy of Child and Adolescent Psychiatry); Women's Health Care Physicians

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– November 2015 (ACOG); Treatment of Anxiety Disorders (NIMH); Medication Assisted Treatment (SAMHSA); Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse (USPSTF); Practice Guidelines for the Psychiatric Evaluation of Adults, Third Edition (AHRQ); Screening for Depression (USPSTF); American Psychiatric Association: Treatment of Patients with Schizophrenia Second Edition, 2010; Practice Guideline for Treatment of Patients with Bipolar Disorder in Adults, as amended by the Guideline Watch from the American Psychiatric Association (APA), November 2005

- Substance use: Committee Opinion No. 633: Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice: July 2015 (ACOG) Guidelines for the Identification and Management of Substance Use and Substance Use Disorders in Pregnancy, World Health Organization (2014); CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016, Centers for Disease Control and Prevention

- Alzheimer's/dementia: New Diagnostic Criteria and Guidelines for Alzheimer's Disease (Alzheimer's Association); Guideline Watch (October 2014): Practice Guideline for the Treatment of Patients with Alzheimer's Disease and Other Dementias

- Congestive heart failure: A Report of the American College of Cardiology Foundation/Heart Association Task Force on Practice Guidelines: 2013 ACCF/AHA Guideline for the Management of Heart Failure

- COPD: Global Initiative for Chronic Obstructive Lung Disease (GOLD): Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease, Updated 2016

- Coronary artery disease: A Guideline From the American Heart Association and American College of Cardiology Foundation (AHA/ACCF): AHA / ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2011 Update; A Scientific Statement From the American Heart Association Council for High Blood Pressure Research and the Councils on Clinical Cardiology and Epidemiology and Prevention; A Guideline from the American Heart Association (AHA): Treatment of Hypertension in the Prevention and Management of Ischemic Heart Disease

- Hypertension: A Scientific Statement From the American Heart Association Council for High Blood Pressure Research and the Councils on Clinical Cardiology and Epidemiology and Prevention A Guideline From the American Heart Association (AHA): Treatment of Hypertension in the Prevention and Management of Ischemic Heart Disease; A Guideline From the American Heart Association: Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women, 2011 Update; A Guideline from the American Heart Association and American College of Cardiology Foundation (AHA/ACCF): AHA / ACCF Secondary Prevention and Risk Reduction Therapy for Patients With Coronary and Other Atherosclerotic Vascular Disease: 2011 Update

Our clinical guidelines are maintained and reviewed by our Office of Medical Policy and Technology Assessment (OMPTA) to ensure our programs are always operating using the most current evidence base. Two dedicated workgroups, one for medical guidelines and one for BH guidelines, review, comment and offer recommendations for adoption, rejection, or revision of a guideline. These interdisciplinary workgroups are called the Clinical Practice and Preventive Health Guidelines (CPG/PHG) Workgroup and the Behavioral Health National Council Advisory

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Subcommittee (BH-NCAC). They include Medical Directors, DM program owners, Clinical Program Development Managers, participating providers, and Clinical and Operations staff.

Our process includes the systematic review of new scientific evidence at least annually for all our DM clinical practice guidelines. We also review our guidelines more frequently when national guidelines change or when substantively new scientific information is published. We begin with a literature search using the National Library of Medicine's PubMed service or other similar service. If there is research indicating a guideline is no longer current, the research is sent to the CPG/PHG Committee or BH-NCAC Subcommittee for review and feedback. Their recommendations are presented to our Quality Improvement Committee (QIC) for review and formal approval.

We develop all staff training materials and program content, for both members and providers, according to our adopted DM clinical practice guidelines, professional clinical and technical literature, governmental research sources, and the recommendations of professional societies and relevant foundations. Separately, our DM Clinical Advisory Group (CAG), composed of providers and DM staff, meets at least quarterly to review member and provider materials for accuracy of clinical content. They also review and carefully consider relevant recommendations made by members, providers, and staff to update program content.

2. OUR DM APPROACH ADVANCES AGENCY GOALS

Our comprehensive DM programs are designed to identify, educate, and coach members to take greater responsibility for their health, wellness, and quality of life. We empower them to adopt improved self-management skills that increase participation in primary and preventive care, enhance health outcomes, and reduce potentially preventable admissions, readmissions, and ED visits.

Specifically, our DM programs directly support many of the Agency's key goals:

- Agency Goal #1: Reducing potentially preventable inpatient and outpatient hospital events, and unnecessary ancillary services

Clear Health has the second lowest rate of potentially preventable hospital admissions (PPAs) in the state, a remarkable achievement given the complex population we serve. Our integrated HIV/AIDS DM and case management approach, as well as our gaps in care focus supports the delivery and receipt of primary and preventive care services and reduces preventable hospitalizations. We define gaps in care as missed care opportunities (for example, annual preventive screenings, routine labs, and medication adherence) for chronic conditions. Managed Care Coordinators use our integrated information systems, like our Case Management System, to easily identify the number of gaps a member has, outreach to the member's provider, and create plans of care to address the gaps related to a member's condition. They also emphasize the importance of preventive care and establishing or maintaining a close relationship with the member's PCP. Our holistic focus on providing comprehensive education and support to give members the tools to self-manage their chronic condition, identifying risk factors and helping members address those risks, and counseling members about when they need to see their provider. We also equip members with knowledge and support to reduce the likelihood of a potentially preventable admission or an ED visit.

- Agency Goal #2: Improving birth outcomes.

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We recognize our HIV/AIDS specialty population has an additional need for pre- and post-natal care to avoid HIV transmission to the baby. We refer all pregnant members to our OB Managed Care Coordinator who manages and follows all pre- and post-natal care identified as high risk, up to three months following delivery. We always encourage pregnant members who smoke to participate in our evidence-based tobacco cessation program designed specifically for pregnant members. One of the primary focuses of the Clear Health OB Case Management program is the prevention of HIV/AIDS transmission to the baby by ensuring adherence to HIV/AIDS medication therapy. In addition, the Managed Care Coordinator ensures that the member is treated by an OB with specialization or experience in the treatment of HIV/AIDS. At the time of writing this response, no vertical transmissions from mother to baby have been reported.

3. DM ALGORITHM AND RISK STRATIFICATION APPROACH

3.1. Identification of Members and Comprehensive Health Assessment

All Clear Health members are eligible for DM and case management through our HIV/AIDS DM and Case Management program. Our goal is to intervene early, before members have a potentially preventable hospital admission, readmission, or ED visit or progress to an advanced disease state. We make multiple attempts to contact new members and aim to complete a comprehensive assessment within 30 days of enrollment. We also include an comprehensive health assessment in our new member enrollment packages. As part of the initial health risk assessment, we ask whether the member would like to receive HIV/AIDS DM and case management support. For unresponsive members, we make at least six attempts to contact them over a 90-day period.

We capture comprehensive health assessment results in our Case Management System. This system uses proprietary algorithms to score and stratify members into one of three risk categories based on the comprehensive health risk assessment and our more tailored HIV/AIDS Health Risk Assessment. The risk categories are low, moderate, and high and consider risk factors such as disease severity, co-morbid conditions, socioeconomic factors, medication use and compliance, and utilization patterns. The Managed Care Coordinator may adjust the overall risk level based on additional assessments, communication with the provider, or other information.

Our robust processes and systems integrate information from multiple sources, including claims and encounter data, comprehensive health assessments, and referral information from both internal and external sources, to identify comorbid conditions, modify risk levels, and drive additional outreach and engagement efforts for members who did not indicate a desire to enroll in our HIV/AIDS DM and Case Management program but would benefit from the program. These important sources include but are not limited to:

- New member welcome call screening
- Member self-referral, family members, and caregivers
- Customer Care Representatives and Nurse help line representatives
- Participating providers
- External community-based organizations serving individuals living with HIV/AIDS
- UM team

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- Integrated clinical rounds
- Lab reports (for example, low CD4 count)
- Hospital discharge reports
- ED High Utilization Report (monthly)

3.2. Risk Stratification

Our risk stratification algorithm and predictive modeling tools use demographics, clinical data, and historical physical and BH claims data to predict future outcomes, determine the frequency of contact with our Managed Care Coordinators, and identify and refer members with co-occurring conditions to other DM programs. The tools include:

- Our Chronic Illness Intensity Index (CI3), which identifies members who are very ill and those with the most complex health conditions needing intensive case management. The model incorporates specific diagnoses that our team of medical and BH specialists consider clinically impactable and, therefore, particularly amenable to DM and/or case management. It identifies members who have the greatest disease burden and are most likely to benefit from intervention.
- Our Likelihood of Inpatient Admission (LIPA) index, which prioritizes members for outreach by predicting the probability of inpatient services. By evaluating data on the use of hospital services, diagnoses, and demographics, the LIPA model determines a member's probability of a medical/surgical or BH admission within the next 60 days.
- Emergency Room TRIAGE: Predicts likelihood of low-level ED utilization
- STORK: Assesses for a poor pregnancy outcome or NICU admission based on results of our OB High Risk Screener
- Readmission Risk: Recalculates based on the inpatient daily census report to determine the likelihood of readmission
BH health issues that may result in a first-time admission
- Pharmacy: Identifies indicators of over-utilization and possible substance use disorder

Figure 5-1 in Attachment SRC# 5-2: DM Predictive Modeling Tools illustrates our comprehensive suite of predictive modeling tools.

Our predictive model integrates and continuously reviews member eligibility data, claims, number of potential chronic disease care gaps by disease band (CDCG indicator), and encounter information to predict future risk. This monthly process considers claims information, including diagnosis, prescriptions, prior costs, gaps in care, and prior utilization. It also considers individual demographics sourced from member eligibility information to determine individual risk. The process assigns members a clinical profile that indicates their individual levels of risk and risk ranking, physical and behavioral conditions, gaps in care, co-morbidities, and both past and prospective utilization patterns. In this way, we can prioritize member contacts based on clinical risk ranking.

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The comprehensive health assessments identify member needs across a continuum of services and supports. The process includes the use of our comprehensive health assessments to identify and confirm both physical and BH conditions and other-comorbidities, identify additional health concerns (such as cognitive impairments and physical limitations), screen members for substance use and smoking status, evaluate risky behaviors, and assesses both psychosocial and environmental needs, including family, caregiver, and natural supports.

Data collected through the comprehensive health assessments is documented in our Case Management System. It is then automatically channeled through a standardized stratification algorithm to calculate an additional risk ranking used to determine both the intensity and frequency of interventions and care planning tailored to individual member needs. The same information is summarized and communicated to the member's health care team (including PCPs and specialists).

We recognize that our members' needs may frequently fluctuate across the spectrum of services and supports needed to prevent deterioration of their functioning, manage difficult or painful symptoms, preserve their emotional and physical well-being, and avoid potentially preventable hospital admissions, readmissions, and ED visits. We generate risk profiles monthly for each member, and use our Managed Care Coordinators' sound clinical judgement to identify changes in status to swiftly meet a member's changing needs. To help Managed Care Coordinators assess changes, we offer an abbreviated version of the comprehensive health assessments at each follow-up discussion with the member. New information is used to update the member's stratification and risk ranking.

Updated risk profiles contain information on the member's future utilization patterns using our LIPA and Emergency Room Triage predictive models, which identify impending need for hospital or emergency services. Managed Care Coordinators use this vital information to proactively meet additional member needs and work timely to deliver an appropriate plan of care including condition-specific interventions to ensure members receive the right care, at the right time, with the right support.

3.3. Interventions by Stratification and Risk Level

Members are prioritized for clinical outreach by Managed Care Coordinators according to risk levels. These risk levels are described below.

- **Low Risk.** Members stratified as low risk are typically members whose condition is stable, have few co-morbidities, a stable support system, and access to needed care. Example interventions include educational materials to help the member manage his or her disease, referral to community-based resources, follow up contact every 90 days, monitoring of labs and compliance, case management as needed, and onsite and telephonic case management supports, if admitted to the hospital.

- **Medium Risk.** Members stratified as medium risk are most frequently members who need assistance managing their condition(s) and/or accessing care. Managed Care Coordinators contact these members as frequently as needed based on the member's plan of care, but no less than every 60 days. Example interventions include those provided to low risk members as well as:

- Monitoring adherence to treatment guidelines

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- Education regarding co-morbid conditions and lifestyle issues
- Helping the member monitor and manage symptoms, including CD4 counts
- Developing interventions that provide emotional support to caregivers
- Behavioral management
- Medication management and review
- Conducting a Member Cultural Assessment to identify and address cultural and sensory barriers to managing the member's disease
- Coordination of PCP and specialty appointments, arranging transportation, and other assistance as needed to help ensure the member receives necessary care
- High Risk. Members stratified as high risk are typically members who have HIV symptoms, an AIDS diagnosis, and/or multiple co-morbidities. Managed Care Coordinators deliver the same interventions as provided to medium risk members, but contact the member at least every 30 days until the member's plan of care goals are met.

4. INTEGRATION OF DM IN OUR CASE MANAGEMENT PROGRAMS

Clear Health understands that health outcomes improve dramatically when care is fully integrated. We have a single program that provides both HIV/AIDS DM and case management, and all members have access to a Managed Care Coordinator knowledgeable in medical, BH, and social support service needs of persons living with HIV/AIDS. With additional resources and infrastructure support from our legacy plans, we offer person-centered case management, DM for co-occurring conditions, and UM in house across all physical health, BH, pharmacy, and social support needs.

Managed Care Coordinators develop a plan of care in collaboration with the member and, based on the member's preference, also include the member's caregiver, legal guardian, and provider. The Managed Care Coordinator develops the plan of care according to the member's risk stratification for all members participating in our HIV/AIDS DM and Case Management program. The plan of care is updated at least annually and used to:

- Identify and address co-morbidities
- Identify and address risk factors to prevent further medical deterioration and complications
- Document the member's ability to adhere to their treatment regimen
- Monitor and document progress toward meeting the member's individualized goals
- Document medication management to avoid duplication of therapies and avoid adverse effects or interactions with contraindicated medications

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- Communicate with the member's PCP and community agencies, such as Ryan White agencies, if applicable

Our Managed Care Coordinators help members schedule PCP and specialist visits and arrange for transportation. They also outreach to the member after discharge from a hospital, urgent care facility, or ED to coordinate needed follow-up care.

Our Case Management System facilitates integration of DM into our case management functions. Member utilization data, such as claims history, authorizations, lab results, immunization records, and DM and case management data, are available in an organized format with tools for Managed Care Coordinators and providers to identify and manage member needs. The system collects, organizes, and presents information enabling management and coordination of member care. It also consolidates clinical data from various sources into a single record to deliver a holistic picture of each member's utilization, plan of care, and gaps in care. The system integrates seamlessly with our Core Operations System and is the system of record for DM and case management information.

4.1. Behavioral Health Referrals

If, during a comprehensive health assessment or through other contact, the Managed Care Coordinator identifies a member as needing further BH assessment, the Managed Care Coordinator engages a BH Managed Care Coordinator. The BH Managed Care Coordinator determines whether the BH needs are specialized or basic in nature. If more specialized BH interventions are needed, such as therapeutic services, psychotherapy, substance use treatment, or detoxification, the BH Managed Care Coordinator will co-manage the member to ensure those needs are met.

If at any time the BH need is deemed a crisis (defined as, but not limited to verbalization of suicidal and/or homicidal thoughts or plans, concerns for member safety, altered thought processes, and/or member's ability to make decisions), the Managed Care Coordinator will warm transfer the member the BH service line and identify a BH Managed Care Coordinator to get involved in the member's case immediately.

4.2. OB Case Management Referrals

When a Clear Health member becomes pregnant, the Managed Care Coordinator refers the member to an OB Managed Care Coordinator who assumes the primary role during the pregnancy and up to three months post-partum. The OB Managed Care Coordinator is specially trained on HIV and pregnancy, and becomes the link with the obstetrician and follows the member to monitor all pre- and post-natal care.

Today, if a woman takes HIV medicines as prescribed throughout pregnancy, labor, and delivery, and provides HIV medicines to her baby for four to six weeks, the risk of transmitting HIV can be one percent or less. Our OB Managed Care Coordinators reinforce the importance of antiretroviral drugs to prevent vertical transmission to the fetus. They also monitor the use of antiretroviral drugs and intervene as necessary to help make sure HIV medicines are taken as prescribed to reduce the risk of transmitting HIV to the baby.

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In developing the plan of care, the OB Managed Care Coordinator also identifies co-morbidities and their condition-specific risks early on and provides education to help the member self-manage her condition. This is particularly important for pregnant women with diabetes or substance use disorders, and the OB Managed Care Coordinator emphasizes risks to the infant as well as the mother if risky behaviors or unhealthy lifestyles are not changed.

**** RESULTS & SUCCESSES: OB Managed Care Coordinators Positively Impact Care**

In 2016, 82.9 percent of our high-risk pregnant members enrolled in our OB Case Management program. This significantly exceeded our goal of 70 percent. Other remarkable outcomes include 81.35 percent of engaged high-risk members meeting their plan of care goals and 57.14 percent completing the recommended post-partum visit (representing a 40 percent increase from 2015).

5. COMPONENTS OF OUR DM PROGRAMS

All plans of care for members in our HIV/AIDS DM and Case Management program address coordination of services, symptom management, medication support, emotional support, behavior change, and coordination with providers. However, the plans of care are individualized with distinct types of interventions and intensity of services based on the member's risk level and personal goals, and as indicated in evidence-based clinical guidelines.

5.a. Symptom Management

Empowering members to self-manage their condition is a key component of all our DM programs, and our Managed Care Coordinators encourage members to actively participate in establishing and reaching their plan of care goals. They use motivational interviewing and other techniques and education to help the member overcome real and perceived barriers and adhere to treatment regimens. Managed Care Coordinators also provide education to help members understand their symptoms, and when to seek medical attention.

For persons living with HIV/AIDS, viral suppression is key to staying healthy and reducing the risk of transmission to others. Our Managed Care Coordinators emphasize education regarding the meaning of CD4 count and viral load, with the goal of increasing immune function and decreasing viral activity. They also encourage members to learn how to manage their HIV disease by attending community education events, accessing reliable HIV/AIDS online resources, and our own, Agency-approved educational materials.

Importantly, our DM programs also identify missed care opportunities and work with providers to fill gaps in care. We communicate care opportunities impacting a member's condition, such as failure to fill a medication, missed screenings, and out of range test results, with the provider in a timely manner. These reminders facilitate provider outreach to the member to improve management of the member's condition.

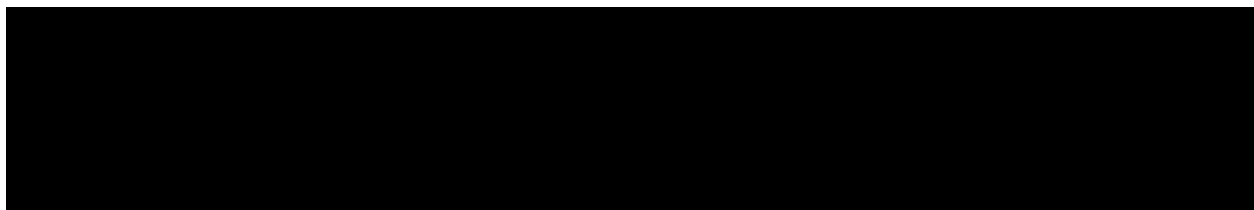


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self-management practices for chronic diseases and providing education about preventive care and personal wellness, such as tobacco cessation and nutrition.

5.b. Medication Support

Our Managed Care Coordinator works with our pharmacy team to carefully review medications the member is currently taking, including supplements and other over-the-counter drugs, to avoid adverse effects, duplication and underutilization of HIV medications that may lead to resistance, interactions from contra-indicated medications, and other polypharmacy issues. They conduct these reviews regularly to determine compliance and appropriateness of the treatment regimen. If there are concerns, the Managed Care Coordinator will work with the member and the member's PCP to resolve. He or she will help schedule an appointment with the PCP, if necessary, or resolve other barriers to medication adherence. The Managed Care Coordinator also uses pharmacy reports to monitor patient use of antiviral, antibiotic, and antifungal agents.

**** RESULTS & SUCCESSES.** Significant Improvements in HAART Adherence
Clear Health recently implemented a program that monitors all members with a low CD4 count and establishes an action plan to help improve member compliance with prescribed medications. Weekly meetings are held to discuss these members with our Medical Director and interventions to improve compliance. This focus on HIV medication adherence improved our Highly Active Retrovirus Treatment (HAART) rates by 64 percent from 2015 to 2016 (from 57.33 percent in 2015 to 93.85 percent in 2016). **

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** RESULTS & SUCCESES: MedReview Note Improves Diabetes Care in Legacy Plan

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Clear Health Alliance recognizes that a new HIV/AIDS diagnosis can lead to crisis and be perceived as devastating to their future ability to live a full and active life. We recognize that while persons with HIV/AIDS are likely to continue to thrive with proper treatment, the initial impact of the diagnosis and fear of associated stigma can become a barrier to engaging in care. To overcome this barrier, Clear Health Alliance will contract with additional trained Peer Educators, including from former PAC Waiver entities, who are role models for positive living with the disease and can conduct face-to-face outreach at any location where the member feels safe. They also conduct follow-up calls to provide emotional support. This has been invaluable to altering member perspective and setting those who are newly/recently diagnosed on the right path. In addition, all Managed Care Coordinators are skilled in discussing member concerns regarding stigmas associated with the disease and emotional issues associated for all members. The Managed Care Coordinator assesses needs and works closely with our behavioral health providers to refer for care or added community supports.

[REDACTED]

EXHIBIT A-4-a

GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

5.d. Behavior Change

As part of our screening and assessment process, we identify lifestyle issues that may impact the member's ability to manage their condition. These issues include smoking, exercise, diet, alcohol use, home environment, medication adherence issues, and other potential risk factors. The Managed Care Coordinator educates the member about the impact of their lifestyle choices on their condition, and through motivational interviewing and other techniques encourages the member to modify their behaviors in order to improve their health and reduce risk of HIV transmission. They also refer the member to appropriate internal and external resources, such as obtaining condoms through the OTC program and smoking cessation programs.

Clear Health's Healthy Behaviors programs reinforce this education by offering members incentives to make healthy lifestyle choices and modify risky behaviors that contribute to poor health outcomes. By limiting risk factors that make it harder to manage a chronic condition, we decrease the likelihood of potentially preventable ED visits or inpatient admissions.

In our Healthy Behaviors programs, members earn points for healthy behaviors like quitting smoking for a period of three months or receiving a 30-day sobriety chip from Alcoholics Anonymous or Narcotics Anonymous. They can use the points to redeem a range of health-related gifts, such as cooking essentials, foot spas, and scales.

We have the following Healthy Behaviors programs:

- Alcohol and Drug Abuse Healthy Behaviors program
- Maternity Healthy Behaviors program
- Quit Smoking and Using Tobacco Healthy Behaviors program
- Weight Management Healthy Behaviors program
- Well Child Visits Healthy Behaviors program

5.e. Communication with Providers, Including PCPs/Specialists

In our experience, most HIV/AIDS specialists are comfortable with a community-based approach to member care and welcome communication with our Managed Care Coordinators. We send a copy of the plan of care for all members who are at moderate or high risk. We ask for the provider's review and feedback, and we adjust the plan of care based on feedback received. We accompany the plan of care with a letter of introduction explaining the member's participation in our HIV/AIDS DM and Case Management program and the provider's responsibility in the care planning process. We also include the evidence-based guidelines associated with the member's conditions.

Our Managed Care Coordinators collaborate with a member's healthcare team and discuss interventions that may improve a member's health outcomes. They also encourage members to work with their providers to meet their plan of care goals, and add the discussed intervention to the member's plan of care, as appropriate, to make sure the member receives the right supports and services.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

We engage all treating providers, as appropriate, throughout the process by:

- Providing regular status updates regarding the member's stratification level, changes in health status, hospitalizations, and contact frequency
- Assisting with scheduling appointments or arranging transportation
- Identifying gaps in care or other issues that may worsen a condition or trigger a potentially preventable admission, readmission, or ED visit, such as tests out of range, medications not refilled, significant fall risks, and potential adverse medication interactions
- Addressing provider questions about the member's care
- Sharing provider collaboration and communication details
- Reinforcing evidence-based guidelines

**** RESULTS & SUCCESSES: Providers Recognize the Value of Our DM Programs**

Helping members self-manage their conditions in partnership with providers distinguishes our DM approach from other Medicaid Managed Care Plans. Most providers (96 percent) perceive our DM programs as having a positive impact on member health status and 89 percent of providers confirm quality of life improves for our members after enrolling in our DM program. Importantly, 90 percent of providers would recommend our DM program to others and rate our DM program as "better" than programs offered by other Medicaid Managed Care Plans. **

We capture our members' information in a secure, centralized Case Management System to support timely access to the most appropriate services for the member's conditions and prevent duplication. Through the Case Management System's provider-facing tools, providers who have members attributed to them can see the member record using our provider portal, giving them simple, easy-to-access data and information to assist in engaging the member in their health and well-being. They see the full picture including the plan of care and assessment information, enhancing their ability to reduce duplication and improve quality of care.

We make the most of our contacts with providers by telephone, and also regularly deliver updated information by mail or fax to the provider.

We educate our providers on reciprocal sharing of information, as well as other important components of our DM programs during our initial, ongoing, ad hoc, and annual trainings. Information includes:

- Provider rights
- Services provided by our DM programs, and benefit to members
- How to enroll a member in the program and use its services
- Provider access to our provider-facing Case Management System tools
- Reciprocal referral and sharing of information policies and procedures
- Managed Care Coordinator contact information, including phone number, address, and email
- How to provide feedback or communicate complaints

EXHIBIT A-4-a

GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

When the member's healthcare team consists of several types of providers, such as PCPs, medical and BH specialists, and social workers, Managed Care Coordinators can facilitate information sharing across the entire health care team to make sure services are synchronized, unduplicated, and consistently delivered. Our Case Management System, as well as the claims system and data warehouse, helps Managed Care Coordinators identify treating providers.

6. METHODOLOGY FOR EVALUATING OUR DM PROGRAMS

Clear Health evaluates our DM programs as part of our continuous quality improvement (QI) process. Formal evaluations occur annually, and we report results to our UM Committee and our QIC for recommendations and approvals. The evaluation includes measures from the following sources:

- Process and outcome measures
- Clinical outcomes
- Health services utilization outcomes, including pharmacy utilization, inpatient admissions, ED visits, and physician visits
- Member self-reported adherence to treatment plan
- Staff performance appraisals
- Staff productivity measures
- Member satisfaction surveys

Our clinical outcomes measures:

- Capture a relevant process or outcome
- Are population-based
- Are measured with quantitative methodologies
- Have a benchmark or performance goal
- Have data and methodology that are valid for the process or outcome measured
- Have results analyzed in comparison with the benchmark or goal

To promote continuous quality improvement, we identify at least two clinical quality measures for improvement as part of our annual evaluation, implement interventions to improve performance, and measure the effectiveness of interventions to improve each measure. We also target at least five member satisfaction survey questions for performance improvement to help us maintain the highest level of member satisfaction.

Collaborating with providers to improve member outcomes is very important to us, so we solicit written feedback and comments from providers on DM program content strengths and areas for improvement. Annually, a minimum of one program experience measure is targeted for improvement, at least one intervention is implemented, and the effectiveness of the intervention is measured.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

6.1. Methodology and Outcomes

Clear Health measures the effectiveness of our DM programs with quantitative information that captures processes and outcomes for which we have established benchmarks. Each program has its own performance measures and goals, many of them HEDIS measures, as identified in the program descriptions above. Additionally, most programs evaluate the following standard measures to determine their effectiveness in encouraging healthy behaviors, improving self-management, and influencing appropriate utilization of services:

- ED utilization
- Inpatient admissions
- Assessing tobacco use: total identified and participating
- Influenza vaccination: total identified and participating
- Pneumococcal vaccination: total identified and participating
- Medication adherence
- Plan of care adherence
- Member's perceived ability to self-manage health condition
- Members who successfully meet their goals and complete the program
- High member satisfaction with DM

6.2. Reducing Potentially Preventable Events (PPEs)

Evaluating PPEs such as ED utilization and inpatient admissions is a key step in measuring the success of our DM programs. Our holistic approach helped us achieve the second lowest rate of potentially preventable hospital admissions in the state. This is a remarkable achievement given our medically complex population.

Targeted interventions, performance improvement projects, and our investments in additional clinical staff are also resulting in quality improvements likely to reduce the risk of PPEs.

- Our DM programs focus on closing gaps in care has improved many HIV quality measures that indicate better management of the condition and reduce the likelihood of unnecessary ED visits or inpatient admissions and readmissions:
 - Increased Highly Active Anti-Retroviral Treatment (HAART) by 64 percent, from 57.33 percent in 2015 to 93.85 percent in 2016

— Reduced HIV-Related Medical Visits – 0 Visits (reverse measure) by 49 percent, from 21.22 percent in 2015 to 10.87 percent in 2016

— Increased HIV-Related Medical Visits – 2 or More Visits by 17 percent, from 64.43 percent in 2015 to 75.19 percent in 2016

- We reduced our All Cause 30-Day Hospital Readmission rate by 2.6 percent, from 31 percent in 2015 to 28.40 percent in 2016

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

6.3. Evaluating New DM Opportunities

In addition to evaluating our existing DM programs, Clear Health conducts frequent and ongoing prospecting activities to identify additional conditions that are prevalent in our membership (especially as the proportion of older individuals increases), are chronic in nature, and are impacted by lifestyle issues such as tobacco use, lack of physical activity, poor hygiene, and poor eating habits. We review and analyze available data about our member population, including daily census reports, open authorizations, member demographics, including diagnoses, BH, pharmacy, and dental utilization reports, and case management enrollment. Based on these evaluations, and Agency priorities, we continue to consider adding new conditions for targeted health education and DM.

For example, we recently initiated a rare disease program. This program, called Accordant, is an adjunctive, telephonic rare disease program designed to help members find the additional answers and support they need to manage their unique health care needs and maximize their overall health status. It targets members with specific conditions such as sickle cell disease, epilepsy, rheumatoid arthritis, multiple sclerosis, and cystic fibrosis, among others. A Nurse Managed Care Coordinator (RN) who specializes in rare conditions provides a health risk assessment to identify risk factors, gaps in care, knowledge deficits, and self-management skills to develop a personalized plan of care. The Nurse Managed Care Coordinator provides ongoing support and education to prevent complications and optimize medication management, co-morbidity support, and psychosocial support.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions:
 - (a) Cancer (Section 409.966, Florida Statutes);
 - (b) Diabetes (Section 409.966, Florida Statutes);
 - (c) Asthma;
 - (d) Hypertension;
 - (e) Mental health; and
 - (f) Substance abuse.
2. The adequacy of the respondent's description of how its respective disease management programs will be incorporated into its overall approach to advance the Agency's goals.
3. The extent to which the respondent's algorithm and risk stratification approach is well defined and describes the data sources that will be utilized.
4. The adequacy of the respondent's description of how its disease management programs will be integrated into case management/care coordination programs.
5. The extent to which the respondent's disease management programs include the following components:
 - (a) Symptom management;
 - (b) Medication support;
 - (c) Emotional support;
 - (d) Behavior change; and
 - (e) Communication with providers, including the PCP/specialists.
6. The extent to which the respondent has described a methodology for evaluating the impact of the disease management programs and provided results/data based on previous experience that supports the reduction of potentially preventable events.

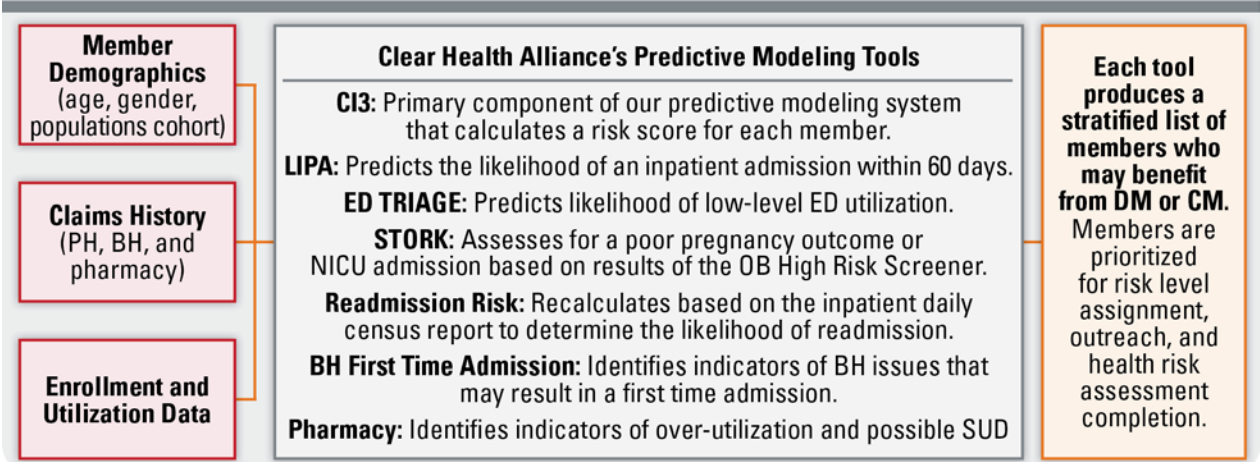
Score: This section is worth a maximum of 75 raw points with each component being worth a maximum of 5 points each.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
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Figure 5-1. Clear Health's Predictive Modeling Tools Identify Comorbid Conditions and Needs



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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 6 – HEDIS Measures (Statewide):

The respondent shall describe its experience in achieving quality standards with populations similar to the target population described in this solicitation. The respondent shall include, in table format, the target population (TANF, ABD, dual eligible), the respondent's results for the HEDIS measures specified below for each of the last two (2) years (CY 2015/ HEDIS 2016 and CY 2016/ HEDIS 2017) for the respondent's three (3) largest Medicaid Contracts (measured by number of enrollees). If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one (1) of three (3) states for the last two (2) years.

The respondent shall provide the data requested in **Exhibit A-4-a-1**, General Performance Measurement Tool to provide results for the following HEDIS measures:

- Adults' Access to Preventive/Ambulatory Health Services (Total);
- Child and Adolescent Access to PCPs (all 4 age bands reported as separate rates);
- Medication Management for People with Asthma (75% - Total);
- Controlling High Blood Pressure;
- Comprehensive Diabetes Care – HbA1c Control (<8%);
- Follow-up after Hospitalization for Mental Illness (7 day);
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation – Total);
- Antidepressant Medication Management – Acute Phase; and
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Based on the ITN requirements for SRC 6 and SRC 7, we have submitted HEDIS data for the Simply legacy plan in Florida with the largest Medicaid membership (Amerigroup). Additionally, Amerigroup's membership is more comparable to that of the population from which the Medicaid 50th percentile is derived than the HEDIS results for Clear Health. Because of its specialized nature, Clear Health is not one of Simply's largest three contracts by membership. In addition, we are reporting results for our two largest affiliate Medicaid contracts based upon the number of Medicaid members served by each contract. These two contracts are in New York and Texas.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1. EXPERIENCE ACHIEVING QUALITY STANDARDS

Simply and our affiliate health plans currently serve more than 6.5 million beneficiaries of state-sponsored health plans in 20 markets. We collect and report HEDIS® and state performance measures in each of these states. Since we began operations in Florida over 14 years ago, Simply has collected and reported HEDIS® and state performance measures, and today we collect and report all required measures to the National Committee for Quality Assurance (NCQA and Agency for Health Care Administration (Agency). Simply is further sharpening our focus on quality by bringing together the best practices and innovative solutions of three Florida health plans that have recently merged to become one entity. Our Chief Medical Officer and our Quality Management leadership spearhead our Quality Management program, bringing more than 40 years of combined experience in performance improvement programs and HEDIS® reporting. As a result of our experience, we continue to achieve high marks for performance, as demonstrated in our HEDIS® 2016 and 2017 scores described below and in Attachment SRC# 6-1: Exhibit A-4-a-1.

**** RESULTS & SUCCESSES:** In HEDIS® 2016 Simply's legacy plan, Amerigroup, was the only plan that scored above the statewide average for all components of each Quality of Care Indicator developed by the Agency for the Medicaid Health Plan Report Card (Report Card). Quality of Care Indicators are a set of measures that are used to report the performance of health plans. Data for these measures came from HEDIS® and were designed for use by Medicaid consumers. The Report Card includes six Quality of Care Indicators: Living with Illness, Keeping Adults Healthy, Keeping Kids Healthy, Mental Health Care, Pregnancy-related Care, and Children's Dental Care. ******

Health plan ratings, shown as stars, are assigned to each health plan for each indicator based on the plan's score for the indicator. Plans are assigned between one and five stars, based on the health plans ratings for the associated measure. The designation of stars is denoted below:

- 5 stars – Best: at or above 50 percent of all Medicaid health plans' scores
- 4 stars – Good: better than at least 40 percent of all Medicaid health plans' scores
- 3 stars – Fair: better than at least 25 percent of all Medicaid health plans' scores
- 2 stars – Poor: better than at least 10 percent of all Medicaid health plans' scores
- 1 star – Very Poor: worse than 90 percent of all Medicaid health plans' scores

In HEDIS® 2016, Simply, through our legacy plan, Amerigroup, was awarded:

- 5 out of 5 stars in all five components of the Living with Illness Quality Indicator (better than any other health plan)
- 5 out of 5 stars in four of five components in the Keeping Adults Healthy Quality Indicator (only one other health plan earned as many as 5 stars)
- 5 out of 5 stars in seven out of 11 components in the Keeping Kids Healthy Quality Indicator (only two other health plans earned as many as 5 stars)
- 5 out of 5 stars in two of four components in the Mental Health Care Quality Indicator (only two other health plans earned more than 5 stars)

EXHIBIT A-4-a

GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- 5 out of 5 stars in all three components of the Pregnancy-related Care Quality Indicator (only one other health plan earned as many as 5 stars)

1.1. Florida Experience Achieving Quality Standards

As stated above, and in accordance with the directions provided in this question, we selected the legacy plan with the largest enrollment (Amerigroup) to represent our Florida experience. In the HEDIS® 2016 submission, we led the state of Florida at the NCQA Quality Compass 90th percentile for Child Immunizations Status (CIS - Combo 3); Comprehensive Diabetes Care (CDC - Medical Attention for Nephropathy), and Annual Monitoring for Patients on Persistent Medication (MPM - Combined). In addition, for HEDIS® 2016, we were the first in the state of Florida for the following measures: Cervical Cancer Screening (CCS), Childhood Immunization Status (CIS – Combo 3), Comprehensive Diabetes Care (CDC – HbA1c testing rate), Controlling High Blood Pressure (CBP), Prenatal Care Frequency (PCF - 81 percent or higher), and Well Child Visits 15 months of age (W15 – 6 visits). Simply's legacy plan, Amerigroup, exceeded the Medicaid National Mean for eight of the 12 measures in this submission requirement for both HEDIS® 2016 and 2017.

Adults' Access to Preventive/Ambulatory Health Services (Total) rates of 78.17 percent for HEDIS® 2016 and 74.84 percent for HEDIS® 2017 scoring.

Child and Adolescent Access to PCPs – 12 - 24 Month Age Band rates of 96.82 percent for HEDIS® 2016 and 95.97 percent for 2017, scoring above the 50th percentile each measurement period and above the Medicaid National Mean in HEDIS® 2016 and 2017. When compared to other health plans in Florida, we performed as well as or better than all other Standard MMA plans on this measure in HEDIS® 2016.

Child and Adolescent Access to PCPs - 25 months – 6 Years Age Band rate of 91.04 percent for HEDIS® 2016, scoring above the 75th percentile and above the Medicaid National Mean. When compared to other health plans in Florida, we performed as well as or better than all other Standard MMA plans on this measure in HEDIS® 2016. For HEDIS® 2017, we reported a rate of 90.69 percent, scoring above the 60th percentile and above the Medicaid National Mean and state goal.

Child and Adolescent Access to PCPs - 7 to 11 Years Age Band rates of 90.65 percent for HEDIS® 2016 and 91.16 percent for HEDIS® 2017, scoring above the Medicaid National Mean and above the 50th percentile in HEDIS® 2016 and 2017. Compared to other health plans, we performed as well as or better than all but one other Standard MMA health plan in HEDIS® 2016.

Child and Adolescent Access to PCPs - 12 to 19 Years Age Band rates between HEDIS® 2016 and 2017 demonstrated improvement year-over-year of .22 percentage points (88.29 percent for 2016). For HEDIS® 2017, we reported a rate of 88.51 percent, scoring above the Medicaid National Mean and Florida Mean. Compared to other health plans, we performed as well as or better than all other Standard MMA health plans for HEDIS® 2016.

Medication Management for People with Asthma (75 percent - Total) rates improved in this measure (2.31 percentage points) from HEDIS® 2016 to 2017, as we reported a rate of 20.62 percent for HEDIS® 2016 and 22.93 percent for HEDIS® 2017.

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GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Controlling High Blood Pressure rates of 67.41 percent for HEDIS® 2016 and 66.23 percent for HEDIS® 2017 exceeded the 75th percentile in each reporting year. Additionally, we performed better than all other health plans (Standard and Specialty MMA) by a range of 7 – 34 percentage points in HEDIS® 2016.

Comprehensive Diabetes Care – HbA1c Control (<8 percent) rates of 49.07 percent for HEDIS® 2016 and 51.04 percent for HEDIS® 2017, which demonstrates improvement year-over-year of 1.97 percentage points and achievement above the HEDIS® 50th percentile for HEDIS® 2016 and 2017, and above the Medicaid Nation Mean and Florida Mean for each measurement period.

Follow-up after Hospitalization for Mental Illness (7 day) rates of 46.37 percent for HEDIS® 2016 and 46.88 percent for HEDIS® 2017 exceeded the Medicaid National Mean and the 50th percentile in both reporting years. Compared to other health plans reporting HEDIS® 2016, we performed better than all but one other Standard MMA health plan.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation – Total) rates for both reporting years exceeded the Florida Mean (39.96 percent for HEDIS® 2016 and 38.79 percent for HEDIS® 2017), and exceeded the 50th percentile for HEDIS® 2016.

Antidepressant Medication Management – Acute Phase rates of 53.65 percent for HEDIS® 2016 and 50.99 percent for HEDIS® 2017 exceeding the 50th percentile for HEDIS® 2016.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia rates of 62.36 percent for HEDIS® 2016 and 63.28 percent for HEDIS® 2017, a year-over-year improvement of .92 percentage points, scored above the Medicaid National Mean and above the 50th percentile in HEDIS® 2016 and 2017.

1.2. New York Experience Achieving Quality Standards

One of our affiliate's Medicaid contracts with New York began in January 2005 and currently serves 380,224 members. The most recent contract was executed in March 2014 and extends through February 2019. The current contract covers the TANF, ABD, and Medicaid expansion populations. For measurement year 2016, New York met 20 out of 41 state-specified targets and earned more than \$16 million in performance-based incentives.

Adults' Access to Preventive/Ambulatory Health Services (Total) rates increased slightly between HEDIS® 2016 and HEDIS® 2017 (84.67 percent and 85.07 percent) exceeding the 50th percentile in for HEDIS® 2016 and 60th percentile for HEDIS® 2017.

Child and Adolescent Access to PCPs - 12-24 Month Age Band rates of 95.20 percent for HEDIS® 2016 and 96.80 percent for HEDIS® 2017 exceeded the Medicaid National Mean for both reporting years and exceeded the 60th percentile for HEDIS® 2017.

Child and Adolescent Access to PCPs - 25 months – 6 Years Age Band rate of 95.32 percent for HEDIS® 2016 exceeded the 90th percentile and scored above the Medicaid National Mean. In HEDIS® 2017, our NY affiliate reported a rate of 95.62 percent, scoring above the 90th percentile.

EXHIBIT A-4-a

GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Child and Adolescent Access to PCPs - 7 to 11 Years Age Band rates of 97.75 percent for HEDIS® 2016 and 97.87 percent for HEDIS® 2017 scoring more than 7 percentage points above the Medicaid National Mean in HEDIS® 2016 and above the 90th percentile in both reporting years.

Child and Adolescent Access to PCPs - 12 to 19 Years Age Band rates of 95.81 percent for HEDIS® 2016 and 96.12 percent for HEDIS® 2017 exceeding the 90th percentile in both reporting years.

Medication Management for People with Asthma (75 percent - Total) rates of 30.43 percent for HEDIS® 2016 and 29.14 percent for HEDIS® 2017.

Controlling High Blood Pressure rates of 62.06 percent for HEDIS® 2016 and 56.10 percent for HEDIS® 2017 exceeded the 60th percentile for HEDIS® 2016.

Comprehensive Diabetes Care – HbA1c Control (<8 percent) rates of 54.41 percent for HEDIS® 2016 and 55.79 percent for HEDIS® 2017, which demonstrates improvement year-over-year of 1.38 percent and achievement above the HEDIS® 75th percentile for both reporting years.

Follow-up after Hospitalization for Mental Illness (7 day) rates of 56.06 percent for HEDIS® 2016 and 58.18 percent for HEDIS® 2017, which represents a year-over-year improvement of 2.12 percentage points and results above the 75th percentile in each reporting year.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation – Total) rates of 41.39 percent for HEDIS® 2016 and 43.16 percent for HEDIS® 2017, which represents a year-over-year improvement of 1.77 percentage points and results above the 60th percentile for HEDIS® 2016 and above the 50th percentile for HEDIS® 2017.

Antidepressant Medication Management – Acute Phase rates of 52.83 percent for HEDIS® 2016 and 48.38 percent for HEDIS® 2017 scoring slightly below the 50th percentile for HEDIS® 2016.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia rates for both HEDIS® 2016 and 2017 exceeded the National Medicaid Mean and HEDIS® 50th percentile in both reporting years (62.68 percent for HEDIS® 2016 and 60.78 percent for HEDIS® 2017).

1.3. Texas Experience Achieving Quality Standards

One of our affiliate's contracts for the Texas Medicaid program began in September 2011 and extends through August 2018, serving 646,398 members. The initial Medicaid contract with Texas was executed in 1996. The current contract covers the TANF, CHIP and ABD populations. Texas Medicaid reports by product within the contract and has currently suspended their quality-related withhold program due to necessary methodological changes. The State of Texas aspires to the Medicaid 75th percentile as the goal for comparison of Texas rates.

Adults' Access to Preventive/Ambulatory Health Services (Total) rates of 84.02 percent for HEDIS® 2016 and 83.83 percent for HEDIS® 2017 scoring above the Medicaid National Mean both reporting periods, above the 50th percentile for HEDIS® 2016 and above the 60th percentile for HEDIS® 2017.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Child and Adolescent Access to PCPs - 12-24 Month Age Band rates of 97.19 percent for HEDIS® 2016 and 96.84 percent for HEDIS® 2017 exceeded the Medicaid National Mean and the 60th percentile in each measurement period.

Child and Adolescent Access to PCPs - 25 months – 6 Years Age Band rates for HEDIS® 2016 and 2017 exceeded the 60th percentile in both reporting years. (90.95 percent and 90.13 percent)

Child and Adolescent Access to PCPs - 7 to 11 Years Age Band rates of 94.49 percent for HEDIS® 2016 and 94.13 percent for HEDIS® 2017 exceeded the 75th percentile in both reporting periods.

Child and Adolescent Access to PCPs - 12 to 19 Years Age Band rates for HEDIS® 2016 and 2017 (93.23 percent and 93.11 percent) exceeded the Medicaid National Mean and the 75th percentile in both reporting years.

Medication Management for People with Asthma (75 percent - Total) rate for HEDIS® 2016 was 23.78 percent and for HEDIS® 2017 was 23.14 percent.

Controlling High Blood Pressure rates were 56.88 percent for HEDIS® 2016 and 56.54 percent for HEDIS® 2017.

Comprehensive Diabetes Care – HbA1c Control (<8 percent) rates of 46.17 percent for HEDIS® 2016 and 46.53 percent for HEDIS® 2017, which demonstrates improvement year-over-year of .36 percentage points and exceeded the Medicaid National Mean for HEDIS® 2016.

Follow-up after Hospitalization for Mental Illness (7 day) – Texas Medicaid program reported a significant year-over-year improvement of 6.65 percentage points between HEDIS® 2016 and 2017 (45.11 percent).

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation – Total) reported an improvement year-over-year of 2.90 percentage points between HEDIS® 2016 and 2017.

Antidepressant Medication Management Acute Phase rate of 65.71 percent for HEDIS® 2016 exceeded the 75th percentile for HEDIS® 2016 and was just below the 50th percentile for HEDIS® 2017 (51.47 percent).

Adherence to Antipsychotic Medications for Individuals with Schizophrenia rate of 64.42 percent for HEDIS® 2016 exceeded the 60th percentile. (58.39 percent for HEDIS® 2017).

2. THE EXTENT THE RESPONDENT EXCEEDED THE NATIONAL MEAN AND APPLICABLE REGIONAL MEAN FOR EACH QUALITY MEASURE

See Exhibit A-4-a-1 in Attachment SRC# 6-1 General Performance Measurement Tool. This General Performance Measurement Tool shows our calendar year 2015 and 2016 rates for each of the 12 HEDIS® measures requested in this solicitation.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for the HEDIS performance measures included in this submission requirement.
2. The extent to which the respondent exceeded the national mean and applicable regional mean for each quality measure reported and showed improvement from the first year to the second year reported.

Score: This section is worth a maximum of 160 raw points with component 1 worth a maximum of 10 points and component 2 worth a maximum of 150 points as described below:

Exhibit A-4-a-1, General Performance Measurement Tool, provides for seventy-two (72) opportunities for a respondent to report prior experience in meeting quality standards (twelve (12) measure rates, three (3) states each, two (2) years each).

For each of the measure rates, a total of 10 points is available per state reported (for a total of 360 points available). The respondent will be awarded 2 points if their reported plan rate exceeded the national Medicaid mean and 2 points if their reported plan rate exceeded the applicable regional Medicaid mean, for each available year, for each available state. The respondent will be awarded an additional 2 points for each measure rate where the second year's rate is an improvement over the first year's rate, for each available state.

An aggregate score will be calculated and respondents will receive a final score of 0 through 150 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 360 points, the final score will be 150 points (100%). If a respondent receives 324 (90%) of the available 360 points, the final score will be 135 points (90%). If a respondent receives 36 (10%) of the available 360 points, the final score will be 15 points (10%).

EXHIBIT A-4-a
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EXHIBIT A-4-a-1
SRC# 6 - GENERAL PERFORMANCE MEASUREMENT TOOL (10-2-2017)

INSTRUCTIONS:

Respondents should submit calendar year 2015/HEDIS 2016 and calendar year 2016/HEDIS 2017 performance measure data for the selected HEDIS measures for the respondent's three (3) largest Medicaid contracts (measured by number of enrollees).

If the respondent does not have HEDIS results for at least (3) three Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one of three (3) states for the last two (2) years.

The performance measures that respondents are required to report on can be found on the Performance Measure Group A tab.

Use the drop-down box to select the state for which you are reporting and enter the performance measure rates (to the hundredths place, or XX.XX) for that state's Medicaid population for the appropriate calendar year.

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SRC# 7 – HEDIS Measures (Statewide):

In addition to providing HEDIS measure data, describe any instances of failure to meet HEDIS or Contract-required quality standards for the measures listed below and actions taken to improve performance. Describe actions taken to improve quality performance when HEDIS or Contract-required standards were met, but improvement was desirable.

- Adults' Access to Preventive/Ambulatory Health Services (Total);
- Child and Adolescent Access to PCPs (all 4 age bands reported as separate rates);
- Medication Management for People with Asthma (75% - Total);
- Controlling High Blood Pressure;
- Comprehensive Diabetes Care – HbA1c Control (<8%);
- Follow-up after Hospitalization for Mental Illness (7 day);
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation – Total);
- Antidepressant Medication Management – Acute Phase; and
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia.

Response:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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Evaluation Criteria:

1. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way and to successfully remediate all failures for the HEDIS performance measures included in this submission requirement.
2. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way even when HEDIS or Contract-required standards were met, but improvement was desirable, for the HEDIS performance measures included in this submission requirement.

Score: This section is worth a maximum of 10 raw points with each component worth a maximum of 5 points each.

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SRC# 8 – Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Robert, a 50-year-old man, was diagnosed with chronic obstructive pulmonary disease (COPD) five (5) years ago. His symptoms have been worsening recently, and he has presented at the emergency department three (3) times during the past thirty (30) days. Robert previously smoked twenty-five (25) cigarettes per day for thirty (30) years, but cut down to ten (10) cigarettes per day after his first COPD exacerbation two (2) years ago. He has attempted to quit smoking on several occasions without any success. Robert is prescribed several regular medications for his COPD, as well as for hypertension and hypercholesterolemia. He is pre-diabetic and obese with a BMI of 35. His last appointment with his specialist was ten (10) months ago. Robert has difficulty taking his medications regularly, as he is sometimes unable to get his prescriptions in his rural community and he lacks transportation. After his last visit to the emergency department, Robert was prescribed oxygen treatments and a new medication; however, he has not filled these orders. Robert lives with his 15-year old son and is a single parent. Robert and his son have been on Medicaid for the last four (4) years since he lost his job. Robert has been a member of the plan since December 2016.

The respondent shall describe its approach to coordinating care for an enrollee with Robert's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

- a. New Enrollee Identification;
- b. Health Risk Assessment;
- c. Care Coordination/Case Management;
- d. Service Planning;
- e. Discharge/Transition Planning;
- f. Disease Management;
- g. Utilization Management; and
- h. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan. Clear Health's integrated care model supports delivery of seamless, whole-person care across the continuum to decrease fragmentation and achieve the best outcomes for members, like Robert, who have complex conditions. In the response below, we describe Robert's story and how we address his physical, behavioral, and social support needs, and then outline our activities in meeting each of the Evaluation Criteria. By coordinating care across the continuum – between providers, case management, pharmacy, behavioral health, subcontractor management, and medical utilization oversight – and by using all available tools and data points, we identify and comprehensively address our members' health care needs.

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**** Meeting Robert's Needs Through Clear Health's Comprehensive Case Management ****


Following Robert's latest emergency department (ED) visit, he is assigned a Clear Health Case Manager (Managed Care Coordinator), Maria. Maria is a registered nurse who has experience working with individuals experiencing cardiac and pulmonary conditions, in addition to HIV disease, which Robert is also living with. Maria reviews Robert's personal health record to understand his current situation. In her review, Maria notes Robert's original assessment shows a history of COPD, HIV, hypertension, and tobacco use, but also compliance with his current treatment plan, his PCP, and his progress toward his treatment goals. She also notes that Robert was referred to Clear Health's Case Management and Healthy Behaviors program (for smoking cessation support). While Robert has declined case management in the past, he has expressed interest in the program to help him quit smoking. Maria also sees that over the course of Robert's last three ED admissions, several attempts were made by our Managed Care Coordinators to reach him, including outreach to his PCP who is an HIV experienced provider, but were unsuccessful. His phone had been disconnected and his email returned as "user not found." On his last ED visit, Robert indicated he no longer had a phone and provided the ED with his new residential and email addresses, which were then updated in Clear Health's Case Management System and shared with his HIV provider.

After thoroughly reviewing his record, Maria uses the updated email information to reach out to Robert, introduce herself, and to ask for a face-to-face visit at a time and place that works for Robert. She explains in the email that, as his Managed Care Coordinator, she's here to help him understand his benefits and the services available that can help him. Within a day, Robert responds and agrees to meet Maria two days later at his home.

During the comprehensive assessment, Maria talks to Robert about his medical history and how he is feeling now. In her review of Robert's record, she noted several additional risk factors, including that Robert isn't taking his medications and has not seen a specialist in more than 10 months as well as his need for a prescription for oxygen (while still an active smoker). Robert may also be at risk for things like heart disease, deep vein thrombosis, stroke, peripheral vascular disease, renal disease, opportunistic infections due to his HIV, and nicotine dependence. Together, they talk about his conditions as well as his challenges with smoking and his recent attempts to quit. Maria listens to Robert talk about his experiences, and she congratulates him on his accomplishments of cutting back on smoking and encourages him to continue.

He tells Maria how unpleasant the recent ED visits have been, and Maria assures him she understands and they can work together to identify ways to prevent these occurrences and to find alternatives for when he is not feeling well. Maria learns the reason Robert has presented so often in the ED is that it is the closest health facility to where he lives and he doesn't have a car or means of transportation to go anywhere else. Maria explains to Robert about his benefits and tells him she will help him arrange transportation and an appointment with his PCP. Maria also gives Robert information on some of the nearest urgent care clinics, emphasizing when they are appropriate to use and that they often have shorter wait times and are easier to access. Maria also tells Robert about our 24/7 Nurse help line and our LiveHealth Online. She shows him how to access LiveHealth Online (using her iPad), so Robert can see how he can quickly access medical advice for any questions he may have about medications or his conditions. Maria also reminds Robert that she is also available to help him.

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Maria also facilitates access to an uninterrupted supply of medications for Robert, which will improve medication adherence through coordination of his mail order pharmacy benefit. Since Robert does not have a phone at the time of the visit, Maria contacts the pharmacy to set up a 30 day mail order supply of current medications after a review by our in-house pharmacist for contraindications.

Maria and Robert also talk about his situation at home and Robert's desire to have a more stable environment for his son, a Simply (not Clear Health) member who has not received the recommended well child visits and screenings. Maria makes sure to listen carefully and support Robert, who reveals that he has not disclosed his HIV status to his son. Given his challenges, financial constraints, and the burden of his current physical health conditions; Maria also thinks Robert may be at risk for depression and sets up a referral for Robert to see a therapist. She also inquires about any additional family support that may be in the area.

Robert agrees to develop a plan of care to help him follow his discharge plans, fill his prescriptions, and get properly linked with a specialist. Maria explains the plan of care development to Robert and that other individuals may be able to contribute to this plan. She asks Robert if he'd like to identify participants for his personal multi-disciplinary team and Robert agrees that he would like his PCP to participate. Robert chooses not to include his son at this time due to concerns about his HIV disease, but understands that he may change his mind at any time, if and when he chooses to disclose his status. Maria shares information regarding the local AIDS services in the area where he may attend support groups and where specialized counselors may assist Robert in disclosing his HIV status to his son and other members of his family.

At the end of the visit, Maria explains the various options available to Robert and confirms that email is his preferred method of communication. Maria walks through the next steps with Robert, including explaining his plan of care development and identifying potential meeting times for his MDT to meet. She asks Robert if it is ok if she reaches out to Robert's current providers, and he agrees. Maria makes sure that Robert has her contact information (both email and phone) and the number for Clear Health's 24/7 call center, so that Robert can reach someone at any time.

Following the assessment, Maria reaches out to Robert's PCP, introduces herself, and explains that she is working with Robert to develop his personalized plan of care. She reviews Robert's assessment results and personal health record to ask his PCP for recommendations regarding services and care to help Robert attain his identified goals.

After this call and using all available information, Maria contacts Robert again five days later, as agreed, to review his finalized personalized plan of care. She also helps him schedule a PCP appointment and says she will review his prescriptions and treatment plan with him after his visit, so she can help him closely monitor things like his body mass index (BMI) and risk for diabetes. Maria also helps Robert create a list of questions to bring with him to his PCP appointment about his long-term care and conditions. Although the HIV disclosure concern is important, Maria and

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Robert agree to focus on the immediate health concerns regarding his recent COPD exacerbations.

During the call, Robert reviews and approves his care plan, and Maria prepares to initiate case management, including service and health interventions associated with Robert's identified goals and milestones. Maria makes sure all services are authorized and updated in the Clear Health Case Management System within 14 days. She also follows up with Robert by telephone during the 14 days to see that his services are initiated according to his approved plan of care.

Maria, who lives in Robert's area, continues to contact him by phone at least monthly after the initial 14 days. She also offers to meet him quarterly face-to-face or more often if requested. During these monthly visits, Maria and Robert review his plan of care and see that all services are being received. She also reviews his care goals and any barriers or challenges he encounters. She reviews his claims to verify that he attends his physician visits as well as his report of medication fills and determines whether he has any unaddressed needs or additional risks to be incorporated into his current plan of care. Throughout this process, Robert and Maria work together to track his progress towards his identified goals.

1.a. IDENTIFY MEMBERS WHO NEED CARE COORDINATION

In addition to member self-referral, Clear Health uses a multi-modal approach to identify members who have complex conditions, need care coordination, and who may benefit from interventions. Through initial screeners, the comprehensive health assessment, provider referrals, our Utilization Management (UM) team, and predictive modeling; we identify members, no matter where they live, who may benefit from any of our clinical programs – including our Case Management and Disease Management programs. In addition, our predictive modeling tool, the Chronic Illness Intensity Index (CI3) helps us proactively monitor and mine utilization data to identify members with high rates of utilization who may be at risk for ED, inpatient, medication adherence issues, and other key health factors. Among our suite of predictive modeling tools, we will identify members who need more intensive support, such as when a member has three ER visits within a 60-day period. Our subscription to the Emergency Notification System which provides real time notification when members present in the hospital, including ED visits, is also a valuable tool in the rapid identification and referral of at risk members.

In Robert's case, he was enrolled in our plan and, following his initial screener and original assessment, was referred to our Case Management program to address his complex conditions and our Healthy Behaviors program for smoking cessation. His recent ED visits, as well as non-compliance with medication adherence/refills and equipment, triggers a referral through our CI3 for more intensive outreach and care coordination efforts.

1.b. THE ASSESSMENT PROCESS, DATA/INFORMATION UTILIZED AND TIMEFRAMES

During the first 30 days of enrollment, the member receives a Welcome Packet that includes an HRA form. Welcome calls are also made to the member during this period which includes discussion of the HRA form, the opportunity to complete the form on the phone or mail it back to the plan.

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Once referred to case management – either through the CI3 score, member or provider request, or Member Services referral – the Managed Care Coordinator reviews all of the member's information available and makes the initial member contact attempt within 72 hours. During the first 14 days of the referral, at least three contact attempts must be made and a "please contact us" letter is issued to ensure members, like Robert, are actively engaged in case management.

During first contact, the Managed Care Coordinator completes the comprehensive assessment. If a member is unable to complete the assessment, our Managed Care Coordinator schedules one at the member's earliest convenience, but not to exceed 14 days from the initial contact.

Clear Health uses a variety of information to assess the member's total health care needs (physical, behavioral, functional, cognitive, social, and occupation). Using structured tools, Managed Care Coordinators conduct an in-depth clinical assessment to gather information, including:

- General health
- ED use and hospitalizations
- Medications
- Health care utilization
- Functional capacity
- Preventive care history

Our comprehensive health assessment comprises more than 20 potential clinical areas that help Managed Care Coordinators, like Maria, identify potential risk factors and areas of need. It also includes specialized assessment modules for each member's specific conditions (including physical, behavioral, functional, social, and psychological health) using branching logic.

Prior to meeting with Robert to complete the comprehensive assessment, Maria follows the department's checklist to ensure a comprehensive review of all of Robert's records in Clear Health's Case Management System, including his personal health historical data from several domains and sources, such as utilization, claims, authorization, and case management data regarding:

- Physical health
- Pharmacy
- Behavioral health
- ED
- Hospital admissions
- Event notification service (ENS)
- Outpatient services
- Ancillary services

Information from our Case Management System is reviewed with Robert during the comprehensive assessment process and used to formulate his plan of care. For example, Maria cross references the medications listed in the Case Management system with Robert's medications in the home to determine any adherence issues or gaps. The plan of care is finalized within 5 business days of Robert's assessment.

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1.c. RISK STRATIFICATION PROTOCOL

Clear Health uses our proprietary Chronic Illness Intensity Index (CI3) for risk stratification. Its predictive modeling algorithms show the relative risk ranking of members regarding their likelihood to consume significant medical service resources in the future. These members often have complex medical issues, high service utilization, intensive health care needs, and higher inpatient (IP) and/or ED usage. All clinical data is entered into a reporting system, where it is synthesized to identify and stratify members by severity and risk level. Once stratified, our Clinical team accesses the information to identify opportunities for outreach, education, enhanced access, and care coordination to identify members with co-morbid medical or mental health and substance use disorders, assess their conditions, and implement interventions. Utilization and chronic condition data are claims-driven and based on the prior 12-month history.

As stated above, at the time of his initial enrollment with Clear Health in December 2016, Robert was identified as moderate risk (Level 2). He was verified to be under a treatment plan with his PCP for his chronic conditions and referred to our Case Management program; however, his recent ED utilization and claims history (medication plan adherence) resulted in raising his risk level to Level 3 (high risk) in our CI3 report, prompting assignment for more targeted outreach by our case management team. Maria continues to monitor Robert's care and service needs, progress to goals, PCP and ED usage, to identify any changes in his risk stratification or care plan. Given Robert's recent use of ED services, Maria communicates with our in-house Pharmacist, who reviews Robert's current medications (to verify appropriateness and make sure there are no contraindications) and flags any items for his PCP to review.

1.d. IDENTIFYING SERVICE NEEDS AND MAKING REFERRALS

Clear Health's guiding principle is and will continue to be person-centered care and service planning across the member's system of care, optimizing but never duplicating services. Our Managed Care Coordinators coordinate personalized care and service supports across the full continuum of care to address the member's needs holistically (across physical health, behavioral health, and social supports).

Clear Health's process for identification of service needs occurs during the development of the plan of care. In this process, Maria reviews with Robert the findings from the assessments and information gathered through our systems. This information is used to develop the plan of care, which includes problems, interventions, short- and long-term goals, timeframes, and anticipated outcomes. Maria asks Robert to identify his preferred providers for the services and care included in his plan of care. He includes his PCP as a member of his MDT for inclusion in this review.

During the assessment process, Maria also asks Robert about any community agencies or supports he is currently using, including Ryan White HIV service agencies, community/mail-order pharmacies, home health, durable medical equipment (DME), and transportation options. She asks if he's involved in or interested in participating in community programs, such as exercise, parenting, and peer support (tobacco cessation and HIV), among other options. She incorporates all current covered and non-covered services and supports identified during the assessment, as well as any new covered or non-covered services Robert would like to include. Maria helps identify provider or community agency options for services that Robert can select. Within five days of the initial visit and using the data collected during the assessment, Maria works with Robert to review

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and finalize the person-centered plan of care. Following approval, Maria initiates the tasks identified in the plan of care.

Given Robert's recent medical challenges as well as the other potential risks to his physical and behavioral health, his comprehensive plan of care includes the following service needs and referrals:

- Case Management/Care Coordination — To address member's needs, improve adherence to the treatment plan, remove barriers to care and reduce health risks. Maria will provide these functions that reinforce progress toward Robert's goals and facilitate communication between the member, providers, and health plan.
- Coordination of PCP/Specialist Appointments — As part of the case management/care coordination services, Maria helps Robert set and attend appointments to make sure he is receiving timely, ongoing health checks. She also reviews his prescriptions and treatment plan with him after these visits. This helps promote better compliance with medications, management of his COPD and hypertension, and monitoring of his BMI and pre-diabetes, in addition to ensuring that Robert remains adherent to his HIV treatment regimen. Maria helps him create a list of questions for his PCP regarding his long-term care and will provide coordination of any specialist appointments as identified by his PCP. During contact with Robert's PCP to schedule his first visit, Maria asks the PCP to review Robert's personal health record for additional potential COPD medication needs (for example, bronchodilator and systemic corticosteroid within required HEDIS timeframes post ED visit). In addition, Maria asks Robert if she can assist in coordinating his son's care and he agrees to have her help refer his son to a Simply Case Manager for assistance with scheduling a well-visit and transportation at this time.

Maria will follow up with Robert after the PCP or any specialist visit on the importance of coordinating the pulmonologist oxygen orders with his PCP for review as his PCP serves an important role in seeing there are no safety conflicts with medications and treatment plans, particularly with his co-morbidities.

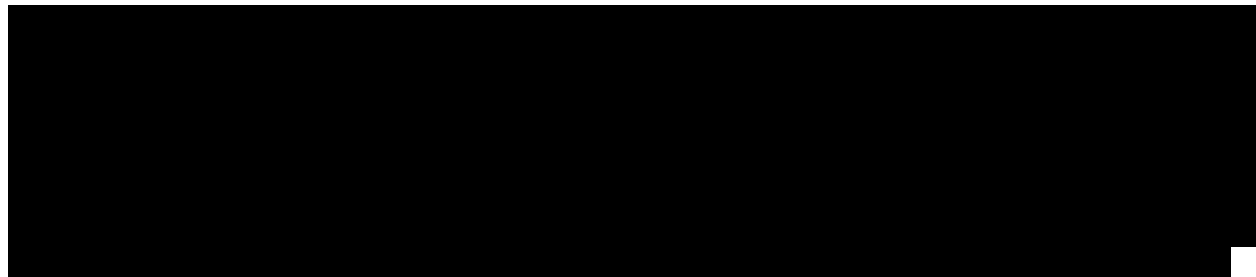
- HIV/AIDS Services — Maria refers Robert to an area Ryan White-funded agency that provides specialized programs using peer-led support groups and referrals to resources specifically designed for persons living with HIV/AIDS such as housing programs, legal aid, and food programs that he may qualify for.



- Transportation — To address the challenges Robert has experienced getting to his and his son's health care appointments, Maria helps Robert access transportation services. These services can be requested by either the member, plan, or providers through Clear Health's delegated transportation subcontractor. Maria informs Robert about this benefit and provides the number to call and arrange transportation once he receives a phone. Until that occurs, Maria lets him know she will coordinate transportation for appointments. Maria calls Robert's PCP during the visit to schedule his first appointment.

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- Mail Order Pharmacy — As his Managed Care Coordinator, Maria facilitates access to an uninterrupted supply of medications for Robert, which will improve medication adherence through coordination of his mail order pharmacy benefit. Since Robert does not have a phone at the time of the visit, Maria contacts the pharmacy to set up a 30 day mail order supply of current medications. Maria will also track and assure delivery of medications and check-in regularly with Robert to monitor his medication adherence. Given Robert's recent use of ED services, Maria communicates with our in-house Pharmacist, who reviews Robert's current medications to verify appropriateness and make sure there are no contraindications. The Pharmacist also reviews and flags any items for Robert's PCP to review.
- Behavioral Health Services — Maria explains the behavioral health services available to help address Robert's feelings of anxiety and depression and provide supportive training such as parenting classes. Robert is also interested in exploring the idea of disclosure of his HIV status to his son which he has been reluctant to do so in the past. Maria explains to Robert his options, such as in-person visits and how to access telemedicine, if Robert prefers. Robert likes the telemedicine option given the rural setting where he lives and the other appointments he has. Maria refers Robert directly by fax to an appropriate behavioral health provider. Maria is aware that anxiety and COPD can often create a cycle of breathlessness, which can create panic and make individuals feel more anxious (making it harder to breathe). This creates a breathlessness cycle, making it difficult for an individual to distinguish the symptoms of anxiety from the symptoms of COPD. While having some anxiety when diagnosed with a chronic disease can be helpful, as it prompts the individual to follow treatment, paying more attention to symptoms can impact quality of life. Maria makes sure to indicate in her referral the impact on co-morbidities to be addressed.



- Education — Robert's recent ED visits, which he identifies as an unpleasant experience, identify an opportunity to identify alternatives for his care needs. Maria educates Robert on the benefit of visiting his PCP and remaining current with preventive screenings, medications, and monitoring of his conditions, as well as the option to use Urgent Care/Minute Clinics rather than EDs because they often have shorter wait times and are easier to access for care. Maria also provides Robert with a list of nearby urgent care clinics and guidance on arranging transportation services, if needed. For specific health conditions, Robert agrees to receive educational materials by mail on COPD, hypertension, and hypercholesterolemia but declines those for HIV until he is able to disclose his status to his son. Maria will review what was learned during the next scheduled contact and reinforce key points during subsequent calls.
- Provision of Nurse help line and LiveHealth Online Contact Information for Care Concerns — Maria introduces Robert to available telephone and web-based technologies he can use from home to seek medical advice. She highlights the use of the 24/7 Nurse help line, which can provide Robert with quick access to medical advice for questions related to medications or prescribed interventions. Through Clear Health, Robert also has access to LiveHealth Online,

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which provides tele-access to physicians able to access his personal health records, if he has questions about a health care concern or needs assistance.

- Safely Administer Oxygen (O2) — Maria assists Robert in coordinating his prescription for and delivery of O2 for his COPD. Working with his PCP, Maria also identifies pulmonary and cardiology specialists for Robert to consider for his ongoing COPD needs. Maria also educates Robert and his son on the dangers of smoking while on O2 to reduce the likelihood of injury or damage to the home.
- Clear Health Smoking Cessation program – To support one of his identified goals, Maria asks Robert about his experience with the Clear Health Smoking Cessation program. Robert admits that when he lost phone contact, he also became stressed and was ignoring emails and letters. Robert now feels he will have all the tools necessary to re-engage in the program. He states his motivation has increased since his recent health scares and trips to the ED. Robert is again referred to the Clear Health Smoking Cessation program and receives educational support and information on local support groups, as well as access to smoking cessation medications to help overcome his nicotine dependency. Robert adds questions related to prescribed medication for smoking cessation for his upcoming PCP visit. Robert desires to fully stop his use of nicotine to best meet his goals and health outcomes.

[REDACTED]

[REDACTED]

[REDACTED]

- Over-the-counter (OTC) benefits - Maria discusses with Robert available OTC benefits and his need to maintain a blood pressure log to prevent further complications. He agrees to use his OTC benefit to obtain a blood pressure monitor as an important first step. Robert wants to order this on his own as soon as his phone arrives.

In keeping with his care plan, Maria will provide Robert with ongoing education and support emphasizing the importance of regular doctor follow-ups for continuity of care to prevent unnecessary hospital admissions and ED visits.

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1.e. INTERVENTIONS AND STRATEGIES FOR PLAN OF CARE COMPLIANCE

Through regular, monthly contact (or more frequently as gaps are needed or as identified by Robert), our Managed Care Coordinators reach out to members and review their progress towards the goals they've identified. The Managed Care Coordinator utilizes the member's personal health record which is updated daily with utilization and claims and identification of upcoming preventive screenings or changes in risk stratification, to remain current with the member's utilization and care gaps.

Maria works with Robert to track his continued progress towards his goals and implementation of the interventions described in the preceding section as well as to address any new barriers or challenges within the plan of care. Through regular contact and monitoring to quickly identify gaps in services or ED utilization, Maria remains current with Robert's compliance to the path he has chosen with his care plan. As an effective Managed Care Coordinator, Maria relies on the training and tools she receives as part of Clear Health's case management department to facilitate compliance with the plan of care including how to utilize:

- Motivational Interviewing techniques as a method and strategy to assist individuals to move through the change process in a positive and affirming way
- Techniques for positive reinforcement and facilitating change visualization
- Clinical training for in-depth understanding of prevalent diseases, co-morbidities, and co-occurring disorders

[REDACTED]

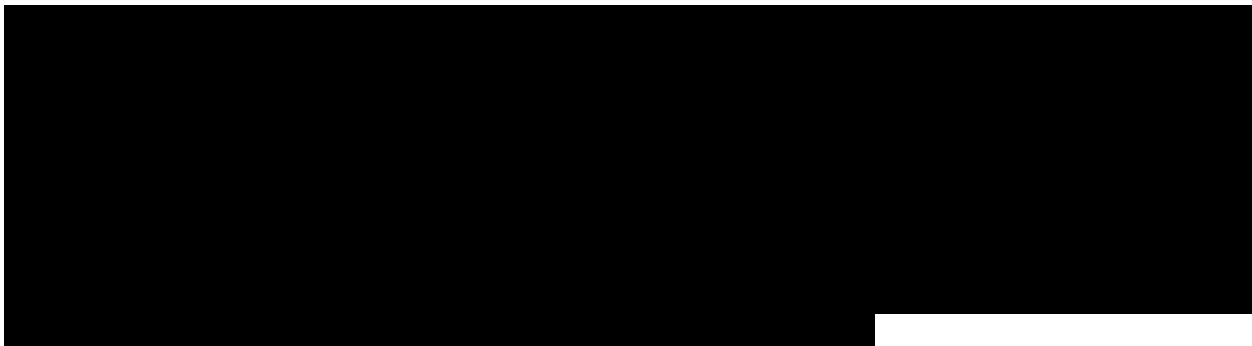
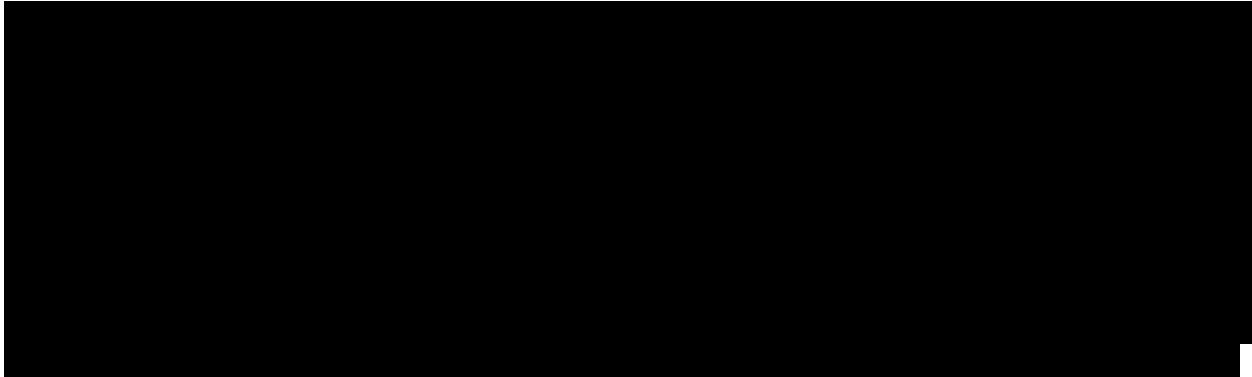
Maria relies on the expertise and support of the multi-disciplinary team, which monitors Robert's health and progress through his plan of care. Through continued communication and coordinated support from Maria, his PCP, and specialists; Robert will have the support he needs to successfully achieve his health goals.

The following represent examples of actions Maria may take to help facilitate Robert's successful attainment of his health goals.

During the assessment and care planning processes, Maria shares the Clear Health Healthy Behaviors program options with Robert. Offered alongside the Clear Health Case Management program, it provides Robert with additional incentives and education about his chronic condition self-management, promoting his personal responsibility, and helping him better understand his conditions and risk factors. Robert is a heavy smoker (10 cigarettes a day), so Maria congratulates him on reducing his cigarette usage and asks if he would like additional resources to help him.

[REDACTED]

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1.f. DISCHARGE AND AFTERCARE PLANNING PROTOCOLS

Discharge planning begins upon notification of an acute inpatient, observation status, rehabilitation or skilled nursing facility admission. Early identification and planning of the member's transition of care is essential in providing quality discharge needs and in making sure that the member is discharged to the appropriate level of care to prevent readmissions and unscheduled transition of care. Clear Health's Transition of Care team works with the member, Clear Health Concurrent Review Nurses, attending physician, hospital staff, and all ancillary service providers to complete all discharge needs for members and identifies any ongoing care needs to coordinate with the designated Managed Care Coordinator.

In the Spring of 2017, Robert's health declined and he was treated in the ED on May 4th, 9th, and 20th. Per Clear Health's processes, each of these visits was captured in our Event Notification System, which triggers an alert to the member's PCP to facilitate follow-up care. In Robert's case neither the PCP nor the plan was able to contact Robert due to a disconnected phone number. Since there was no valid phone number for Robert, a letter was sent to Robert's address with information about our services and to request that he contact us.

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The Managed Care Coordinator contacted the hospital the day after Robert's second visit to the ED to secure correct current contact information. The information from the ED was the same as the information in Clear Health's system; thus, the Managed Care Coordinator requested that it be noted in the ED's system that Robert is a Clear Health member and that his contact information is inactive. The Managed Care Coordinator reaches out to the PCP to also notify that the phone number is still inactive and request notification if Robert contacts them. A second letter is sent to Robert's address with information about Clear Health's Care Coordination services and requesting him to contact us.

Robert's third admission was on May 20, 2017. Upon identification of Robert's third visit in 30 days to the ED, the facility reviewed his record and noted that Robert is a Clear Health member and that his phone number was inactive. Robert indicated that he no longer has a phone number and can best be contacted through a new email address. This information was then updated in the ENS system, notifying us and PCP of the change.

To highlight our discharge and aftercare planning protocols, the following represents an example of our Transition of Care (TOC) program processes, if Robert is admitted to a facility for his COPD.

During his stay, a concurrent review nurse identifies him as a Clear Health member and accesses his personal health record to retrieve pertinent clinical history. Through that review, the nurse determines that Maria is Robert's Managed Care Coordinator, and reaches out to advise her of the admission. Throughout his stay in the facility, Robert's care and service needs are addressed by the concurrent review nurse. Clear Health's Transition of Care team engages members who are not already in case management to provide post discharge management; however, Maria is able to follow discharge protocols and work with the Concurrent Review team as part of the holistic case management she is providing.

Through the transition protocols that follow the Coleman Model, Robert's plan of care is updated and he will receive a discharge assessment, personal health record, medication discrepancy review, post-discharge meals, PCP and specialist follow-up visit coordination, and 7, 14, 21, and 30-day calls to ensure Robert is appropriately following the prescribed care, encourage and assist as needed. Based on daily processes, the PCP is notified by the health plan of admission and discharge. Robert may also receive another home visit if his discharge assessment, length of stay and other factors indicate high-risk for readmission. Maria also conducts a new comprehensive assessment to identify any new care and service needs. Since Robert's admission is related to his COPD, Maria will see that Robert has his prescriptions for inhalation therapy, including nebulizer if appropriate, oral corticosteroids, and all other medications. She also instructs Robert on medication administration as well as potential side-effects while emphasizing the importance of compliance with prophylactic medications. If a visit is indicated, Maria will re-evaluate Robert's home environment for the presence of environmental irritants that could cause his exacerbations and discuss ways to reduce exposure and avoid potential triggers.

Once a member achieves 30 days without readmission, the goal to prevent readmission is "met" and the Managed Care Coordinator resumes working with the member on remaining updated goals and interventions.

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1.g. COORDINATION WITH OTHER INSURERS, PROVIDERS, AND COMMUNITY PARTNERS FOR NON-COVERED SERVICES

Through our care planning processes, we identify and address our members' care and service needs across the full continuum of care (physical health, behavioral health, functional, and psychosocial). We recognize that members sometimes have needs that may not be met through our existing provider network or may not be a covered service. To help these members remain in the community, we engage all existing community resources to provide solutions. Because Managed Care Coordinators know the local area, they access community supports and actively engage community-based organizations, advocacy groups, faith-based organizations, and other community resources to develop creative solutions for services that are not a covered benefit.

Through the assessment and care planning processes, Maria discusses how community resources such as the Aging and Disability Resource Center and the Social Security Administration, in addition to the local Ryan White funded agency, may support Robert's needs. She helps him find applications and prepare questions to these agencies so that Robert can inquire about disability benefits and Medicare. Given Robert's situation, he may also be eligible to receive disability benefits. Maria works with Robert to coordinate with other insurers and apply for Medicare and/or any other coverage for which he may be eligible. As Robert's Managed Care Coordinator, Maria's role includes identifying providers and coordinating across them to make sure Robert receives integrated care (to include PCP, pharmacy, transportations, multi-disciplinary team meetings, and making sure information sharing takes place). For example, if Robert had FFS Medicare primary, then Medicare would cover all of Robert's medical needs. However, since transportation is not a covered benefit, Clear Health Medicaid would provide those services and coordinate this benefit to ensure access to his Medicare-covered medical benefits.

1.h. PROVIDER CAPACITY ASSESSMENT

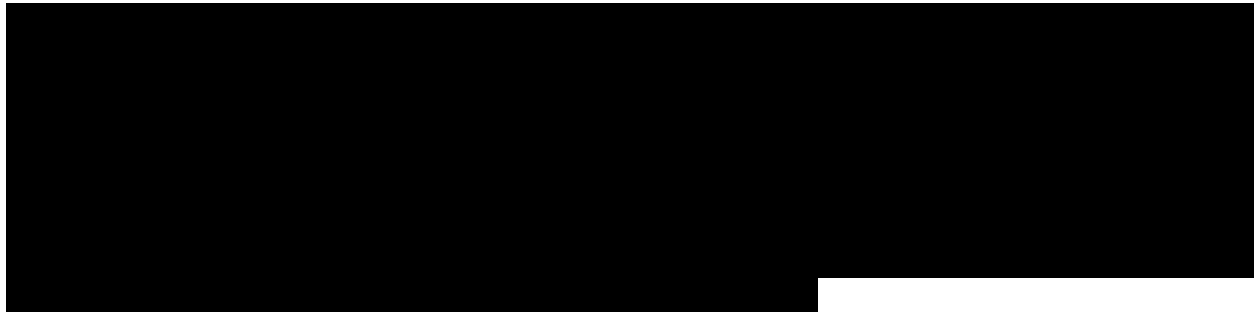

Clear Health's Provider Relations team continuously monitors our provider network to make sure that all contracted providers in the plan are credentialed accordingly and have the capacity to serve our members. Upon making a referral for service, the Clear Health case management team communicates the member's needs with service providers they have identified to see that they are able to meet his needs and have available appointments. All referrals include the member's detailed symptoms and behaviors at the time of referral to facilitate the best pairing. Our expansive provider network includes providers that have enhanced training to meet the needs of the Specialty population such as those with HIV. Our network also includes providers that are diverse and meet different cultural and linguistic needs as well.

Our network assessment process is designed around continued review and improvement. In addition to the regular reporting and monitoring by the Provider Relations team, part of Maria's training and protocol is to report any gaps or network barriers experienced to our Provider Gap Committee. This process allows us to immediately incorporate feedback from our front line staff into the assessment process.

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1.i. STRATEGIES THAT PROMOTE MEMBER SELF-MANAGEMENT AND TREATMENT ADHERENCE

As part of developing the person-centered plan of care, our Managed Care Coordinators include health education to improve upon a member's health literacy, build member advocacy and self-management skills, and to encourage treatment adherence. For example, members like Robert (who have several co-morbid conditions), receive self-care education using evidence-based guidelines, including coaching by the Managed Care Coordinator as well as printed materials and access to online resources.



Maria addresses Robert's overall feeling of health using motivational interviewing to assess how his COPD impacts his daily living activities (including cooking, cleaning, activities with his son) and determine how much he wants to change these circumstances and address his limitations. Maria also provides verbal education on COPD and smoking and identifies educational materials that might be helpful to Robert, while reinforcing his progress to-date on reducing the number of cigarettes smoked daily and discussing barriers he feels prevent him from stopping completely. To assist Robert in his work to reduce or quit smoking, Maria reiterates how smoking impacts COPD and shortness of breath and the dangers of smoking near his oxygen machine. She continues to discuss Robert's use of the Healthy Behaviors Smoking Cessation program, and helps him identify other methods he might use to stop smoking, including nicotine patches, reducing the number of cigarettes per week, and/or oral medications such as Chantix. Maria asks Robert to describe barriers he perceives that hinder his ability to completely quit smoking and continues to provide positive reinforcement and celebrate the work he has accomplished to-date.

Maria's monitoring and follow-up are provided until care plan goals are met and the member has demonstrated the knowledge and appropriate use of resources to continue to successfully self-manage in collaboration with his PCP/specialist.

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1.j. APPLICATION OF UTILIZATION MANAGEMENT PROTOCOLS

Clear Health's comprehensive Utilization Management (UM) program includes well-defined protocols for UM activities that are tailored to meet the needs of our members. We promote the delivery of care and services in a culturally competent manner within the context of members' cultural beliefs, behaviors, practices, disabilities, and language preferences. We use the guidelines and protocols to provide a framework for decision-making that also considers social determinants, geographic location such as rural versus urban, and how those circumstances may impact access to care.

Our fully integrated UM program is compliant with NCQA standards and includes defined protocols for the following components:

- UM program structure and responsibilities
- UM staff qualifications and training
- Medical Necessity Criteria and Level of Care Guidelines including selection, approval, adoption, and resulting implementation
- Medical Necessity Review procedures (prospective, concurrent, and retrospective)
- Integrated Care Rounds
- Service authorization, adverse determination, and appeals procedures
- Transition planning and coordination (initial and continued stay)
- New technology assessment
- Integrated pharmacy management
- Quality committee structure and responsibilities
- Quality oversight and improvement activities

Many of the services for Robert require a Utilization Management review to receive authorization. An authorization requirement will be needed for Robert's Oxygen (O2). Through the assessment process, Maria discovers that Robert has a prescription for new COPD medication, but has never filled it. Maria reaches out to the PCP and shares information from the discharge plan to obtain a new prescription for Robert. The PCP expresses concern about the amount of O2 and instead, refers Robert's case to a pulmonologist to review the discharge plans. Maria coordinates this and arranges transportation for Robert to attend an appointment with the pulmonologist, who examines Robert and writes a new prescription for DME and medication.

Robert also requires authorization for DME depending on the requests made by the PCP. Decisions on authorizations are typically made within seven days, but an expedited authorization may be filed and a decision rendered within two days. The decision is based on Anthem's clinical criteria hierarchy. The State Medicaid Coverage Policies are used to confirm medical necessity.

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Maria monitors these authorizations and sees they are completed in a timely fashion and that the O2 has been delivered.

If, at any time, Robert is dissatisfied with any of the services or supports being provided, he may initiate a complaint/grievance by calling the Member Services line or sending a fax/letter directly to the health plan. For example, if Robert is dissatisfied with a denied prescription, the Clear Health Member Services team completes initial research to see if any medication claims have been denied for Robert and to determine the reason (such as the prescription is too early to fill or authorization is required). The Member Services team escalates Robert's complaint to the Grievance team on the next business day if they are unable to resolve the issue. A Grievance Coordinator sends an acknowledgment letter to Robert and contacts him to provide regular updates of the process. The Grievance Coordinator partners with the Pharmacy team until Robert's grievance is resolved. Once the issue with filling the medications is resolved, a resolution letter is sent to Robert within 30 days to confirm the outcome of the grievance.

1.k. STRATEGIES TO INTEGRATE MEMBER INFORMATION ACROSS THE PLAN AND SUBCONTRACTORS

Robert's information is integrated across our data platform, and we have data exchange processes to assure that each delegate has the needed information, balancing compliance with HIPAA regulations with sharing the necessary information to provide care. All delegates receive enrollment files and other pertinent medical data relevant to their delegated functions. For example, we regularly share with our pharmacy benefits manager member diagnosis data to allow them to auto adjudicate authorizations. Further, the PCP, has access through the provider portal to the utilization and case management history for the member. In addition, each member has a personal health record, which is accessible by all Clear Health staff engaged in care and service coordination for that member.

We can also identify missed prescription fills through reporting. Maria is able to view Robert's medication history as part of her routine case management activities. She sees that Robert is not filling his medications and works with him to resolve any barriers. In Robert's case, his lack of transportation was the challenge, and Maria arranges for Robert to receive his prescriptions by mail to resolve this, and we will assist Robert with refill assistance as needed.

2. WORKFLOW

As illustrated in our workflow, provided as Attachment SRC# 8-1: Workflow, Clear Health meets all State-required timeframes across the care planning process.

3. INNOVATIVE AND EVIDENCE-BASED PROCESSES TO ENHANCE COMMUNICATION AMONG SERVICE PROVIDERS AND SUBCONTRACTORS

Clear Health supports providing access to actionable medical and behavioral health information to our multidisciplinary teams through our Case Management System. We support a shared plan of care approach where clinicians work together, through access to a member's physical and behavioral health assessments, service authorizations and other clinical data, claims history, and gaps in care, to support coordination of all members' care and service needs. The system includes an online dashboard emphasizing utilization of wellness and emergency services that is available to all providers. Providers can send us secure referrals and information by email or fax. They can

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also send a provider-to-provider secure email (if their system permits) or transfer information among providers in a secure manner. We make sure that participating providers have the appropriate signed consents in place to coordinate care.

Maria uses Clear Health's Case Management System to track Robert's plan of care and his and his family's engagement in services. The system is used to view Robert's history, diagnoses, pharmacy, and emergency services. The information helps inform ongoing activities to support him in his recovery.

4. SUPPORTING CARE DELIVERY IN THE MOST APPROPRIATE AND COST-EFFECTIVE SETTING AND AVOIDS UNNECESSARY OR ED USE

Our program uses industry best practices, such as screening in health care settings and schools, motivational interviewing and engaging Peer Support Specialists, to supplement traditional clinician outreach. Our Managed Care Coordinators work to address the health status, health literacy, and engagement of members through targeted interventions and case management, education, self-management principles, and harm reduction. We engage providers, community partners, and others (such as Peer Supports) to make sure members have frequent in-person contact. During conversations with members, we determine their readiness to change, encourage them to identify strengths and needs from their own perspective, and participate in the development of their plan of care. This evidence-based and person-centered engagement methodology enhances the probability that members will develop self-directed plans of care with achievable goals. Our fully integrated program takes every aspect of a member's life into account. We work with members to address social determinants of health and support needs, such as housing, employment, commitment to preventive care, and needs in other life domains that can compromise sustained recovery.

To support care delivery in the most appropriate and cost-effective setting and to avoid unnecessary ED admissions, Maria provided case management and care coordination services, including helping Robert schedule and arrange a visit to his PCP to help keep him healthy (and coordinating transportation services since that was a challenge contributing to his frequent ED visits). She reviewed his medications with him and also worked hard to get his oxygen order processed and all prescribed medications in place to help him avoid frequent pharmacy trips, and she coordinated mail order medications to assist in overcoming this barrier to medication adherence. Maria took the time to explain the services available to him to help him avoid another ED visit, including how to contact her, how to reach our 24/7 Nurse help line, and how to access nearby urgent care clinics, if needed.

5. EXPERIENCE SERVING ENROLLEES WITH COMPLEX MEDICAL NEEDS AND IMPROVING HEALTH OUTCOMES.

To proactively identify members with complex needs, we use a predictive modeling system that synthesizes member demographic and claims data, such as diagnoses, pharmacy, hospitalizations, ED encounters, and expenditures, to predict future outcomes. This enables us to identify and prioritize outreach to members with mental health, substance use disorder (SUD), and other chronic health conditions, including those with the greatest need for ongoing services and the likelihood to be admitted to the hospital in the near future. Using this information, we will identify a designated Managed Care Coordinator who is matched to the member's primary needs, physical health, behavioral health or long-term services and supports, based on training and

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licensure and is located in their geographical area whenever possible. All of our staff has received extensive cross-training to provide for the member's needs, with access to the full Clinical Support team in Clear Health, with expertise in pediatrics, adolescents, infectious disease, nutritional, disease management, and physical, long-term care and behavioral health needs.

Robert is representative of members we see every day. As a health plan, we are very proud of the health outcomes we are able to help our members achieve. This is evidenced by our success in having the best results for potentially avoidable admissions among all Florida specialty health plans, as measured and reported by the Agency.

6. COORDINATED HEALTH CARE INTERVENTIONS DESIGNED TO ACHIEVE COST SAVINGS

Our members in case management frequently identify as having two or more conditions. In fact, throughout our health plan, 62% identify as having three or more. Achieving cost savings while optimizing health outcomes requires a member-centric, integrated approach. Our members work closely with qualified and trained Case Managers (Managed Care Coordinators) to make sure they are receiving the most appropriate level of care. Our model has proven successful. In a 2016 case study, we found that after receiving case management services for at least 90 days, members used health resources more efficiently and required less emergent care, thus reducing costs while improving outcomes. One such outcome was significantly greater: reduction in avoidable emergency room visits and inpatient admissions. Overall, members demonstrated a 39% reduction in non-emergent ED visits.

Our integrated, strengths-based, member-centered Case Management program considers the specialized needs of our members who have complex needs, including their physical, behavioral health (mental health and substance use disorder), pharmacy, and social and community support needs. We offer tailored complex Case Management programs for members with unique, complex, chronic, and co-occurring needs who require higher levels of interventions. Our integrated approach provides access, responsiveness, and effectiveness in the system of care by supporting the following:

- 1) Identification of members with potential or current specialized or complex health care needs through early screening, comprehensive assessments, and predictive analytics
- 2) Risk stratification for each member based on a multi-faceted consideration of information
- 3) Placement of members into Case or Disease Management programs based on needs assessment
- 4) Development of an integrated plan of care that addresses physical, behavioral health/substance use disorder, pharmacy, social, and home- and community-based needs for members as they transition across all settings and incorporates both covered Medicaid benefits and services as well as those not covered by Medicaid that would benefit the member
- 5) Reciprocal referrals and information sharing with PCPs/specialists and community-based Ryan White providers with HIV expertise

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- 6) Formation of multi-disciplinary treatment team for members in complex case management as needed to support them and provide consistency and continuity of contact with their familiar support system, as well as the expertise of a broader team of specialists as their needs evolve
- 7) Care Coordination support to improve member access to needed services, including scheduling appointments, arranging transportation, conducting appointment reminder calls, following up to verify service initiation and member progress, and making appropriate service adjustments and incorporating those into the plan of care
- 8) Ongoing evaluation of our Case Management program, including reviewing, tracking, monitoring, adjusting, and analyzing for outcomes, quality metrics, and improvement
- 9) Emphasis on disease prevention, chronic condition management, and increasing member engagement with recommended treatment protocols
- 10) Establishment of community-based relationships
- 11) Member education to enhance understanding of health care conditions and prescribed treatment
- 12) Encouragement for members to develop their capacity to self-direct their care
- 13) Collaboration with other State and community entities to ensure truly integrated care and prevent duplication of service
- 14) Co-management of physical and behavioral health issues

7. INNOVATIVE AND EVIDENCE-BASED STRATEGIES TO INTEGRATE INFORMATION ACROSS ALL SYSTEMS/PROCESSES INTO ITS WORKFLOWS

Our care coordination/case management workflows use a variety of innovative, evidence-based strategies to integrate information across all processes and systems, beginning with our members' real-time personal health record. Through our advanced Case Management System, each member's personal health record contains updated utilization and claims history along with any "red flags" to alert our staff about upcoming or overdue preventive health screenings. All of our health plan staff who interact with the member have access to this system, so they can offer seamless, integrated assistance in coordinating care and making sure the members' needs are addressed (such as scheduling appointments or arranging transportation). Our system also allows individuals who are part of care management or care coordination to enter tasks, send letters, or connect directly with members based on the information in the personal health record.

As part of our medical necessity reviews, our Case Management System incorporates Clear Health's evidence-based criteria and level of care guidelines and enables our Clinical and Utilization Management staff to document medical necessity reviews of pre-authorization requests. UM Reviewers can easily access critical information and use it to make the most appropriate level of care determinations. The system captures the exact criteria used in a clinical decision, the date and time of the review, and the updated information in the member's personal health record systematically so that all information stays up-to-date to promote integrated care. Our Case Management System is also connected to our calendar system so that our Managed

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Care Coordinators can easily schedule screenings, assessments, and follow-up meetings with the MDT.

Another key part of our clinical workflows is our comprehensive assessment. These assessments include innovative branching logic, which guides our Managed Care Coordinators into areas for deeper details or to conduct additional assessments, such as high-level behavioral health screening (which might trigger an additional behavioral health assessment) or co-morbid chronic conditions that will trigger additional disease-specific assessments. All of this information is retained in our Case Management System, allowing Managed Care Coordinators to fully address a member's total health care needs.

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Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:
 - a. Identification processes for enrollees with complex health conditions or who are in need of care coordination;
 - b. Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
 - c. Application of the respondent's case management risk stratification protocol;
 - d. Identification of service needs (covered and non-covered) and a description for service referral processes;
 - e. Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;
 - f. Application of discharge and aftercare planning protocols that facilitate a successful transition;
 - g. Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;
 - h. Description of the assessment of provider capacity to meet the specific needs of enrollees;
 - i. Identification of strategies that promote enrollee self-management and treatment adherence;
 - j. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
 - k. Application of strategies to integrate enrollee information across the plan and various subcontractors when the respondent has delegated functions.
2. The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process.
3. The extent to which the respondent demonstrates innovative and evidence-based processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).
4. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.

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5. The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provides evidence of strategies utilized that resulted in improved health outcomes.
6. The extent to which the respondent demonstrates a system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.
7. The extent to which the respondent describes innovative and evidence-based strategies to integrate information across all systems/processes into its workflows.

Score: This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.

Table 8-1. Workflow

Day	Description
December 2016	Enrollment: Robert is enrolled in our plan and receives an initial assessment and screening via phone.
	Case Management: Robert is stratified as moderate risk (level 2) and referred to Clear Health's Case Management and Healthy Behavior program for smoking cessation support. Robert declines case management, but enrolls in the Healthy Behavior Tobacco Cessation program.
May 4, 2017	Care Coordination/Case Management Robert receives care from the Emergency Department (ED) on May 4, 2017. The Care Coordination team member attempts to reach Robert, but his phone is disconnected and the second attempt, an e-mail, is returned "user is not found." A letter is sent to Robert's address with information about Clear Health's case management services and requesting him to contact the Care Coordination team. Auto notification is sent to the primary care provider (PCP), due to the event notification system update received.
May 9, 2017	Care Coordination/Case Management Robert receives care from the ED a second time on May 9, 2017. Our Care Coordination team contacts the hospital ED the next day to secure correct current contact information. The phone number provided by the ED is the same one in the Clear Health system, and is still out of service. Clear Health asks that the ED update Robert's record with notes indicating that his phone number is inactive and that he is a Clear Health member. The Care Coordination staff reaches out to the last identified PCP, who also has the same disconnected phone number. A letter is sent to Robert's address with information about Clear Health's case management services and requesting him to contact the Care Coordination team. Robert's case is referred to Clear Health case management. Auto notification is sent to the PCP, due to the event notification system update received by the plan.
Day 2 – following third ED visit	Care Coordination/Case Management: Robert enters the ED a third time on May 20, 2017. Upon identification of Robert's third visit in 30 days to the ED, the facility reviews his record and notes that his phone number has been flagged as unreachable. Robert indicates that he no longer has a phone number and provides the ED with his address and new email address. The following day, the Care Coordination team receives Robert's updated email and address information, and forwards this to Case Management. Maria, a Clear Health Managed Care Coordinator, reviews the CI3 score, which has been upgraded to High Risk. She reaches out to Robert via email and requests a face-to-face visit, in the place of his choice, to review his benefits and services in order to help him navigate his health concerns. Robert agrees via email to meet the next day, in his home.
Day 4	Care Coordination/Case Management: Maria meets Robert in his home. She assures he has received the oxygen and prescriptions ordered by the hospital and had an opportunity to ask the respiratory therapist all of his questions. She reviews the case management process and obtains his approval to complete a comprehensive health assessment and develop a personalized plan of care to address his health concerns. Maria talks to Robert at length, reviewing his conditions and challenges as well as his strengths (Maria congratulates him on his recent decrease in tobacco use). They discuss his living situation, his son, and what Robert wants to achieve, identifying his goals and desired health outcomes. Together, they develop Robert's plan of care to include the services needed in order to help Robert obtain his goals. Robert identifies providers who he would like to be included in the plan of care review. Throughout the care planning process, Maria asks Robert about his concerns for his son's health needs. She works with Robert to address this in his plan of care, identifying how to link his son to the preventive services and coordinates a wellness visit for the son. Maria also arranges PCP visits for Robert and his son and assists Robert with setting up mail order prescriptions for maintenance medications he has not refilled.
Day 5	Care Coordination/Case Management Maria finalizes any pending referrals from yesterday's visit with the Robert. She orders health education materials regarding COPD, hypertension, and hypercholesterolemia for Robert and confirms transportation for him and his son to his upcoming PCP appointments. She also submits Robert's plan of care to his PCP for review and feedback, and mails a copy to Robert. Maria refers Robert to an area Ryan White-funded agency that provides specialized programs via peer-led support groups and referrals to resources specifically designed for persons living with HIV/AIDS – such as housing programs, legal aid, food programs that he may qualify for, and the area Ryan White program. Maria orders a Lifeline smart phone for Robert. She also requests in-house pharmacist review of medications for any potential contraindications. She submits referrals submitted to behavioral health, indicating Robert's preference for telemedicine, nutritionist,

Day	Description
	smoking cessation enrollment, Healthy Behavior enrollment.

Day	Description
Day 9	Care Coordination: Maria coordinates with Utilization Management staff to make sure that Robert has the appropriate existing authorizations and referrals in place. Followed up with Robert to ensure he and his son attended their PCP appointments. Robert advises he has been referred to a pulmonologist and Maria educates Robert on transportation services to facilitate existing specialist appointment.
Day 15	Care Coordination/Case Management: Maria follows up with Robert to assure he received his health education materials and phone, and adds the phone number to his personal health care record. Maria reviews the education materials with Robert to assure understanding and verifies he has ordered a blood pressure monitor through the OTC program and is set to maintain the blood pressure log discussed during the home visit.
Ongoing	Ongoing Care Coordination: Maria will reach out to Robert to assess progress towards the goals identified. She will follow up to assure he has met with his nutritionist and is participating in his telemedicine behavioral health program. She will use Robert's personal health record, along with the Clear Health Case Management System, to monitor his utilization and care. She will review his plan of care, progress toward goals, and his satisfaction with the services as well as continue to identify barriers to his achievement of his goals. Maria confirms the next scheduled call will be in 30 days.

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SRC# 11 – Online Provider Directory (Statewide):

The respondent shall describe the provider search function for the online provider directory, including submission of:

- a. A description outlining the transparency and accessibility of the online provider directory, including the parameters upon which enrollees may search. Include whether or not the online provider directory is mobile friendly.
- b. Screen shots for each mouse click required from the start of the respondent's home page to actual search results for a provider, using durable medical equipment providers and zip code as the search elements.
- c. A list of performance indicators the respondent will include for each provider type listed in its provider directory.
- d. A description of the respondent's process for verification of provider information in the online provider directory, including delegated subcontractor provider information, and the method(s) the respondent uses to ensure the weekly network file submission to the Agency is accurate.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Clear Health brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Clear Health understands the importance of making information for our enrollees (members) easy to find, easy to use, and helpful. We strive to make all information available through our member portal accessible and meaningful for all our members. Find a Doctor, Clear Health's online provider directory and provider search function is accessible, comprehensive, transparent, up-to-date, mobile-friendly, and easy-to-use. We recognize that our Clear Health members have specialized needs that are best met by physicians who have experience in treating patient with HIV disease. While we actively provide education and support for all of our providers so that they can effectively serve our Clear Health members, we also recruit primary care providers (PCPs) and specialists who have additional training in treating HIV/AIDS to join our network. Providers with this specialized HIV/AIDS training are designated with a red ribbon beside their name in the provider directory, informing members of the provider's additional specialized HIV/AIDS care and treatment competency. This "Red Ribbon" program is nationally recognized and is a testament to our patient-centered model of service and support.

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1. NAVIGATING OUR ONLINE PROVIDER DIRECTORY SEARCH FUNCTION

Transparent, Easy to Access, and Mobile-friendly

We transparently present all Find a Doctor descriptions, directions, search options, and other information in a clear, easy to understand manner using language at a fourth-grade reading level or below. We assure that all potential and current members can access Find a Doctor on the internet, in English or Spanish, using any web browser and any internet accessible device — a computer, tablet, smartphone, or other device. We do not require users to have an account or a login and password to access the tool.

Find a Doctor Search Function

Members, potential members, providers, and the public can use Find a Doctor to search for Clear Health providers in Florida who best meet their needs based on user-selected search criteria options. Users can tailor a search for a provider in the following criteria categories:

- Distance from user, (optional – default is 15 miles) based on the user's address, city and state, zip code, or county and state – from one to 100 miles away
- Provider type – (required) users can select certain types of providers such as specialists, PCPs, hospitals and facilities, behavioral health and substance abuse, long-term care, dental, vision, pharmacy, audiology/hearing, durable medical equipment (DME), home health care, laboratory and therapy services.
- Specialties and services (optional) – users may select one or multiple clinical specialties or provider service types that vary for each provider type or users may select “all”
- Provider Name – (optional) individual practitioner names and practice and/or facility names. Note – users sometimes search solely by provider name. Members and prospective members are often looking for a particular provider and know only a portion of a provider's name. Our tool is flexible and allows users to type a portion of a provider's name, for example, searching for “Peter” would return a list of providers who have Peter as any part of their first, last, or facility name
- Accepting new patients

The results page lists all Clear Health network providers who meet the user-selected search criteria with the provider name, address, county location, phone number, website URLs if available, and the following additional information for each provider:

- Distance from user-identified location with link to map displaying provider address and the option to receive directions to the provider's location
- Specialty or service detail
- Indicator if provider is board certified
- Indicator if location is wheelchair accessible

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- Indicator if provider completed cultural competency training
- NCQA logo if the provider is NCQA-certified
- 24-hour access (pharmacies)
- Flu vaccine (pharmacies)
- Hospital and Facility Services (for DME and home health supplies)

While still on the results summary page, users can narrow results by filtering using the following additional search criteria categories (categories vary by provider type):

- PCMH, Diabetes Recognition Program, Patient-Centered Specialty Practice, and Heart/Stroke Recognition Program Certification
- Accreditation
- Board certification
- Languages spoken (both by provider or a skilled medical interpreter at the office)
- Group affiliations
- Hospital affiliations
- Provider ethnicity
- Provider gender
- Red ribbon designation

Users can repeatedly refine search results without ever leaving the search results page and can access previously viewed search result pages. Users also have the option of comparing on one page information on up to three providers of the same specialty or service.

A click on an individual provider name provides a full page of all provider information listed above and additional information including hours of operation and additional addresses as applicable, provider gender, languages spoken, provider licensing information, age groups served, and additional details on board certification including a link to the “Is Your Doctor Certified” website.

Users have the option to use their search results to create a personal provider directory, which they can save as a PDF and print or email to themselves. The online and PDF version of the directory will include the required statement that some providers may choose not to perform certain services based on religious or moral beliefs.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

2. ACCESSING PROVIDER DIRECTORY SEARCH RESULTS

Please see Attachment SRC# 11-1: Online Provider Directory, which includes functionality, layout, and navigation of each screen shot users will see in performing a custom provider search for a DME provider with our redesigned website (Figures 11-1 through 11-3 in the Attachment), pending state approval. Figures 11-4 through 11-7 shows what users see in our current website, beginning with the health plan website home page and ending with the search results summary page. Including search results screens, there are four screens under legacy Amerigroup's current functionality to facilitate access. We are improving the design to needing just three screens to facilitate access that will be completed in 2018.

It currently takes a user four mouse clicks to go from the legacy Amerigroup Florida website home page to the search results summary page. We use the legacy Amerigroup example here because the new Clear Health provider search tool will be based on the same tool legacy Amerigroup uses today as we bring the best of each plan legacy plan into one plan. The four mouse clicks do not include clicks associated with selecting search criteria within a single page. Beginning at www.myamerigroup.com/fl, users click on the following:

- Click 1 – “Find a Doctor” on the home page
- Click 2 – “Provider Search Tool” on the drop-down menu that appears
- Click 3 – “Search” in the orange box on the Find a Doctor page
- Click 4 – “Search” after selecting search criteria options in the search form page

In addition to online searches, members can also access a searchable PDF version of the online provider directory with just one click.

3. PERFORMANCE INDICATORS IN THE PROVIDER DIRECTORY

We have a strong commitment to providing comprehensive provider performance information in the Find a Doctor tool to assist members in making an informed choice about the providers they choose to use. To this end, we provide the following performance and quality indicators, as applicable to individual providers and provider types.

- A “Red Ribbon” indicator for each PCP who specializes or has additional training to treat persons with HIV/AIDS
- NCQA labels for providers who have one of four NCQA accreditations or distinctions (Patient-Centered Medical Home, Diabetes Recognition Program, Patient-Centered Specialty Practice, and Heart/Stroke Recognition Program)
- Recognition by one of the organizations for Patient-Centered Medical Home accreditations (National Committee for Quality Assurance Level 2, Accreditation Association for Ambulatory Health care, The Joint Commission, or Utilization Review Accreditation Commission)
- The specialties in which the provider is board accredited and a link to the “Is Your Doctor Certified” website that provides additional information on the provider including education and whether the provider is participating in maintenance of certification requirements

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- Indicator that members recommend the provider (indicated by the count of “checked boxes” received from individual members)

4. MONITORING ACCURACY OF THE ONLINE PROVIDER DIRECTORY INFORMATION

We employ multiple strategies to monitor the accuracy of the provider data contained in Find a Doctor. As explained below, we assure that provider data, including data on providers with our delegated subcontractors, is consistent in all methods by which members and others access provider data by using our Management Information System (MIS) system as the source of truth for all provider data. We update MIS data each business day. In addition, our Provider Data Quality unit runs a data quality check of Find a Doctor data each week. This check includes 104 edits to identify illogical data and typing errors. These checks look for four main categories of data in the system:

Our Address checks look for items such as:

- Post Office Boxes in the service address
- Keying and spacing errors
- Missing or invalid office hours, phone, fax numbers
- Duplicate addresses
- Zip code validation
- Incomplete addresses
- Service/specialty code validation

Our Network checks look for items such as:

- Missing age limitations
- Market effective dates
- Incomplete out of network set
- Provider auto assignment
- Mismatch network rows
- Overlapping network spans
- Sanctioned providers

Our Provider checks look for items such as:

- NPI missing/invalid
- Taxonomy missing/invalid
- Tax ID missing/invalid
- Missing facility type
- Hospital affiliations
- Name spacing details
- Degree missing/mismatch/invalid
- Pay to information missing
- Duplicate providers
- Practitioner with missing specialty
- Overlapping date spans

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Our Registration checks look for items such as:

- Medicaid ID invalid
- License missing/invalid/expired
- Active credentialing status
- Active network rows
- Missing registration IDs

Provider Data Management reports the results of this check in our weekly quality plan dashboard. Unit staff review each dashboard report to identify and undertake actions required to resolve errors. These reports are reviewed and worked weekly to make sure the data is accurate prior to our directory file submission extract schedules. We assure the integrity of data from external sources by only using verifiable data. The MIS database also includes information on providers from networks developed and maintained by our vision, dental, audiology/hearing, chiropractic, therapy, dermatology, pharmacy, and behavioral health delegated subcontractors. If a member selects transportation, they will be prompted to contact the appropriate transportation subcontractor contingent upon location. Our Vendor Delegation Oversight Group works closely with our external partners to make sure the data we receive meet our standards and is submitted within the appropriate timelines. This team also runs a series of provider data validation checks on the inbound file to ensure the quality of the data prior to loading it into our systems.

Provider information can change frequently. We make every effort to reach out to providers to make sure provider directory information is current and make it easy for providers to report by phone, email, fax, mail, and online changes such as new addresses, new contact information, revised office hours, and changes in status regarding accepting new patients. Through our Provider Relations staff, the provider handbook, provider newsletters, other provider mailings, and the provider website, we frequently remind providers to notify us when any of their provider directory information changes. Provider Relations staff also educate the network on submitting changes using the online provider resource tool on our provider website. Provider Relations staff conduct multiple outreach activities and review demographic and participation information with providers during regularly scheduled face-to-face visits to obtain updated provider information for the provider directory and other purposes. They meet in-person with providers and conduct provider information checks by phone and email.

Often new provider information comes to health plan staff in other departments, including Claims Processing, Credentialing, Provider help line, and Mailroom staff. Clear Health encourages members, providers, and employees to identify and report incorrect or outdated provider directory information. In addition to internal quality checks, Provider Data Management accepts data change requests from a variety of sources, including the following:

- Florida Provider Relations employees through day-to-day interactions with providers or regular data quality checks
- Case Managers (Managed Care Coordinators) who identify incorrect provider services while coordinating care
- Customer Care Representatives who identify incorrect provider data while assisting members with appointments, locating a provider, contacting a provider, or any other day-to-day interactions

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- Self-service tools on our provider portal, enabling providers to update demographics and practice information
- Provider calls to our Provider help line
- Member calls to our Member Services line to report provider data problems

We have a single process for staff throughout the plan to submit provider network information changes to our Provider Data Management Team for input into MIS, the repository for provider information that feeds the online provider search function, online PDF directory, and claims processing systems. We continue to research and consider process improvement opportunities to provide up-to-date provider information throughout our system. For example, we currently assure that staff input provider changes into MIS so that the new information is available to all our provider directory, claims, and other systems within 30 days of receiving the change.

5. PERFORMING ONLINE PROVIDER DIRECTORY UPDATES AND COMMUNICATING WITH THE AGENCY

Each business day the online provider directory, Find a Doctor, and the provider network verification file that we send to AHCA is updated to reflect all provider information changes in our MIS. Find a Doctor features a date stamp at the bottom of the page to let users know when the last update occurred. To make accurate and frequently updated provider network information available to all, no matter how they access the information, we assure data that is consistent from one method to the other by using our MIS as the source of truth for all provider data. We maintain a schedule of frequently updated data contained in each version to mirror MIS data in a manner compliant with all contract requirements in the ITN. The following is a summary of each method by which we make provider network information available and the frequency with which we update data in each.

- Online searchable provider database used by the Find a Doctor tool – updated each business day with a one business day lag between when we enter a provider information change into MIS and when it appears in the online searchable database
- Provider Network Verification (PNV) file sent to AHCA weekly – current as of the day prior to being sent
- Online PDF of the provider directory – updated monthly; current as of the day prior to producing the printable PDF. In lieu of printing and mailing hard copies of the provider directory, we will choose to direct members and others requesting the provider directory document to read the PDF version online. We will also inform them how they can print the PDF version of the directory if they choose

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The extent of the respondent's search functions for the respondent's online directory and ease of access for enrollees' navigation of the online provider directory, including whether or not the online directory is mobile friendly.
2. The extent to which the number of clicks it takes recipients to access the search results, as indicated by the screen shots provided, is less than five (5).
3. The extent and relevance of the performance indicators available in the respondent's provider directory for each provider type listed.
4. The extent of the respondent's efforts to ensure information in the respondent's online provider directory is accurate, including type and frequency of monitoring activities, and delegated subcontractor provider information. Include the frequency of outreach efforts to remediate incorrect provider demographic information and accepting new patient status.
5. The extent to which the respondent's online provider directory updates are performed daily and the extent to which the updates are communicated to the Agency as required to ensure the information the respondent displays on its website align with the Agency's information.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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Figure 11-1. Online Provider Directory
Future Provider Directory Search – Screen #1



Simply healthcare
An Anthem Company

Your Plan Your Health Your Community A A A Español Login Contact Us

Pick the right plan for you:

FL SMMC MMA Medicaid
The new FL SMMC MMA Medicaid program was built just for you – because your health is important. Let us help you make the most of your benefits.

Find out more →

FL Healthy Kids (CHIP)
With Simply Healthcare you and your family can get all the new FL Healthy Kids (CHIP) benefits, like checkups, shots and medicine. Plus, you get extras you can really use.

Find out more →

FL SMMC Long Term Care
With Simply Healthcare, you get all your FL SMMC Long Term Care benefits, like checkups, flu shots and medicine. Plus, you get extras to help keep you healthy and independent.

Find out more →

Announcements

FL SMMC MMA Medicaid members:
Need transportation to a covered medical service?
[Learn more about transportation](#)

Member Services: 1-800-887-6888 (TTY: 711)

Welcome, Simply Healthcare members!

- [Register](#) for secure access to your account and take advantage of fast, convenient online services like:
 - Choosing or changing your PCP
 - Completing your initial health screener, and more!

Tools

[Find a Doctor](#) 

[Enroll & Renew](#) 

What is the Zika virus?

 English
 Spanish

It starts with listening to you.

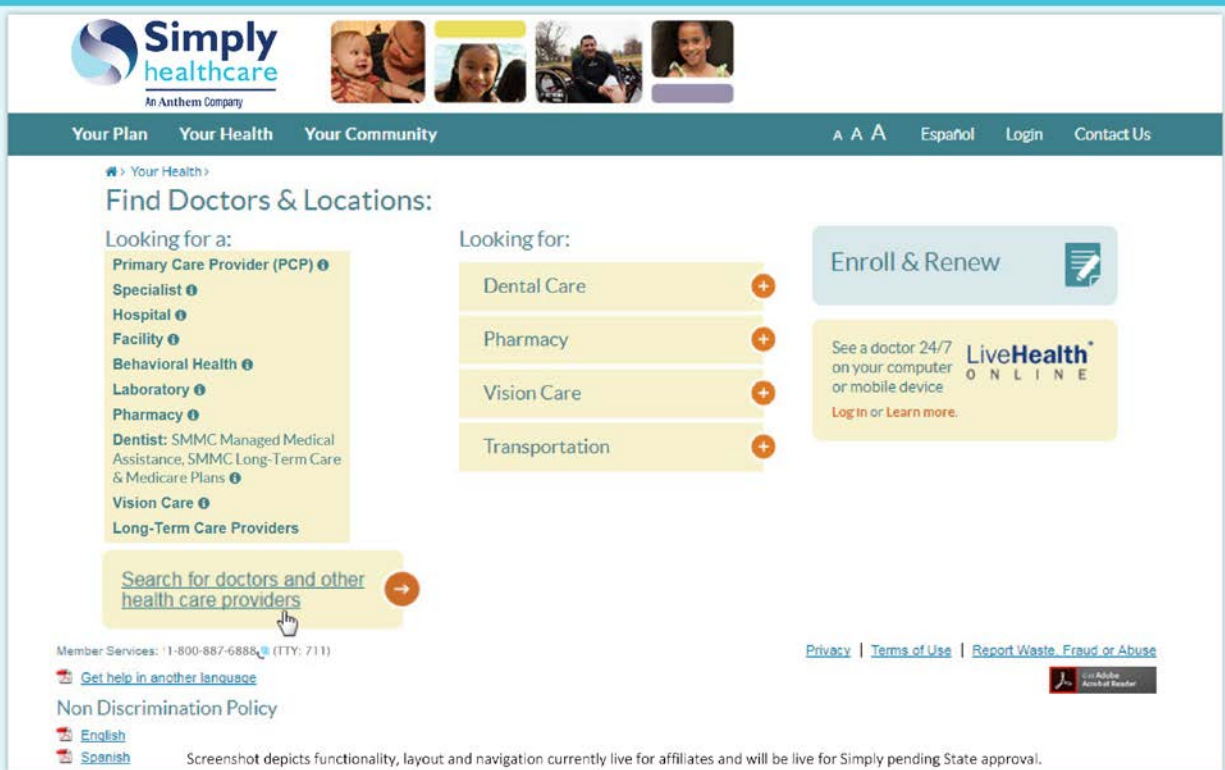
To learn what matters to you, we just ask. If you receive a survey in the mail or by phone, please complete it. Help us make your plan better.

Screenshot depicts functionality, layout and navigation currently live for affiliates and will be live for Simply pending State approval.

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FL_Simply_11_OnlineProDir02_70_WEB_2.1

Figure 11-2. Online Provider Directory
Future Provider Directory Search – Screen #2



Simply healthcare
An Anthem Company

Your Plan Your Health Your Community

Find Doctors & Locations:

Looking for a:

- Primary Care Provider (PCP)
- Specialist
- Hospital
- Facility
- Behavioral Health
- Laboratory
- Pharmacy
- Dentist: SMMC Managed Medical Assistance, SMMC Long-Term Care & Medicare Plans
- Vision Care
- Long-Term Care Providers

Looking for:

- Dental Care
- Pharmacy
- Vision Care
- Transportation

Enroll & Renew

See a doctor 24/7 on your computer or mobile device **LiveHealth** ONLINE
Log in or Learn more.

[Search for doctors and other health care providers](#)

Member Services: 1-800-887-6888 (TTY: 711)

[Get help in another language](#)

Non Discrimination Policy

[English](#)
[Spanish](#)

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FL_Simply_11_OnlineProDir01_70_WEB_1.1

Figure 11-3. Online Provider Directory
Future Provider Directory Search – Screen #3

Simply healthcare
An Anthem Company

Home Search Results <<prev 1 2 3 4 5 next>>

31 of 31 Results found Items per page: 10 Sort by: Distance

You Searched For

Search by Specialty
[Need help with this search?](#)

Where do you live? *
Florida

Where are you searching?
Location *
Miami, FL

Distance
within 15 miles

Select a Product *
I don't know

What kind of Provider are you looking for? *
DME/Home Health Supplier

Select a Specialty or Service (ctrl + select for multiple selection)
All
DME
DME & Supplies
DME & Supplies Group
DME Medical Supplier

Name
Enter Name

* Required Field **Search**

Filter Your Results
Wheelchair Accessible
Accreditation
[Remove All Filters](#)

Previously Viewed

Some of the providers listed here may not treat members who have your product. Please check your Member ID card or call Member Services at 1-800-487-6898 to find out what product you have.

COMPARE

NAME	DISTANCE	SPECIALTIES/SERVICES
Advanced Care Solutions SERVING THIS AREA MIAMI, FL 33101 Miami-Dade (954) 748-1966	0.44 miles (map)	DME & Supplies
Accepting New Patients	Wheelchair Accessible	COMPARE
American Homecare Equipment SERVING THIS AREA MIAMI, FL 33101 Miami-Dade (954) 772-5052	0.44 miles (map)	DME & Supplies Medical Equipment and Supplies
Accepting New Patients	Wheelchair Accessible	COMPARE
Dynamic Orthopedics SERVING THIS AREA MIAMI, FL 33101 Miami-Dade (954) 424-1168	0.44 miles (map)	Orthotics and Prosthetics
Accepting New Patients	Wheelchair Accessible	COMPARE
Mar-J Medical Supply SERVING THIS AREA MIAMI, FL 33101 Miami-Dade (561) 347-7997	0.44 miles (map)	DME & Supplies
Accepting New Patients	Wheelchair Accessible	COMPARE
Medline Industries SERVING THIS AREA MIAMI, FL 33101 Miami-Dade (800) 404-4141	0.44 miles (map)	DME & Supplies
Accepting New Patients	ADA Accessible	COMPARE
Pediatric Supplier SERVING THIS AREA MIAMI, FL 33101 Miami-Dade (305) 969-3484	0.44 miles (map)	DME & Supplies
Accepting New Patients	Wheelchair Accessible	COMPARE
One Medical Supplies 1090 SW 27TH AVE MIAMI, FL 33135 Miami-Dade (305) 643-5253	2.91 miles (map)	DME & Supplies
Accepting New Patients	Wheelchair Accessible	COMPARE
Jairos Medical Equipment 1823 PONCE DE LEON BLVD MIAMI, FL 33134 Miami-Dade (305) 529-9976	4.23 miles (map)	DME & Supplies Medical Equipment and Supplies
Accepting New Patients	Wheelchair Accessible	COMPARE
Suncare Respiratory Svcs 4656 SW 74TH AVE MIAMI, FL 33155 Miami-Dade (305) 267-2278	8.18 miles (map)	DME & Supplies
Accepting New Patients	Wheelchair Accessible	COMPARE
First Quality Medical Supplies 4207 SW 75TH AVE MIAMI, FL 33155 Miami-Dade (305) 262-7005	8.21 miles (map)	DME & Supplies
Accepting New Patients	Wheelchair Accessible	COMPARE


<<prev 1 2 3 4 5 next>>

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Screenshot depicts functionality, layout and navigation currently live for affiliates and will be live for Simply pending State approval.

FL_Simply_11_OnlineProDir03_70_WEB_3.1

Figure 11-4. Online Provider Directory
Current Provider Directory Search – Screen #1



in healthcare



Florida

[Español](#) [A-](#) [A](#) [A+](#)

[Login](#) | [Register](#) | [Contact Us](#)

► Why Amerigroup

Plans & Benefits

Newsletters & More

Health & Wellness

▼ Find a Doctor

Provider Search Tool

Change Your PCP

Why Amerigroup?

Your health comes first.
Make us your first choice.

We're proud to help Statewide Medicaid Managed Care Managed Medical Assistance (SMMC MMA), Florida Healthy Kids (FHK), Supplemental Security Income (SSI) and Statewide Medicaid Managed Care Long-Term Care (SMMC LTC) members in Florida.

We're a managed care organization. And we'll help you and your family get access to benefits you need to stay healthy.

Want to learn more? Check out [Choose Amerigroup!](#)

[How are we doing?](#)

[Compare Amerigroup with other Florida health plans.](#)

WHO'S ELIGIBLE?

SMMC Long-Term Care ►

Florida Healthy Kids ►

SMMC Managed Medical Assistance ►

What is the Zika virus?

[Learn more ►](#)

[Important information about your Durable Medical Equipment, Home IV infusion, home health and respiratory therapy benefits](#)

Did you get a survey?

Your opinion matters! We need your feedback to improve. If you've gotten a survey in the mail, please fill it out and return it. We want to hear from you.

Figure 11-5. Online Provider Directory
Current Provider Directory Search – Screen #2

Amerigroup RealSolutions
in healthcare

Florida

Español Login | Register | Contact Us

Find a Doctor

Use our online search tool to search for the following provider types:

Search

Primary Care Provider (PCP) ⓘ
Specialist ⓘ
Hospital ⓘ
Facility ⓘ
Behavioral Health ⓘ
Laboratory ⓘ
Pharmacy ⓘ
Dentist: SMMC Managed Medical Assistance, SMMC Long-Term Care & Medicare Plans ⓘ
Vision Care ⓘ
Long-Term Care Providers

Some providers may not offer certain services because of religious or moral values

Click below to find a:

► Dentist: Florida Healthy Kids
► Art Therapy ⓘ

Florida Provider Directories in PDF Format

- East Central
- Gulf Coast
- South
- Long-Term Care

Florida Network:
[Adequacy Table - LTC](#)
Florida Network:
[Adequacy Table - MMA](#)

Member Services: 1-800-800-4441 (TTY 711)

Get help in another language

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[Minor Credit Protection Program](#)

Figure 11-6. Online Provider Directory
Current Provider Directory Search – Screen #3

Amerigroup RealSolutions
in healthcare

Find a Doctor

[En Espanol](#) | Text: [a](#) [a](#) [a](#)

We can help you find the right doctor, hospital or lab near where you live or work. To search for any network doctor, hospital or lab, use the **Search by Specialty** box below. To look for a doctor by name or to see if your doctor is part of the Amerigroup network, use the **Search by Name** box.

Search by Specialty

[Need help with the search?](#)

Where do you live? *

Florida

Where are you searching?
Enter Address, City+State, Zip, or
County+State. *

33004

Distance

within 15 miles

Select a Product *

Florida SMMC MMA Medicaid

What kind of Provider are you looking for? *

DME/Home Health Supplies

Select a Specialty or Service
(ctrl + select for multiple selection)

- All
- DME
- DME & Supplies
- DME & Supplies Group
- DME Medical Supplier

* Required Field [Advanced Search](#)

Search

Search by Name

[Need help with the search?](#)

Enter Name

e.g. Rita Smith OR Main Street Pediatrics

Enter Address, City+State, Zip, or
County+State. *

33004

Distance

within 15 miles

* Required Field **Search**

Health A to Z

Check Your Symptoms
Find out
what to do

Start Here

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Figure 11-7. Online Provider Directory
Current Provider Directory Search – Screen #4

Amerigroup RealSolutions
in healthcare

En Español | Text: [a](#) [a](#) [a](#)

Home Search Results

Create a Directory <<prev 1 2 3 next>>

23 of 23 Results found Items per page: 10 Sort by: Distance

You Searched For

Search by Specialty
[Need help with the search?](#)

Where do you live? *
Florida

Where are you searching? Location *
33004

Distance
within 15 miles

Select a Product *
Florida SMMC MMA Medix

What kind of Provider are you looking for? *
DME/Home Health Supplier

Select a Specialty or Service (ctrl + select for multiple selection)
All
DME
DME & Supplies
DME & Supplies Group
DME Medical Supplier

Name
Enter Name

* Required Field [Search](#)

Filter Your Results

Wheelchair Accessible
Hospital/Facility Services Accreditation
[Remove All Filters](#)

Previously Viewed

NAME	DISTANCE	SPECIALTIES/SERVICES	COMPARE
Aldo Surgical and Hospital Supply SERVING THIS AREA HOLLYWOOD, FL 33020 Broward (305) 557-2835	1.13 miles (map)	DME & Supplies Orthotics and Prosthetics	COMPARE
Accepting New Patients Wheelchair Accessible			COMPARE
All Customs Corsets SERVING THIS AREA HOLLYWOOD, FL 33020 Broward (305) 541-5858	1.13 miles (map)	DME & Supplies	COMPARE
Accepting New Patients Wheelchair Accessible			COMPARE
Diabetic Solutions SERVING THIS AREA HOLLYWOOD, FL 33020 Broward (954) 346-7759	1.13 miles (map)	DME & Supplies	COMPARE
Accepting New Patients Wheelchair Accessible			COMPARE
Dynamic Orthopedics SERVING THIS AREA HOLLYWOOD, FL 33020 Broward (954) 424-1168	1.13 miles (map)	Orthotics and Prosthetics	COMPARE
Accepting New Patients Wheelchair Accessible			COMPARE
Health Medical Equipment SERVING THIS AREA HOLLYWOOD, FL 33020 Broward (305) 223-7222	1.13 miles (map)	DME & Supplies	COMPARE
Accepting New Patients Wheelchair Accessible			COMPARE
Medline Industries SERVING THIS AREA HOLLYWOOD, FL 33020 Broward (800) 404-4141	1.13 miles (map)	DME & Supplies	COMPARE
Accepting New Patients ADA Accessible			COMPARE
Pedi Stat SERVING THIS AREA HOLLYWOOD, FL 33020 Broward (305) 623-1222	1.13 miles (map)	DME & Supplies Medical Equipment and Supplies	COMPARE
Accepting New Patients Wheelchair Accessible			COMPARE
SurfMed SERVING THIS AREA HOLLYWOOD, FL 33020 Broward (305) 948-6429	1.13 miles (map)	DME & Supplies Medical Equipment and Supplies	COMPARE
Accepting New Patients Wheelchair Accessible			COMPARE
Tabraue Orthopedic Medical Supply SERVING THIS AREA HOLLYWOOD, FL 33020 Broward (305) 649-4460	1.13 miles (map)	DME & Supplies DME Medical Supplier	COMPARE
Accepting New Patients Wheelchair Accessible			COMPARE
Advanced Prosthetics & Orthotics 5555 HOLLYWOOD BLVD STE 101 HOLLYWOOD, FL 33021 Broward (954) 926-4148	3.35 miles (map)	DME & Supplies Orthotics and Prosthetics	COMPARE
Accepting New Patients Wheelchair Accessible			COMPARE

<<prev 1 2 3 next>>

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Last updated on 08/16/2017

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 12 – Enrollee Grievance and Appeal System (Statewide):

The respondent shall provide a flowchart and written description of how the respondent will execute its enrollee grievance and appeal system, including identifying, tracking and analysis of enrollee complaints, grievances, appeals and Medicaid fair hearing data. The respondent shall include in the description detail regarding how data resulting from the grievance and appeal system are used to improve the operational performance of the respondent.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Clear Health draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations — including our process for handling complaints, grievances, and appeals. Clear Health has been 100 percent compliant with Agency for Health Care Administration's (AHCA) grievance and appeal turnaround time requirements in 2017 to date. Evidenced by our current success, we will continue to meet and strive to exceed Contract requirements throughout the term of our agreement with the State.

Clear Health's structure makes it easy for enrollees (members) to submit a complaint, grievance, or appeal. Strong grievance and appeal processes are critical to protecting the rights and health of members and to improving our program operations and oversight of providers and subcontractors. At Clear Health, we respect the rights of members to make inquiries, file complaints and grievances, appeal health plan decisions, and request Medicaid Fair Hearings in their language of preference and with accommodations for challenges they may face. We take steps to confirm members know of their rights and have any help they need to exercise these rights. We currently comply with grievance and appeal requirements and substantially exceed the AHCA standards for timely resolution of grievances.

We believe that it is essential to continuously listen to feedback from our members, network providers, and other stakeholders and then to incorporate that feedback in our quality improvement efforts. Members and providers are an important source of information regarding our performance. We believe so strongly in obtaining this feedback that we meet our members face-to-face, on a quarterly or more frequent basis, through Member Advisory Committees. Our Quality Management program includes quality feedback activities based on grievance and appeal data to improve the services we provide. Our annual Quality Management Program Evaluation includes an analysis of grievance and appeal data to drive continuous quality improvement.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1. EXTENT TO WHICH RESPONDENT'S GRIEVANCE AND APPEAL SYSTEM FLOWCHART REFLECTS EASE OF ACCESS

We make it easy for members to contact us with a complaint, grievance, or appeal. Attachment SRC# 12-1: Enrollee Grievance and Appeal System provides flow chart depictions of our member complaint and grievance process.

Members, member representatives, or providers on behalf of the member can initiate a complaint, grievance, or appeal, with us by phone, in person, mail, email, and fax. Providers can also submit appeals on behalf of members online. We provide training for our new employees during initial onboarding and on an ongoing basis to make sure all employees understand policy and process updates. All staff and subcontractors who interact with members are provided extensive training on:

- Member rights
- Benefit coverage
- State contractual requirements
- How to accept a complaint, grievance, and appeal
- How to assist members in completing the grievance and appeal process
- How to assist members in completing forms and following procedures throughout the process
- Documentation of grievances and appeals
- How to process a grievance or appeal

Our Customer Care Representatives are typically the first to receive and assist members with the complaint and grievance process. Our Customer Care Representatives speak English, Spanish, and Haitian Creole. Eighty-five percent of our front-line Customer Care Representatives are bilingual in English and Spanish. In addition, 90 percent of the Customer Care management team is bilingual. All employees quickly initiate telephone interpreter services in any other language, as needed, by means of our language translation line, which operates 24/7. Members with hearing or speech challenges reach us through our TTY line and we arrange sign language interpreters as needed for in-person meetings, which include services in a provider's office or at any place of the member's choosing.

We can also receive grievances or appeals requests outside of Member Services, for example from Case Management. As Managed Care Coordinators interact with members, they may identify an issue that will need to be resolved through the grievance and appeal process. In those instances, the Managed Care Coordinator is empowered to initiate the request on the member's behalf. As an additional resource for our members, at their request we provide members and their authorized representatives with medical records and other documentation pertaining to their case at no cost. This allows members and their authorized representatives the opportunity to examine their documents.

We inform members about our grievance and appeal processes and their right to be treated with respect, to receive information about available treatment and provider options, to receive prompt responses to their questions and requests, to participate in their health care decisions, to have impartial access to services without discrimination, and many other rights. Some of our methods for sharing grievance and appeal information with members include the new member welcome packet, welcome calls and other health plan outreach from staff, our member website, notice of adverse benefit determination letters, and grievance and appeal letters.

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Another method we use for sharing grievance and appeal information with members is through attending Member Advisory Committee meetings in partnership with Clear Health's Quality team. We conduct Member Advisory Committee (MAC) meetings designed to provide an opportunity to address members' needs and concerns, offer education, and elicit feedback regarding access to and quality of, care. We also realize that members often attend Member Advisory Committee meetings if they have concerns. Our Florida Director of Grievance and Appeals attends many of these meetings to educate members about their grievance and appeal rights in addition to the process for submitting a request. Often our employees are able to take action to resolve a member complaint on the spot. We provide an example of a grievance we obtained through the Member Advisory Committee below.

**** SPOTLIGHT ON: Reaching Out to Educate Members About the Grievance and Appeals Process**

Member Advisory Committee meetings is one way our Grievance and Appeals team educates members about the process and answers their questions. While at one meeting held in St. Petersburg, our Director of Grievances and Appeals met a member who expressed dissatisfaction with her PCP. Our Director gathered all of the necessary information and assigned the case to a Grievance Coordinator for resolution on the same day of the meeting. Following our practice of one-day resolution, the assigned Coordinator contacted the member that afternoon and listened to the member's concerns. Based on the conversation, the Coordinator assisted the member in identifying a new PCP. The member was pleased with the new PCP assignment and outcome of the complaint resolution.

Of note, during the Member Advisory Committee the member was educated about her rights and responsibilities, which include the right to submit a complaint or a grievance. This is part of the standard agenda of each Member Advisory Committee meeting. Our Grievance Coordinator reinforced this information in their conversation. She acknowledged that she was aware of her rights and plans to exercise them in the future. In addition, our Grievance Coordinator provided the member with information about the nearest urgent care clinic and the toll-free number for our Nurse help line. ******

Our Member Complaint and Grievance Process

Figure 12-1 in Attachment SRC# 12-1 Enrollee Grievance and Appeal System provides a flow chart depiction of our Member Complaint and Grievance Process. We also provide examples of our process through real member stories and spotlight examples throughout this SRC response. These real stories and spotlights highlight our approach through actual situations we have encountered.

Our Florida-based call center receives member complaints through the avenues we described in the section above about any aspect of their coverage including benefits; health plan, provider, or subcontractor customer service; quality of care; privacy concerns; and any other concern. Customer Care Representatives receive comprehensive training on how to properly handle member inquiries and complaints and to provide first call resolution whenever possible. Representatives work in an open and collaborative environment with convenient access to our knowledge repository, as well as Operations Experts and management who can assist them in providing real-time member assistance and complaint resolution. Representatives follow

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escalation procedures to contact other departments or delegated subcontractors to resolve issues.

We closely monitor complaints. Twice each business day, an analyst aggregates member call and complaint data and collaborates with management to ensure timely resolution or escalation of complaints. We also have systems in place to record conversations. Managers review complaint dispositions by reviewing recordings, and can audit “live” calls if needed. They provide immediate coaching and feedback to Customer Care Representatives to resolve complaints effectively, and assign any unresolved complaints to the Medicaid Resolution team for further investigation, follow-up, and resolution.

The Medicaid Resolution team focuses on resolving complex member situations that require numerous outbound calls, extensive follow-up, and cooperation with multiple parties. The team closely manages case inventory and productivity to resolve complaints within one business day of receipt. Team members transfer complaints that we do not resolve to the Grievance and Appeal department the next business day.

We enter all complaints not resolved by Customer Care Representatives into our Grievance and Appeal system within 24 hours of receipt, at which time they become formal grievances. Those that are about adverse benefit determinations become formal appeals. Upon receipt of a formal complaint, the system automatically generates an acknowledgement letter within three days of receipt, which we mail to the member.

If AHCA notifies us that a member with a grievance has a good cause plan change, we will process those grievances as expedited requests in accordance with Contract requirements. We understand that if we do not meet the Agency’s prescribed timeframe in these cases, approval of the member’s request is automatic. We resolve all other grievances expeditiously, considering the member’s health condition. In compliance with NCQA standards, our standard for reviewing and resolving grievances and sending members written notices of results is 30 days from the day we received the grievance, which is much shorter than the 90-day Contract requirement. In cases where a member requests an extension or we document that an extension for additional information is in the member’s interest, we may extend the resolution timeframe by 14 days.

We understand that grievances may be clinical or non-clinical in nature; therefore, our Florida-based Grievances and Appeals team is composed of both clinical and non-clinical staff. Additionally, we collaborate with our Case Management department to assist with grievance resolution using their expertise in areas such as case management, community resources, and behavioral health concerns.

Our Member Appeal Process

Figure 12-2 in Attachment SRC# 12-1 Enrollee Grievance and Appeal System provides a flow chart depiction of our Member Appeal Process; Figure 12-3 Attachment SRC# 12-1 provides a flow chart depiction of our Member Expedited Appeal Process.

Members, providers, or authorized representatives acting on behalf of members may submit an appeal or a request for review of an adverse benefit determination through the avenues we described in the section above. Once the appeal is entered into our grievance and appeal system, the request is reviewed to ensure appropriate classification. When in the member’s best interest

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or if the standard timeframe resolution could jeopardize the member's life or health, the appeals staff will upgrade the request to an expedited appeal. After classification, we send an acknowledgement letter to the member within three days, exceeding the five-day contractual requirement. One of our clinical staff completes a review using medical necessity criteria that is appropriate to the request. If we need additional information from the member, our clinical staff member performs outreach to obtain it. The appeal may include a review by our Medical Director (as long as he or she was not involved in the original adverse decision) or an external specialist as the appeal requires. Once resolved, our clinical staff member assures an appeal resolution letter is sent to the member and closes the case.

Our standard for reviewing and resolving appeals and sending members written notices of disposition is 30 days. Clear Health is successfully meeting this standard in 2017 to date. When a member requests an extension or we document that an extension for additional information is in the member's interest, we may add an additional 14 days to the resolution timeframe. If we initiated the extension, we will notify the member by telephone the same day of this extension and give written notice within two calendar days.

Our expedited appeals process allows for resolution as quickly as the member's condition requires and no longer than 72 hours, when a member's life, health, or ability to attain, maintain, or regain maximum functioning would be in jeopardy with the standard appeal resolution timeframe of 30 days. We do not take punitive action against providers who request or support requests for expedited appeal resolution; in fact, we educate the provider regarding appropriate classification as evidenced by our provider orientation and manual. Only our clinical staff can downgrade requests for expedited appeal. The clinician reviews all available clinical information to make the determination, considering the member's unique circumstances. If we downgrade a request for expedited appeal resolution or if a member requests an extension on an expedited appeal, we transfer the appeal to the standard resolution timeframe of 30 days. We notify the member by phone on the day we downgrade the request and mail a written notice to the member within two calendar days.

When we have resolved an appeal, we send members the written notice of appeal resolution within two calendar days of our decision. We also verbally notify members of expedited appeal outcomes before the end of the day we resolve the appeal.

If a member requests a continuation of benefits during the appeals process, one of our clinical staff will review the request to ensure that it meets Contractual criteria for continuation. We notify the member by letter of our decision on continuation of benefits and inform them they may be liable for the costs of continued benefits during the appeal process if our decision is upheld.

Clear Health is 100 percent compliant with appeal resolution timeliness in 2017 to date; and during accreditation file reviews no deficiencies were found with our appeal process. We are committed to sustaining our compliance with timeliness standards, and we strive toward continuous improvement. To this end, we have studied our processes and implemented changes as described in our response under heading number 3 below.

**** SPOTLIGHT ON: Departments Working Together Result in Satisfied Member**

When Marco came to our Miami office to inquire about the status of his appeal, he spoke with Grievance and Appeals Specialist, Ana, who explained the appeal was in process. Ana also explained that the original denial was because he did not meet medical necessity criteria for a

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heavy-duty power scooter, specifically, weighing 300 pounds or more. Marco told Ana about his volunteer work with retired and disabled veterans and explained how difficult it is with an unreliable power wheelchair. Understanding Marco's situation and his frustration, she invited a Member Services Manager, Joseph, to join the conversation. Joseph thanked Marco for his service to our country, empathized with his struggles, and volunteered to personally follow up on his appeal.

Joseph worked with Provider Relations to obtain a new letter of medical necessity from the provider for a different power scooter model that would meet Marco's needs and was medically appropriate. With the letter in hand, Joseph walked it to the Medical Director who reviewed the case and approved the medically appropriate power scooter, which was delivered to Marco the following week. **

Our Medicaid Fair Hearing Process

Figure 12-4 in Attachment SRC# 12-1 Enrollee Grievance and Appeal System provides a flow chart depiction of our Medicaid Fair Hearing Process.

A member who is not satisfied with the resolution of their appeal may request a Medicaid Fair Hearing. They may also request a Medicaid Fair Hearing if they believe we failed to meet notice and resolution timeliness requirements. Members may request a hearing within 120 calendar days of receipt of our appeal resolution notice. The member, the authorized representative, any member witnesses, and our Grievance and Appeal Representative attend each hearing with AHCA Hearing Unit staff. Our Medical Director (for medical necessity decisions) or a member's Managed Care Coordinator may also attend hearings related to complex cases. Our Grievance and Appeal Representative will bring evidentiary materials, such as an examining physician's report, and may bring witnesses.

Within two business days of receiving the initial request for hearing, we send the AHCA Hearing Unit the notice of adverse benefit determination and the notice of appeal resolution related to the case. We prepare an evidence packet, which we submit, to the AHCA Hearing Unit within ten business days of receiving notice of a hearing, in accordance with AHCA pre-hearing instructions. This packet includes all related documents, a statement of matters or the denial letter, and any medical records or other documentation related to the appeal and to our appeal resolution. We share Medicaid Fair Hearing communications with AHCA through AHCA's portal, and by mail to the member and the member's representative. In the future, to make sure that members promptly receive evidence packets, we will use secure email with the member's permission in addition to mailing the information, assuring protection of protected health information (PHI).

The primary method of attending a fair hearing is by phone, but if a member does not have access to a phone, we provide transportation for members and their authorized representatives to the nearest designated call-in center as Contractually required with arrangements for certified interpreter or translation services if needed. If we receive a member request for continuation of their benefits during the hearing process within 10 days of the appeal resolution notice, we continue their benefits. In these cases, benefits will continue until AHCA makes a hearing decision or the member withdraws their request for a hearing. We advise members that they may be responsible for the cost of the benefits if their appeal is unsuccessful. When the final order is received from AHCA, our Grievance Coordinator updates the authorization within 24 hours of the receipt and will notify the subcontractors if necessary.

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2. TIMELINESS FOR ACKNOWLEDGING AND RESPONDING TO COMPLAINTS, GRIEVANCES, AND APPEALS

We closely monitor complaints. Twice each business day, an analyst aggregates member call and complaint data and collaborates with management to ensure timely resolution of complaints. This allows us to make sure we are resolving complaints in less than 24 hours or are escalating according to the grievance process.

Understanding the requirement is to send the acknowledgement letter within five business days, Clear Health's internal benchmark is to send the acknowledgement letter within three business days. Each acknowledgement letter includes the date we received the grievance or appeal, contact information for the Grievance and Appeals Representative, instructions for accessing translation services, and a description of member rights including non-discrimination rights. For expedited appeals, we communicate acknowledgement of receipt of their request to the member by phone within 24 hours.

We resolve grievances in compliance with the NCQA standard of 30 days from receipt, which is more stringent than the 90-day Contract requirement. Standard appeals are resolved within an average of 20 days. Expedited appeals are resolved within an average of 48 hours.

If our appeal determination is favorable or partially favorable, we begin the service or authorization on the same day of the decision. If we receive a Medicaid Fair Hearing determination that is favorable or partially favorable, we will begin the service or authorization on the same day as the receipt of the Medicaid Fair Hearing determination. Our process is more stringent than the Contractual 72 hours.

We typically send grievance and appeal resolution notices to members within 24 hours of the decision.

The notice for a grievance resolution includes the following information:

- The results of the grievance
- The date completed
- Grievance staff contact information
- A description of member rights including non-discrimination rights

The notice for an appeal resolution includes the following elements:

- The results of the appeal resolution process and the date completed
- A unique identifying number corresponding to the number on the notice of adverse benefit determination that is the subject of the appeal
- For dispositions that are not entirely in the member's favor
 - Information about the AHCA Subscriber Assistance Program review process, including how to initiate a review, that the member must request a review within one year of receiving a Disposition Notice, that a review is only for appeals that have not initiated or completed the Medicaid Fair Hearing process, and contact information for the program (address, toll free phone number, and secondary phone number)

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— Information describing the Medicaid Fair Hearing process, their right to request a Medicaid Fair Hearing, their right to request benefits while the hearing is pending, how to request continued benefits, and contact information (address, toll free phone number, fax number, and email address) for AHCA's Medicaid Hearing Unit

We have reports and monitoring strategies to be sure we meet our internal benchmarks and exceed all Contractual timeliness standards. As an additional market investment, we are changing our grievance platform to achieve additional integration, ease of use, and improved functionality. The new grievance platform, scheduled to begin operation in October 2018, will offer the following increased efficiencies:

- Automatically routing clinical grievances and quality of care concerns to our Medical Director
- More detailed classification and reporting of grievance topics
- Built-in system reporting and work lists for individual grievance staff
- Dedicated business and IT support staff for grievance platform

The appeals process is currently using new platform and all of the above-mentioned features apply for appeals.

3. USING COMPLAINT, GRIEVANCE, APPEAL, AND MEDICAID FAIR HEARING DATA FOR ANALYSIS AND PRIORITIZATION OF CORRECTIVE ACTION AND IMPROVEMENTS

We categorize, track, trend, and aggregate all data related to complaints, grievances, appeals, and Medicaid Fair Hearings including the type of issue and other details such as resolution status and timeframes for completing process steps. We review the AHCA member Complaints, Grievances, and Appeal Report for monthly submission to the State and to our Quality Management Committee (QMC).

The Clear Health QMC reviews data related to grievances, appeals, complaints, and Medicaid Fair Hearing volumes by topic type, region, outcome, and timeliness of grievance and appeal resolutions. After reviewing grievance and appeal data, the QMC creates plans to address areas of concern and to improve the member experience through process and system improvements; feedback to providers and delegated vendors; staff, provider, or vendor training; and provider or vendor corrective action plans. The QMC reports the results of grievance and appeal data review and planned priorities for actions to address concerns and improve the member experience to our Board of Directors.

Through web-based training tools such as HIPAA and security trainings, our employees are educated to understand the importance of protecting member's protected health information. For complaints, grievance and appeal, and fair hearing data submitted to the QMC, the data is aggregated and excludes any protected health information. Additionally, Clear Health makes sure that we are meeting all HIPAA requirements including encrypting data at rest.

As described throughout this SRC response, actionable strategies that result from our grievance and appeal tracking process include provider, vendor, and internal plan strategies to improve the delivery of care to our members. We have similarly implemented strategies to improve the grievance and appeal process. For example, we implemented the following strategies in 2016:

- Completed Process Improvements for Appeals Turnaround Time Compliance

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- Daily monitoring of work lists for Grievance and Appeal Nurses and our Medical Director to provide frequent notifications about pending cases approaching maximum timeliness standards
- Grievance and Appeal staff training to increase use of appropriate timeliness extensions when permitted by federal and State policy
- Addition of new Grievance and Appeal employees to address increased volume and support meeting timeliness standards
- Scheduling of a Grievance and Appeal Nurse on weekends to assure timely responses to expedited appeal requests
- Review of any appeals that come close to exceeding turnaround time requirements to determine the root cause
- Completed Process Improvements for Medicaid Fair Hearings
 - Weekly Medicaid Fair Hearing team meetings to prepare for hearings scheduled for the upcoming week
 - Improved scheduling practices to ensure necessary plan and vendor Medicaid Fair Hearing participants attend all hearing meetings
 - Addition of a new Grievance and Appeal Auditor who audits each evidence packet prior to AHCA submission to ensure timely, complete, and accurate submissions
 - Consistent and comprehensive use of an internal Medicaid Fair Hearing database in addition to the AHCA portal to provide backup in monitoring of Medicaid Fair Hearing activities

4. CORRECTIVE ACTION PLANS AND QUALITY CONTROLS TO MONITOR AND IMPROVE COMPLAINT, GRIEVANCE, AND APPEAL PROCESSES

Clear Health's Compliance, Subcontractor Oversight Program, and Special Investigation Unit (SIU) use corrective action plans as a method to escalate and track issues of non-compliance with our Contractual requirements that may be identified through our complaint, grievance and appeal processes.

Network Providers

Clear Health has policies and procedures for imposing provider sanctions, restrictions, suspensions, or terminations. Our Provider Relations Department typically terminates providers for non-compliance with Contractual responsibilities. These types of administrative terminations do not involve Compliance.

Clear Health's SIU uses corrective action plans (CAPS) with network providers, when necessary, due to findings of investigations or audits. We use CAPs as a tool to educate providers. For example, when we identify and validate billing irregularities, we use CAPs as a tool to correct their billing or documentation practices. SIU investigators issue CAPs with the notification of overpayment letters. The CAP outlines the specific findings from the audit while providing education and a need for the provider to adhere to the local/federal policies and our

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reimbursement policies as a condition of eligibility to remain in the network. The CAP process includes implementation of prepayment review for claims identified in CAP. Clear Health's SIU frequently collaborates with providers on revising an acceptable CAP that both parties agree upon. The SIU requests the providers sign and return the CAP within 30 days of receipt. The SIU cannot enforce the providers to agree and sign to acknowledge the SIU findings, however the SIU representative does document the case notes and all communication with the providers. Investigators from our SIU monitor the providers billing and adherence to the CAP.

An example of a provider CAP that we implemented to improve member fall events at a facility is provided below.

**** SPOTLIGHT ON: Implementing a Provider Corrective Action Plan Improves Facility Fall Risk Protocols**

We received a grievance to be investigated as a potential quality of care concern regarding a member who had fallen during ambulation therapy. Following our policies and procedures, we discussed the case in our weekly staffing conference under the leadership of the Quality Management Medical Director. We sent the provider an inquiry letter requesting the facility's fall protocols and the corrective action developed to prevent events like this from happening in the future.

The provider's response described the facility's risk management protocols that applied to falls and included a description of the event. As per their report, the member missed the wheelchair as he was attempting to sit. The therapist present at the time attempted to assist him; however, attempts were unsuccessful and the fall could not be prevented.

The corrective action plan included re-education of the entire therapy department. All staff was re-educated on fall prevention techniques and body language, which included their ability to respond to non-verbal cues. Patients were also educated on fall prevention skills such as feeling for the chair or the bed before attempting to sit. The case was assigned a Severity Level 2, meaning that although there was a quality issue identified, this did not impact the care outcome. Quality Management will continue monitoring this facility tracking and trending all fall events. **

Subcontractors

Our Florida-based Vendor Delegation Oversight Group (VDOG) team with support from national subcontractor oversight resources work hand-in-hand with our subcontractors and monitor their compliance with Contractual requirements. If we determine a subcontractor has an issue or risk due to non-compliance or an increase in volume of complaints, grievances or appeals, our VDOG notifies the subcontractor and provides them with details about each area that requires improvement. The issue is reported to the Florida Medicaid Compliance Committee for tracking purposes, and monthly updates are provided. In addition, our Compliance department tracks the issue using our Risk and Issue Tracking tool. If the subcontractor is unable to resolve the issue promptly, Clear Health's VDOG requires the subcontractor to provide a formal CAP with a deadline for submission, inclusion of root cause analysis, and actions and timeframes for completion. Clear Health's VDOG reviews the CAP, may propose changes, and sets a deadline for a revised CAP. Clear Health's Compliance department is part of the review of the CAP. Once we approve a CAP, we monitor provider or subcontractor compliance with the CAP and achievement of milestones by due dates specified in the CAP. We set controls by engaging in weekly (or every other week), or monthly (or as set forth in the CAP) meetings with the

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subcontractor, depending upon the severity of the issue. Our Compliance department also participates in the monthly VDOG meetings in which the CAP is addressed with the subcontractor. During the meetings, we review the action plan to monitor the progress for each action item. We discuss accomplishments as well as areas of concern, including any risks of not meeting a deadline.

If after 90 days it becomes apparent that CAP implementation is not addressing areas of concern as expected, the VDOG will alert our Compliance department and executive leadership. Our Compliance department also makes monthly updates in the Risk and Issue Tracking tool. The VDOG representative, Compliance department representative and executive leadership will determine the risk of the subcontractor's ongoing non-compliance. Depending upon the severity, our legal and national Compliance departments may also be involved. If the subcontractor is unable to resolve the issue or comply with Contract provisions, the VDOG will invoke the subcontractor contingency plan, which addresses de-delegation of subcontracted functions and subcontractor/provider contract termination.

5. TRACKING AND RESOLVING ALL COMPLAINTS

When we receive complaints from AHCA, the process of tracking and resolving these complaints is the same as mentioned earlier. The only difference is for complaints received through AHCA's Complaint Hub, when our Regulatory team participates in the process at initial receipt and resolution finalization. Our Regulatory department enters the complaint into our database of AHCA-submitted complaints, grievances, and appeals, which triggers an automated email to our Grievance and Appeals department with a description of the issue and the priority level of the complaint. With this email, our Grievance and Appeals department initiate the grievance process as described above by entering the complaint in the grievance and appeal system. Throughout the process, our Grievance and Appeals department contacts our Regulatory department with updates on the case, as required by AHCA. We also have weekly meetings to discuss open AHCA complaints and any possible risks to timely resolution.

For subcontractors, Clear Health believes that maintaining complete visibility into the volume and topics of member grievances and appeals is a critical component of subcontractor oversight, which is why we do not delegate grievances or appeals processes to any subcontractors. Our Florida-based team oversees the entire process (intake, investigation, and resolution), working closely with our subcontractors. We instruct subcontractors to forward any member complaints that are unresolved to Clear Health for grievance processing. As part of subcontractor oversight, we record and resolve all member grievances and appeals, including for services provided by our subcontractors, such as pharmacy, dental, vision, and transportation. We assume responsibility for all member grievances and appeals because we hold ourselves accountable to our members for all aspects of our plan and we believe that member concerns provide us with valuable insight into subcontractor performance.

6. TRACKING GRIEVANCE AND APPEAL SYSTEM DATA TO ACHIEVE OPERATIONAL IMPROVEMENTS

Combining the leadership, resources, and capabilities of our three proven legacy health plans in Florida allows us to bring together best practices to assure effective processes. This is true for our grievance and appeal process. We have a strong commitment to continuously looking for opportunities to improve our grievance and appeal processes. This is evident in the efficiencies

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our grievance and appeal system platform brings, and in the improved processes for timely appeals and complete and timely Medicaid Fair Hearing evidence packets we describe above. We also have a strong commitment to using grievance and appeal data to identify opportunities to improve processes throughout our plan.

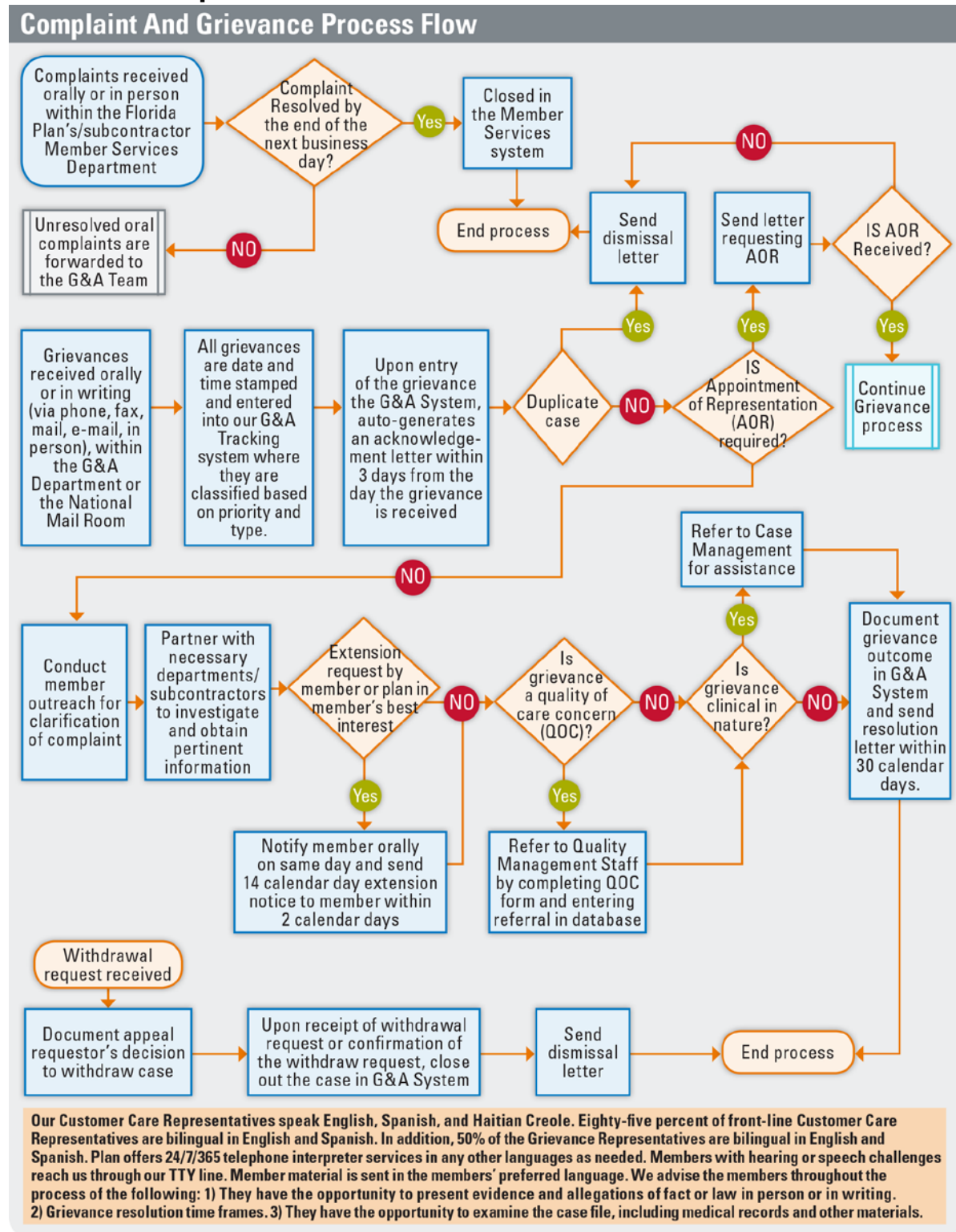
As described above, we use grievance and appeal data to identify areas in which we can work with providers, vendors, and our employees to improve performance. For example, we track complaints, grievances, and appeals to identify any policies and procedures that are not administered correctly. Once we identify an issue, we promptly provide training and resources to the appropriate providers, vendors, and plan employees to prevent future errors. Finally, our Quality Management Committee structure enforces accountability for continuous improvement. Our local leadership chairs this committee and promotes consistent reporting, transparency, and operational enhancements that will benefit members.

Evaluation Criteria:

1. The extent to which the respondent's grievance and appeal system flowchart reflects ease of access for individuals with complaints, grievances and appeals, including ease of access for persons with disabilities or who speak other languages.
2. The extent to which the respondent's timelines for acknowledging and responding to complaints, grievances and appeals are less than those specified in federal and State requirements.
3. The extent to which the respondent's complaint, grievance and appeal and Medicaid Fair Hearing data are aggregated so that results are actionable, protect enrollee privacy and are reviewed by the appropriate staff or committee for analysis and prioritization of corrective action and/or improvement initiatives.
4. The extent to which the respondent's complaint, grievance and appeal process imposes deadlines on completion of corrective action plans implemented as a result of verified complaints, grievances or appeals and have set quality controls in place to review outcomes.
5. The extent to which the respondent is able to ensure all complaints (including those submitted to the respondent by the Agency or respondent's subcontractors) are tracked and resolved as part of the respondent's established complaint, grievance and appeal process.
6. The extent to which the respondent's grievance and appeal system data resulted in operational improvements of the respondent.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

Figure 12-1. Enrollee Grievance and Appeal System
Member Complaint and Grievance Process

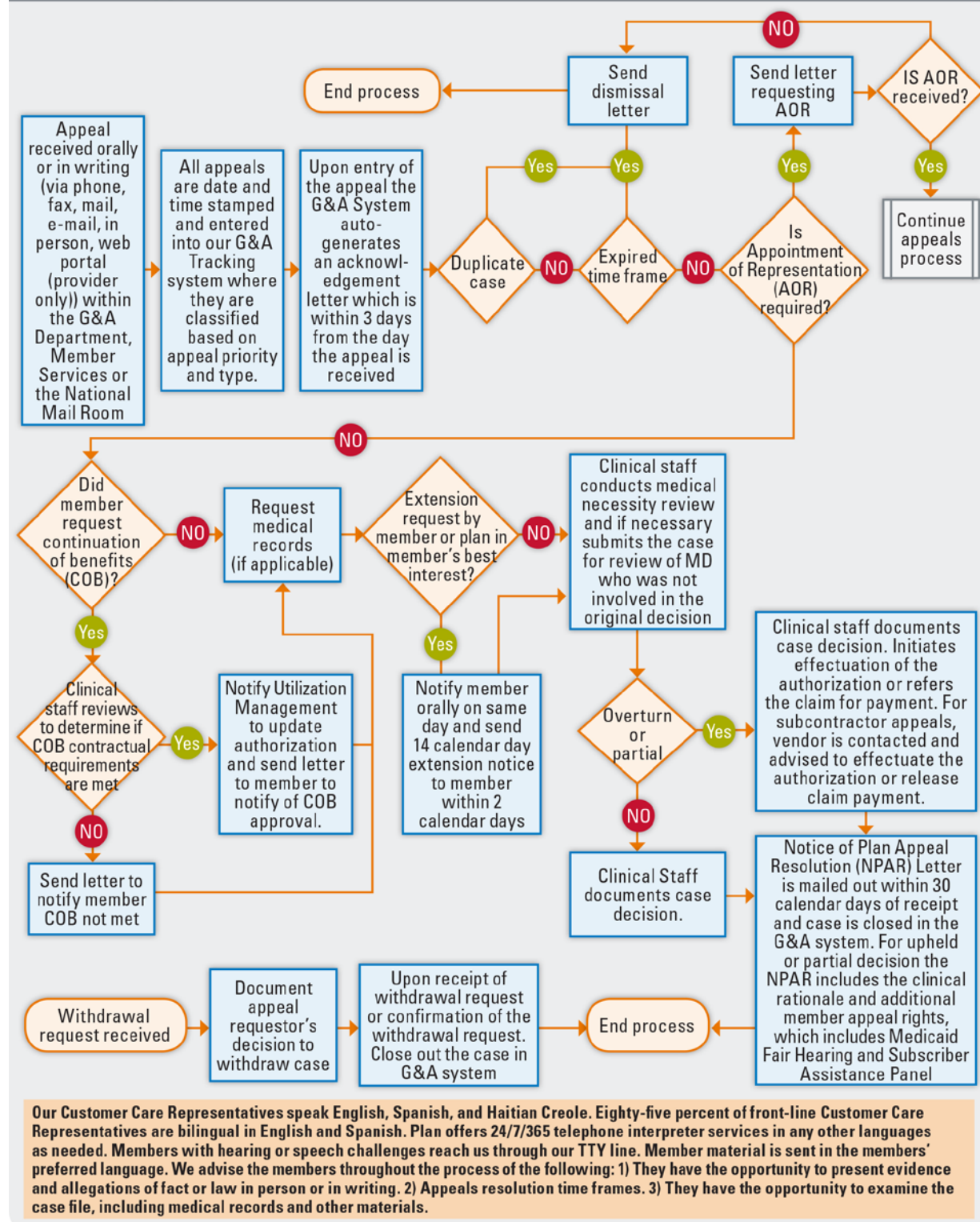


FL_CHA_12_ComplaintGrievance_35_PFC_2.1

Figure 12-2. Enrollee Grievance and Appeal System

Member Appeal Process

Standard Appeal Process Flow

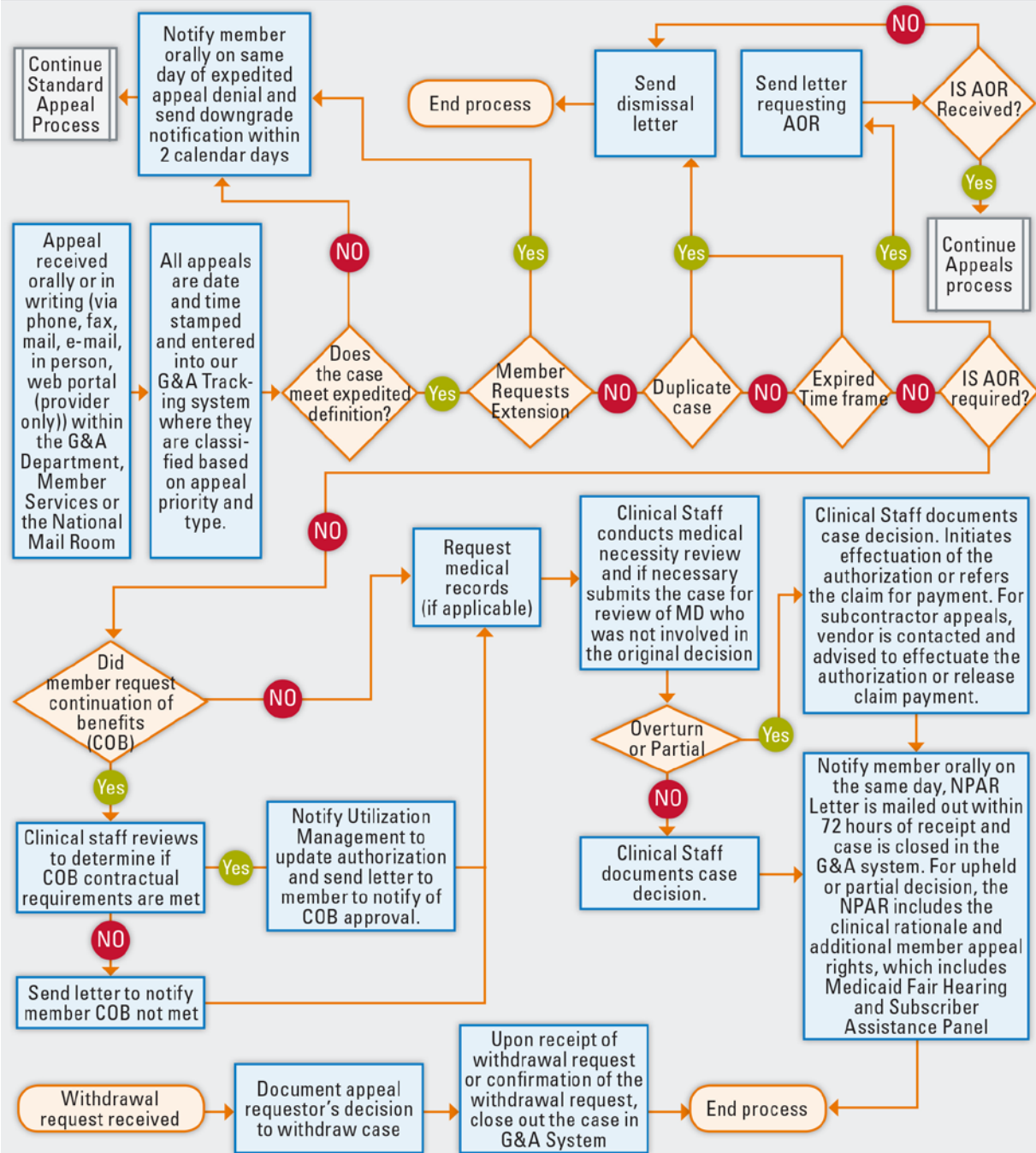


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Figure 12-3. Enrollee Grievance and Appeal System

Member Expedited Appeal Process

Expedited Appeal Process Flow

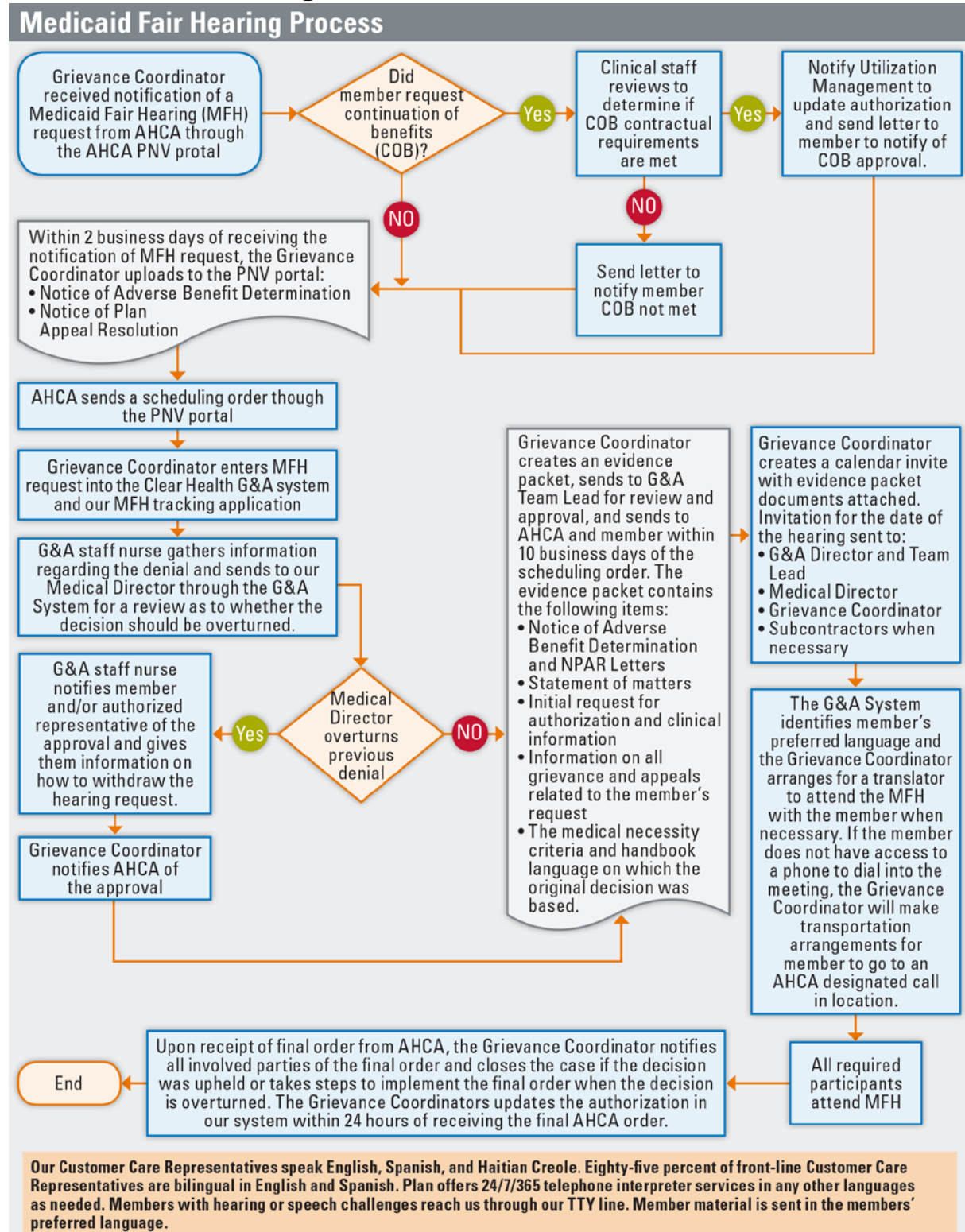


Our Customer Care Representatives speak English, Spanish, and Haitian Creole. Eighty-five percent of front-line Customer Care Representatives are bilingual in English and Spanish. Plan offers 24/7/365 telephone interpreter services in any other languages as needed. Members with hearing or speech challenges reach us through our TTY line. Member material is sent in the members' preferred language. We advise the members throughout the process of the following: 1) They have the opportunity to present evidence and allegations of fact or law in person or in writing. 2) Appeals resolution time frames. 3) They have the opportunity to examine the case file, including medical records and other materials.

FL_CHA_12_ExpAppealProc_35_PFC_4.1

Figure 12-4. Enrollee Grievance and Appeal System

Medicaid Fair Hearing Process



FL_CHA_12_FairHearingPro_35_PFC_3.1

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SRC# 13 – Social Media (Statewide):

The respondent shall describe its approach for engaging enrollees by using innovative communication methods and technologically advanced resources, including, but not limited to the use of social media, texting and smartphone application platforms.

Response:

Technology is changing the way people interact with the world around them, and health care is right at the heart of this phenomenon. For example, just two years ago, less than a third of our national membership (29 percent) used a mobile device to access our website. By contrast, our most recent data indicates that this has grown to nearly half (45 percent). Digitization – defined as the use of new technologies to create new experiences that transform health care – creates unprecedented opportunity to improve health literacy, health outcomes, and relationships between members and their providers. At Clear Health, we understand that technology can enhance everything from the patient experience at a provider's office, to improved health literacy, to supporting desired health outcomes, to addressing social determinants of health. We have invested, and continue to invest, significant resources in a pipeline of innovations that will help continue to shape the way our members interact with us. Keeping pace with the technology is one way that we will leverage advancements to improve the health of our Florida enrollees (members). Clear Health is supported by the resources of our parent company, Anthem, Inc., and every solution used to support our membership is handpicked, customized to be relevant to Floridians, and supports AHCA goals.

The innovations underway will roll out prior to and during the term of the upcoming contract, and will add to the many digital tools we already make available to our members. When taken in total, we think of these solutions as enhancing the member "journey," a concept that emerges from our use of the Agile methodology for developing innovations. Agile is a proven framework that focuses on the constant evolution of our technical and functional solutions. By executing in short, targeted, and iterative cycles – "sprints" – we maintain a high degree of focus on the rapid delivery of value to our members.

Our digital innovations all address one or more of the following "journeys" or needs from the member point of view:

- Help me with my everyday health
- Help me navigate the health care system and talk with my providers about my goals
- Answer my questions and solve my issues
- Help me understand how my choices affect my health
- Provide me with tools to understand and maintain my eligibility
- Help me find community resources that I need
- Help me stay connected to my health care when natural disasters strike

We use innovative communication strategies and advanced technology to engage members and promote health. While we will maintain and continue to improve upon our award-winning member website in this contract, we have moved well beyond this basic platform to a host of other state-of-the-art initiatives described below. We continue to innovate by employing a variety of technology strategies to assist our members in understanding their personal healthcare needs. Social media and similar innovations can help make members healthier by targeting health

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literacy. We use secure communication channels, to protect patient privacy and facilitate information sharing, medication adherence, and help the member engage with their health care community.

Because innovation is a core value of our company, our national organization has created the Innovation Studio to keep us laser-focused on helping our members reap the benefits of the technological changes evolving around us. The Innovation Studio is a multidisciplinary team of experts responsible for working to generate, accelerate, and incubate innovative solutions. Their task is to find and evaluate ideas from all of our affiliate health plans and each of Anthem's more than 53,000 employees. In Florida, we will use the Innovation Studio to test new ideas and strategies that improve person-centered care and engagement, advance quality of care, and lower total cost of care. We use the Innovation Studio's capabilities to vet and evaluate new ideas and processes, prior to implementation with our membership or providers. In support of AHCA's goals, our member-centered and provider-led innovations emphasize collaboration, value-based objectives, and shared rewards. The Innovation Studio is the embodiment of our core value of "First we listen, then we act."

One example of the Innovation Studio in action is the development of a Person Centered Engagement Tool, scheduled to go live as a pilot in Kansas in November 2018. This tool is an application that uses an innovative web-based digital platform designed to help build trusting relationships between members, their circle of support, and their service coordinators through bi-directional information sharing. Members can create a personal profile, see information about themselves, make corrections, and share information about what is important to them and for them by answering open-ended questions. Members use person-centered narratives that reflect capabilities, strengths, preferences, health, and supportive service needs as well as goals and aspirations. This technology will enhance member engagement and self-determination, and simplify communication among the circle of support. Through this technology, members can use various devices to share information in real time to improve the discovery and assessment processes across life domains (medical, behavioral, social, environmental, functional, and social determinants of health).

Innovation is in our DNA as a company. We have established a new division, the Diversified Business Group, to extend our innovation beyond insurance products. We are not just an insurer that adopts solutions available in the marketplace – we are creating new solutions designed to support the best outcomes for our Medicaid members. To advance our capability, our ultimate parent company, Anthem Inc., has entered into an agreement for the custom development of a 352,000 square foot building in the heart of Atlanta, which is already home to the Innovation Studio. The 21-story state-of-the-art structure will be a hub for some 3,000 multidisciplinary IT professionals dedicated to creating new capabilities that will help enhance the member experience, improve quality of care, and lower costs. Construction is set to begin in January of 2018.

When developing innovations, we do not let traditional organizational silos limit us. For example, the mobile technology and voice portal teams are working together on an artificial intelligence (AI) pilot that will provide a chat-based option for members to get answers in real time from an AI engine. This AI is far more sophisticated than existing solutions our members may be familiar with, such as Google Assistant or Siri, and will allow members to ask questions in a natural language and receive answers that make sense. The chatbot will be capable of reading the

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emotional content of a user's response, thus escalating to a human operator in the event that the member grows upset or impatient.

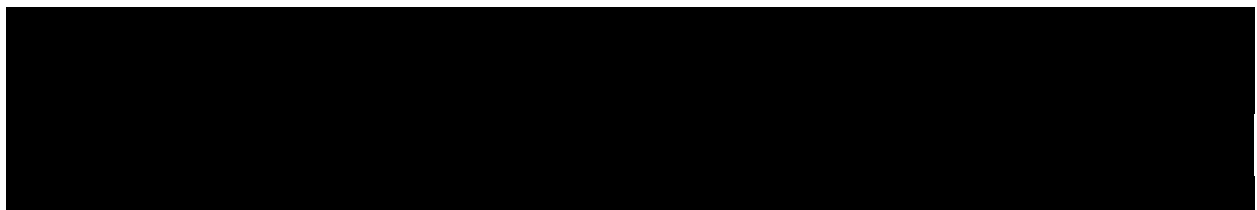
In addition to establishing the Innovation Studio, we are engaged in an initiative designed to build the next generation workforce to keep our innovations ahead of the curve. We work with colleges to update their curricula to make sure that graduates are up to date and can support our forward-facing environment. Technology, or in health care's case, the frameworks for building mobile health care applications, are evolving faster than at any time in our history. As part of this initiative, we take new graduates and enroll them in 12-person boot camps. We provide mentors and establish checkpoints on their progress before they join our workforce in cohorts to incubate innovation throughout the organization. As part of the boot camp and integration process, the participants survey what works and what does not work with members, to evaluate our innovations to make sure they are meaningful and effective, and adapt them as necessary.

Below we outline the innovations under development and provide detail on the many solutions in use today by our membership.

1. OUR TECHNOLOGY INVESTMENTS IMPROVE HEALTH LITERACY AND PROMOTE IMPROVED HEALTH OUTCOMES

Increased health literacy and improved health outcomes are inseparable. Only 12 percent of adults have proficient health literacy, according to the National Assessment of Adult Literacy. In other words, nearly nine out of ten adults may lack the skills needed to manage their health and prevent disease. Fourteen percent of adults (30 million people) have below basic health literacy. These adults were more likely to report their health as poor (42 percent) and are more likely to lack health insurance (28 percent) than adults with proficient health literacy according to the Office of Disease Prevention and Health Promotion. Health literacy increases when members are empowered with knowledge about their conditions and what it takes to keep them healthy in a whole-person context. In addition, health literacy helps a member communicate with their providers so they can develop a shared approach to desired health outcomes. Outcomes improve when members stay connected with their providers and have tools to make changes that improve their health. Technology can support both of these. First, we use technology to empower members with information about their health care in accessible, engaging formats. Next, we use technology to create a three-way partnership between member, provider, and health plan so that members can meet their health care goals while we play a supportive role.

We use innovative communication strategies and advanced technology to engage members and promote health. We have moved well beyond the standard member website to a host of other state-of-the-art initiatives described below. We continue to innovate by employing a variety of technology strategies to assist our members in understanding their personal health care needs and to encourage their active participation in improving health literacy and achieving improved health outcomes. Members will always have the ability to opt out of these tools.



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• CommonGround (secure portion of member portal). This is a comprehensive suite of tools specifically designed for our members with behavioral health needs. Support tools include worksheets/checklists, videos of first-person accounts on recovery and wellness, and other materials grouped into learning tracks on a particular topic. Sample topics include Managing Anxiety and Improving Concentration. Materials emphasize patient-centered care, patient empowerment with respect to treatment, and shared decision-making.

• My Advocate (multi-modal technology – currently leveraged in Clear Health for pregnancy, Asthma and Diabetes). This program provides condition-specific proactive, culturally appropriate outreach and education through a multi-faceted technology tool. It does not replace our high touch case and disease management approach, but instead serves as a supplementary tool to extend our health education reach. The goal of the expanded outreach is to identify members who have emerging risk factors, to facilitate connections between them and our Case Managers (Managed Care Coordinators), and improve member outcomes. My Advocate communicates with members through interactive voice response calls, texts, and smart phone application messages integrated with our Case Management System. Outreach begins with a risk screening call and continues with multiple contacts depending upon the member's condition. Responses to questions posed during outreach activities can generate alerts to Care Coordinators. Members also have access to the My Advocate website with additional information and a chat feature.

My Advocate takes condition education and breaks the information down into small pieces over a series of calls. The system presents bite-sized pieces of information to the member during the call and then the member can respond to specific questions. An example for the Clear Health population with complications, such as diabetes, would be a summary of HbA1c and why it is important in diabetes management, followed by a series of questions such as "have you had an HbA1c test in the last year" and "can you tell me your result". The member responses to the questions can create alerts in our real-time dashboard for live outreach.

This bidirectional exchange of information allows us to establish member engagement, provide valuable information and intervene with a live touch in a timely manner where needed. We tailor the alerts to provide the member with the correct level of service ranging from non-clinical outreach to the Managed Care Coordinator contact. Our goal is to provide members with information that is critical to the management of their condition. This will improve health outcomes and promote health literacy.

• My Wellness Guide (web-based and mobile app). Clear Health will offer My Wellness Guide to our members, a solution that our affiliate health plans in Maryland, Washington, and Nevada have been piloting since late 2016. Initial results are positive and member engagement rates for this tool have surpassed benchmark standards to date. As of our September 2017 update on the three-state pilot, members have viewed more than 50,000 pages. Fifty-nine percent are in at least one action plan, which is 23 percent above the standard. Members spend an average of eight minutes per session on the site, or 60 percent above the standard. In all, 628 action plans have been started, 431 members are participating in action plans, and more than 868 habits were completed and 20 habits mastered.

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My Wellness Guide is a one-stop lifestyle, health, and wellness engagement platform that augments our ongoing efforts to support and encourage our members to take charge of their health. My Wellness Guide uses a combination of industry-standard health information, custom campaigns and challenges, health tracker integration, health dashboard and user activity and input to deliver personalized experiences and tools that promote healthy behaviors. It is accessible online, by Apple and Android mobile applications, and on the Internet.

My Wellness Guide aggregates data about personal activities like exercise, sleep, and eating, from a variety of inputs, including a user's activity tracker (e.g. Fitbit, Jawbone, etc.), smartphone, or other applications. Our pilot data indicate that anywhere from a quarter to a third of our membership (25 percent to 33 percent) already have wearables or compatible cell phone apps that collect this data, e.g., AppleHealth in iPhones. Users can also manually enter information. The platform analyzes this data and delivers actionable insights, like how sleep affected eating on a particular day. The insights help the user to be more aware of their habits. Going a step beyond awareness, My Wellness Guide offers several tools to help members use health information to form and maintain healthy habits. The following list of features demonstrates improved member engagement and information understanding for better outcomes:

- User or My Wellness Guide developed plans to meet member wellness goals
 - Tips and reminders to help members stay on track with their action plans
 - Challenges that members participate in featuring social competitions, points and badges, progress tracking, and reminders. Members can also opt for private health challenges that offer the same resources.
 - Timely information delivered to members at specific times of the day based on user activity. Users get targeted information related to their goals and actions, not general information that can be overwhelming and impersonal.
 - A dashboard that provides members with quick updates to see how close they are to meeting their goals. The dashboard presents information relevant to the user's goal, for example, calories consumed or calories burned for someone who wants to lose weight, or steps taken for someone who wants to be more active.
 - Health Information through Harvard Health Publications (HHP) which licenses its peer-reviewed clinical health information to My Wellness Guide, providing users with easily understandable content on a wide variety of topics. HHP is the media and publishing division of the Harvard Medical School of Harvard University. HHP draws on the expertise of Harvard Medical School's 11,000+ physicians, researchers, and other faculty members to deliver peer-reviewed clinical health information.
- Personal Health Record (web-based application). Our health plan advocates the deployment of a Personal Health Record (PHR) to help members better engage in their health care. Prior to the start of the new Contract, we will deploy a PHR from WebMD Health Services (WebMD) for our Florida members. WebMD's PHR will serve as a repository of member health information, integrating our health plan clinical data (claims, pharmacy, and lab results) with data the member adds. WebMD's PHR will support members' involvement in driving their own health care. It will provide the necessary personalized content for improved benefit, treatment, and provider decisions. The PHR is a repository for self-reported and imported medical information from

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multiple sources. It can receive imports of medical and behavioral health claims, lab results, and medications. In addition, WebMD offers a health assessment and trackers that members can complete to gain additional insight to manage their overall health.

The following list demonstrates improved member engagement and information understanding for better outcomes. The PHR intuitively:

- Translates clinical data into easy-to-understand terms
- Checks medication interactions
- Checks allergic reactions
- Reminds about overdue tests
- Adds to the central profile for message and content targeting

Members can print the WebMD PHR and can allow provider access through a publicly accessible website and unique ID number and PIN that the member controls. Providers use a specially designed PHR Viewer, which delivers the data in the most useful format and context. Members can also export their health information and send it to their providers if desired. This will allow the PHR to become a secure, portable platform that helps members facilitate data exchange to make sure their PHR contains essential health data across the continuum of care—for example, if a member changes insurers or moves to a different state.

- Facebook – We are in the process of developing the Clear Health Alliance Facebook page in accordance with practices of our affiliate plans. The purpose will be to engage with members and potential members through educational health-related content and supportive community events. We have found this to be an effective way to get general information out to members. We frequently post messages, including images, articles, and short videos. We respond to all comments and direct messages within 24 hours. We track a wide range of performance metrics such as likes, shares, comments, followers, impressions, and timing of posts. We have goals for numbers of followers in 2018 and engagement and reach rates per month. Some of our best performing posts involved topics such as real stories about member successes, health information posts related to allergies and diabetes, information, and pictures from health plan sponsored community events. We plan to expand our Facebook content to include more real stories about role models living with HIV/AIDS and overcoming its stigma, like our spokesperson Earvin “Magic” Johnson. We will also include more videos, use of hashtags, a link to the Facebook page on our member website, and more community events promotion.

- MyHealthTeams (web-based application). Our innovative MyHealthTeams program provides members with HIV/AIDS, Alzheimer’s disease, obesity, diabetes, depression, and heart disease the opportunity to engage with other people who have the same chronic condition in a safe online environment. In chat rooms, which the MyHealthTeams Site Administrator closely monitors to assure member safety, members can learn more about their chronic condition through safe connections with others dealing with the same condition. Often when members receive a chronic condition diagnosis they are confused and feel alone. They want to learn more about what the diagnosis means and connect with others who have been through what they are experiencing. By providing members with a network of peers, members connect and learn from each other, ask questions, gain additional information about their condition, get referrals and share practical tips.

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- Online and Mobile Transportation Scheduling (mobile app)– members can contact our transportation subcontractors online and by using downloadable mobile applications to schedule, revise, or cancel rides to covered services. For many members, transportation is an important part of accessing care. This is an important technological intervention that allows members to self-manage their care and make informed choices.

Mobile Pharmacy Application (web-based and mobile app):

Members can connect to our pharmacy benefit manager's mobile pharmacy application online and by downloading a mobile application that helps members to understand their medications and risk factors and seek answers to questions about issues like side effects through a wide range of features to facilitate the management of prescriptions anywhere, anytime. The following list of features demonstrates improved member engagement and information understanding for better outcomes:

- My Rx Choices checks for potential drug interactions against the member's prescription history. For members with chronic or complex conditions who may be seeing multiple physicians, this functionality prevents errors in prescribing that could harm a member.
- Pharmacy Care Alerts. Pharmacy Care Alerts provide members with the opportunity to review personalized alerts to ensure they are following their treatment plan as described by their doctor. The application displays alerts for adherence, omission, and compliance reasons and encourages members to take informed, immediate action to address any items.
- Medicine Cabinet. This feature automatically synchronizes with the member's current prescription drug history. This feature provides members with the ability to track all their prescription medication-dosing regimens, while allowing the member or caregiver to create alerts on their phone to remind them when it is time to take their medication throughout the day. Medicine cabinet also notifies members when they are running low on their medications. The application sends these alerts to members when our records indicate the remaining medication level reaches intervals of 15, 10, five and zero days. In addition, members can self-report over-the-counter medications, vitamins, and supplements for which they can set reminders and alerts, and receive notifications if there is a possible health risk with these items and their medications.
- Drug Information. Members can search detailed drug information by medication name, condition, or drug category, and see potential side effects, drug interactions, and more.
- Locate a Pharmacy. Members can search for the nearest in-network retail pharmacies by their current location or by entering an address or ZIP code. The application displays closest available pharmacies in a list and map view. Members can view pharmacy contact information and get directions.

Texting Programs:

The Wellpass Health Program provides two avenues for engagement and improvement of health outcomes and health literacy.

The Wellpass Health Program is a series of pre-defined health messaging programs delivered to members through a combination of text and secure messaging. Wellpass focuses on preventive

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health through Txt4health. In 2016, more than 27,000 members received at least one Txt4health message, and more than 39,000 messages were received from users, showing a strong patient engagement rate with the tool.

Along with texting, Wellpass provides an online platform as well as condition-specific smartphone applications that members can access should they choose to. We will provide reward cards via mail, phone, and online where members will be able to select their desired reward card by reviewing options on a link provided by the vendor. Once vendor contracts are in place, we will revise all programs and member/provider materials to reflect new vendor processes.

Website and Related Tools:

Our new innovations emerge from our long history of being at the forefront of using technology to connect with our members, beginning with our website. As explained below, the website is both a powerful tool to help members understand how to get the most from their benefits, and a gateway to a suite of tools to improve health literacy and health outcomes. Visits to the legacy Amerigroup website for the 12-month period ending July 31, 2017 averaged more than 16,000 per month. Active users, those who logged in to the secure portion of the website at least once in a 365-day period, average 16,000 per month.

Upon agency approval our website will feature content specifically targeted toward individuals with HIV/AIDS, including a video with Magic Johnson based on the theme “The Fight Isn’t Over.” The website currently offers suggestions on HIV/AIDS-related mobile apps for our members. Some examples are:

- AIDSinfo, created by the U.S. Department of Health and Human Services, with definitions of all the terminology related to HIV/AIDS in English and Spanish.
- The Body, which includes the latest news about ongoing research of interest to individuals with HIV/AIDS and related illnesses.
- Care4today, which allows users to input all their medications with dosage and timing information. Then the app reminds the individual when to take a specific dose.

The website also serves as a gateway to a number of features designed to support health literacy and health outcomes, as outlined in the bullets below:

- Community Resource Link. As an expanded benefit, we provide members and their families access to an easy-to-use resource that helps members identify and locate local, community-based programs, benefits, and services that help members and their families and caregivers in building increased personal responsibility and self-management.
- Online Well-being Program. Another innovative expanded benefit provides members with an online community promoting health and wellness through instruction, games, goal setting, and monitoring. This behavioral health-focused tool has an online community feature that helps instill a strong sense that consumers are not alone in becoming and staying emotionally and physically well.

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- Health A to Z. Members have access to Health A to Z, powered by the Healthwise® KnowledgeBase, through our member website and in the mobile app. Health A to Z includes a variety of tools such as a symptom checker, condition lookup, a heart attack risk quiz, and a body mass index calculator. Pregnant members have access to useful tips, interactive tools, pregnancy and childbirth-related applications, and helpful resources.
- Linking members to Useful Applications. We maintain a curated suite of mobile applications on our website to support health, well-being, and self-care for chronic conditions such as diabetes, asthma, and hypertension. Many of these applications also provide a fun, interactive venue for members to learn about their conditions, alerting them to symptoms for which they should seek help.
- ID Cards. Members can log in to the secure website to request that we mail them a new Clear Health ID card (ID card says CHA in lieu of Clear Health to protect member privacy). Pending state approval, members will also have the option of logging in to download and print a copy of their ID card themselves, or using the mobile app to access a digital version they can show, email, or Fax (similar to an electronic airline boarding pass).
- Member Materials – Through the website, members have immediate access to educational materials and self-service functions including the following:
 - Clear Health contact information
 - Ability to update personal information
 - Ability to select preferred methods for receiving plan communications
 - Eligibility information
 - Primary Care Provider (PCP) information and ability to change PCPs
 - Online provider directory
 - Member handbook
 - How to submit complaints and appeals
 - Safety and privacy information
 - Preferred drug lists
 - Care coordination information
 - Behavioral, social, and physical health information
 - Health- and condition- specific materials
- Find a Doctor Tool. As required by AHCA, our searchable online provider directory helps members to select a PCP or other provider based on their preferences such as office hours and languages spoken. A unique Clear Health directory feature is the Red Ribbon designation for providers. Red ribbon providers are Board Certified infectious disease specialties that cater to the HIV/AIDS population. This allows members to be able to identify specialists PCPs for HIV/AIDS.
- Clear Health's Healthy Behaviors Program - members can get online access to our Healthy Behaviors program, which promotes personal responsibility by encouraging and rewarding healthy behaviors and age- and gender- appropriate preventive care. Coupled with our extensive Health Promotion, Case Management, and Disease Management programs, Healthy Behaviors encourages members to collaborate with us and with their PCP to build their health literacy and self-care skills, and improve their health and productivity, while reducing the risk of poor long-term health outcomes. Members can access the Healthy Behaviors Program through a Managed Care Coordinator or PCP referral, or independently, by requesting to enroll in the program after receiving program information in the mail, through a conversation with Member Services, or by

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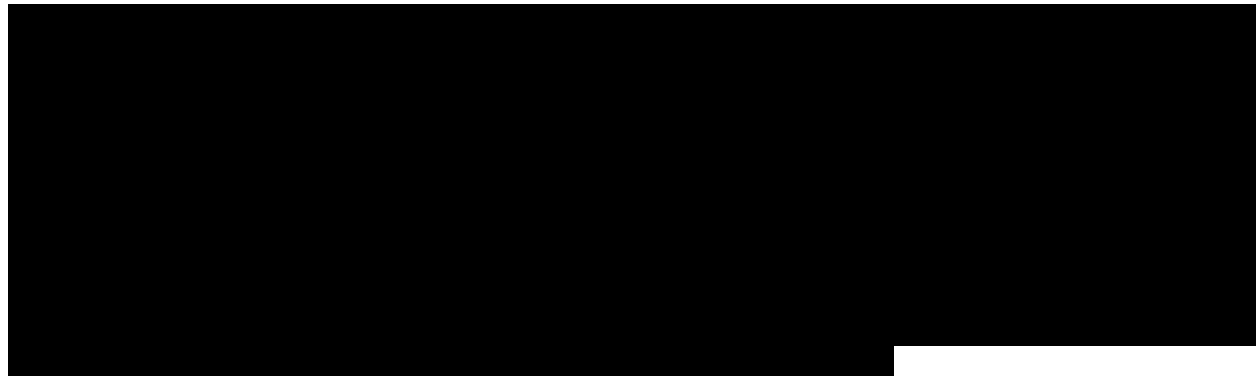
accessing program information on the member website. The member website includes information about the five established Healthy Behaviors programs, program specific educational materials, and the required forms, which members sign and submit to us to indicate their commitment to participating in the program.

2. COLLECTING DATA THAT SUPPORTS THE EFFICACY OF THE PROPOSED APPROACH IN ACHIEVING THE INTENDED GOALS AND HEALTH OUTCOMES FOR THE TARGET POPULATION

A companion to the principle of “First we listen, then we act” is the imperative to “listen” to the data. We continue to improve our development and use of new tools by understanding how people interact and use new technology and information.

We capture usage data, solicit feedback from members using the tools, identify what is being used the most and the least, and synthesize all of this information when developing future enhancements. We continually measure health literacy through the evaluation of our health promotion programs and initiatives by developing and implementing a Florida-specific health education plan and evaluating its impact on member and provider engagement and satisfaction through the evaluation of EPSDT, HEDIS®, and CAHPS® scores. Our Consumer Advisory Council in Florida solicits guidance and recommendations on the effectiveness of our efforts, identifies additional member health education needs, and recommends additional health education programs.

For the tools in use today in Florida and other markets, data show that the tools keep members connected, which increases the opportunity for our plan and providers to increase health literacy and improve outcomes.



For the innovations in our pipeline for Florida (and recently implemented tools), we have definitive data collection and analysis plans. Whenever we develop or modify a tool, one of the first questions we ask is “How will we know it is having the intended effect?” This is how we make sure we set our systems up to collect, and more importantly, analyze and use, the data that will answer that question.

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Some examples of the data that we will collect for new tools are as follows:

Text messaging/instant messaging: How many members have phones that allow text messages; how many members opt in; does text messaging reduce the need for multiple attempts to reach the member; did utilization of inpatient, emergency room, or other services decline?

Web-based and mobile tools: How often do members visit websites; how often do they download recommend mobile apps; from what types of devices do they visit the sites; how often do they click through to available libraries vs. just staying on the landing page?

In addition, we will track tangible results associated with our tools, such as points our members earn after enrolling in a Healthy Behaviors program supported by the online tools. We also monitor member engagement and satisfaction, as well as health outcomes, through routine quality measurement.

3. OUR SOCIAL MEDIA, TEXTING, AND SMARTPHONE APPLICATIONS ARE MOBILE FRIENDLY AND AVAILABLE ON ALL OPERATING SYSTEMS AND INTEROPERABLE WITH OTHER TECHNOLOGIES CURRENTLY USED BY THE MEDICAID POPULATION

We meet our members where they are, and that includes in the world of technology. We continually update, modify, and improve our digital communication tools to be available and accessible no matter what platform they are using. We also are deploying innovations that support members who experience barriers to accessing information in a digital format, such as our groundbreaking interactive video brochure.

When members reach out to us, they often start with our member website, and nearly half the time they access our website using smartphone and mobile technology, including the smartphones available through the Lifeline program. It is important to recognize that for many members, a handheld device may be their only connection to the Internet. Therefore, making our solutions compatible with mobile technology is an imperative, not just “icing on the cake.” The member website is the primary place members can go to better understand their coverage, learn how to access services, and obtain information to improve their health. Since our website is the first and often the most frequent source of information to members, maintaining an engaging and helpful website is essential. We have leveraged the expertise and experience of our national team, which develops award-winning websites for our affiliate plans, to apply website best practices. For this contract, we will combine the website features of our legacy plans on a new platform for a redesigned Clear member website that will feature responsive design, which displays the website in the optimal way regardless of the user’s device. In addition, pending state approval, members will be able to access popular features of the member website by means of a downloadable application for mobile devices (iOS and Android).

Our digital experts achieve interoperability to provide easy access to our websites and Internet-based tools regardless of the device they are using (smartphone, tablet, or computer) or the speed of their Internet connection by using up-to-date, secure, and modern coding technology and practices. When developing apps, we use the React Native framework, so that apps work seamlessly across different platforms without the appearance that they were converted. This facilitates a more user-friendly experience. The migration of our websites and tools to a new platform, which will occur with the website redesign in 2018, affords us the latest available features and technology in content management. Through responsive design, our website will respond to

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the users' behavior and environment based on screen size, platform, and orientation, enhancing our support of mobile device use by our members. We avoid techniques or tools that require significant memory or disk resources or special intervention on the user side to install plug-ins or additional software. Since we know our users visit our sites from a variety of devices with different technologies, our websites are cross-browser tested to confirm proper display and functionality. Digital Solutions codes and tests for the latest versions of Google Chrome, Firefox, and Safari, as well as compatibility with Internet Explorer 9 and later. In addition, our Medicaid mobile app is Android and iOS compatible.

One example of our technology being interoperable with tools our members are already using is My Wellness Guide, explained above. Many of our members already use activity trackers (e.g., Fitbit, Jawbone, etc.). My Wellness Guide uses information from these trackers or from member smartphones. Users without such devices can also choose to manually enter information. The platform analyzes this data and delivers actionable insights, such as how activity level affects calories burned. The insights help the user to be more aware of their habits. Going a step beyond awareness, My Wellness Guide offers several tools to help members use health information to form and maintain healthy habits.

Video Brochure

We also understand that not all members have internet access or a smartphone or tablet, and we believe technology can be useful in reaching beyond internet access. We are piloting an innovative approach to engage hard to reach members in Virginia, and will bring it to Florida if we find it successful. This new outreach approach makes use of an interactive, video-based brochure that will leverage an unconventional social media format to engage members who are candidates for complex care management. Upon opening the brochure, an approachable, easy-to-understand animated video will launch automatically and provide members with information about their available benefits and services. This includes benefits such as transportation and community-based resources such as food and housing that can help them in times of need and an overview of how Case Managers can help members with personalized contact information to reach the member's assigned Case Manager. We will pilot this new approach for members aged 20-40 who have been nonresponsive to more traditional outreach mechanisms and will track the number of members who engage with their Case Managers, as well as any uptick in claims activity to evaluate additional implementation and expansion of this approach.

4. PROVIDING ROUTINE PERFORMANCE DATA TO SUPPORT ENROLLEE USAGE TRENDS

The digital revolution brings unprecedented opportunities to leverage utilization data to improve existing tools, develop new tools, and even to gather data on member concerns by tracking the inquiries and questions related to both health conditions and their experience with the plan and providers. The innovative tools in our pipeline are being designed to make the best use of this data in the interest of improving health and outcomes for our members and contributing to the drive for quality that permeates every interaction at every level of our work with members and providers.

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As a part of our commitment to data driven performance and outcomes, we have a dedicated team that gathers, analyzes, and trends performance data related to our overall member engagement goals and to each engagement strategy. We gather qualitative and quantitative data related to member engagement with our website, our Facebook page, My Wellness Guide, My Health Teams, our subcontractor's pharmacy application, email, texting, and all other strategies. We identify trends that affect how we communicate with members. For example, we are seeing steady growth in members' use of mobile technology to access health plan information. Our most recent data about how members access our website indicates that nearly half – 45 percent – use a mobile device. This is a significant change compared to two years ago, when less than a third (29 percent) used a mobile device. In addition to the ongoing monitoring that takes place in our national information technology department, for this contract we will hire a dedicated staff person in Florida to monitor the Facebook page and other social media interfaces, and to make sure that the specific needs of Florida members are reflected in the innovation pipeline.

Through enhanced reporting and ad hoc reports, we analyze engagement data and comparable data related to health literacy and health outcomes to identify engagement methods that appear to affect our progress in achieving health outcome goals. We plan to implement a strategy of our affiliate plans to track and trend a variety of measures to determine the impact of member engagement initiatives related to health literacy. For example, they monitor: 1) change in the rate of ER use to gauge understanding of how to access primary care for non-emergent needs; 2) the ability to increase HEDIS® rates for measures because of initiatives implemented; and 3) related measures of member experience, such as communication, using an annual survey. Based on the results of these and similar measures, they continue to refine our efforts to help members be better health care consumers. We will leverage our affiliates' experience to monitor change and improvement in HEDIS® measures for our Florida members.

In addition, the vendor for the My Wellness Guide program has offered even more assistance on interpreting data and helping to drive engagement. They will share information and results collected by the My Wellness Guide tools as well as plans for improvement of outreach and adoption and will present this information to the Health Plan and, if so desired, the state every six months.

We are encouraged by the results of our technological innovations to date, and excited about the potential for even greater member engagement, improved health literacy, and better outcomes that are promised by the innovations in our pipeline, especially for the HIV/AIDS population.

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GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The extent to which the respondent described how these technology investments will be used to improve health literacy and promote improved health outcomes.
2. The extent to which the respondent provides data that supports the efficacy of the proposed approach in achieving the intended goals/health outcomes (e.g., increase in appointment compliance) for the target population.
3. The extent to which the respondent describes how social media, texting and smartphone app(s) will be mobile friendly and made available on all operating systems (iOS, Android, Windows, etc.) and interoperable with other technologies currently used by the Medicaid population (e.g., Lifeline).
4. The extent to which the respondent is able to provide routine performance data to support enrollee usage trends.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 14 – CAHPS Results (Statewide):

The Respondent (including respondents' parent, affiliate(s), or subsidiary(ies)) shall include in table format, the target population (TANF, ABD, dual eligible) and the respondent's results for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) items/composites specified below for the 2017 survey for its adult and child populations for the respondent's three (3) largest Medicaid Contracts (as measured by number of enrollees). If the Respondent does not have Medicaid CAHPS results for at least three (3) states, the respondent shall provide commercial CAHPS results for the respondent's largest Contracts. If the Respondent has Florida Medicaid CAHPS results, it shall include the Florida Medicaid experience as one (1) of three (3) states reported. Respondents shall provide the data requested in **Exhibit A-4-a-4**, Standard CAHPS Measurement Tool, to provide results for the following CAHPS items/composites:

- a. Health Plan Rating;
- b. Health Care Rating;
- c. Getting Needed Care (composite);
- d. Getting Care Quickly (composite); and
- e. Getting Help for Customer Service (composite).

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Quality is fundamental to everything we do, and Clear Health is committed to listening to our enrollees (members) and incorporating their feedback into improvement activities to support better outcomes and a more positive member experience. We gather information from members through a variety of means including our Member Advisory Committee and Health Education Committee, community events, member grievances and appeals, and member satisfaction surveys.

Clear Health systematically analyzes outcomes data, including member satisfaction data, to identify opportunities to better serve our members. The annual CAHPS® Health Plan survey is a critical tool we use to understand the member perspective relating to interactions with the health care system and the services we provide. It is a national standard for measuring and reporting member experience, and helps us target areas for improvement.

1. CAHPS® SCORES DEMONSTRATE FOCUS ON IMPROVING THE MEMBER EXPERIENCE

Attachment SRC# 14-1: Exhibit A-4-a-4 — Standard CAHPS® Measurement Tool provides the results of our 2017 survey for selected measures. We are providing the results of one of our legacy organizations, Amerigroup, because it is our largest contract in Florida. Our results as Clear Health are even stronger. In 2017, Clear Health exceeded the 90th percentile in 14 measures for adults, including "Rating of Health Plan" and "Rating of Health Care".

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Attachment SRC# 14-1: Exhibit A-4-a-4 — Standard CAHPS® Measurement Tool also includes the results of our affiliated health plans in New York and Texas. Health plans in these states represent the largest Medicaid contracts of all our affiliated health plans.

Amerigroup's CAHPS® scores include TANF, ABD, and dual eligible populations. Our affiliated health plan in New York's scores include TANF, ABD, and Medicaid expansion populations. Our affiliated health plan in Texas's scores include TANF, CHIP, and ABD populations.

As Attachment SRC# 14-1 indicates, our legacy health plan, Amerigroup, exceeds the national mean in three out of the five adult measures reported, and two out of the five child measures reported. Our affiliated health plans in New York and Texas demonstrate similar performance in many of the reported measures.

If Clear Health was included in Attachment SRC# 14-1, the scores would exceed the national mean in all five adult measures reported:

- Health Plan Rating – 79.68 percent (above 2016's 75th percentile)
- Health Care Rating – 81.77 percent (above 2016's 90th percentile)
- Getting Needed Care (composite) – 84.15 percent (above 2016's 75th percentile)
- Getting Care Quickly (composite) – 87.33 percent (above 2016's 90th percentile)
- Getting Help for Customer Service (composite) – 90.58 percent (above 2016's 75th percentile)

1.1. Focus on CAHPS® and Other Member Satisfaction Data Improves Member Experience

Clear Health uses the CAHPS® survey to assess member experience in Florida, helping us listen first and then develop targeted improvement plans. We use an Agency-approved, NCQA-certified vendor to administer the Health Plan survey annually. This vendor follows current HEDIS® protocols and Agency-specific requirements, including alternate survey specifications, applicable supplemental item sets, and Agency-defined survey items. Our vendor employs both a mail and telephone survey process with multiple reminders to maximize response rates.

In accordance with Contract requirements, we submit results of our CAHPS® survey to the Agency each year. If there are any deficiencies identified by the Agency, we will develop an action plan to address them. Since we started conducting CAHPS® surveys in 2015, the Agency has not identified any deficiencies; however, our Member Satisfaction Workgroup meets to proactively create action plans for any measure falling below the NCQA's Quality Compass 50th percentile. Past action plans have resulted in the development of tips for members to improve communications with providers, reformatting our provider directory to make it easier to locate urgent care facilities as well as providers offering evening and weekend hours, and working with Primary Care Providers (PCPs) to identify and outreach to specialists who are difficult to schedule appointments with to improve access for our members.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

We incorporate CAHPS® results into our Quality Management (QM) program, and regularly use the results to enhance member touchpoints. Our QM team is responsible for obtaining member satisfaction data and implementing necessary improvements. Once identified, any CAHPS® related or other member satisfaction improvement activities will be incorporated into our annual QM work plan, assigned staff, and monitored to completion. Typically, a cross-departmental team supports the project providing a range of functional expertise.

Quality is fundamental to everything we do, and we are always looking for innovative ways to capture data to evaluate our performance on a continuous basis. For example, we ask our Member Services line callers to rate their satisfaction, and administer an automated follow up survey to a random sample of callers, with the goal of identifying new opportunities to streamline processes and enhance the member experience. We adopted this best practice from one of our legacy organizations, Amerigroup, to provide additional attention to all facets of our interactions with members. By continuously compiling member satisfaction data, we can proactively identify and address opportunities for improvement before waiting for the release of annual CAHPS® data.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The extent to which the respondent exceeded the national Medicaid mean for each CAHPS survey item/component reported.

Score: This section is worth a maximum of 20 raw points as described below.

Exhibit A-4-a-4, Standard CAHPS Measurement Tool, provides for thirty (30) opportunities for a respondent to report prior experience in providing desirable experiences with health care (five (5) measures, three (3) states each, adult population for each, and child population for each). For each of the five (5) measures, a total of six (6) points are available.

The respondent will be awarded 1 point if their reported plan rate exceeded the national Medicaid mean, for each available state, for adults and for children, respectively. An aggregate score will be calculated and respondents will receive a final score of 0 through 20 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 30 points, the final score will be 20 points (100%). If a respondent receives 27 (90%) of the available 30 points, the final score will be 18 points (90%). If a respondent receives 3 (10%) of the available 30 points, the final score will be 2 points (10%).

EXHIBIT A-4-a-4
SRC#14 - STANDARD CAHPS MEASUREMENT TOOL

INSTRUCTIONS:

Respondents should provide results for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) items/composites specified below for the 2017 survey for its adult and child populations for the respondent's three (3) largest Medicaid contracts (as measured by number of enrollees).

If the respondent does not have Medicaid CAHPS results for at least three (3) states, the respondent shall provide commercial CAHPS results for the respondent's largest Contracts. If the respondent has Florida Medicaid CAHPS results, it shall include the Florida Medicaid experience as one (1) of three (3) states reported.

The CAHPS items/composites that the respondent is required to report on are located in the CAHPS Results tab.

Use the drop-down box to select the state for which you are reporting and enter the CAHPS results (to the hundredths place, or XX.XX) for that state's Medicaid population for the 2017 survey.

EXHIBIT A-4-a-4
SRC#14 - STANDARD CAHPS MEASUREMENT TOOL

RESPONDENT NAME: Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance

	State #1:	Florida	State #2:	New York	State #3:	Texas
CAHPS Item/Composite	2017 Adult	2017 Child	2017 Adult	2017 Child	2017 Adult	2017 Child
Rating of Health Plan (the percentage of respondents rating their plan an 8, 9, or 10 out of 10)	70.97	84.96	74.95	86.07	76.22	90.66
Rating of Health Care (the percentage of respondents rating their health care an 8, 9, or 10 out of 10)	74.29	88.97	71.26	86.45	76.38	88.22
Getting Needed Care Composite (the percentage of respondents reporting it is usually or always easy to get needed care)	80.84	78.57	80.35	81.22	80.33	82.13
Getting Care Quickly Composite (the percentage of respondents reporting it is usually or always easy to get care quickly)	81.89	87.44	77.16	83.68	79.77	85.57
Getting Help from Customer Service Composite (the percentage of respondents reporting it is usually or always easy to get help needed from customer service)	85.95	85.19	83.64	85.19	88.90	88.77

Total Points	13
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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

D. PROVIDER EXPERIENCE

SRC# 15 – Provider Engagement Model (Statewide):

The respondent shall describe in detail its provider engagement model. The respondent shall include the following elements in its description, at a minimum:

- a. The respondent's staff that play a role in provider engagement;
- b. The presence of local provider field representatives and their role;
- c. The mechanism to track interactions with providers (electronic, physical and telephonic);
- d. How the respondent collects and analyzes utilization data and provider feedback, including complaints received, to identify specific training needs;
- e. The metrics used to measure the overall satisfaction of network providers with the respondent; and
- f. The approach and frequency of provider training on respondent and Agency requirements.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

As Florida's largest HIV/AIDS specialty plan, Clear Health has extensive experience and qualifications in contracting and servicing networks designed to meet the special needs of this population. We recognize that to develop and maintain a high quality network to serve the HIV/AIDS Medicaid population, our company must have the respect and trust of the community. We know from experience that an integrated, high-touch provider engagement model is one of the most important contributing factors to our success. Everyone at Clear Health is responsible for interacting with providers in a way that drives superior results and outcomes. All areas within our organization (such as executive leadership, member services, utilization management, case management, pharmacy, claims, quality management, HEDIS®, and medical economics) work with providers to make sure they have the information, tools, and ongoing support necessary to achieve the best outcomes for our members and reduce providers' administrative burden. Across Florida, we support providers with timely communications, effective and informative one-on-one training, user-friendly technical assistance, actionable data and analytical support, and proactive issue resolution to foster continuous improvement and high-quality care.

1. PLAN LEADERSHIP INVOLVEMENT IN PROVIDER ENGAGEMENT

Clear Health's leadership team is fully engaged with network providers. Our leadership team has a combined 105 years of experience serving the Florida Medicaid community. Our collaborative provider engagement model transforms health care delivery, creates an integrated system of care, and drives improved access and health outcomes for our enrollees (members). We understand that local collaboration and engagement is essential to meet the challenges of improving health care for low-income and underserved individuals.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Our leadership team drives our provider engagement approach and sets the tone for the rest of the organization. Our local and innovative approach, focused on supporting providers' growth capabilities and capacity to optimize member outcomes, allows us to leverage our local presence to develop and refine strategies that address our members' needs.

We spend a significant amount of time and resources building and maintaining a high performing network driven by our understanding that a network of high quality providers is key to improved member outcomes, positive member experience, and appropriate utilization of services. We have designed our engagement model to move providers along the value-based continuum, providing support to advance them through the array of value based services.

Our approach to provider engagement has changed the dynamics of traditional provider/health plan relationships by developing lasting provider partnerships. Leadership seeks out provider feedback and responds rapidly to improve both our network and internal processes. We support our high-performing network with value-based payment agreements that tie in both risk and rewards to performance. Our provider engagement model supports increased high quality scores, improved member outcomes, and solid consistent performance.

We have developed a provider recruitment strategy and message of inclusivity and collaboration and actively provided education and support for the providers who serve our population. Clear Health has built an extensive HIV/AIDS Medicaid network in Florida, establishing close relationships with PCPs, specialists, county health departments, federally qualified health centers (FQHCs), rural health clinics (RHC), and teaching institutions. We have been able to induce PCPs and specialists in infectious disease, cardiology, dermatology, rheumatology, gastroenterology, and endocrinology who have experience in treating patients with HIV disease to become Medicaid providers and contract with us.

We provide an enhanced level of support to our red ribbon providers. These are providers with specialized HIV/AIDS training designated by including a red ribbon beside their name in our provider directory, informing members of the provider's additional specialized HIV/AIDS care and treatment competency. Our red ribbon program is nationally recognized and is a testament to our patient-centered model of service and support.

Our regionally based Provider Network Managers live and work in their local communities and have developed strong relationships with providers in each region. Our local and innovative approach, focused on supporting providers' growth capabilities and capacity to optimize member outcomes allows us to leverage our local presence to develop and refine strategies that address our members' needs. Our Provider Network Managers have extensive experience and expertise meeting the needs of providers servicing members with HIV/AIDS due to our experience across Florida. Our Provider Network Managers in Regions 1,2,3,8, and 9 focus solely on meeting the needs of Clear Health providers.

Our Provider Network Managers are in the community meeting face-to-face with providers. They collaborate with our Pharmacy and Care Management teams and make joint visits to providers. We support providers with actionable data (gaps in care reporting, HEDIS® care alerts, pharmacy utilization, lab results, and more to help identify and address barriers to accessing care and services) they can use immediately to make sure members are getting the right care, at the right time, and in the right place. This provider engagement model supports increased high quality scores, improved member outcomes, and solid performance.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Members of the leadership team are fully engaged with network providers, as described below.

President and Chief Executive Officer

Lourdes T. Rivas, Simply's President and Chief Executive Officer, drives our overall network development and provider engagement approach, instilling in the organization the understanding that our ability to serve our members well is contingent on development and maintenance of a stable, satisfied, high-functioning provider network. She establishes community outreach; oversees coordination of mutual projects with physicians, hospital administrations, and other health care administrators; and maintains relationships with potential network providers. Ms. Rivas is involved in major negotiations with larger groups, finalizing capitation, establishing risk parameters, and setting overall contract requirements. She approves all subcontractor negotiations and meets with Provider Relations leadership to discuss subcontractor services, specific contract terms, compliance standards, and performance metrics.

Chief Medical Officer

Vincent Pantone, MD, Simply's Chief Medical Officer (CMO) leads Simply's Medical Advisory Committee. Network providers participate on this committee, support medical policy and guideline approval, and also help to identify issues and opportunities to improve plan performance and ease of use for members and providers. He participates in Joint Operating Committees (JOCs) that involve larger groups, educating them about the different support teams in our Utilization Management department (case management, disease management, concurrent review, and precertification).

Dr. Pantone provides one-on-one collaboration with any provider managing a challenging member. He works to assure that we align plan case management efforts and benefit deployment to mitigate challenges in member management and case management. He also visits providers in the field, offering guidance on referral patterns, medication management, proper place of service, and utilization management techniques. Dr. Pantone supports the Medical Management staff in delivering timely and consistent responses to members and providers, and identifies and develops opportunities for innovation to increase both quality and effectiveness. He also leads the credentialing process, assuring fair assessments of providers and also making sure only high-quality providers join the network.

Regional Vice President, Provider Solutions

Efrain Duarte, Regional Vice President of Provider Solutions, serves as a mentor for the provider practice guiding them to improve member access to care, improve quality of care, and focus on the proper utilization of resources. Mr. Duarte is a medical school graduate, giving him a unique understanding of medical practice and how to best meet provider needs. As a former Director of our Medical Economics department, he regularly provides support to our providers regarding trends on prescription management, utilization management practices, and data analysis and use. He is involved in all large group negotiations and implementation processes. Mr. Duarte approves all vendor, PCP, and Specialty contracts. He is responsible for the proper implementation of all contracts and visits providers on a regular basis.

President Medicare East Region

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Tomas Orozco, President Medicare East Region, leads our Medicare team and has been instrumental in implementing our network sculpting strategy for Medicaid. Mr. Orozco brings more than 25 years of leadership experience in provider relations. Mr. Duarte and Mr. Orozco collaborate across Medicaid and Medicare to make sure that each line of business uses the best possible provider network. This collaboration has resulted in several Medicare providers who have invested heavily in their infrastructure opening their practices to Medicaid

Staff Vice President of Pharmacy

Dr. Alex Borges, Simply's Staff Vice President of Pharmacy, designed and currently manages our Pharmacy Provider Engagement program. Its goal is to provide an effective means to deliver important clinical information to our network prescribers, with the primary intention of facilitating sound clinical decision-making that translates into the delivery of the highest quality medical care. Under the leadership of Dr. Borges, the program provides an interactive clinical detailing platform, leveraging four clinical pharmacists who meet regularly with network physicians one-on-one to educate, inform, review medication prescribing patterns, and communicate best clinical practice guidelines. This clinician-based delivery model provides network providers with real-time utilization metrics, comparative performance measures, educational materials, and additional critical information in a format that promotes quality based and medically appropriate clinical decision-making. The use of clinician-based detailing has proven most effective in communicating Simply's message to providers.

Chief Operating Officer

Suzanna B. Roberts, Simply's COO, participates in new provider meetings to coordinate loading the fee schedule, claims payment testing, as well as coordination with our Provider Services line, audit and recovery, Technology Services, and other departments. She listens to providers and assists in developing creative ways to help reduce their administrative burden. Ms. Roberts is involved with large groups and subcontractors when there are payment issues or for coordination of large credentialing files. She also participates in hospital JOCs.

Chief Financial Officer

Holly Prince, Simply's Regional Vice President of Finance, works with financial and operational leadership to resolve issues and provide guidance on financial issues. She supports the market by meeting regularly with providers to discuss opportunities for improvement. She helps identify high-risk members to support providers by engaging case or disease management as needed. Ms. Prince oversees the local Medical Economics department that prepares reconciliations and reports for providers in our value-based purchasing (VBP) programs (both standard monthly reports and ad hoc reports as needed). Medical Economics also prepares and monitors reports on potentially preventable events and provider-level encounter dashboard reports that support interventions.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Quality Management Director

Lila Labarces, Simply's Quality Management Director, works with providers to assure satisfaction with the quality management process. Ms. Labarces personally trains providers in their offices and is readily available to help them by email or phone. She developed tools to help providers better meet outcomes, including the Early and Period Screening, Diagnosis and Treatment (EPSDT) Coding tool and HEDIS® descriptions and coding tool. She makes sure that both the HEDIS® and medical record review processes are organized to reduce providers' administrative burden. She actively participates in the medical record review process, quality of care concerns, and risk management activities. Ms. Labarces actively participates in the Medical Advisory and Peer Review committees.

2. INCORPORATING LOCAL PROVIDER REPRESENTATIVES INTO THE MODEL

2.1. Florida Provider Relations Team

In addition to Efrain Duarte, our Provider Relations leadership team includes six directors with a combined 120 years of experience. We assign Directors who live in the regions and they provide leadership at the local level. They engage providers, listen to their feedback, and work with our Provider Relations team to implement changes that improve our network. They oversee orientation, ongoing training, and quality performance improvement initiatives. They also serve as a resource to providers when they encounter challenges. Directors monitor the training of and provide ongoing support to Provider Network Managers to make sure they are offering accurate, actionable data and information.

Our Regional Vice President of Provider Solutions and Provider Relations Directors engage with providers on a regular basis utilizing JOCs, face-to-face visits to provider offices, phone, email, and webinars to deliver an open access model. The Provider Relations leadership team also participates in monthly meetings with hospitals and large groups to discuss quality and performance metrics. Our Provider Network Manager serves as a coordinator between us and the provider, managing meetings and education with different departments such as Quality, Pharmacy, HEDIS®, Case Management, and other provider support teams. Additionally, regional Provider Relations team leadership is directly involved in the training and education of each Provider Network Manager.

Under the new Contract, our Provider Relations department will increase to 68 employees as we anticipate adding an additional seven Provider Network Managers to our team. To allow for increased contact with and support for our providers, we are adding seven Network Provider Managers to our team who will be distributed throughout the state, providing more accessibility to Clear Health. Our proposed ratio of Provider Network Managers for the new Contract will be 1:157.

Florida-based Provider Relations staffing under the new Contract will include:

- One Vice President
- Six Directors
- Forty-five Provider Network Managers (an addition of seven)
- One Provider Relations Manager
- One Project Manager

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- Four Network Management Representatives
- One Data Analyst
- One HEDIS® Lead
- Two Hospital Representatives
- Five Business Development Leads
- One Administrative Assistant

We recently created a new role to focus on identifying and working with providers new to managed care. Business Development Leads are located regionally throughout Florida. Complementing the work performed by our Provider Network Managers, Business Development Leads listen and respond to the specific needs of providers new to managed care, providing targeted training, and expediting issue resolution. They also work with more experienced providers, introducing them to our value-based purchasing (VBP) programs. In addition, they introduce the opportunity of adding Medicaid to providers with Medicare portfolios and support them through the onboarding process. One unique group of people that are also part of the provider network team are Clear Health's OB Practice Consultants who supplement the work of the Provider Network Managers related to OB/GYN collaboration and performance and provide support to providers in improving prenatal care and birth outcomes. We advocate for healthy deliveries through provider and stakeholder collaborations, innovative payment models, and performance-based incentives. Provider education and collaboration efforts are enhanced by OB Practice Consultants, Registered Nurses who meet regularly with provider partners to build and maintain a coordinated approach to caring for women before, during, and after pregnancy. We will continue to enhance our program, with a focus on safe deliveries, Neonatal Intensive Care Unit (NICU) support, social determinants of health, and using member engagement technologies.

We maintain four offices across Florida to support our regionally based Provider Relations team. Provider Network Managers are locally based, meeting face-to-face with providers to build trust and open communication while promoting collaborative relationships. They have a deep knowledge of their local communities and providers there. During face-to-face visits, Provider Network Managers support PCPs with actionable information about the care their patients are receiving, including information related to pharmacy, quality, HEDIS®, inpatient admissions, specialty utilization, medication alternatives, and interactions. Our ongoing partnership with network providers results in high quality scores, improved member outcomes, and solid health plan performance.

We will continue to maintain regionally based Provider Relations teams exclusively dedicated to Medicaid and Medicare Provider Relations functions. These functions include establishing and maintaining effective communications with existing and potential network providers to improve quality and cost effectiveness of care; and conducting ongoing provider education, training, and outreach aimed at improving providers' ability to increase quality of life and health outcomes for members. Provider Network Managers serve all lines of business, providing them with a uniquely broad view of the Florida health care landscape.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

**** TESTIMONIAL: Dr. Camejo Primary Care**

I just wanted to take a moment to express gratitude to your organization for your well-developed insurance plan on behalf of Dr. Camejo Primary Care. My office staff has had no problems with ease of access to customer service and/or resolution of any issues that may arise with eligibility and benefits or referrals and authorizations. It has been a pleasure working with Simply on all levels. We will continue to recommend Simply and hope to continue our business relationship for more years to come. — Jennifer Denni, Office Manager, Dr. Camejo Primary Care ******

2.2. Provider Network Managers

Across Florida, Provider Network Managers collaborate with network providers and support them with timely communications, effective and informative one-on-one training, user-friendly technical assistance, actionable data, and proactive issue resolution to foster continuous improvement and high-quality care. Our regionally based Provider Network Managers are located in communities throughout the state. They know their communities and have strong relationship with local providers.

Each Provider Network Manager has assigned providers that they meet with monthly to share information and provide support and technical assistance. Provider Network Managers serve all lines of business, providing them with a uniquely broad view of the Florida health care landscape.

Provider Network Managers offer targeted support to providers regardless of how comfortable they are with managed care. They work alongside those who are rendering care for our members, committed to the ongoing success of our network providers. They also work to contract any specialists not in our network that a PCP recommends or has member referral patterns.

Provider Network Managers understand their providers' challenges and offer ongoing support to help them improve the effectiveness and efficiencies of their practices. By analyzing quality metrics, utilization trends, and reports of missed care opportunities, Provider Network Managers help providers implement case management and create action plans. Action plans help improve cost, quality, performance, and their patient's experience, while encouraging them to adopt practice management strategies that have proven effective for top-performing peers. They collaborate with providers to analyze quality metrics and reports for care opportunities and help design, develop, and implement community learning forums.

Each Provider Network Manager has assigned providers that they meet with monthly to share information. Provider Network Managers conduct an average 16-24 visits per week, during which they provide quality and performance metrics. Our Provider Network Managers receive ongoing training from our internal subject matter experts in Finance, Claims, Quality Management, Utilization Management, Case Management, and other areas assuring they are well-informed resources for providers.

We adapt our approach to meet the unique needs of each provider, regardless of where they are on the care management continuum. In addition to providers having online access to actionable data, Provider Network Managers hand deliver reports and review data during monthly visits. This is one way we assure that all providers not only have the data they need but they also understand how to use it to improve member outcomes. Provider Network Managers provide ongoing support to providers, work to add them into a VBP program, with the goal to maximize their overall performance.

EXHIBIT A-4-a

GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

2.2.1. Facilitating Integration Efforts

Many of our members have behavioral health (BH) co-morbidities in addition to HIV/AIDS and other medical conditions. Thirty-one percent of Clear Health members have a diagnosed mental illness, with mood disorders, anxiety, dissociative and other nonpsychotic mental disorders, and schizophrenia and other psychotic disorders accounting for the majority of diagnoses. In addition, 37 percent of members have an addiction disorder, including smoking and alcohol. Approximately seven percent of our members have personal histories of substance use disorder (SUD). Given this high burden of mental illness and the known impacts of co-morbid physical health (PH) and BH conditions on the cost of care and the outcomes, we prioritize effective integration of BH and primary care for our members. We work hard to assure proactive information sharing across settings.

Clear Health has long supported state integration efforts using a system of care approach that integrates PH, BH, and substance use treatment, pharmacy benefits and social supports. Our goal is to support the delivery of more individualized, person-centered care to achieve better health outcomes.

We focus on opportunities to integrate PH, BH, and pharmacy service provision across the system of care by increasing acute care provider knowledge of health-related topics. Topics include depression and substance abuse screening and increasing BH provider knowledge of health-related topics such as co-occurring PH conditions and preventive screenings.

Our Provider Network Managers partner with our Case Managers (Managed Care Coordinators) to enhance integrated care for our high-risk members by filling the traditional information void – we proactively communicate with and engage primary care, medical specialty, obstetrics, BH providers, home and community based service providers as well as all types of inpatient facilities, to promote our member's care and goals. Provider Network Managers often reach out to Managed Care Coordinators, BH, Quality, Medical Economics and other areas to accompany them on monthly provider visits. Our integrated team approach is responsive to our providers needs while focusing on improved member outcomes. We partner with providers to innovative and build incentive programs that reward providers for improvements integration of BH and PH at the practice level.

2.3. Provider Services Line

In addition to our regionally based Provider Relations teams, we support our providers through our Provider Services line. It is available toll-free for questions, concerns, and assistance with billing issues, covered services, pharmacy support, and other inquiries. Customer Care Representatives are available to assist providers Monday through Friday from 8 a.m. to 7 p.m. They answer questions, provide information and guidance, and serve as a resource and support to ongoing provider training initiatives. Providers can reach us 24/7 for prior authorization requests.

EXHIBIT A-4-a

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Customer Care Representatives can also help providers register and access information on our secure provider portal. Providers can call the toll-free line, access our provider portal, or speak with our clinical team 24/7 to verify eligibility for members with urgent or emergent conditions and request authorizations. Year to date 2017 (as of August) our Provider Services line answered more than 222,700 calls with an abandonment rate of less than one percent and an average speed of answer of 20.5 seconds.

Our integrated desktop technology provides rapid access to information and displays all data related to member benefits, assigned PCP, service utilization and claims history, enrollment, authorizations, and other health insurance coverage. The Provider Services line also communicates with the provider's assigned Provider Network Manager if there is an urgent need that requires follow-up. Provider Relations maintains a SharePoint site that serves as an organization-wide communication vehicle. We log and track each inquiry to assure an appropriate response to each request. Requests are trended and identified issues inform ongoing training activities and improvement initiatives.

2.4. Clear Health's Comprehensive Network Management Strategy

Our network management strategy, with a focus on reducing administrative burden and allowing providers more time to take care of our members, includes the following:

- Assistance for providers at the point of care by offering actionable information using a variety of delivery methods to help manage members' care. Actionable information includes alerting providers to care gaps through online clinical alerts; providing periodic gaps in care reports for their assigned members (report frequency is monthly; providers in a VBP program have online access 24/7 to updated information); and providing access to our provider-facing Case Management System that displays HEDIS® care alerts, prescriptions, lab results, and more to help identify and address barriers to accessing care and services.
- Practices to simplify and minimize administrative burden, including technology solutions such as online claims and prior authorization submission. For example, our quick authorization form enables referrals to a specialist without requiring an authorization. It also enables the specialist to provide care in a timely manner in the lowest cost setting without any additional administrative work. In addition, our web portal features an online tool that provides guidance on which CPT codes require authorization.
- Ongoing collaboration with providers to improve member outcomes. Because we are committed to incorporating our providers in on-going improvement efforts, our network providers serve on a variety of committees that craft policies that improve the efficient delivery of care to our members. We support and empower providers in our network with access to timely data, ongoing education, and access to referrals to a robust network of facilities and specialists. Continued growth of our VBP programs promotes collaboration with providers and enhances member quality outcomes. This proven model assures ongoing provider communication and collaboration.
- Technical assistance to help providers succeed, such as proactively contacting providers if we identify possible submission errors through ongoing claims review. We provide face-to-face and telephonic technical assistance to providers so they can get the help they need where they need it.

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- Proactive education delivered by a team of professionals focused on Medicaid that addresses the specific needs of providers.
- Sound reimbursement practices and innovative incentive programs that reward providers for improvements in quality measures, leading to improved outcomes and integration of BH and PH at the practice level. We focus our programs on improving quality of care while supporting providers as they deliver the most cost-effective care. Our programs such as the MMA Physician Incentive Program (MPIP) and other value-based payment programs deliver enhanced payments to providers who achieve better outcomes based on recognized criteria from NCQA and medical guidelines. We believe that delivering high-quality care and increasing member access to primary care services should drive value to providers.
- Educating PCPs on identifying members with BH needs, including our Primary Care Integrated Screening, Identification, Treatment, and Evaluation (PC-INSITE) program and Screening, Brief Intervention, and Referral to Treatment (SBIRT).

We will continue working to improve member outcomes through a combination of focused face-to-face provider interventions and innovative technology solutions. While we will continue to comply with time and distance requirements, our contracting strategy is to deliver a network that supports PCPs and provides our members with options when seeking specialty care. Our Provider Network Managers target continued growth of our specialty network in every region resulting in our exceeding requirements in most regions where provider specialists are available.

3. TRACKING INTERACTIONS WITH PROVIDERS TO PRODUCE MEANINGFUL DATA TO ADDRESS BOTH CLINICAL AND ADMINISTRATIVE PROBLEM AREAS

Our Provider Relations team uses a field visit form to note any issues or requests providers bring up during face-to-face office visits, documenting clinical and administrative problem areas. We enter information about each provider visit into Salesforce, where we track this information and use it to inform our provider engagement strategy and network development plan. We maintain information about each provider in our network in our internal provider database, Salesforce.

The Salesforce database maintains administrative information, identifies and tracks staff field visits and engagement as well as clinical issues, remediation activities, follow-up activities scheduled, and outcomes. Our Provider Relations staff document and track all activity, including quality of care concerns, in Salesforce to trend occurrences and use in re-credentialing activities. Salesforce contains current and historic data per provider and provider type. Management pulls reports monthly or as frequently as needed to monitor field visit activity and the quality of our management of the network. This allows us to identify and respond to trends in a timely manner. In addition, the Gap committee analyzes this information and uses it to inform ongoing network development plan. We analyze trends in letters of agreement (LOAs) and single case agreements at Quality Management Committee meetings and, with the input of Utilization Management and other departments, new contracting targets are developed.

Clear Health uses data from multiple sources to continuously improve our support for our members and our providers. Our Quality Management (QM) department collects, analyzes, and monitors data from member satisfaction surveys, provider satisfaction surveys, timely access (including after-hours) surveys, and member and provider complaints. We share results with Provider Relations, Member Services, and other departments as needed through a formal

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committee process. The QM team presents results its analysis to the QM committee to assure all departments are aware of opportunities for improvement and are engaged in the development of action plans to address them. Action plans vary widely, based on the nature of the identified issue. An action plan may include addressing internal workflow processes or it might indicate a need for network-wide provider training. We immediately route any feedback about access to our Provider Relations department for investigation and follow-up.

QM works closely with Provider Relations in the investigation of potential quality of care concerns. Provider Relations is informed of any issues identified including bedside manner exhibited by the provider or staff, recurrence of complaints, or the need for further education. Provider Relations and Quality Management also collaborate in obtaining medical records from providers when necessary.

We have a history of soliciting and incorporating provider feedback into our operations. For example, providers requested that our Care Management team provide them with access to more information about their patients. In response, PCPs are now provided a copy of all member plans of care (PCPs only receive BH or SUD information if the member has signed a release) and are asked to provide feedback or acknowledgement as part of a team approach to member care, referred to as our multi-disciplinary team (MDT) approach.

We regularly meet with large provider groups in MDT meetings to review difficult cases, and providers are welcome to request an MDT meeting when they want to collaborate in member care improvement strategies. Our provider satisfaction survey includes questions related to our Case Management and Disease Management (DM) departments. We also gather feedback from providers during the Joint Operating Committee (JOC), which includes the group, the Provider Network Manager, and Health Plan leadership.

**** TESTIMONIAL: Florida Family Primary Care Center Praises Working Relationship**
Florida Family Primary Care Center has a great working relationship with Simply Healthcare. We share the common goal of providing excellent care to our members/patients. And we work together well in this endeavor. We are all busy and don't often take the time to offer recognition. So we just wanted to take a moment to let you know that we appreciate our relationship with Simply Healthcare, and to thank your team for your ongoing support. — Emilio J. Monte, Chief Financial Officer, Florida Family Primary Care Center, LLC ******

3.1. Provider Pharmacy Engagement Program

Our Provider Pharmacy Engagement program uses data to support performance improvement. The program is part of our Integrated Pharmacy Services Model. Clinical Pharmacy detailing complements utilization reviews and involves a focused educational exercise to encourage and assist providers in making medically appropriate and cost-effective clinical decisions. Specialized clinical pharmacists engage providers in a one-on-one.

The goal of this program is to provide an effective means of delivering important clinical information to our network prescribers, and facilitating sound clinical decision making that will translate into the delivery of the highest quality medical care. The Pharmacy Provider Engagement Program provides an interactive clinical detailing platform that includes a dedicated clinical pharmacist who meets regularly with network physicians at their offices or via web conference. Meetings are conducted on a "one-on-one" basis, to educate, inform, review

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medication prescribing patterns, and communicate best clinical practice guidelines. They provide real-time utilization metrics, comparative performance measures, and educational materials focusing on cost-effectiveness and quality.

We understand that providers face multiple challenges including:

- Increasing complexity of drug lists and networks making it difficult to understand pharmacy benefits
- Difficulty understanding the cost of prescriptions and the availability of lower-cost alternatives
- Multiple insurers, multiple provider interfaces, and portals
- Barriers to filling a prescription, such as narrow networks and prior authorization requirements
- Coordination among other prescribers and specialists (who is prescribing what), making it difficult to understand pharmacy benefits

The Provider Pharmacy Engagement program helps providers mitigate the challenges described above with real-time member utilization data and actionable interventions. The program assists providers in selecting medically appropriate and cost-effective medications. We provide meaningful and actionable interventions by identifying brand to generic conversions opportunities; formulation optimization opportunities; member polypharmacy issues; high-risk medication utilization; and instances of non-adherence or therapeutic duplication. Our program also benefits providers by closing the physician drug pricing knowledge gap (Daraprim, Hep C); educating them on market drug pricing; offering therapeutic class comparisons; providing insight to full member medication history and prescriptions written by other prescribers; providing timely reporting and utilization data to providers on the front-line; and offsetting the persuasive marketing strategies of pharmaceutical manufacturers.

The Provider Pharmacy Engagement program involves extensive data analysis as well as face-to-face meetings between our clinical pharmacists and providers within our network. The program has been responsible for a combined 75 percent reduction in the incidence of polypharmacy over the past two years in two cohorts which have been consistently monitored for incidence of polypharmacy.

The Provider Pharmacy Engagement program includes analysis of monthly claims to identify outliers and intervention for non-responders, and the selection of therapeutic areas of concern; development of group and one-on-one educational materials for the therapeutic area of concern; on a monthly or quarterly basis, a health plan clinical pharmacist meets one-on-one with identified network providers; presenting report analysis, educational materials, and a list of targeted interventions; providing member medication history and metric performance reviews; analyzing data to report anticipated quality improvements and cost savings as a result of intervention activity; and recording follow-up items.

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The Provider Pharmacy Engagement program provides a suite of standard reports to providers including full member panel utilization; monthly drug spend; polypharmacy; high-risk adherence medications; and cost-effective therapeutic alternatives. Ad hoc reports are available as needed and may include medication cost guides, high-cost member profiles, prior authorization metrics, high-cost therapeutic areas, and specialist prescribers.

4. USING DATA FROM PROVIDER INTERACTIONS TO IDENTIFY TRAINING NEEDS

We view every interaction with a provider as an opportunity to obtain feedback on our performance as a health plan and to gather insights that can help us continue to improve our processes. Providers' input is particularly valuable in helping us identify additional training opportunities that we should offer providers within our network and in helping us identify additions and/or changes needed in our internal training for Provider Relations and provider help line staff.

4.1. Tracking Interactions

Provider Network Managers use Salesforce to track provider visits and interactions. At the end of each visit, we offer providers an opportunity to take a brief survey where they can provide feedback on how well we met their needs. The survey is real-time and is completed via Salesforce. Survey results are shared with the Provider Relations leadership team and used to identify training needs and inform process improvements.

For example, based on provider feedback we heard that information was not being consistently delivered. We have expanded our training opportunities and provide monthly training options for all Provider Relations employees covering a variety of topics including systems, data analysis and interpretation, and various processes and procedures. Provider input is particularly valuable in helping us identify additions and/or changes needed in our internal training for Provider Network Managers and provider help line employees.

Provider Relations leadership is directly involved in the education and training of new Provider Network Managers and monitors their performance once assigned to a market. Experienced Provider Network Managers have the opportunity to receive refresher training during onboarding sessions conducted for employees or via self-paced web-based trainings.

4.2. Onboarding Provider Relations Employees

Training of Provider Relations employees begins well before an individual has contact with a provider. It is important that our Provider Network Managers and other Provider Relations employees have the skills and information necessary to assist our network providers. Clear Health provides all Provider Relations employees with a comprehensive onboarding experience.

Our onboarding program consists of five days of classroom training followed by two weeks of shadowing an experienced employee. The objective of our Provider Relations Onboarding Training program is to provide a foundation of tools, resources, and knowledge to support effective collaboration with providers in our network, keeping focus on the company's values of being accountable, caring, easy to do business with, innovative, and trustworthy. This broad training includes in-depth review of systems, policy and procedures, and regulatory requirements including:

- A day in the life of Provider Relations – tips and strategy

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- Cultural competency and sensitivity training
- Specialty specific onboarding
- An introduction to National Provider Relations (NPR) and continuing education offerings
- Credentialing
- Salesforce
- Detailed regional Florida provider community overview
- Provider visit and site assessment requirements
- Comprehensive training in cultural competency, HEDIS®, value based purchasing (VBP) programs, claims payment system, credentialing, reporting including frequent ED usage, inpatient census, financial outcomes, pharmacy generic versus brand name drugs, contract requirements, network adequacy, and fraud, waste, and abuse (FWA).

Education of Provider Network Managers does not end with onboarding. Representatives continue to use information and training resources within the Resource Center Continuing Education curriculum, specific training conducted by Clear Health, additional standalone trainings, job shadowing, and mentorship opportunities.

Provider Customer Care Representatives are trained across all business lines to be a one-stop service to assist providers with services, eligibility, or claims. Beginning with new hire training, we educate Representatives on our member-centered approach to care, best practices, and strategies for engaging callers. Throughout their employment, we provide continuous training, coaching, and supervision that support employees' consistent application of these principles when serving providers in our network. We conduct training in controlled environments with supervision and coaching, followed by evaluation. Our training curriculum covers a variety of topics, including thorough Florida-specific training, enabling them to assist providers with needed information rapidly.

5. USING METRICS TO PRODUCE ACTIONABLE DATA FOR MEASURING PROVIDER SATISFACTION

Our Provider Network Managers will continue to be in the field offering ongoing support to providers, helping them improve the effectiveness and efficiency of their practices. For example, they will analyze quality metrics and reports for care opportunities; help providers implement care coordination. They also create action plans to help improve cost, quality, and the member experience; refer provider to our Clear Health Training Academy for VBP training; and help design, develop, and implement community learning forums.

**** REAL STORY: Sharing Strategies to Improve Provider Performance**

A Provider Network Manager reached out to an assigned provider who presented with low quality and performance metrics. The Provider Network Manager met with the provider monthly to review and track trends for HEDIS® care gaps and performance outliers. Through the ongoing support and consistent access the provider had with the Provider Network Manager, the group was able

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to drive significant change in their overall performance, moving them on target for quality and performance goals. The Provider Network Manager offered some strategies to help improve performance. These included assuring that all members are aware of extended office hours; establishing each new member so they are familiar with the office; and making sure that all members that come in for a sick visit are given the after-hours service phone number and a list of urgent care facilities near each of the offices. Other strategies included ensuring that the provider's specialist referral patterns are engaged with the PCP's practice in sharing data. The PNM also coordinated visits with a clinical pharmacist to review all pharmacy utilization reports. The group is working with Clear Health now to enter into a VBP agreement. **

5.1. Provider Reports and Data Sharing

Our provider engagement model supports provider data solutions and performance reporting, ongoing provider outreach, and focused support to help providers meet quality and performance targets, measure performance, and implement interventions. We use a suite of data- and information-sharing tools to help providers understand their performance and implement interventions. These tools include both profile reports, which compare a provider's performance to peers and/or established benchmarks, as well as integrated data solutions, member dashboards, and provider scorecards that support our VBP models and help providers improve performance and manage care more effectively.

5.1.1. Reports Provided to all PCPs

We provide actionable performance and utilization data to all PCPs monthly via Financial Recovery Group (FRG) and our secure web portal and FTP site. Examples of the types of data and reporting available to providers on this website include:

- Daily reports such as daily census and daily utilization data
- Financial summary reports such as funding and expense (by month and consolidated), member by PCP, report card summary by PCP
- Facility Utilization reports such as bed days ED admissions, admission frequency, and readmissions data
- Claims reports such as institutional claims detail list, outpatient and ED claim detail list, professional claims detail, including specialty trends
- Member care and engagement opportunity reporting
- Membership reports such as member list summary, member by diagnosis
- Pharmacy detail reports such as prescription detail by member, prescription detail by prescribing physician, prescription detail by script, polypharmacy, and prescription detail by member
- Specialty reports such as claims detail by service provider (facility and non-facility)

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In addition, each Provider Network Manager is responsible for reviewing monthly reports for their assigned PCPs. They compare current results to the previous month and review the results with the PCP during their monthly visit. These reports include:

- Member Opportunity report – PCPs are encouraged to call the members who participate or have potential to participate in Case Management to be seen in the office at least once a month.
- HEDIS® and Child Health Check-Up (CHCUP) care gaps
- ED Frequency report – PCPs are reminded: to assure members are established within the first 30 days of being assigned; to assure members are aware of extended office hours and know which urgent care facilities are nearby; of the importance of PCPs accommodating sick members into their daily schedules
- PCP summary report – Provider Network Managers use this report to review utilization trends with PCPs

5.1.2. Providers in Shared Savings / Shared Risk Arrangements (non-PQIP)

In addition to the data and reports described above which are available to all providers, providers contracted in our shared savings/ shared risk VBP programs have access FRG, our secure portal via Availity, and/or our secure File Transfer Protocol (FTP) site, where they can pull a variety of reports to meet their data needs. These sites are updated daily and monthly and includes the following data available to providers:

- Monthly capitation report with member detail in excel format
- Daily inpatient census report with member detail in excel format
- Daily roster of membership assigned to PCPs
- Cumulative financial summary of group which includes stop loss and IBNR
- Cumulative report detailing all capitation paid to vendors and PCPs
- Cumulative report detailing all claims paid on behalf of members assigned to the PCPs
- Cumulative report detailing all revenue and major expenses of members assigned to the PCPs
- Cumulative financial summary of PCP which includes stop loss and IBNR

In addition, Provider Network Managers also review the monthly reports for their assigned PCPs contracted in one of our VBP programs:

- PCP Member Medication Detail Report - includes all medications filled by the plan for members assigned to each PCP
- Current Prescription for Adherence Medications Report - provides the name of the medication that needs to be filled for medication adherence compliance
- Medicaid Provider Dashboard (HEDIS® Gap Report) – HEDIS® gap data for members including the compliance score per measure for the provider



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5.1.3. Providers Enrolled in PQIP

PCMS is a web-based population management application that is available to providers who participate in our PQIP program. PCMS uses alerts, icons, hover-overs, drop-downs, and drill-through functionality to help providers identify actionable, member-specific information that supports their population health management efforts, including member outreach and engagement activities that may affect a provider's performance.

Providers can use PCMS filters to stratify their member populations by key conditions, risk factors, gaps in care, visit history, ED utilization, inpatient admissions, and readmissions. PCMS reports include:

- Attributed Members - identifies the members for whom a practice is responsible for providing primary care (active members) and coordinating care with other providers to make sure member needs are met
- Inactive Members - includes a list of members who are no longer attributed to the selected provider group (members will appear on this report if their attribution ended within the past 12 months)
- Care Opportunities - indicates how many members assigned to the provider have a potential care opportunity within the HEDIS®-like quality measures captured in PCMS (updated monthly based on claims data)
- Care Opportunities By Provider - displays the provider's list of members who have care opportunities
- ED Visits – displays a list of members attributed to the organization who have been to the ED during the past year
- Inpatient Admissions - Includes the list of members who have had at least one inpatient stay during the past 12 months as well as the date of the most recent inpatient stay (based on claims and is updated daily)
- Pharmacy By Therapeutic Class – provides detailed information about drugs dispensed through a retail or mail-order pharmacy for providers' attributed members (providers can use this information to identify opportunities to manage pharmacy-related costs for their assigned members)
- Pharmacy By Provider - displays information regarding the prescriptions written for the provider's assigned member panel, broken down by provider name

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- Pharmacy By Member - List of the provider's assigned members who have filled at least one prescription during the previous 12 rolling months (for each member listed, the provider can see the total number of prescriptions as well as the total cost associated with the member's pharmacy claims)
- Pharmacy By Scripts - detailed information about each prescription filled during the past 12 months for all assigned members currently in the provider's panel
- Longitudinal Member Record - within PCMS, providers can launch the longitudinal member record to view additional details about the member (includes data such as claims, utilization, and pharmacy)

5.2. Provider Satisfaction Survey

Clear Health is committed to developing and maintaining a quality improvement program to achieve and sustain measurable improvements in performance for services provided to members and in our relationship with network providers. In addition to the satisfaction survey we ask providers to complete after each face-to-face visit with a Provider Network Manager, we conduct an annual Medicaid Provider Satisfaction Survey. The goals of the annual survey include measuring how well we are meeting providers' expectations as well as assuring compliance with AHCA requirements and the accreditation standards of Clear Health's accrediting body, NCQA.

The survey process includes carrying out an objective and systematic review of activities and systems that assess quality of care and service that meets or exceeds all acceptable prevailing standards. We evaluate provider satisfaction with our communications, services, and procedures and then use the results as part of our continuous quality improvement efforts. The survey assesses provider satisfaction with training and education, communications, provider enrollment, complaints resolution, claims processing and reimbursement, and utilization management processes. Survey information helps us better understand our provider network: its needs, challenges, and opportunities for member-focused, cost-saving innovations.

Simply and our D/B/A Clear Health are focusing on quality by bringing together the best practices and innovative solutions of three Florida health plans that have recently merged to become one entity. We are proud of our provider satisfaction survey scores. Provider satisfaction scores were reported separately for each of the legacy plans comprising the new unified Simply; we are presenting the legacy Simply scores as an example of our Florida provider satisfaction scores. For legacy Simply in 2016, overall satisfaction with the health plan was 100 percent, with 100 percent of respondents stating they would definitely or probably recommend the health plan to other provider offices. Simply received satisfaction ratings of 85 percent or higher in 26 out of 29 items. The following areas received the highest satisfaction ratings:

- The majority of respondents (99 percent) expressed satisfaction with the quality of Simply's health education and wellness promotion services for members
- Simply's credentialing process received a satisfaction score of 99 percent
- The information provided in the provider handbook, as well as communication provided via letters and faxes from Simply, received a composite score of 95 percent. The highest scoring item was the provider handbook with a 98 percent satisfaction rating

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- The authorization and appeals processes received a composite score of 95 percent. Respondents were satisfied with the various avenues for requesting an authorization, the timeliness of the process, and the clarity of the review decisions
- The claims area received a composite score of 95 percent. This score included four components: claims processing accuracy, timeliness, helpfulness of staff when resolving a claims issue, and claims review or appeal
- Provider Relations received a score of 94 percent. This score included satisfaction with the response time and provider education conducted by this area

The annual Provider Satisfaction Survey helps us identify training needs. The survey asks providers what information they would like from Clear Health. This information includes Disease Management programs, HEDIS® measures, participation in a quality incentive program, innovative programs providers can implement, providing after-hours care, electronic claims processing, and any other issue they specify. Provider Relations receives feedback from the survey and uses the information to address provider specific areas of opportunity, including provider satisfaction, overall performance, which will result in improving the provider engagement with Clear Health.

5.2.1. Opportunities for Improvement

We develop strategies to improve any survey item that does not score above 85 percent. The Gap Committee meets to further analyze the results of the survey and then brainstorms ways to improve provider satisfaction. Their goal is to develop long- and short-term interventions to enhance provider satisfaction with us. Measures that fell below 85 percent and corresponding mitigation strategies include:

- The time it took to resolve a complaint (any type). Two telephone areas (authorizations/pre-certification and claims) receive the most complaints from providers. These two units are not part of the Claims or Health Services departments that process the respective claims or authorizations.

Interventions: In 2015, Clear Health introduced streamlined systems and processes for handling disputes and delivering quicker turnaround times for resolutions. In addition, we deployed a management system to assure appropriate timeliness and resolution of disputes. This system provides daily aging reports discussed with the team each morning to manage the appropriate allocation of resources. In February 2016, we added two employees trained to work exclusively on claim related provider disputes, one of the most common disputes from providers. Additionally, Provider Relations employees received greater access to other departmental processes/systems contributing to quicker complaint-resolution turnaround time.

Evaluating Effectiveness: The Complaint and Appeals unit reviews daily aging reports to comply with all regulatory timeframes. We present this information to the GAP Committee quarterly.

- The knowledge of the Provider Customer Care Representatives. Provider Customer Care Representatives had limited access to other departmental processes and systems. This resulted in an inability to provide first contact resolution. Instead, staff had to escalate the concern internally via email or phone and then call the provider office once receiving the response from the other area.

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Interventions: We monitor our Provider Customer Care Representatives on a monthly basis to make sure that callers receive accurate information. The Call Monitoring and Quality Review program consists of monthly monitoring of every Provider Customer Care Representative. The Quality Analyst randomly chooses five pre-recorded calls, for objectivity. The departmental benchmark is 95 percent, with coaching and disciplinary action as needed. We complete an evaluation form that includes the evaluation of soft and hard skills within the following components: call opening, provider issue identification, provider verification, resolution, effectiveness, documentation, and call closing. We track and trend results monthly at the individual, team, and unit levels.

Provider Customer Care Representatives also received greater access to other departmental processes/systems contributing to first call resolution. For example, Representatives received access to finance files allowing them to see offsets occurring throughout the providers' claims. Additionally, the management team received access to certain fax folders to enhance access to incoming authorization requests. They also gained access to the audit and recovery system in order to access outgoing communications to providers regarding financial audits.

Evaluating Effectiveness. We conduct monthly audits of all Provider Customer Care Representatives to make sure they are courteous and provide accurate information. We present audit results to the GAP Committee.

- The number of specialists available for referrals. PCP offices encounter push back from specialists that are in network who state they do not take the plan. Possible reasons for this include provider staff not being educated on the plans they accept and turnover of knowledgeable provider employees.

Interventions: When onboarding a new PCP office, the Provider Network Manager asks which specialists the office usually uses for referrals. If the specialists are not participating, we will try to contract with the providers. Additionally, Provider Network Managers work with PCP offices to identify the specialists with whom they were having the most problems scheduling appointments. We contact those specialists and re-educated them on their contractual obligations.

Evaluating Effectiveness: The Gap Committee will review the results of the annual Provider Satisfaction Survey, as well as quarterly reviews of Quest Analytics geographic analysis reports and maps. We conduct an annual review of specialist appointment access and present the results to the Quality Management Committee.

6. PROVIDER TRAINING

6.1. Our Approach to Provider Education and Outreach

Comprehensive, face-to-face education and outreach help providers in our network take good care of our members. Our role as an active partner in the provider community gives us valuable insight into what works and what matters. Our education and outreach efforts are provider-focused with the goal of delivering information needed to enable providers to engage members, improve member outcomes, and simplify practice management. We are proud that AHCA acknowledged our training program and we will continue to make training available to all providers regarding the requirements of the Statewide Medicaid Managed Care (SMMC) Contracts, including contract amendments and special needs of members.

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We understand the importance of collaborating with and supporting AHCA to make sure we are reinforcing areas of critical importance for providers serving members. Our training programs including a thorough overview of AHCA requirements. For example, all providers participate in orientation within 30 days of joining our network. Our comprehensive orientation includes an overall of topics to providers including service coverage guidelines, service authorization requirements, billing procedures, claims processing, payment timeframes, and our dispute resolution process and timeframes. We include a complete description of our provider orientation program later in this response.

We will continue to coordinate and support AHCA-sponsored outreach activities, as requested, and our regionally based teams will continue to work with our network providers to assure successful completion. We are pleased that AHCA recognized our onboarding process as a best practice. In 2016, legacy Simply received a satisfaction rating of 95 percent when providers were asked to rate the training and education provided to their office staff concerning our processes and requirements.

Frequent, ongoing provider education, delivered through multiple channels, promotes enhanced quality of services and improved member outcomes. As their local contact, providers will know we are available to them when they have questions or need additional education. For a period of at least 12 months following implementation of the Contract, we will conduct monthly education and training for the top five specific provider types identified through our monitoring and QI processes, and claims submission and payment processes, which will include an explanation of common claims submission errors and how to avoid those errors. This period may be extended as determined necessary by us or the Agency.

Our comprehensive provider education and outreach strategy helps make sure providers have the information necessary to provide high quality care to our members and includes:

- Clear Health Training Academy. Our Training Academy (described in detail later in this response) is a powerful vehicle that fosters a robust, consistent, compliant, and comprehensive approach and provides a multitude of expert-developed, customized trainings, accommodating various formats, media, and schedules while offering providers the opportunity to earn CMEs and CEUs, allowing the provider to achieve a Red Ribbon status at no cost. Frequency: Ongoing, available on demand.
- Provider Onboarding. We initiate new provider education when a provider has joined our network. We meet individual providers in their offices and provider groups in private facility settings and use group presentations at a convenient location when several providers join our network within a short time frame. Frequency: Ongoing, within 30 days of new providers joining our network.
- Provider Handbook. A comprehensive resource that informs providers of our program guidelines and requirements and assists them in caring for members. We review the handbook with network providers during orientation. Frequency: Providers have 24/7 access via our provider website.
- Provider Portal. A critical tool to enhance provider communication, deliver actionable information, and streamline plan administration. It features tools that promote convenience and transparency by allowing authorization submission and viewing claim status. Frequency: 24/7.

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- Ongoing Training and Workshops. We hold ongoing educational sessions for providers several times a year. Provider Network Managers meet one-on-one with PCPs and hospitals quarterly. Existing providers can also request and receive one-on-one focused education. Frequency: Ongoing as needed or requested.
- Provider Bulletins. We use bulletins to communicate program updates, new AHCA initiated programs or updates, policy clarifications and updates, updates to our provider handbook, or to reinforce current policy and procedure. We also utilize bulletins to distribute guidelines and medical policy. Frequency: Ongoing, posted to our provider portal as needed.
- Network e-Updates. Includes important information and topical updates for network providers. Network e-Updates have included information on a variety of topics such as ICD-10, claims submission process, pharmacy, BH, chiropractic code set, and the prior authorization process. Frequency: Quarterly.
- Blast Faxes. Helps assure providers in our network have access to important program updates and promotes our educational events. Frequency: Ongoing as needed.
- Webinars, Online Videos, and Seminars. Webinars enable providers to participate in educational events from the comfort of their offices. Sample topics include access to care, EPSDT, Individuals with Disabilities Education Act (IDEA), telemedicine, contracting, credentialing, prior authorization, utilization management, BH, integrated care, and claims processes. Frequency: Monthly.
- Provider Newsletter. Our provider newsletter offers relevant and helpful information. We post the newsletter to our provider website and alert providers by fax blast that a newsletter is available. Frequency: Every other month.

6.1. Clear Health Training Academy

Our Training Academy offers a truly comprehensive approach to all AHCA-required and Clear Health-offered trainings for providers and staff. Our internal learning and development team regularly assesses the effectiveness of our training to assure it meets the needs of providers, staff, and members.

Our Training Academy incorporates multi-modality delivery training venues (in-person, online courses, tailored webinars, written materials) and mechanisms to track, monitor, alert, and report compliance and completion. Through the Training Academy's robust features, we are able to offer required, population-specific, and culturally competent training. We offer specific "intentional trainings" for targeted providers who support specific populations to promote recognized practices of excellence. We update our training programs to assure they remain relevant, meet audience needs, and comply with AHCA requirements.

Our provider education plan includes initial, annual, and ongoing training that begins prior to contracting and supports continuity of care and seamless transition. Our training materials support the full range of PH, BH, and LTC benefits using a person-centered planning process.

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Our Training Academy's robust features offer required, regionally identified, population-specific, and culturally competent trainings. We offer ongoing training sessions to network providers several times per year, and as needed. These sessions give providers program and regulation updates, information on industry and care trends, new ways to improve member outcomes, recommendations for reducing administrative burdens, information, and steps that can affect performance, and enhancements to our Florida services and programs.

Our Provider Relations staff supports individual and on-site training sessions whenever a provider requests or when we identify a need. Options include group presentations, webinars, and training at the provider's location. Trainings are specific to provider type and we tailor them to meet the needs of local providers.

We encourage providers to engage in our "intentional training" programs. These targeted training programs encompass four key strategies: 1) integrated care training based on a library of offerings for specific providers 2) targeted training libraries and content related to vulnerable subpopulations and population-driven health needs 3) training to support value-based care, and practices of excellence recognition programs that reward providers for their additional knowledge and capabilities related to quality-based management of specific conditions, and 4) training related to specific contract requirements, HEDIS® measures, and NCQA requirements. Many of these trainings offer providers the opportunity to earn CME or CEU credits.

6.2. New Provider Onboarding

Newly contracted providers complete initial onboarding within 30 days of becoming active. We require all providers to attend an initial orientation session to make sure they understand the managed care program and our policies and procedures. We conduct ongoing training with providers to share best practices, communicate new and updated policies and procedures, and reinforce education. During 2016, more than 1,300 providers completed onboarding.

We offer formal group training for all providers using various modes and venues to maximize participation. We offer multiple dates at convenient times and locations for each training session and serve food to encourage attendance. We take attendance at every training session and track individual provider participation. When a provider does not attend scheduled training sessions, our Provider Network Managers contact the provider and re-schedule training, including the option of a one-on-one or webinar session.

At initial training, we distribute copies of our provider handbook and member benefit collateral. Updates and distribution of the provider handbook comply with requirements. We focus on scope of service requirements for numerous topics including service coverage guidelines, service authorization requirements, billing procedures, claims processing payment timeframes, and dispute resolution process and timeframes. We present instructions on how to use our provider portal and website, which contain key provider education information. We also offer a question-and-answer session where providers and employees can address specific questions. When providers do not attend scheduled training, we follow up with them to reschedule.

We provide training to all new providers within 30 calendar days of placing the provider on active status. Under the new Contract, we recognize that both new and existing network providers will require training on new program features. In addition to individualized training for providers in their offices, we will offer regional orientation sessions for providers no later than 30 days before the

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first enrollment date in each region. The orientation session includes components of our typical provider training session, described below, as well as highlighting for existing providers any differences under the new Contract, such as additional covered services and expanded benefits. We provide orientation sessions in-person in at least one central location within the region and will be available via webinar for those who cannot attend in person.

Our standard training for all newly active providers, facilities and their staff addresses the requirements of the contract, interaction with us regarding claims and authorizations, and special needs of members. Specific topics (including corresponding requirements in scope of service requirements) include:

- An overview of the SMMC program
- Overview of AHCA priorities
- Service coverage guidelines
- Service authorization requirements
- Billing procedures
- Claims processing payment timeframes
- Dispute resolution process and timeframes
- MAXIMUS and the Agency's third party claims resolution process
- Provider handbook
- Member access standards
- The use of evidence based guidelines and Clinical Practice Guidelines
- Preventive health care guidelines
- Medical necessity criteria
- Overview of EPSDT, the periodicity schedule, compliance requirements
- Advance directives
- Fraud, waste, and abuse policies and procedures and Compliance Plan
- Quality Management program and plan
- Cultural competency and interpreter services
- Reporting requirements, including communicable disease reporting requirements
- Privacy and confidentiality of Protected Health Information
- Mental illness and alcohol and drug abuse protocols and resources
- Meeting the needs of members
- Important Clear Health contact information
- The role of the Provider Network Manager
- Provider portal and available resources
- How to check eligibility (through our secure provider portal and automated phone system)
- Utilization management and how to obtain prior authorization
- Member rights and responsibilities
- Provider roles and responsibilities
- VBP models
- Provider Satisfaction Survey
- Member Satisfaction Survey
- Health education programs such as disease management including population health
- The importance of encounter data
- High-level discussion on HEDIS®

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Training for OB/GYNs includes the information above as well as training on the following topics:

- Notification of pregnancy
- Presumptive eligibility information
- Taking Care of Baby and Me
- Alere — Coverage of home care for members with high-risk pregnancies
- 24-hour Nurse Advice Line — our Nurse help line

We conduct an initial in-person training session at the provider's location and via web conference within 30 calendar days of placing a newly contracted provider, or provider group, on active status. We conduct training via web meeting at the provider's request. Provider resource materials, including an orientation binder, formal agreement, CD, provider handbook, and quick reference guides are provided to the office. Once an orientation visit is completed, providers have the opportunity to respond to a survey in real time via Salesforce technology. The survey evaluates the Provider Network Manager and advises us of any additional training needed in general or in particular subjects. We analyze and trend responses to establish if general training sessions are needed, if educational materials need to be developed as additional resources to providers, or if Provider Network Managers require additional training.

For hospitals, we provide a comprehensive orientation session that includes policies, procedures, and formal agreements to communicate between our Care Management team and the hospital. We also conduct monthly Joint Operating Committee meetings with hospitals to provide further education and work through any operational issues.

Following the initial orientation session and individualized trainings sessions for new providers, we offer monthly training sessions that cover claims submission and payment processes for at least the first 12 months of the Contract. These sessions include explanations of common submission errors and how to avoid errors in the future. If we determine there is a need to continue training based upon high claims errors or frequent provider questions through our provider help line, we continue the trainings beyond 12 months. We also continue trainings at the request of the Agency.

Provider Network Managers provide individualized training to providers at each of their on-site visits. These trainings target provider-specific issues that have been identified either by the provider or by one of our internal departments, such as utilization management or quality management. Examples of training topics include clean claim submissions, over or under-utilization, HEDIS® scores, or referral criteria into case management and disease management programs.

6.2.1. Training for Red Ribbon Providers

Our Provider Relations team focuses on educating the providers on our benefits, services, and policies and procedures to make sure the provider and his/her staff understand how to gain access to care for their patients and provide continuity of care. The provider handbook includes the requirements for providing care in accordance with the most recent clinical practice guidelines for HIV/AIDS treatment.

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The handbook also states that the provider must follow the Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents developed by the HHS Panel on Antiretroviral Guidelines for Adults and Adolescents' policies and procedures on referral for services offered by the plan and outside of the plan. CMEs are provided to red ribbon providers upon the completion of select courses.

Referral guidelines for BH and substance abuse services are also included. Beacon Health Options, our BH subcontractor, has most FQHCs and community mental health centers (CMHCs) in-network. These providers are experienced in working with people living with HIV/AIDS.

We offer and encourage all providers to attend sensitivity training on how to work effectively with people living with HIV/AIDS. All provider handbook information is available to providers on the Clear Health website. We also offer a provider portal on the site, which the provider can use to access member eligibility, claim status, referrals, and authorizations.

We refer providers that require and/or request additional training on HIV/AIDS to our partner, the AIDS Education and Training Centers (AETC), which conduct targeted, multidisciplinary education and training programs for health care providers treating persons living with HIV/AIDS. We partner with Dr. Jeffrey Beal, Principal Investigator and Clinical Director for the Florida/Caribbean AIDS Education and Training Center, to provide direction and education to providers identified in the communities we serve who need or who would like to improve their HIV/AIDS treatment expertise.

Provider Network Managers engage frequently with our provider network to make sure providers are continuing to meet the needs of enrollees by providing access to care that meets our general quality standards and those necessary to provide specialty services to our enrollees with HIV/AIDS. We collect and analyze performance measurement data regarding the services provided to our enrollees to implement enrollee and provider interventions in order to exceed benchmark quality performance.

Using provider profiles, we are able to identify providers who are outliers on metrics such as adult immunizations, annual PCP visits, the percentage of enrollees prescribed antiretroviral therapy, hospitalizations and emergency department visits. We also monitor the clinical status of every enrollee, including viral load and CD4 count, indicators that treatment is effective.

If patterns of service utilization or concerns about individual enrollees emerge, our Provider Network Managers, Case Management team, Medical Director, or Pharmacy team member reach out to the provider to provide additional education. The entire Clear Health team is available to support providers, with technical assistance, consultation, and by coordinating ancillary services and referrals for timely access to services.

6.3. Frequent and Ongoing Training for Network Providers

We use a robust approach to training. We provide targeted outreach when there are significant changes to program requirements. We also conduct sessions when we have new information that will improve member outcomes, reduce the administrative burden for providers, or affect performance goals.

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We conduct continuing training that reinforces areas covered in initial training and provides specialized training on identified topics. Topics include sensitivity and cultural competency, updates providers on changes in program policies or procedures, referrals to Case/Disease Management programs, and supports compliance with program standards and Contract requirements. Our continuing education includes in-person visits and monthly webinars and provides targeted training on tools to manage and transform providers' practices and improve outcomes for our members. Infectious Disease specialists typically do not provide primary care services. Clear Health has engaged these providers in a primary care role. We put special emphasis on training in areas of primary care services such as HEDIS®, utilization management, referrals, Case and Disease Management, and all other tools available to our primary care network.

Existing providers can request and receive one-on-one education on topics of interest, and our Provider Network Managers tailor presentations to suit their needs. We also organize sessions when we have new information that will improve member outcomes, reduce administrative burden for providers, and affect performance goals. We will provide targeted education whenever there are significant changes to AHCA program requirements. In addition, Provider Network Managers conduct education session for new office staff at existing network providers. We identify additional opportunities for training through our provider help line, Salesforce surveys, grievance and appeals filings, feedback from the Gap and Quality Management Committees, and member outreach.

We also use provider bulletins, newsletters, conference calls, emails, fax blasts, and our provider portal for continuing education and training for our provider network.

We take care of providers in our network so they can take care of our members. We conduct webinar training sessions at times that are most convenient for providers — early morning, lunch, and after business hours. Webinars and video-based training have proven to be effective means of communication and training. We make video-based training available on our provider portal, utilizing a highly scalable, secure video hosting platform. We are excited to give providers the opportunity to participate in training at their convenience by providing the ability for self-paced viewing, allowing for greater comprehension. We deliver high-quality video on demand to any device or destination, including a PC, mobile phone, tablet, or Mac.

6.4. PCP Training on Behavioral Health Disorders

We recognize that PCPs provide a significant proportion of mental health treatment in Florida and across the country and that they are best positioned to identify BH conditions early on. We provide comprehensive training for PCPs on screening, treating, and referring members with BH disorders.

Additionally, we recognize that BH and PH conditions are interdependent and we recognize the value of integrating care across all conditions. We provide BH providers within our network training on integration with PH providers. We offer monthly training meetings, webinars, and personalized help to make sure providers have the necessary information and tools to deliver care appropriately. We support our education and training programs with consistent and frequent outreach through our provider policy and procedures manual, newsletters, portal, and provider help line. Our Clear Health Training Academy comprises a truly comprehensive training approach for PCP in integration, value base payment, and screening for BH and substance use disorders.

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PCP training and online resources are designed to educate providers on when and how to screen members for BH disorders, and the process for making referrals to a BH specialist. We also provide information on responding to members with co-occurring mental health and substance use disorders, the importance of addressing both concurrently, and collaborating with all providers involved in caring for members. In addition, we offer providers continuing medical education sessions that focus on identifying and coordinating PH and BH needs.

We use multiple strategies to educate PCPs on identifying members with BH needs and how to connect members to services and supports. Our strategies for educating PCPs to identify members with BH needs. For example, SBIRT is a comprehensive, integrated approach to screening, the delivery of brief interventions, and referral for treatment for individuals who meet criteria for a SUD. We work closely with PCPs to share evidence-based practices, such as screening tools, that enable them to assess their members' needs and provide targeted treatment or referrals. Clear Health is also contracted with FQHCs throughout the state, that have an integrated model of BH services within their clinics.

6.5. Cultural Competency Training for Providers

We know that many health care professionals are committed to providing culturally competent care but lack the awareness, knowledge, or skills to do so. Through our provider training, we furnish information that providers and their staff can use to remove cultural barriers. We work hard to make sure that our providers are not only culturally sensitive, but also reflect the culture and languages of our members.

All providers receive cultural competency training during initial onboarding, educational outreach from Provider Network Managers, and annually through refresher training.

Training materials are available in our provider handbook and online. Topics include:

- The importance of understanding cultural differences and increasing cultural competency awareness
- Our expectations for our providers and their staffs, including the mandate that they continually expand their cultural competency knowledge and skills
- A review of the 15 national CLAS standards with a link to the U.S. Health and Human Services website for more information
- Assessment tools for providers and their staffs to improve their cultural competency
- Examples of best practices
- A link offering providers no-cost medical education credits from Georgetown University for further study of cultural competency topics

Our Clear Health Training Academy comprises a truly comprehensive training approach for providers and their staffs. We offer specific "intentional trainings" for targeted providers who support specific populations as needed to promote recognized practices of excellence.

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We identify languages spoken by our providers during their application, credentialing, and re-credentialing processes. A review of provider language data, as reported by providers, indicates that 100 percent of the providers speak English. For all providers, 63 percent speak Spanish, and seven percent speak Creole. Our provider directory contains information on the languages spoken by providers in addition to English. The provider directory is available online on the member web portal and in writing upon request.

We expect our providers, as well as subcontractors who have direct contact with our membership, to demonstrate cultural awareness and appropriate skills, such as the ability to understand members' values, beliefs, and cultures. Our network strategy and performance measures incorporate NCQA standards – most notably: “The organization assesses the cultural, ethnic, racial, and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.”

It is essential that all stakeholders recognize and thoroughly understand the role that age, culture, ability, socioeconomic status, and ethnicity play in our members' lives to make sure that all receive equitable and effective health care at the right time and right place. Consequently, we are committed to credentialed providers and subcontractors who understand and appreciate the socioeconomic and cultural challenges that our members face, as well as their medical needs.

We have seen how the quality of the patient-provider interaction profoundly affects members' ability to communicate with their providers and follow recommended treatments. In response, our members' languages, customs, and cultural beliefs are front and center when we develop our provider and subcontractors networks. We train our providers and subcontractors in the delivery of culturally appropriate services for our members, their families, and communities.

6.6. Our Provider Portal

We maintain a comprehensive, secure, provider portal that maximizes usability and administrative simplicity. It offers a variety of tools and resources, including an online copy of our provider handbook along with a variety of training and education resources from the latest provider communications to toolkits (such as our EPSDT Toolkit), all designed to make providers' jobs easier. We showcase basic information and tools such as our provider handbook, prior authorization procedures, formularies, and reimbursement policies, and use the portal to deliver information to providers, including announcements, alerts, and forms. The latest forms and training materials are always available on the provider portal. We have staff available to support provider queries about portal information, ranging from our Provider Network Managers staff who can help find data to Customer Care Representatives who can help providers register and access information.

Our portal simplifies practice management, enables users to navigate easily to the information they need, and support provision of excellent care to members. The site also simplifies practice management by giving providers the ability to review billing and claims payment information. They are able to access important billing news and administrative updates, claims submission and status, prior authorization requirements and request status. Our web technology offers the following benefits:

- Providers can use a single sign-on process instead of logging in to multiple payer systems

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- Providers can submit claims, determine member eligibility, view claims status, and access payment information for multiple payers in one place

6.7. Supporting Providers New to or Hesitant about Managed Care

We use a high-touch approach for all new providers and then adjust the intensity of interaction based on their comfort level. Providers new to and hesitant about managed care continue with high-touch until they are comfortable navigating within the system.

To best serve these providers, we solicit their concerns about managed care. Depending on the nature of their concerns, we tailor our interactions to meet their needs. We explain to the providers why managed care delivers better-coordinated, higher quality, and more cost-effective care to all members. We also assist providers in informing them on how to apply for state Medicaid numbers.

We provide a variety of tools and reports that have been used and updated through the year and have proven to be valuable to our providers. We explain the benefits of being in a managed system and use various tools and strategies to explain the benefits of participating in the SMMC program.

Provider Network Managers support providers throughout the credentialing process, tailoring their approach to each individual provider type and circumstance. We also schedule webinars for providers to explain the credentialing and contracting processes. All new providers are assigned a regionally based Business Development Lead (in addition to their assigned Provider Network Manager) available to them to walk them through all processes and answer questions related to the program, credentialing, billing, and reimbursement.

Evaluating the Effectiveness of Provider Education. We embrace a multifaceted approach to evaluating the effectiveness of our provider education strategies. We design our education and communication programs to comply with AHCA's requirements, and we monitor adherence through our robust quality management and compliance infrastructure. Some of the ways we monitor effectiveness are our annual provider satisfaction survey and post-training surveys. We incorporate data from these sources into our communication strategy to optimize effectiveness.

Provider Satisfaction Survey. We administer an annual survey to evaluate provider satisfaction with our communications, services, and procedures and then use the results as part of our continuous quality improvement efforts. The survey assesses provider satisfaction with training and education, communications, provider enrollment, complaints resolution, claims processing and reimbursement, and utilization management processes. Survey information helps us better understand our provider network — its needs, challenges, and opportunities for member-focused, cost-saving innovations.

Post-training/Post-visit Surveys. Our Provider Network Managers conduct post-visit audits of provider office visits to determine whether on-site training has met objectives. We incorporate this feedback to improve the provider education program and the performance of our team.

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Evaluation Criteria:

1. The extent to which plan leadership are involved in provider engagement.
2. The extent to which local provider field representatives are incorporated into the model, including the ratio of local provider representatives to providers.
3. The extent to which the method the respondent uses to track interactions with providers is capable of producing meaningful data the respondent will use to address both clinical and administrative problem areas.
4. The extent to which the method the respondent uses to track interactions with providers addresses potential provider field representative training needs.
5. The extent to which the metrics used produce actionable data for measuring provider satisfaction, increasing provider performance, improving the provider engagement model, and identifying areas of improvement for provider related communications or written materials.
6. The extent to which the training includes service coverage guidelines, service authorization requirements, billing procedures, claims processing, payment timeframes, and respondent's dispute resolution process and timeframes, including corresponding requirements in scope of services.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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SRC# 16 – Dispute Resolution (Statewide):

The respondent shall describe in detail its provider dispute resolution process.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Strong provider relationships is our focus and critical to our success. We listen to the concerns of our providers, respond to them in a courteous, professional manner, and make every effort to resolve issues through a well-defined and documented process that supports them every step of the way. By developing a consultative relationship with providers, Provider Relations staff become a trusted resource to them and the first people providers contact if they have a complaint.

We facilitate this by our high-touch model, where we communicate with providers on a regular basis to present information based on monthly claims statistics to help them navigate claims, disputes, and other processes, and whenever possible, resolve concerns before they become formal disputes. If a dispute indicates a provider may need guidance, we assign a Provider Network Manager to meet with him or her and discuss the disputed claims, our processes, and other concerns. Our dispute resolution staff works to promote provider satisfaction by reviewing and investigating all issues in a fair, unbiased, and comprehensive manner.

Understanding and resolving provider concerns gives us important feedback and the opportunity to improve performance. By analyzing data on provider disputes, we learn what causes dissatisfaction, identify its root cause, and address root causes with process and system changes to improve our performance and provider satisfaction. We compile provider dispute data with data on complaints from enrollees (members), subcontractors, AHCA, and third parties to make sure we get a complete picture of our performance and areas where we can improve.

In the following evaluation criteria responses, we delineate the process our leadership team follows to monitor our processes promoting complete, appropriate, and timely resolution of disputes, including those AHCA sends to us; and timely provider payments resulting from a dispute. For claims disputes, we go beyond contract requirements to provide a three-level dispute resolution process that includes level one reconsiderations, level two appeals, and the Agency's claims dispute process with MAXIMUS as level three. We also describe below our processes for tracking and trending complaint resolutions to identify and implement improvement strategies, responding promptly to complaints from AHCA, compiling complaints from all sources, and participating in the AHCA claims dispute resolution process.

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**** RESULTS & SUCCESSES:** In 2016, our legacy Amerigroup Florida plan processed 5.3 million claims with 95.5 percent successfully resolved on initial adjudication. Of those claims received as a level one reconsideration, we resolved 88 percent without moving to level two appeal process. ******

1. IDENTIFYING CLAIMS RELATED DISPUTE TRENDS AND INITIATING PROCESS IMPROVEMENTS AND SYSTEM ENHANCEMENTS

Our Process for Identifying Dispute Trends and Initiating Improvements

We use trend analysis of level one reconsiderations and level two appeals data to identify root causes of inappropriate denials or underpayments. Once we identify the root cause, we review all correlated claims to identify issues that span multiple providers and provider types and select additional claims that are potentially eligible for reprocessing. The result of the analysis enables us to initiate process improvement activities and system enhancements. We have found root causes and mitigated them — for instance, claims processing configurations that affected automated processing, external clearinghouse data issues, manual processing errors, unclear standard operating procedures, or provider training needs.

We categorize, track, trend, and aggregate all provider dispute data, including type of issue and other details such as resolution status, and time frames for completing process steps. We process and review the AHCA Provider Complaints report for monthly submission to the State and to our Quality Management Committee (QMC).

Our QMC reviews data related to provider dispute volumes by topic, region, outcome, and timeliness of resolutions. After reviewing data, the QMC identifies action plans to address areas of concern and improve the provider experience through process and system improvements. The QMC reports the results of provider dispute data through the annual evaluation that we present to our Board of Directors.

**** SPOTLIGHT:** Our tracking and trending revealed a high volume of disputes for a particular provider type, lab pathology. While we researched the issue and until we implemented a permanent solution, we adjusted related claims every two weeks to be sure provider payments were accurate and on time. We identified the root cause as a system configuration anomaly affecting claim payment accuracy and resulting in the increased volume of denial disputes. The Reconsideration and Appeal team partnered with the Configuration department to update the logic in the claims payment system. Since this system update, our trending and monitoring reports have shown no recurring disputes correlating to this issue. ******

2. OVERSIGHT TO ENSURE APPROPRIATE DISPUTE DETERMINATIONS, TIMELY PAYMENTS, AND CLAIMS DISPUTES RESOLVED WITHIN REQUIRED TIMEFRAMES

Our provider claims dispute processes (Figure 16-1. Dispute Resolution in Attachment SRC# 16-1: Flow Chart) promote prompt and appropriate resolution and prompt payments required by resolution decisions. Two pieces of data indicate the appropriateness of our decisions: providers appeal approximately one-half of one percent of claims; and we resolve 88 percent of disputes as level one reconsiderations. This is further supported by the fact that, to date, MAXIMUS has not accepted a Medicaid appeal for any of our plans. When we overturn a previous claims decision, we re-adjudicate claims and have historically sent provider payments within 15 days.

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We will continue to optimize this process. For claims disputes, we go beyond contract requirements to provide a three-level dispute resolution process that includes level one reconsiderations, level two appeals, and the Agency's claims dispute process with MAXIMUS as level three. (Figure 16-2. Dispute Resolution in Attachment SRC# 16-2: Flow Chart)

Providers may submit claims disputes within 90 days of claim determination. Disputes may involve claims denials, timely filing denials, late payment, underpayment, lost or incomplete electronic or mailed forms or other information, requests for additional information related to services provided, and decisions related to retrospective claims reviews. Reconsideration Specialists from our Reconsideration and Appeals team process level one reconsiderations. We have three business days from date of receipt of the dispute to send the provider a letter acknowledging receipt of the complaint with the expected resolution time frame.

We provide a written notification of the dispute status to the Agency and the provider every 15 days until we reach a resolution. We will resolve all level one reconsiderations within 30 days of receipt and send written notice of the disposition and its basis to the provider within three business days. If the dispute requires additional time to review, the plan will submit a written request to the Agency within three business days of its receipt. When the resolution for a level one reconsideration upholds our initial action, our resolution notice explains how the provider can request a level two appeal. Providers may submit a request for a level two appeal within 30 calendar days of receiving an upheld level one reconsideration resolution notice. The level two appeal process follows the level one reconsideration process, executed by senior claims appeal staff.

When a level two appeal resolution upholds our level one reconsideration decision, our resolution notice offers information about level three, the Agency's claims dispute resolution program with MAXIMUS. The letter explains how to file a level three written claims dispute resolution program request with AHCA.

Providers may submit non-claim disputes within 45 days of the date of the occurrence. Disputes may involve service authorizations, contracting, credentialing, plan staff, and member discharge requests. We send a letter to the provider within three business days to acknowledge that we received the complaint and provide the expected resolution time frame. We provide a written notification of the dispute status every 15 days to the provider until we reach a resolution. We resolve all disputes within 90 days of receipt and send written notice of our decision and its basis to the provider within three business days of resolution.

The Florida Resolution leadership team monitors the provider dispute process. The oversight process includes supervising staff, monitoring inventory reports, and monitoring policies and procedures to promote accurate and on-time resolutions and provider payments. Leadership performs sample file reviews each month to identify opportunities to improve the quality and timeliness of provider dispute resolutions and payments through coaching, re-training, or revised procedures.

In addition to the monitoring oversight described above, the Leadership team conducts the specific tasks listed below:

- Monitors data related to the number and percentage of level one reconsiderations that come back as level two appeals

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- Reviews the numbers and individual circumstances of overturned decisions during level two appeals; unless we received additional information after the level one determination, these cases may indicate inappropriately denied level one reconsideration determinations or an inadequately explained decision to uphold
- Investigates outlier cases, such as those that take the longest to resolve
- Monitors the top 10 topics addressed in provider disputes

3. TIMELY RESPONSE TO AGENCY REQUESTS RELATED TO COMPLAINT RESOLUTION

We encourage our providers to contact us at any time with questions and complaints. Although we give them multiple options for submitting disputes to us, they sometimes go directly to the Agency with complaints. When this happens, the Agency forwards the dispute to our Regulatory team through the Agency's complaint hub, and we promptly and thoroughly resolve the disputes. Upon receipt of a complaint from the Agency, Regulatory team staff quickly enters the complaint into our grievance and appeal system, which triggers an automated email to the Resolution team describing the issue and the high priority of the complaint. Team staff promptly initiates the provider dispute resolution process as described above.

Our Regulatory team participates in each step of the process from initial receipt through final resolution. With resolution of a dispute that we received from the Agency, Resolution team staff provides the Regulatory team with a detailed resolution summary that they promptly submit to the Agency through its complaint hub. The time frame for complaint resolution is based on the priority status assigned to it by the Agency. Our goal is to exceed Agency expectations for time frame resolution of all complaints they send us.

4. INTEGRATING ALL COMPLAINTS, REGARDLESS OF COMPLAINT REFERRAL SOURCE

We compile, in the grievance and appeal system, detailed individual case and aggregated volume data, performance metrics, and descriptive and summary data on all disputes we receive from providers, members, subcontractors, AHCA, and other third parties. This includes data on complaints, grievances, reconsiderations, and appeals. We track and trend this data and include it in monthly reports to our QMC for analysis, identification of concerns, and implementation of strategies for process and system improvements.

5. PARTICIPATING IN THE AGENCY'S CLAIMS DISPUTE RESOLUTION PROGRAM

When we uphold prior decisions on level two appeals, we send a resolution notice advising providers that they may further appeal our decision through the Agency's claims dispute resolution program with MAXIMUS, its resolution organization. To date, none of our Medicaid claims have gone through the MAXIMUS process. If a provider submits one of our claims to MAXIMUS, we are ready to participate in this process and will comply with all State requirements, including those in Sections 641.3155 and 408.7057 Florida Statutes. We fully understand the Agency's process for managing, addressing, and resolving provider claims disputes and MAXIMUS' role. We will consider all Agency decisions binding on our health plan.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

We will notify providers of the MAXIMUS process available to them after they have exhausted all opportunities to appeal with us through level one reconsideration and level two appeal processes. We inform providers of the MAXIMUS process in reconsideration and appeal resolution letters, in our provider handbook, through our Provider Relations team, on the provider portal, and also direct them to further information on the Agency's website.

5.a. Responding to Requests from the State Contracted Independent Dispute Resolution Organization

We participate in the Agency's process as the third level of our provider dispute process. Senior staff from our resolution team will perform all health plan activities related to the Agency's process under the oversight of our Medicaid Operations Manager, who will be MAXIMUS' contact regarding these disputes. Senior staff will participate in any evidentiary hearings, including presenting information and examining witnesses.

Upon notification from a contracted or non-contracted provider that they have filed a dispute against us with MAXIMUS, we will enter this as a level three Agency appeal in our grievance and appeal system. This system will contain information and key dates related to the level three Agency appeal, including all information related to prior appeals and the disputed claim.

When we receive a request from MAXIMUS for documentation, we will immediately gather all requested and other relevant information regarding the claim and prior appeal activities. We will organize this information into a case file with a table of contents, a sequence of events summary, and numbered tabs for each item. Within 15 days of receiving the request, we will send the case file to MAXIMUS in the format it specifies and by the method it prefers, hard copy or electronic. We will promptly respond to any follow-up requests from MAXIMUS.

5.b. Analyzing Arbitrated Cases for Identification of Process Improvements and System Enhancements

As with all provider disputes, if we receive one, we will closely track and monitor the circumstances of the claims related to each level three Agency appeal to identify process and system improvements related to end-to-end claims processing, other operational areas, and our provider dispute process. Our QMC will consider each level three Agency appeal individually, including trends that indicate areas for improvement, and will implement strategies for improvement.

5.c. Prompt Payment of Final Orders Issued by the Agency

Decisions by the Agency through the claims dispute resolution process are binding. When it overturns a decision, we will reprocess the claims in the time frame directed by the Agency and MAXIMUS in their resolution letter and pay the provider, with interest as required, typically within 15 days and no longer than 35 days. We will also promptly pay the State's costs for conducting this process, as required.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
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Evaluation Criteria:

1. The extent to which the respondent's process identifies claims related dispute trends and initiates process improvement activities/system enhancements.
2. The extent to which the respondent's process includes oversight to ensure appropriate plan dispute determinations are made, timely payments are made, and claims disputes resolved within required timeframes.
3. The extent to which the respondent's process incorporates timely response to Agency requests related to complaint resolution in accordance with the scope of services.
4. The extent to which the respondent integrates all complaints, regardless of the complaint referral source (e.g., Agency, third party).
5. The extent to which the respondent's resolution process includes the respondent's participation in the Agency's claims dispute resolution program authorized in Section 408.7057, Florida Statutes, as well as includes the following:

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
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- (a) Responding to requests for information from the State contracted independent dispute resolution organization;
- (b) A global process for analysis of arbitrated cases for possible identification of process improvement/system enhancements; and
- (c) Prompt payment of final orders issued by the Agency related to claims arbitration case determinations.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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GENERAL SUBMISSION REQUIREMENTS
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SRC# 17 – Claims Processing and Payment Process (Statewide):

In a manner suitable for the provider community, the respondent shall submit key components of its claims processing and payment process, addressing both paper and electronic claims submissions for both participating and non-participating providers.

The response shall include detailed information on the metrics to be employed by the vendor to track timeliness and accuracy of claims adjudication and payment for claims submitted by participating providers and how these metrics will be used by line level and management staff to improve processes and provide for rapid cycle improvement.

The response shall also include a detailed description of how the respondent will make data and metrics regarding claims and payment available to the Agency and will ensure that network providers have access to real-time and trend data regarding claims processing and payment by the respondent and all applicable proposed subcontractors.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations. As an experienced and trusted partner to the Agency for Health Care Administration (AHCA) for over 14 years, we recognize the critical value that accurate claims and encounter data bring to effective management of clinical and health care services information — and the systems, processes, and staffing necessary to maintain high standards.

Optimal claims and payment processing is achieved not only with robust and highly functioning systems, but must also be supported by strong operational leadership and a fully engaged provider community. To that end, Clear Health has built locally based Provider Relations teams that provide training, technical support, and billing assistance to providers at their location. This hands-on approach builds trust and open communication — changing the dynamics of traditional provider/health plan relationships through the development of lasting and collaborative provider partnerships.

Clear Health's Management Information System (MIS) is already configured to support Florida SMMC operations and is compliant with Agency claims processing requirements. We have established electronic data interchange (EDI) connectivity with the Agency and with our providers, offering free access to electronic billing via our partnership with Availity. We process Florida claims in our Core Operations System (COS), which is seamlessly integrated with other components of our MIS. Since 2014, we have processed almost 20 million Florida claims, and we continue to process claims in accordance with Florida and federal statutes and regulations.

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GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

We have reviewed our system configuration based on any new requirements of the SMMC program and agree to modify as necessary to support ongoing timely and accurate claims processing for both electronic and paper claim submission, adjudication, and payment according to Agency requirements. During implementation, our Florida-based Claims Operations team will work with our Implementation team to capture all claims-related requirements on the work plan, including benefits configuration, the Agency's fee schedule, timely provider filing, timely provider payment, and claims reports. Rigorous testing will confirm our claims processing system's full compliance with Florida SMMC requirements prior to Program effective date.

After Contract implementation, additional processes will support continued compliance with Agency requirements. When a regulatory change impacts claims processing, our dedicated Regulatory Oversight Manager will alert all potentially impacted business owners, and a team will review the change, develop an action plan, and finalize a testing strategy. For changes that may affect processed claims, such as a fee schedule change, implementation will include identification and re-processing of affected claims.

1. CLAIMS PROCESSING AND PAYMENT

Ensuring our providers are paid timely and accurately is a key component of providing patient centered care and care coordination to our enrollees (members). Clear Health maintains a claims payment lifecycle that is closely monitored at multiple levels within the organization to support timely and accurate payment. Our Florida Operations team, supported by our national Claims department, uses several operational reports to monitor daily claims processing, notifying providers of reasons for claims denials and answering any questions they may have. Timely review of denial rates and trends along with prompt root cause analysis minimizes the occurrence of inappropriate claim denials and any undue administrative burden on our providers.

Clear Health processes claims in our COS, which is fully integrated with our enrollment and provider systems. We have been processing Medicaid, CHIP, Medicare, and cross-over claims for more than 14 years.

Our claims system leverages effective technology and employees who specialize in Medicaid to consistently deliver prompt and accurate claims payment. Clear Health's claim operations incorporates innovations, best practices, and lessons learned from our affiliates and delivers efficiency and quality to our Florida SMMC claims processing. Our claims system supports medical and behavioral health operations and enables us to achieve the following:

- Compliance with federal and Agency requirements
- Provider satisfaction through prompt claims payment and focused attention to inquiries
- The highest degree of claims adjudication accuracy
- Submission of complete, accurate, and timely reports and encounter data to the Agency
- Performance and scalability to support current volume and future growth

Clear Health processes and pays claims in compliance with federal and State requirements set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S., with the most stringent requirement prevailing. Clear Health's claims processing system is currently configured to meet State, federal, and Agency claims processing rules as specified in the ITN and Contract and in accordance with state implementation guidance, including the following:

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

For electronic claims:

- Provide electronic acknowledgement of the receipt of claims to the electronic source within 24 hours after the beginning of the next business day following receipt of the claim
- Pay or deny/contest within 10 business days of receipt of nursing facility (NF) and hospice clean claims
- Pay or deny within 15 days after receipt of a non-NF or non-hospice claim

For non-electronic claims:

- Provide acknowledgement of the receipt of claims to the provider or designee or provide electronic access to the status of the submitted claim within 15 days after the receipt of the claim
- Pay or deny within 20 days of receipt of a clean claim
- Pay or deny within 120 days after the receipt of all claims (failure to pay or deny the claim within 140 days after the receipt of the claim creates an uncontestable obligation to pay the claim per Chapter 641.3155(3) (F.S.))

Additionally, Clear Health currently complies and will continue to comply with the following standards regarding timely processing for all providers:

- Pay 50 percent of all clean claims submitted within seven calendar days
- Pay 70 percent of all clean claims submitted within 10 calendar days
- Pay 90 percent of all clean claims submitted within 20 calendar days

Established processes confirm that our claims processing system remains compliant with federal regulations and the State-specific requirements for each of our affiliates. Internal experts monitor federal claims regulations to assess the potential impact on our systems and processes. They will create action plans, as necessary, to implement changes in accordance with federal regulations.

For example, for inpatient hospital stays, the Plan counts inpatient days based on the lesser of the actual number of covered days in the inpatient hospital stay and the average length of stay for the relevant All Patient Refined Diagnosis Related Group (APR-DRG or DRG). If a member has not yet met the 45-day hospital inpatient limit per the State's fiscal year for non-pregnant adults, at the start of a new hospital admission, the entire new stay must be covered by Clear Health in which the member was enrolled on the date of admission. This requirement applies even if the actual or average length of stay for the DRG puts the member over the inpatient limit. There is no proration of inpatient days.

1.1. Clear Health's Claim Processing System

Clear Health requires the submission of complete and accurate claims and encounter data for every service delivered to a member within six months after the date of service or discharge. We accept paper and electronic claims to offer providers maximum flexibility, and adjudicate claims nightly to deliver prompt turnaround.

EXHIBIT A-4-a

GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Claims formats are industry-standard and HIPAA-compliant. Regardless of entry source (paper or electronic) or provider type (network or out-of-network), all claims pass through the same edits and adjudication processes.

Our claims processing system — from claims intake through payment — includes controls that validate and account for all claims submitted. We maintain an image of each electronic claim in our document management system, and real-time access to images facilitates adjudication and research tasks. We quickly capture and adjudicate claims with minimum manual intervention by combining our core claims transaction platform with electronic document imaging, a workflow management system, and electronic claims solutions. This leads to faster, more accurate claims turnaround and provider payment.

Clear Health accepts electronic claims and utilizes electronic transactions, notices, documents, forms, and payments to the greatest extent possible. We encourage and support providers to submit claims electronically because it facilitates accurate, timely, and efficient processing, and we currently receive over 85 percent of claims electronically. Recognizing that providers' technology environments and needs vary, we accept electronic claims from the following:

- Three nationally recognized EDI clearinghouses: Change Healthcare (formerly known as Emdeon), Availity, and Smart Data Solutions
- Our secure provider portal (submission of an ASC X12 837 file or entered using direct data entry to the provided claim form)

Clear Health delivers all of its electronic claims submission methods, including clearinghouses, at *no cost* to providers.

1.2. Processing Electronic and Paper Claims

The clearinghouses perform HIPAA-compliant editing and submit 837 files daily to Clear Health. We have an automated process to upload 837 files into the COS for processing. The claims system assigns each claim a unique internal control number to track its progress from initial entry into our system to final adjudication. We maintain an image of each electronic claim in our document management system, and real-time access to images facilitates adjudication and research tasks. The claims process applies HIPAA compliance and initial business rule edits to electronic and paper claims prior to adjudication. We reject claims that fail edits (prior to loading into our adjudication system) and notify the provider of the reason via the ANSI 999 Functional Acknowledgement and ANSI 277 Unsolicited Notification. Rejection notification for claims that were submitted on paper will be provided via letter.

For claims we receive on paper, throughout each day, Document Services batches, scans, and exports the files for data entry throughout each production day. After we perform quality checks, we create 837 claims data files for processing into our claims system. On average, this cycle occurs within 48 hours of receipt, helping us process clean claims in a timely manner.

There are daily exception reports to monitor the loading of claim batches into the COS. Claims are processed daily through a mass adjudication process via an automated job once the claims upload into the COS is completed.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

We currently acknowledge claims receipt according to the Agency's requirements. Claims submitted electronically receive an electronic receipt within 24 hours after the start of the next business day; receipts for paper claims are available through our secure provider website within 15 days of receipt.

Claims that pass EDI edits are loaded to the adjudication system and subject to a series of processes which:

- Apply claims adjudication edits to all claims based on member eligibility, provider status, timely filing, medical necessity, type and quantity of benefits, valid dates of service, pricing, prior authorization, third-party liability, and fraud and abuse detection. Front-end edits are closely aligned with encounter submission requirements to make sure that we have complete and accurate claims data to support the encounters reporting requirements established by the Agency.
- Verify that the provider is not excluded by Medicare or Medicaid. We screen against the federal exclusion databases monthly. If we identify any, we update our MIS and deny those claims.
- Use a series of sophisticated edits to evaluate the claim against processed claims data to identify duplicate claims. We automatically deny claims that are definitively identified as duplicates and pend claims for review when we cannot make a positive determination.
- Apply enhanced clinical and National Correct Coding Initiatives (NCCI) edits to check each claim for codes subject to unbundling or Medically Unlikely Edits for codes on a claim that may be incompatible. We base the criteria on industry standards and internal reimbursement policies.
- Audit claims to validate services across providers, reviewing claim modifiers, provider specialty, and service specific rules regarding frequency.
- Evaluate claims for never-events and provider-preventable and hospital-acquired conditions, reducing or denying payment if indicated.

We process claims that pass automated adjudication edits during the next payment cycle. The system denies claims that fail adjudication edits and notifies the provider of the reason for the denial on the remittance advice (RA). The RA is available both electronically and on paper and identifies the level of payment or denial reason using standard procedures and definitions. The RA also includes instructions on how to file a claims dispute and lists the designated timeframe for doing so.

Our claims processing system uses automated workflows to manage the steps required to auto-adjudicate a claim and maximizes the speed and efficiency of the claims process. A claim moves automatically through the system based on its status at points in the process, minimizing manual work. When manual intervention is required, the workflows automatically route claims to specific work queues and analysts skilled in addressing the specific edit.

We closely monitor the claims process to ensure we are adjudicating and paying claims in a timely manner. There are several checkpoints with service level agreement (SLA) reporting throughout the claims workflow to provide insight into the timeliness of claims processing. On an immediate basis, we receive feedback on EDI claims that have successfully loaded into the COS and can track claim movement from adjudication to payment through reporting and workflow queues.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

**** INNOVATION: Electronic Billing Support for Non-traditional Providers**

Clear Health understands that health care billing can be a challenge for Assisted Living Facilities (ALFs) and other non-traditional providers. As we have built relationships with these providers over the past 14 years, we have listened to their concerns and are working to build a solution that supports ease of billing and timely payment for non-traditional providers such as ALFs, Adult Day Health Care, home modification, and emergency response services. While we currently have a roster billing form for providers to use, we are also building a user-friendly, online claim submission tool where providers will be able to enter required billing details and submit electronically. This billing solution will “remember” previous submission details entered for that tax identification number, thereby streamlining the billing process for providers and will also support billing prior to the first of the month, so that checks can be processed as early as possible each month. **

1.2.1. Claims Payment

Clear Health executes claim payment cycles daily, Monday through Saturday, generating physical checks or initiating Electronic Funds Transfer (EFT) and preparing provider RAs.

Paying providers quickly and efficiently is a priority, and we encourage providers to take advantage of our free EFT program. We give providers several options for receiving RAs:

- View the electronic RA online and print it at their office
- Download a HIPAA-compliant 835 data file to load into their system
- Receive paper RAs by mail

Electronic payments and RAs are available the day of payment, and paper copies (checks or RAs) are mailed within two business days.

1.2.2. Standards for Speed and Accuracy of Processing

Clear Health has a strong track record of consistently meeting and exceeding claims payment timeliness standards. We pay claims accurately and timely and have configured our claims payment system to fully comply with Florida requirements and will make required adjustments to satisfy the Florida SMMC Contract.

Our claims system stores the receipt date for paper and electronic claims and the adjudication date of payment or denial decision, using these dates to monitor and measure timely processing and compliance with State and federal regulations. We also maintain the claims payment and check dates for all processed claims where payment amount is greater than zero.

Since 2014, Simply, (inclusive of Clear Health) has processed almost 20 million claims under our Medicaid Contracts, achieving the following results for clean claims payment:

- 84.8 percent paid within seven days
- 86.7 percent paid within 10 days
- 93.8 percent paid within 20 days

We will continue to improve our performance for claims processing timeframes under the new SMMC Contract.

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GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1.2.3. Resolving Pended Claims

When edits trigger during claims processing, the system pends the claim for manual review. The claims workflow system routes pended claims to specific work queues based on claim tiers that reflect the complexity of the claim. The Claims department aligns Claims Analysts with claim complexity tiers so that specialized analysts with experience handling the specific claim type or pend reason review those pended claims. This alignment helps us deliver timely and accurate payment to providers. Analysts follow specific processing instructions based on the pend code applied to the claim and approve or override the edit. The claim then adjudicates.

To facilitate timely resolution, throughout each day Claims Management monitors claims that pend for additional review related to medical necessity, prior authorization, or other reasons. Daily, weekly, monthly, and ad hoc reports list the number of pended claims by aging category so we can quickly react to any fluctuations in claims submission and volumes. By working pended claims in the order of priority, we pay providers efficiently and achieve processing goals.

1.2.4. Claims Denial Criteria/Protocol

Our MIS gives us the flexibility to configure our claims processing system with Florida SMMC Contract rules and Program benefits, including what to do if a claim fails an edit (pend, pay, or deny). During implementation, we will document and execute claim edit configuration changes based on new Florida SMMC requirements. We configure our claims system with an extensive list of denial reason codes, which provides meaningful information regarding the cause for a claim denial. Some of the common reasons for a claim denial include the following:

- Benefit Denials – such as member not eligible on the date of service, service rendered without required authorization, and benefit limit reached
- Provider Contract Denials – such as claim submitted after timely filing limit, duplicate, service not covered under contract, coordination with other health insurance, and invalid Medicaid ID
- Clinical Denials – such as services not supported by documentation, medical records required, procedure not supported by diagnosis, and NCCI edits to promote national correct coding standards and control improper coding that could result in inappropriate payment
- Program Integrity Denials – such as rendering provider under federal or State investigation

1.2.5. Identifying Claims and Claim Lines that Meet Denial Criteria

During the adjudication process, our claims processing system reviews each claim line against a series of business rules and validations in compliance with federal and Florida SMMC requirements. Each claim line passes through all business rules, so a single claim line could receive multiple denial reasons. After all edits have been applied, the system checks the results and sets the claim and claim line status to pay, deny, or pend as appropriate. Individual claim lines may have a deny status but if other claim lines on that claim pass all edits and are marked to pay, the system marks the overall claim to pay. The system automatically adjusts the claim to pay once the denied claim lines are addressed. We list all applicable denial reasons on the RA so that providers have complete information for any corrections that may be indicated.

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GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1.3. Processing Claims for Non-participating Providers

We are committed to facilitating access to medically appropriate care for our members and assuring the needs of members are met and covered services are provided, even if we are unable to provide the service through our provider network. In the unlikely event a network provider is unavailable, our procedures foster timely access to non-participating providers so that our members can access the full range of services quickly, regardless of network capacity. When an access issue is identified, our Provider Relations Director assigns a representative to negotiate a case contract or letter of agreement, guaranteeing reimbursement of services to out-of-network providers for as long as we are unable to provide the medically necessary covered services within our network. The case contract or letter of agreement will be used as part of the claims process and the provider will be reimbursed accordingly.

When a claim is received from a non-participating provider, we first check to see if the member is within their continuity of care period, and, if so, the system pends the claim for manual processing. A Claims Analyst works with the Provider Relations team to contact the provider and request documentation to support reimbursement at their prior level, creating a corresponding case contract or letter of agreement to facilitate appropriate claims payment. If the provider does not supply the required documentation, the claim will be processed according to the Medicaid fee schedule.

Most services that are provided by a non-participating provider outside of the member's continuity of care period require an authorization, and the system will automatically check to see if one exists. If an authorization is required and none is found, the claims will deny for missing authorization, and the provider will be notified via the RA.

1.4. Cost Avoidance and Third-party Liability

Clear Health's cost avoidance and third-party liability processes currently comply with all State and federal requirements including those specified in Attachment B, Section D, Third Party Resources in the ITN. Our claims processing system fully supports coordination of benefits (COB) functionality, recognizing Medicaid as the payer of last resort.

We emphasize and prefer prospective cost avoidance versus post-pay recovery whenever possible. To maximize cost avoidance, we:

- Accept other health insurance (OHI) leads from a variety of sources, including members, providers, and an external vendor who analyzes our members against data from more than 150 health insurance organizations
- Dedicate employees to daily review and verification of potential OHI and third-party liability leads

When the claim or the member record indicates alternate insurance, our claims processing system automatically evaluates the claim for COB. During adjudication, the claims processing system compares claim service dates to OHI coverage dates. If dates match, the system pends the claim for analyst review. If the claim is eligible for cost avoidance, the analyst coordinates the claim using COB guidelines.

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If an OHI source is identified and the required Explanation of Benefits is not attached to the claim, we deny the claim pending review by the primary payer and return of an explanation of benefits, provided the claim is not subject to pay-and-chase rules, such as EPSDT, Title IV-D, or pregnancy related services. Claims that are subject to pay-and-chase rules will be paid up front. If the Explanation of Benefits is attached, the system pends the claim for review. For services where Clear Health is determined to be secondary, we pay the claim in accordance with State and federal guidelines.

We also analyze paid claim data to retrospectively identify opportunities for COB or third-party liability recoveries. We provide our recovery vendor with a monthly data file of all processed claims to compare to their data repository to identify the appropriate primary carrier.

When overpayments are identified, we follow documented procedures to recover overpayment. We send written notification to the provider of the overpayment, furnishing supporting documentation. We offer providers the option of refunding the overpayment directly to Clear Health or offsetting future payments by the overpayment amount. We note recovery amounts in the claims record, and when new OHI information is identified, it is incorporated into the member record to facilitate COB for future claims.

1.5. Medicare Crossover Claims

For members with our Medicare Advantage Special Needs Plan (SNP), a provider can submit a single claim that will be automatically processed through Medicare, SNP crossover, and Medicaid, regardless of whether the provider submits the claim under the member's Medicare or Medicaid identification numbers, our claims processing system identifies the member as dual eligible and processes the claim first through Medicare. In our claims processing system, each service line on the claim is:

- (1) First adjudicated against Medicare benefits
- (2) Then adjudicated against crossover/SNP Agreement benefits, picking up service lines not covered under Medicare and any cost-sharing amounts for covered service lines
- (3) Finally adjudicated against Medicaid benefits

For members with third-party Medicare, Clear Health accepts the Coordination of Benefits Agreement (COBA) file that includes Medicare adjudicated claim data and automatically processes crossover claims for all our dual eligible members who are not participating in our Medicare Advantage plan — covering the Medicare deductible or coinsurance amount up to the Medicaid maximum fee, less any amounts paid. We fully adjudicate each crossover claim, enabling the provider to document any unpaid portion of the deductible or coinsurance as a bad debt on the Medicare cost reports.

1.6. Provider Training and Outreach

We educate providers on claims submission and billing using multiple strategies, including orientation and ongoing training via webinars, one-on-one training by Provider Network Managers, email bulletins and blast faxes. We give Florida SMMC providers the option to submit claims through the clearinghouses — Change Healthcare (formerly known as Emdeon), Availity,

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

and Smart Data Solutions — with claim submission at no cost using Availity. Availity is a multi-payer portal that enables claims submission to multiple payers through a single sign-on and offers providers many services that include eligibility and benefit inquiries, claims submission, claims status inquiry, and claims appeal submission.

Educating providers on claims submission is not enough; a true partnership involves us proactively outreaching when we see they need help with claims submission. Our Provider Network Managers meet monthly with our providers to answer questions and provide assistance and training on proper billing practices and how to appeal a claim for a denial or other reason, such as payment amount. Our provider education program covers claims submission during orientation and ongoing outreach. In addition to in-person visits, we use a variety of other methods, including newsletters, bulletins, updates, and training resources available on our provider portal blast faxes with important need-to-know information.

We also reach out to providers when our review of denied claims data indicates a potential problem with proper billing procedures. For example, if a provider has a high number of claims denying because of a missing prior authorization, we educate the provider on the list of services that require prior authorization and the methods they can use to submit the request and monitor approval.

2. USE OF METRICS

Clear Health utilizes various tools and reports that allow management to monitor and measure processing performance, identify problem areas, and review quality. Reports list the number of pended claims by aging category and allow us to quickly react to any fluctuations in claims submission and volumes. By working pended claims in order of receipt, we can pay providers efficiently and achieve processing goals.

- Claims Dashboard — Reports key metrics, including claims received, claims paid, percentage of claims submitted electronically, percentage of claims auto-adjudicated, and percentage of claims paid or denied. Health Plan leadership uses this report to monitor claims trends and highlight any areas of concern.
- Claims Activity and Inventory Report — Comprehensive report of various claims metrics, including claims turnaround time, claim denial rates, and claims count by input method. Health plan and Claims Operations leadership use the reports to monitor performance and trends.
- Work Item Aging by Queue — Reports the volume and age of pended claims volume by work queue. Health plan and claims operation leadership review the report daily to resolve pended claims and identify any outliers quickly. The report highlights claims based on regulatory SLAs to target intervention, as needed.
- Claims Audit Report — Monthly reports of claims audit results for payment and financial accuracy. Health plan and Claims Operations leadership analyze data monthly to monitor trends and identify opportunities for claims process improvement.

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GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

2.1. Monitoring Claims Accuracy

Claims adjudication accuracy is vital to our role as stewards of State funds and as true partners to providers, committed to their satisfaction.

We have incorporated several checkpoints throughout the claims workflow process to review claims samples in real time for processing accuracy. These checkpoints include:

- Pre-payment audits of auto-adjudicated claims
- Sampling of Examiner adjudication prior to payment

At each step, claims accuracy is assessed and any issues are identified with the payment amount, the source of the problem (errors with claims data entry, procedural errors, or system issues) is researched for resolution, and the claims are corrected and reprocessed.

We also subject all our Florida SMMC claims to periodic quality audits by our national Claims Quality department to verify timeliness, accuracy, and integrity and to evaluate the financial, payment, and statistical accuracy of our claims processing system. As a result, we have been cited as one of the best financially performing plans in Florida and consistently receive high quality scores.

To measure overall claims accuracy, Claims Quality will conduct an end-to-end audit (from receipt to final disposition) on a random statistically representative sample of Florida SMMC claims each month to verify compliance with all federal, State, internal requirements, and provider contracts. In addition, Claims Quality performs specialized audits across all markets, including the following:

- High-dollar Audits — Daily pre-payment audits of all high-dollar claims with payment amounts over \$30,000, often including denied claims with charges greater than \$75,000
- Individual Focus Audits — Weekly audits on five claims from each claims analyst and daily audits of up to 10 claims during the new-hire training period to confirm processing accuracy
- Focus Audits — Targeted audits on specific claim types, specific scenarios, or surrounding processes to measure performance and remediate claims issues
- Post-implementation Audits — Targeted audits on new contract or program implementations (including our Florida SMMC operations) to help assure accuracy

2.2. Denials Management Program

Clear Health recognizes the vital role timely and accurate claims processing plays in provider satisfaction. We are committed to paying claims timely and accurately, and we manage claim denials and proactively communicate with providers as part of our daily operations. Monitoring and managing claims denials is a crucial part of our duty and commitment to pay provider claims accurately and in compliance with federal, State, and Agency requirements.

Our Florida Operations team operates a denials management program with support from our national Claims department. Together they deliver accurate and timely adjudication, notify providers of the reason for claims denials, and answer and investigate any provider questions.

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Through careful review of denial rates and trends and prompt analysis of any unexpected results, we minimize the occurrence of inappropriate claim denials and minimize any undue administrative burden on our providers.

Claims Operations includes daily monitoring of many claims metrics, including denials.

Via our Denials Management program, our Florida Operations team and Claims department regularly review reports (many available on demand), including these four key reports:

- Top 10 Denial Reasons — lists the top denial reasons, including the denial code, reason, and count of denied claims, and also includes the total number of denied claims for any reason
- Top 10 Providers — lists providers with the highest count of denied claims
- Denial Reason Tracking — organized by reason, shows the number and percentage of denials for a variety of time periods, including month by month, year to date cumulative, and comparisons to prior month and year run rates
- Provider Claims Report — run on demand for a specific provider, shows claim counts by status (paid or denied), denial reason, and average claim turnaround times

Clear Health carefully monitors claim reports and metrics, including denials, focusing on trends and variances (up or down). If we see an outlier in the data, we investigate, drilling down into the details, conducting a root cause analysis (if warranted), and promptly rectifying any processing problems. We always strive to identify and fix any inaccurate processing before providers call or appeal claims. If we do encounter a problem, we implement a fix, identify and reprocess affected claims, and alert Provider Relations so that they can inform providers.

2.3. Identifying and Addressing Deficiencies or Contract Variances

Clear Health has historically maintained an average of 98 percent or greater for payment accuracy and closely monitors our performance against Agency standards to confirm our continued compliance. To monitor and maintain our high claims processing timeliness and accuracy standards, our leadership reviews detailed dashboards of key program metrics to track our performance.

Key metrics include average turnaround time for clean claims, percentage paid within seven, 10, 20, and 90 days of receipt, and claims financial and payment accuracy. Regular and focused visibility into claims processing performance helps us identify and address deficiencies early. In addition to monitoring claims timeliness and accuracy metrics, our national support centers have several mechanisms and processes to identify provider or system issues related to claims, and our Florida-based team adds additional opportunities, resources, and touch points.

Internal audits are conducted by the Audit and Recovery department, and results are reviewed with Claims staff monthly to assess any payment or procedure errors found, their individual accuracy scores, and provide training, when needed.

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Throughout the organization, our staff may identify issues in the following ways:

- Claims Department Management and Analysts — during claims adjudication and monitoring
- Encounters Team — during preparation of encounter file submissions for the Agency and review and analysis of response files
- Claims Quality Department — during routine and focus audits of Florida SMMC claims and claims from affiliate states (which may indicate system-level issues)
- Provider Services call center and EDI Helpdesk — through tracking and trending call topics
- Clear Health Internal Resolution Unit (IRU) — during review of provider claim disputes
- Provider Data Management — through regular quality audits to validate data integrity

The IRU is a key component of our approach to issue resolution. Clear Health staffs an IRU with highly trained and experienced research analysts focused on researching and resolving complex provider claims disputes and appeals. IRU staff determine whether the claim was paid appropriately based on the configuration of the system, including business rules, provider contract, plan benefits, and federal and State regulations.

When we identify a potential provider- or system-level claims issue, we route the information to the appropriate department (such as provider configuration or front-end claims editing) and track it to resolution. Provider education plays a big part in the resolution process.

3. FACILITATING RAPID CYCLE IMPROVEMENTS

Clear Health's Claims Operations and local management analyze claims reports for issues such as possible provider submission problems, system problems, or other areas of improvement. If, for example, we see a high number of claims pending for a specific reason, we will analyze the claims to determine if there is an appropriate intervention such as provider education, verifying authorization rules, or modifying a system edit. A high volume of claims pending or denying for a specific provider will prompt additional review and often results in proactive outreach to the provider by Provider Network Managers.

Pre-adjudication processing is one of the cornerstones of timely and accurate claims processing. Based on specific business rules and regulatory guidelines, the claims pre-processor uses programmed logic to perform automated, adjudication processes. This process has a direct impact on the improvement of the auto-adjudication rate and accuracy. This is a dynamic and scalable process that is continuously audited and enhanced to meet the demands of changing regulatory requirements as well as business needs.

We monitor claims information daily, including timeliness reports, aging reports, denial reasons, audit results, and provider issues to identify opportunities to fine-tune programs and processes and to improve results. Reports help us ensure that we are not only meeting Agency requirements but also paying claims as quickly and accurately as possible. When we identify an opportunity for improvement, we dedicate resources toward implementing change.

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With the roll-out of the new COBA process in 2017, we received an unusually high volume of claims in the process queues and quickly pulled together a cross-functional team to identify the root cause and deploy a short-term production fix. We created separate COBA work queues and production reports while working on the long-term automated solution which, when implemented, quickly moved the auto-adjudication rate from almost 0 percent to 90 percent with 99 percent accuracy.

Our national quality and process improvement department is dedicated to improving operational performance. They conduct extensive audits to establish performance baselines and provide feedback to operational departments. They combine audit data with other data inputs to identify improvement opportunities to increase efficiency and reduce errors. The local Claims Operations team combines this data with their own root cause analysis to explore system capabilities and improve services that we deliver to our network providers. Cross-functional workgroups meet on a regular basis to analyze data associated with the most prevalent causes of provider dissatisfaction, including claim denials, provider disputes, complaints, grievances, and appeals. The information is used to identify the root cause and implement solutions.

Clear Health actively shares best practices across the enterprise so that all our members and providers can benefit from innovation in any of our markets. For example, provider training materials on claims submission are used throughout the State network to help educate providers on timely and accurate claims submission, as well as upcoming regulatory billing changes.

3.1. Best Practices Generate Results

Routine claim audits help us rapidly address deficiencies or variances and prevent provider complaints and appeals. Our frequent monitoring efforts have also helped to avert claims payment errors caused by incorrect coding practices. During a claim audit, a random sample of claims is selected for review and verification. During one such audit, we identified a billing error for a provider who was submitting claims with the incorrect modifier and receiving payment for multiple services when only one had been provided. As a result, additional monitoring has been added to our claim process, which has helped our Plan and our affiliate health plans avoid claims payment errors due to this issue.

**** RESULTS & SUCCESSES:** Focused review also helps to identify potential fraud, waste, and abuse (FWA) cases for further investigation. Our Finance team partners with Claims Operations and the Special Investigations Unit to identify statistical outliers in billing that may be related to cases of FWA. Here are a few examples of FWA cases that were identified during our regular reviews:

- During one financial review for claims expenditures by service type, it was noted that one provider had significantly higher claims payments for that period than all other providers in that sample. Additional research showed that this was not an isolated incident for this provider, and the case was turned over to our internal investigation unit who determined that the cause was fraudulent billing practices. This provider is no longer part of our network.

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- One recent review of billing patterns for NCCI Procedure-to-Procedure (PTP) edits resulted in identifying a provider whose billing patterns stood out from the statistical norm for providers of that type. This provider was billing more than one-third of their claims with a modifier 59 with a total of \$3.5 million paid in a one-year period. As a result, this provider has been terminated and an investigation has been opened by our Special Investigations Unit.
- We also evaluate cost trends and noticed that growth hormones had become a growing cost trend in pharmacy. Further investigation uncovered a physician who had prescribed \$2.6 million of growth hormones to 42 unique members over 2 years. The provider was subsequently terminated, and the case was referred to our Special Investigations Unit for a review of over prescribing. **

4. PROVIDING THE AGENCY WITH ACCESS TO METRICS AND DATA

Clear Health has established claims payment performance metrics, including those for quality, accuracy, and timeliness, and will make documentation of such metrics available for Agency review upon request.

We currently submit an aging claims summary in compliance with the schedule and format specified in the Managed Care Plan Report Guide and will continue to comply with this requirement.

5. PROVIDING NETWORK PROVIDERS WITH ACCESS TO DATA, METRICS, AND TRENDS

As active partners with our providers, Clear Health recognizes that they need actionable information to drive their business performance and we provide them with multiple methods to access claims data and pertinent metrics including the following outward facing tools:

- Our provider portal lets providers quickly and easily check claims status or download a HIPAA-compliant ASC X12N 835 remittance file. By integrating with Availity, our provider portal gives providers access to all of Availity's functionality via single sign-on, including access to check eligibility or download remittance data. The portal also provides a Claim Status Listing tool which allows providers to obtain a list of claims submitted to Clear Health for a specified 30-day period. The listing includes high level submission details including Claim ID and status.
- Our interactive voice response system allows providers 24/7 access to claims status information.
- Our provider help line can also provide claims status and information during regular business hours.

We give providers several options for receiving RAs - view online, download a HIPAA-compliant ASC X12N 835 data file, or receive paper copies by mail. The RA provides detailed status information for each claim including amount paid and multiple denial reason codes, if applicable.

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Clear Health employs contemporary business intelligence technology with our Clear Health Analytics tool, creating near real-time data analytics that we share with providers on a consultative basis. The following are some examples of metrics and trends that can be shared with providers:

- Inpatient authorizations per 1000
- Top specialty referrals
- Medical Loss Ratio (MLR) with main cost drivers such as pharmacy, inpatient, outpatient
- Average cost per encounter
- Average cost per member
- Average cost per visit
- Average visits per member
- Hospital equivalence reports for hospital performance comparison

Provider Network Managers meet regularly with their providers to review the information from our data analytics as well as details from the high claims denial trend report. We share this information with providers to give them details on their claims, including average claim turnaround, paid and denied claims (dollars and count), claim counts by denial reason, and claim counts for other metrics, including input, procedure code, and diagnosis code. This practice provides consultative insights into their business.

6. MANAGING SUBCONTRACTOR CLAIMS

Select benefits and services are delegated to Agency-approved subcontractors representing an extension of Clear Health and the services we deliver to our Florida members. We have an established and proven Subcontractor Oversight Program which we have employed and refined over a 14 year history of serving members under Agency programs. Clear Health sets clear expectations with our subcontractors through our local Vendor Delegation Oversight Group (VDOG) supported by national subcontractor management resources. We focus on providing the best service experience for our members, verifying contractual compliance, and enforcing consequences for non-compliance.

Prior to selection, we conduct a pre-delegation audit to verify each subcontractor's ability to provide the services for which they are contracted. During this audit, the subcontractor must provide evidence of the following:

- HIPAA compliance for systems and security
- Systems' capability to timely and accurately produce Plan and State required reports in correct format
- Systems' capability to capture required data reporting elements to support encounter data submission, required claims report for the Agency as indicated in the Medicaid report guides, required ad hoc claims data for submission to the Agency, OIG, and OAG as required, and required performance metrics as required by Clear Health

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Our subcontracted vendors with claims delegation are required to comply with the statutory claims processing requirements and the requirements of the SMMC Contract. When there is a conflict in the requirements, the more stringent policy prevails. Subcontractors are held to the service level requirements in the SMMC Contract, including timeframes for electronic and paper claims for the following:

- Claims acknowledgement
- Claims payment
- Notice of claims denial

When Clear Health delegates claims payment, we maintain our responsibility for ensuring the function is conducted in compliance with the SMMC Contract. For this reason, we require the following of all our delegated subcontractors:

- We require our subcontractors to submit all claims data in a condensed time frame to allow for review and consolidation with our submission to the state.
- We require our subcontractors to submit monthly encounter data and claims processing performance metrics that demonstrate the subcontractor's compliance with all Plan, State, and federal requirements.

Details for each subcontractor's claims payment processes are provided in the following subsections. Clear Health has delegated claims processing functions to the following subcontractors:

- Beacon Health Options
- Chiro Alliance Corporation
- DentaQuest of Florida, Inc. (DentaQuest)
- DentaQuest of Florida, Inc. D/B/A EyeQuest (EyeQuest)
- Express Scripts, Inc.
- Health Network One, Inc.
- LogistiCare Solutions, LLC (LogistiCare)

6.1. Beacon Health Options

6.1.1. Claims Processing and Payment

Clear Health's behavioral health subcontractor, Beacon Health Options (Beacon) has been paying behavioral health claims for more than 20 years. Beacon processes 22 million behavioral health claims annually and understands the importance of prompt, accurate claims payment.

Beacon's FlexCare360 MIS supports managed behavioral health programs starting with the eligibility process and continuing through claims adjudication and payment. The system maintains benefit structures, provider reimbursement methods, and adjudication rules for each program and is fully integrated with eligibility (including data collected regarding other coverage), provider fee schedules, benefits, timely filing, and authorization requirements.

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Beacon offers web portal capabilities to make administrative requirements more efficient and user-friendly for providers. Through the eServices provider web portal or EDI gateway, providers can upload electronic claims which are then run through the FlexCare360 claims adjudication engine for processing. The eServices and EDI systems are available to providers 24/7. The system supports electronic submission of claim batches in HIPAA-compliant 837P and 837I formats and secure, timely, and accurate payment to providers. When a paper claim is submitted, Beacon will either enter the data directly from the scanned image on the day of receipt, or create an 837 from the paper image submitted to FlexCare360.

6.1.1. Claim Submission

Beacon's FlexCare360 system provides streamlined paper and electronic claim submission for participating and non-participating providers. Regardless of how the claim is submitted, Beacon requires industry standard service codes (revenue codes, CPT codes, HCPCS codes) and ICD-10 diagnosis codes. Claims that are submitted electronically and paper claims that are manually keyed or converted into an electronic format during a scanning process are loaded into the FlexCare360 system and then processed. The system automatically applies edits, including specific benefit requirements for Florida Medicaid claims.

Beacon is committed to helping Florida providers manage their administrative functions more efficiently by making electronic claims submission a viable option for all providers. Beacon accepts HIPAA-compliant 837 formatted files from any provider's software application or third-party vendor. Alternatively, providers without electronic claims software can submit via web-based direct claims submission. The application is easy to use and provides immediate validation results.

6.1.1.1. Electronic Claims

Providers are encouraged to submit all institutional and professional claims electronically. Electronic submission results in fast processing times, high claims approval rates, and fast revenue cycles, while reducing unnecessary administrative time. Electronic claims can be paid in a little as one day. Beacon makes it easy for providers to submit claims electronically, through any of three methods:

- EDI (837 format)
- eServices as primary method or in conjunction with EDI
- Change Healthcare claims clearinghouse

Beacon receives approximately 88 percent of all claims electronically. About 75 percent of Beacon's Florida providers use a clearinghouse, such as Change Healthcare, to submit claims electronically and 25 percent submit 837s directly to Beacon's eServices portal.

6.1.1.2. Paper Claims

While paper submission of claims is not encouraged, providers can submit them manually, using the CMS 1500 or UB-04 claim form. Beginning in Q1 2018, Beacon is consolidating and streamlining paper claims by outsourcing to a preferred vendor, Fidelity Information Services Inc. (FIS). By collaborating with FIS, an industry leading organization headquartered in Jacksonville, Florida, Beacon enhances the consistency, quality, and timeliness of paper claims. FIS will

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manage the intake of all claims and correspondence received through a variety of channels, including paper mail, email, and faxed documents, as well as images submitted through online member portals. All paper claims will be received and scanned by FIS. FIS generates an 837 and sends it to Beacon's FlexCare360 system for adjudication. This enables Beacon to receive and enter all incoming paper claims via a single, standardized process, improving turnaround time and efficiency.

6.1.2. Use of Metrics

Clear Health has established benchmarks for our behavioral health subcontractor, Beacon, for all delegated areas, including SLAs related to claims payment. These include the following:

- Electronic claims must be paid or denied/contested within 15 calendar days after the receipt. Notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.
- Non-electronic claims must be paid or denied/contested within 20 calendar days after the receipt. Notification to the provider of a contested claim shall include an itemized list of additional information or documents necessary to process the claim.
- 50 percent of all clean claims must be submitted within seven calendar days. 70 percent of all clean claims must be submitted within 10 calendar days. 90 percent of all clean claims must be submitted within 20 calendar days.

These metrics are used to assure that all Beacon staff are aware of the benchmarks and targets. Each Claims Processor is measured for productivity and accuracy. Beacon reviews three to 10 percent statistically random samples of all claims processed after payment and reports these results to Clear Health each month. All claims errors identified are returned to the originating examiner for correction. Each Claims Processor is expected to maintain a 98 percent mechanical accuracy rate and a 99 percent financial accuracy rate.

6.1.3. Facilitating Rapid Cycle Improvements

Clear Health's subcontractor Beacon uses an accountable, data-supported continuous quality improvement (CQI) process to refine and improve claims processing across the organization. Beacon delineates thresholds and benchmarks, identifies responsible parties who are accountable to monitor and promote the change process, implements corrective action plans and monitoring procedures, and acts on the results of those plans. Through data collection, measurement, and analysis, aspects of claims processing that demonstrate opportunities for improvement are identified and prioritized for quality improvement activities.

Beacon's claims processing quality review is an integral part of the claims adjudication process. Beacon has both internal and external audit processes in place. Staff performs daily internal audits on claims using an auditing process that mirrors an external audit. There are multiple levels of audits conducted that focus on the financial outcome of the claim and on policies and workflows used in the adjudication process.

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Claims are audited both pre- and post-payment to evaluate the abilities of Claim Processors to consistently meet individual and departmental goals. Each claim audit reviews 41 elements to check mechanical and financial accuracy, such as:

- The correct authorization was used
- The correct provider record is selected for adjudication
- The benefits have been applied correctly
- The correct procedure codes have been entered
- The dates of service match the bill lines on the claim image
- The appropriate fee schedule or rate was applied
- The claim received date meets timeliness provisions
- The diagnosis is valid and payable based on client's benefit structure
- The place and type of service is accurate
- Checking claims history to ensure that the claim is not a duplicate
- Confirming eligibility against the dates of service on the claim
- Determining if coordination of benefits applies
- Confirming the number of units against the claim image

Beacon's claims quality assurance process includes daily internal claims audits, as well as independent external audits. All audited claims are entered into an audit database specifically designed to allow flexible reporting. The results of these audits are used by the entire claims management team to ensure processes and procedures are working effectively. This information is used to continually improve the claims adjudication process and validate the accuracy of business rules contained in Beacon's information system. Claims Supervisors can also run real-time reports at the Claim Processor and client level to ensure claims are processed appropriately, to identify retraining needs, and for performance evaluation purposes. The claims management team meets with the individual Claim Processor monthly to review the audit results for the previous month. Monthly trending of audit errors is also completed to identify problems and implement continuous improvement. Additional trending is completed to identify any outlier providers requiring further review for potential fraud and abuse.

Beginning Q1 2018, Beacon is streamlining quality review functions through an independent audit team. Claims will be audited by Beacon's Corporate Claims Quality Improvement Program. This program is an effective tool in evaluating the abilities of the Claims Processor to achieve the goal of assuring that accurate and efficient application of the appropriate policy and procedures are used. This includes the review of all high dollar claims before payment.

6.1.4. Providing the Agency with Access to Metrics and Data

Beacon submits encounter data and monthly reports with detailed timeliness and accuracy metrics to Clear Health, who then aggregates this information with other claims data to produce all Agency required reports.

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6.1.5. Providing Network Providers with Access to Metrics and Trend Data

Beacon's eServices web provider portal allows authorized administrators and users to view aggregate claims information for their entire provider practice or organization. The Claims Approval with Denial Report displays a table chart and pie charts, showing the number and percentage of claims approved along with claim denials by reason. The report includes an option to calculate totals by member and provides additional details for each denial code when the user moves the cursor over the code in the table. If the provider is contracted with Beacon to serve more than one health plan, results for each health plan are displayed separately. Users can also print this report.

Beacon Managers of Provider Partnerships (MPPs) also work closely with providers across multiple outreach channels to provide assistance and build highly collaborative relationships and drive performance improvement through education and data review. MPPs serve as a hybrid position encompassing clinical, quality, and provider supports as a single point of contact. The MPP serves as a "concierge" for high-volume providers by providing timely resolution of provider concerns, presentation of data identifying provider performance over time, and identification of strategic plans to address performance improvement. Today, Beacon employs four MPPs across Florida (positioned regionally) who are focused on assuring full engagement with 80 of its major network providers throughout the state.

Beacon shares practice level information from the provider profiler quarterly to high-volume practices. Beacon's MPPs typically hold meetings in person. These meetings focus on the interpretation of quality reports and collaborative technical assistance intended to assist practices in reducing variation in practice patterns and improving the quality of care.

Beacon's MPPs share more than 20 metrics with providers, which are benchmarked against like providers in the state. Utilization management metrics for inpatient and higher Levels of Care include readmission rates, the length of stay by the hospital, the length of stay by the attending provider, quality of care and service issues, admissions to each facility, and admissions to lower levels of care, such as step downs.

Beacon also evaluates those outpatient providers with high no-show rates and those providers with members who only attend one post-discharge visit with no follow-up. This information is reviewed facility by facility. For high-volume facilities, this information is shared with the facility by using a blinded comparison to other facilities, with instances of unusual patterns of utilization discussed. Information on members is also tracked, such as high-dollar claims, readmissions, and diagnosis; review of these items allows Beacon to offer intensive case management services when it is needed. For outpatient care, metrics include the length of stay; members seeing multiple providers; providers seeing multiple family members; providers and their rate of admission to higher Levels of Care; and quality of care and quality of service.

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6.2. Chiro Alliance Corporation

6.2.1. Claims Processing and Payment

Clear Health's chiropractic subcontractor, Chiro Alliance Corporation (CAC), accepts provider claims submitted by paper or electronically. All paper claims and correspondence are scanned and stored with the document's received date. CAC auto-adjudicates any claims where additional review is not necessary and engages its third-party administrator, ClaimsXpress, to review and process any claims that are not system adjudicated. CAC processes payments daily, with checks and EFT's generated based upon received date, and payments issued in compliance with regulatory guidelines.

6.2.2. Use of Metrics

Claims Managers review a daily aging report to make sure that issues are addressed and claims are processed according to required timelines. A monthly version of the report tracks and trends the timeliness of claims processing and payment. In 2017, to improve accuracy of claims processing, CAC implemented a daily claims pre-pay audit and conducted monthly audits to verify the quality and accuracy of their claims processing efforts.

6.2.3. Facilitating Rapid Cycle Improvements

CAC uses the daily and monthly metrics to identify issues that need to be addressed and conducts a root cause analysis to determine the changes that are needed. We monitor claims information daily including timeliness reports, aging reports, denial reasons, and provider issues to identify opportunities to improve results. Implementation from identified continuous improvement opportunities is mutually agreed upon with the plan to meet Agency requirements.

6.2.4. Providing the Agency with Access to Metrics and Data

CAC submits encounter data and monthly reports with detailed timeliness and accuracy metrics to Clear Health, who then aggregates this information with other claims data to produce all Agency required reports.

6.2.5. Providing Network Providers with Access to Metrics and Trend Data

CAC has a toll free provider help line that can provide claims status and information.

6.3. DentaQuest

6.3.1. Claims Processing and Payment

Clear Health's dental services subcontractor, DentaQuest, allows providers to submit dental claims using three methods: paper (mail or fax), electronically via electronic data interchange (EDI), or using the DentaQuest web portal. Providers can submit EDI claims using a clearinghouse or as a direct Trading Partner with DentaQuest submitting X12 837D claim files via either a direct SFTP connection or using DentaQuest's Trading Partner Portal (TPP). Providers can also enter claims directly using DentaQuest's web portal.

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DentaQuest's system automatically auto-adjudicates clean claims and authorizations that are submitted electronically and provides claim status determination and payment amounts online the following business day. Once a week, DentaQuest processes payment for claims adjudicated as of 5 p.m. that day, and their customer service agents are able to provide data on these real-time events immediately.

6.3.2. Use of Metrics

DentaQuest tracks claim processing timeliness and accuracy through multiple reporting mechanisms. DentaQuest utilizes a "first-in-first-out" prioritization of claims in queue and reviews age of claims queue reports daily to ensure the system functionality is effectively prioritizing claims in queue. DentaQuest also reviews turnaround time reports at a minimum on a monthly basis, with claims audits performed by the Quality Assurance team to ensure processing accuracy.

6.3.3. Facilitating Rapid Cycle Improvements

DentaQuest uses aging reports and audit results to identify problems and determine root cause. When claims are determined to be processed outside of SLAs, DentaQuest reviews claim processing details to determine root cause and implements an action plan to prevent future occurrences.

6.3.4. Providing the Agency with Access to Metrics and Data

DentaQuest submits encounter data and monthly reports with detailed timeliness and accuracy metrics to Clear Health, who then aggregates this information with other claims data to produce all Agency required reports.

6.3.5. Providing Network Providers with Access to Metrics and Trend Data

DentaQuest provides the following tools to facilitate provider access to metrics and trend data:

- DentaQuest's provider portal lets providers quickly and easily check claims status.
- DentaQuest's interactive voice response system allows providers 24/7/365 access to claims status
- DentaQuest's Provider Services call center can also provide claims status and information during regular business hours.

Currently, they do monthly reporting of claims and payment data. Upon completion of auditing, audit results are entered into DentaQuest's claims auditing system, and field and payment error counts are regularly reviewed to verify the quality of claims and payments processed. Defined error trends are identified and brought to the attention of the Quality Assurance and Claims Payment management staff members.

DentaQuest's Audit Department will compile monthly tracking and trending report, inclusive of claims payment accuracy percentage. These reports are used to identify any salient trends that might need addressing or a Corrective Action Plan. The monthly report details dollar and procedural accuracy rates, overall accuracy rate and claims payment accuracy. Among other

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attributes, each audited claim in the monthly report will be reviewed for correct claim data entry, proper authorization, member eligibility on the processing date, application of proper benefit limits, non-existing duplicate payment, appropriate denial, correct application of modifier codes, and the proper review of other insurance.

6.4. EyeQuest

Clear Health's vision services subcontractor, EyeQuest, employs a HIPAA-compliant claims processing system designed to meet the processing needs of its vision clients. This flexible, parameter-driven system has an open architecture to accommodate the full spectrum of vision care plan designs and benefit levels as well as multiple line items for each claim.

6.4.1. Claims Processing and Payment

EyeQuest paid more than 99 percent of its claims in the past year within 30 days. Its claims system permits real-time access to utilization data for client reporting and clinical quality improvement and has no clinical processing limitations.

EyeQuest has experience using HIPAA-compliant health information exchanges that are related to delivery of care and payment/processing of claims, including the following:

- Inbound 837 Claims: EyeQuest accepts electronic claims submissions through EDI transactions uploaded to their secure Trading Partner Portal. Files are run through a HIPAA translator and claims are directed into its claim processing system, or, when syntax errors occur, are rejected on the 999 response transaction.
- Outbound 837 Claims: EyeQuest sends Clear Health 837P encounter files with claims paid the previous week.
- 834 Eligibility: EyeQuest processes electronic eligibility data via partial daily files and full monthly update files provided by Clear Health.

6.4.2. Use of Metrics

EyeQuest tracks claim processing timeliness and accuracy through multiple reporting mechanisms. EyeQuest utilizes a "first-in-first-out" prioritization of claims in queue. Additionally, age of claims and queue reports are reviewed daily to verify the system functionality is effectively prioritizing claims in queue. Turnaround time reporting is reviewed at a minimum monthly. Claims are audited by EyeQuest's Quality Assurance team to assure processing accuracy.

6.4.3. Facilitating Rapid Cycle Improvements

EyeQuest uses aging reports and audit results to identify problems and determine root cause. When claims are determined to be processed outside of SLAs, EyeQuest reviews claim processing details to determine root cause and implements an action plan to prevent future occurrences.

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6.4.4. Providing the Agency with Access to Metrics and Data

EyeQuest submits encounter data and monthly reports with detailed timeliness and accuracy metrics to Clear Health, who then aggregates this information with other claims data to produce all Agency required reports.

6.4.5. Providing Network Providers with Access to Metrics and Trend Data

EyeQuest provides the following tools to facilitate provider access to metrics and trend data:

- EyeQuest's provider portal lets providers quickly and easily check claims status.
- EyeQuest's interactive voice response system allows providers 24/7/365 access to claims status
- EyeQuest's Provider Services call center can also provide claims status and information during regular business hours.

Currently, they do monthly reporting of claims and payment data. Upon completion of auditing, audit results are entered into EyeQuest's claims auditing system, and field and payment error counts are regularly reviewed to verify the quality of claims and payments processed. Defined error trends are identified and brought to the attention of the Quality Assurance and Claims Payment management staff members.

EyeQuest's Audit Department will compile monthly tracking and trending report, inclusive of claims payment accuracy percentage. These are the reports that we use in conjunction with the client to identify any salient trends that might need addressing or a Corrective Action Plan. The monthly report to the client details dollar and procedural accuracy rates, overall accuracy rate and claims payment accuracy. Among other attributes, each audited claim in the monthly report will be reviewed for correct claim data entry, proper authorization, member eligibility on the processing date, application of proper benefit limits, non-existing duplicate payment, appropriate denial, correct application of modifier codes, and the proper review of other insurance.

6.5. Express Scripts, Inc.

Our partner, Express Scripts, Inc.'s (ESI's) single, integrated claims processing system provides consistent access to patient information for its retail pharmacy network and for our specialty and home delivery pharmacies.

6.5.1. Claims Processing and Payment

ESI requires 100 percent of the retail pharmacies in its network to submit claims electronically through our system. Of the claims received, 99.9 percent are processed electronically at the point of sale. The system allows participating pharmacies to submit claims to ESI 24/7. ESI claims processing system adjudicates a claim, performing all edits and related functions (including eligibility, patient cost share, accumulators, and drug utilization review), and transmits a response back to the pharmacy, detailing claim acceptance or rejection in less than two seconds.

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Electronic claims adjudication includes the steps outlined below:

- For retail prescriptions, the member submits a pharmacy benefit ID card and prescription. Network pharmacies use a switching company or have direct connection to our claims adjudication system. For home delivery prescriptions, the member submits the prescription to the ESI Pharmacy.
- The pharmacist submits the required information to ESI. Depending on FL SMMC's plan design, other fields may be required with claim submission. Our claims adjudication system verifies that the person is eligible for pharmacy benefit coverage and then applies benefit design and concurrent drug utilization review (DUR) edits to the claim.
- ESI's claims adjudication system checks the current prescription against the member's claim history to identify possible clinical concerns. Checks for state or federal-mandated dispensing requirements are also completed. Member claim histories include all claims processed through ESI and may include any claims history records that were integrated into their system from a prior pharmacy benefit manager. Information for each new claim is added to the member's online pharmacy claims history.
- Calculated benefit information is returned to the pharmacist, including information on the applicable copayment, deductible due from the member, and clinical messaging. If the claim rejects, ESI's system provides the pharmacy with the appropriate National Council for Prescription Drug Programs (NCPDP) error code and the rejection reason. This information is available online for review.
- For retail prescriptions, the retail pharmacist collects appropriate payment from the member, as determined by the online message from ESI, and dispenses the drug to the member along with a receipt. For home delivery prescriptions, the payment is deducted from the member's credit card or debit card. If the member has mailed in the payment, they verify the correct payment has been included with the prescription order. The prescription is then mailed to the member along with a receipt.

6.5.1.1. Paper Claims Processing

When necessary, such as when a member uses an out-of-network pharmacy, the pharmacy can submit a direct reimbursement claim form to ESI to get reimbursement.

The paper claim adjudication process begins when claims are received, imaged, and stamped with the date received, sorted, and batched at our claims processing facility. The process concludes with the pharmacy receiving reimbursement.

A step-by-step description of the paper claims adjudication process is detailed below:

- Pharmacy submits paper claims to ESI using the Prescription Drug Reimbursement form.
- The mail room dates, sorts, and prepares claims for the scanning process.
- Claims are scanned and assigned a document control number.

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- Data entry operators key each claim into ESI's claims processing system.
- The claims processing system verifies the member's eligibility and reviews the claim against all applicable edits.
- If the claim passes all applicable edits, a check and explanation of payment (EOP) are mailed.

6.5.1.2. Claims Pending Process

ESI does not pend retail point-of-service claims — claims are either approved or rejected. The claim is adjudicated subsequent to data entry and is either paid or rejected. If the claim is rejected for missing information, the member can return the rejection notice with the missing information for reconsideration.

6.5.1.3. Claims Data Retention for Medicaid

ESI complies with contractual obligations and all applicable state guidelines and policies relative to claims data retention. They retain all claims data records relating to Medicaid services for the current contract period and up to 10 prior contract periods. If, for any reason, the Medicaid contract is terminated, the claims data will continue to be retained for its applicable retention requirement.

6.5.2. Use of Metrics

ESI uses detailed metrics to track the timeliness and accuracy of the claims processing and payment process. To track claims financial accuracy, ESI uses the following metrics - (i) the dollar value of claims adjudicated and paid accurately by ESI in a contract year, divided by (ii) the total dollar value of claims adjudicated and paid during the measurement period. Claims financial accuracy is defined as the absolute dollar value of any inaccuracy relating to the processing of the claim that resulted in an incorrect charge to the client or the patient. In other words, this measures the dollar value of correctly adjudicated and paid claims over the total dollar value of claims paid during the measurement period. ESI financial accuracy in 2016 was 99.9 percent. Metrics for paper claims financial accuracy include the percentage of claims audited that reimburse the member accurately. In other words, the right member receives the right reimbursement amount at the right address, which is based on an audit conducted by the ESI Quality team. In 2016, the financial accuracy was 97.67 percent.

Claims timeliness is tracked through ESI's integrated claims processing system, which adjudicates mail and retail claims, performing all edits and related functions (including eligibility, patient cost share, accumulators, and drug utilization review), and transmits a response back to the pharmacy, detailing claim acceptance or rejection in less than two seconds. Claims accuracy is defined as any inaccuracy relating to the processing of the claim that resulted in an incorrect charge to the client or the patient. The metrics used to track non-financial accuracy include (i) 100 percent minus the (ii) number of claims with non-financial errors divided by the number of claims audited.

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To support accurate and timely processing of claims, we carefully load and test program information, including eligibility data, benefit parameters, network information, and discount rates. For member-submitted (paper) claims, we employ a dedicated Quality Control team to monitor and report on turnaround time adherence. All metrics reporting, as well as our entire manual claims operations, are subject to annual independent internal audits and Medicare compliance audits. In accordance with CMS requirements, ESI processes member-submitted claims within 14 calendar days.

6.5.3. Facilitating Rapid Cycle Improvements

ESI regularly monitors performance against the metrics described above and has processes in place to rapidly address any shortfalls against those metrics. Leveraging performance testing, ESI proactively identifies bottlenecks in the system, supports performance tuning, determines compliance with performance goals and requirements, and collects performance-related data and metrics. Testing assures response time, throughput, and user satisfaction metrics are met. After test execution, ESI shares detailed analysis and reporting with various internal teams to support operational improvements to facilitate achieving the desired results.

ESI tests applications using simulated workload and records the behavior of the application throughout the test at varying load levels. Post-test status reports may include:

- Number of concurrent users executed
- Average transaction response time under varying load levels
- Average transaction response time over the duration of the test
- Total number of transactions per second
- System resource utilization as available
- Throughput in bytes per second
- Hits per second
- Errors
- Any additional performance indicators, depending on project requirements

ESI thoroughly tests all aspects of Clear Health's pharmacy benefit, validating claims prior to the effective date and after the benefit is built in the system to ensure that benefits and claims adjudicate appropriately and as expected on the effective date. ESI tests targeted scenarios, positive and negative scenarios, and uses risk-based methodology when needed.

6.5.4. Providing the Agency with Access to Metrics and Data

ESI submits encounter data and monthly reports with detailed timeliness and accuracy metrics to Clear Health, who then aggregates this information with other claims data to produce all Agency required reports.

6.5.5. Providing Network Providers with Access to Metrics and Trend Data

ESI provides network providers with online access to individualized and comprehensive performance metrics and trend data. Additionally, ESI generates Pharmacy Scorecards to monitor compliance with retail pharmacy performance standards and to profile pharmacies against their GeoCompetitors. ESI also leverages the scorecards as a means to identify pharmacies that need educational guidance. When indicated by the Pharmacy Scorecards, ESI's Supply Chain

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leadership meets and collaborates with senior network provider leadership (at either a national or regional level) to develop action plans designed to ensure pharmacy networks perform at the highest levels. Items discussed during these meetings may include:

- Actionable, pharmacy-level metrics to drive performance, including comparisons with geographic or meta-area competitors, average among peer group of pharmacies, and overall network average
- Brand, generic, and multisource brand dispensing rates and generic efficiency rates among GeoCompetitors
- Total claims and total claims growth
- Vaccine claims volume versus total vaccine claims
- Compound volume
- Present type of pharmacy support, such as calls and the online Pharmacist Resource Center

6.6. Health Network One, Inc.

6.6.1. Claims Processing and Payment

Health Network One, Inc. (HN1) utilizes a claims application called GDSClaimsNet (Global Delivery System). GDS is a proprietary system created by HN1's IT department to support the various specialty networks and health plans for which it administers claims. The GDS claims system utilizes custom claims edits specific to specialty network and health plan guidelines. Additionally, it purchases code sets from Optum/Ingenix, which are received and processed quarterly. It also monitors communications from CMS and downloads directly from the CMS website any relevant data updates that are made available. These CMS edits contain items addressing unbundling, NCCI, fee schedules, etc. On an annual basis, the network reviews the covered procedure codes for each specialty network and makes modifications to the list of covered procedure codes based on CMS and Medicaid guidelines. In addition, the Specialty Network, Compliance, and Claims departments review the CMS and Agency provider bulletin notifications that are sent throughout the year. Any necessary modifications are submitted to HN1's IT department for system update.

The GDS system applies a three-step automated process to all claims: (1) pre-processing, (2) adjudication, and (3) pricing. Each step of the claims process interacts with set programmed criteria that validate data and apply business rules. Any item that fails the programmed criteria is flagged for a claims examiner to review. Clear Health sends the delegated membership to the specialty network monthly via FTP file transfer. The HN1 IT department downloads the eligibility files and processes the information into the eligibility module of GDS where it is used by the UM and Claims departments to support daily operations and claims processing.

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We send benefit information (copayments, plan codes, covered services) to HN1 where it is reviewed and then forwarded to the IT department to be loaded into the GDS system. As part of the pre-processing and adjudication steps of the claims process, the system validates the member information submitted on the claim against the membership data received from Clear Health and loaded to GDS, confirming eligibility and using benefit plan data to verify covered services and application of any copayments.

The HN1 UM team also enters and creates referrals/authorizations for delegated members and contracted providers in their module under GDS. This module directly interacts with the claims system upon adjudication so that network rules pertaining to the use of referrals and authorizations are incorporated in to the adjudication logic.

The HN1 Specialty Network executes contracts between the providers and the network. These contracts are then keyed in to the GDS Provider Administration module. The Provider Administration module contains provider demographics, ID numbers, and contractual payment terms. During all three steps of the claims process — pre-processing, adjudication, and pricing — the GDS Claims module interacts with the data loaded in GDS Provider Administration. Pre-processing identifies the provider information submitted on the claim and validates that information against what is loaded in GDS Provider Administration; adjudication verifies provider eligibility; pricing calculates claims payment based on the contractual payment term loaded in GDS Provider Administration. Any discrepancy will result in a claims edit to be further reviewed by the claims examiner. The Provider Administration module includes a data element that stores the relationship of the provider to the specialty network. This data element is included in the interaction between the Claims module and the Provider Administration module and allows for business rules/edits to be written by network.

Providers have the ability of sending their claims in one of three different ways:

- Traditional paper CMS 1500 or UB04 claims
- Through a clearinghouse via and 837P or 837I file
- Data entry of their claims directly into the HN1 web-portal

Providers also have the option of one of three payment methodologies:

- Traditional paper check
- EFT (electronic funds transfer)
- Credit card payment

6.6.2. Use of Metrics

HN1's system uses Microsoft SQL Server — all data fields and elements are available to suit a wide array of reporting requirements. As such, it is able to tailor its reporting functions to meet the needs of Clear Health and any client-specific reporting requirements. HN1 currently provides us with a wide variety of proprietary reports that we utilize to monitor HN1 as a delegated subcontractor. However, in addition to any reports we require, HN1 has developed internal reporting that is used as a mechanism for monitoring turnaround times, inventory, and trending. These reports are produced on a routine basis by the management teams to verify that claims are meeting requirements.

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HN1's Claims department has a formal internal individual claims quality program, whereby a random three percent sample of all claims processed is subjected to internal audit. The Specialty Network designees also routinely review claim runs for their associated specialty networks, and the health plans conduct annual audits of their delegation. The combination of these three reviews allows for the accuracy of claims processing to occur.

6.6.3. Facilitating Rapid Cycle Improvements

All reporting that occurs in HN1's claims department is shared throughout the organization. The specialty network designees are included in the distribution of the specific health plan reports. In addition, the internal reporting is reviewed during internal specialty network operations meetings. The health plan committee meetings also promote the review of the metrics for their specific plan and delegation. These reviews and sharing of reporting metrics allows for all parties to work collectively in addressing any need for facilitating rapid cycle improvements.

6.6.4. Providing the Agency with Access to Metrics and Data

HN1 provides claims encounter data to Clear Health on a scheduled basis and in accordance to Agency requirements. We incorporate this data in encounter data and regulatory reports submitted to the Agency.

6.6.5. Providing Network Providers with Access to Metrics and Trend Data

HN1 provides real-time access via its provider web portal to all contracted providers. The HN1 provider web portal is available 24 hours a day, 365 days a year and allows providers to view all of their submitted claims, print an EOP, submit new claims, and request referrals.

6.7. LogistiCare

6.7.1. Claims Processing and Payment

Clear Health's transportation subcontractor, LogistiCare, provides non-emergency transportation coordination and pays claims for transportation services provided to our members. Transportation providers submit driver's logs with their invoices to LogistiCare on a weekly basis. To verify correct billing, LogistiCare's Billing department compares the invoice with the information in the LogistiCAD (LCAD) reservation system. Verification includes the following trip details:

- Member who received service
- Transportation service provider
- Driver information
- Vehicle information
- Drop off time
- Pick up time
- Wait time
- Mileage

Each provider is paid weekly, based on invoice date, by check or EFT in accordance with their contract with LogistiCare.

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6.7.2. Use of Metrics

LogistiCare has several system controls in place to manage the payment process along with additional back-end controls or reports used to manage accuracy or timeliness. The system will process a payment based on the lowest payment between the billed amount from the Provider and the calculated amount in the LCAD system which is generated from the base rate and mileage of the trip's level of service and distance based off Google Maps. This controls the risk of overpayments.

Prior to payment, the Claims team will review all trips that had an override or payment above the calculated system rate to confirm proper approval was obtained to help maintain payment accuracy. Rates being used in LCAD to calculate the trip have been reviewed and signed off by the General Manager of the Operation, Senior Vice President of the Division, and the Chief Administrative Officer of LogistiCare prior to being included in LCAD. This provides control over rate accuracy. On a monthly basis, we also review the timeliness of payments through a Prompt Payment report to validate LogistiCare is meeting the requirements of the contract.

6.7.3. Facilitating Rapid Cycle Improvements

If the details on the Prompt Payment report show that LogistiCare is outside the requirements for timely payment of claims, they perform a root cause analysis and make processes adjustments to bring timeliness into compliance. LogistiCare also runs reports to review trip trend data. If variances are noted, the process is reviewed and adjustments are made to eliminate the issues. Prior to all payment submissions, the Claims Department will review trips for overrides or any trips exceeding a large dollar amount. If there are any discrepancies, Claims will work with Operations to confirm the issue or adjust the process for future periods.

6.7.4. Providing the Agency with Access to Metrics and Data

LogistiCare submits encounter data and monthly reports with detailed timeliness and accuracy metrics to Clear Health, who then aggregates this information with other claims data to produce all Agency required reports.

6.7.5. Providing Network Providers with Access to Metrics and Trend Data

Providers have access to LogistiCare's Transportation Providers' portal where they can check payment status for trips logs that have been submitted. The portal includes details on payment amount and expected payment date. Providers can also call the dedicated customer service number where they request claims status information.

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Evaluation Criteria:

1. The extent to which the respondent has described key components of its claims processing and payment process in a format suitable for the public, including a description of the processes for claims submitted both on paper and electronically.
2. The extent to which the respondent has included detailed metrics to be employed by the respondent to track timeliness and accuracy of the claims processing and payment process.
3. The extent to which the respondent has included a detailed description of how metrics from the claims processing and payment process will be used throughout its organization to provide for rapid cycle improvement.
4. The extent to which the respondent has included a detailed description of its process to make data and metrics regarding the claims processing and payment process available to the Agency and that the described process provides sufficient opportunity for the Agency to access this data.
5. The extent to which the respondent has included a detailed description of its process to make data and metrics and trend data regarding claims processing and payment process available to network providers on a real-time basis and that the described process provides sufficient opportunities for network providers to access this data.
6. The extent to which the respondent has included its applicable proposed subcontractors in its response, with each component addressed for each applicable proposed subcontractor.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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E. DELIVERY SYSTEM COORDINATION

SRC# 18 – Utilization Management (Statewide):

The respondent shall describe the following related to its utilization management (UM) approach:

- a. A description of the process used to determine whether a service should be prior authorized and that the UM criteria for each service have been evaluated to determine their appropriateness for administering a Medicaid benefit.
- b. A description of how the respondent will ensure consistent application of the review criteria for authorization decisions.
- c. A description of how the respondent will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope.
- d. A description of the approach used to determine whether a service will be needed short-term vs. long-term (i.e., maintenance therapy) for an enrollee, specifically highlighting any differences in the respondent's service authorization approach (if any exists) based on the length of time that the service will be needed.
- e. To the extent that a service is needed long-term, a description of the strategies that the respondent utilizes to ensure continuity of care and safeguards that are in place to reduce gaps in authorization.
- f. A description and example of how the respondent will detect, monitor and evaluate under-utilization, over-utilization and inappropriate utilization as well as processes to identify and address opportunities for improvement.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Clear Health's utilization management (UM) program is built by focusing on the special needs and considerations of HIV/AIDS patients and facilitates the delivery of the right care, at the right time, in the right place. We design and administer our UM programs by focusing on the goals of improving outcomes for our enrollees (members) and serving as an effective steward of state resources. Our UM team closely collaborates with our members' providers and other departments, including disease management (DM), case management, and pharmacy, to meet our members' social, physical, and behavioral health (BH) care needs in an integrated and holistic way.

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Our UM program is guided by a written UM Program Description, as well as state-specific and nationally recognized medical policy and clinical guidelines. The program features a local perspective based on more than 14 years of experience serving Florida's Medicaid population. We deeply understand our members' unique needs and the capacity of the local delivery system to care for patients with HIV/AIDS. We deliver UM processes and an overall UM approach dedicated to meeting the health care needs of our special population.

Our UM process and overall UM approach helps the Agency meet its goals related to the provision of medically necessary services in a timely manner and in the most appropriate setting, reducing unnecessary ancillary services and potentially preventable admissions, readmissions, and ED visits. It:

- Leverages national resources, best practices, and data analytics, while maintaining a flexible, local approach to establishing UM criteria and services requiring prior authorization
- Prioritizes and acts on both formal and informal provider input to reduce burdensome or unnecessary prior authorization criteria and remove barriers to care
- Supplements our annual inter-rater reliability (IRR) audits with frequent, comprehensive reviews to assure consistent application of review criteria
- Systematically captures and reports over- and under-utilization data to identify opportunities for improvement and works collaboratively with providers to improve delivery of the right care, in the right place, at the right time
- Generates ad hoc reports to drill down on issues and develop tailored interventions to continuously improve the effectiveness of care
- Handles authorizations for short- and long-term authorizations differently to prevent gaps in the treatment plan
- Is always innovating with new programs, policies, and initiatives, such as our Transitions of Care (TOC) program, weekly outlier process, Highly Active Antiretroviral Therapy (HAART) initiative, and CD4 Project

Clear Health delegates UM for BH services to Beacon Health Options, therapy services to Health Network One, Inc. (HN1), dental services to DentaQuest, optometry/ophthalmology to eyeQuest, radiology and genetic testing to AIM Specialty Health, and audiology/hearing services to HearUSA. These delegates and their delegated functions are extensions of Clear Health and are held to the same rigorous standards as noted above.

1. SERVICES REQUIRING PRIOR AUTHORIZATION

First and foremost, our prior authorization policies and procedures comply with Agency-specific requirements as set forth in Attachment B, Scope of Services, Section VI.G. (and related MMA and Specialty Plan requirements). We are continuously evaluating new opportunities to reduce administrative burdens and eliminate barriers to medically necessary physical and BH services, while at the same time developing systems to avoid the provision of unnecessary or inappropriate care.

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1.1. Process Used to Determine Services Requiring Prior Authorization

Setting prior authorization policy requires balancing the dual objectives of promoting efficiency and ease of use with making sure our members receive the right care, in the right place, at the right time. At Clear Health, we believe providers have the “boots on the ground” experience and expertise to inform these decisions. Provider input, in combination with our own analysis of utilization trends and Agency guidance, drives our process for determining which services require prior authorization.

We monitor over- and under-utilization reports and prior authorization approval rates to identify opportunities to update our list of services that require prior authorization. These reports support the work of our Precertification Committee, which meets monthly and includes UM, case management, and Medical Directors. The committee reviews prior authorization requirements, trends in approvals and denials of services, and trends in utilization patterns not currently on our list of services that require prior authorization. With this information, the committee discusses opportunities to improve the effectiveness of our UM program and the need for any changes to our services requiring prior authorization.

Clear Health determines whether a service requires prior authorization at the code level instead of the service group level. This process enhances efficiency in the application of our prior authorization criteria, and provides for greater cost-effectiveness in our coverage of services.

We provide covered BH services as outlined in the Contract, and establish prior authorization policy in accordance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and all other applicable state, federal, and Contract requirements and will continue to do so.

Our local UM Committee and Medical Advisory Committee (MAC) reviews and approves all changes in services that require prior authorization. Our local MAC currently includes 11 network physicians, including Clear Health network providers and representatives from specialties like internal medicine, infectious diseases, cardiology, otolaryngology, surgery, pulmonology, gerontology, obstetrics and gynecology, BH, and pediatrics.

The MAC is particularly useful in securing provider feedback because it includes providers from the local delivery system and represents the full spectrum of services we provide to our members, including BH services. Through the MAC, we listen first and develop prior authorization policy in partnership with our network providers.

1.2. Data Sources Used to Make Decisions About Prior Authorization Requirements

In addition to the MAC, other data sources inform our prior authorization policies. We review over- and under-utilization trends and prior authorization approval rates to identify when a change in prior authorization policy may be appropriate. We also review national utilization reports when available, such as data published by the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC), and changes in nationally recognized medical necessity criteria.

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Our changes to the therapy services prior authorization policy illustrate our continuous monitoring of utilization data to improve efficiency and effectiveness of care. We recently observed an increase in costs for outpatient therapy performed in hospital settings compared to the same services performed in provider offices and freestanding facilities. We worked with our subcontractor, Health Network One, Inc. (HN1), to identify non-complex diagnoses that could offer safe and equally effective therapy services outside of a hospital setting. We then added therapy evaluations to our list of services requiring prior authorization. This change helps us identify therapy evaluations being requested in a hospital setting, and provides an opportunity to redirect the evaluation to a provider office or freestanding facility. Because most therapy services are performed in the location of the evaluation, we increased utilization of therapy services at lower cost, more appropriate settings, and realized \$150,000 in savings in the first eight months of 2017. Requests for therapy services in the hospital setting dropped by half, and we have successfully redirected 60 percent of the remaining requests for therapy services in the hospital setting to an office setting or freestanding facility without Medical Director review. We continue to approve therapy services in the hospital setting for complex diagnoses that require higher levels of care.

We also pay careful attention to provider input to identify whether a prior authorization requirement is burdensome or unnecessary. We systematically handle provider complaints as part of our Quality Management (QM) program. Quality Management staff track provider complaints by subject area monthly and report trends to plan leadership. To the extent there are negative trends, we develop interventions or identify policy changes to address common provider concerns. For example, we used to require certain lab work to be processed through our capitated laboratory services provider. Providers complained because using this laboratory delayed results that could otherwise be obtained immediately in the provider office setting. We listened to our providers and now cover certain lab work in office settings without prior authorization.

We also react swiftly to individual provider complaints outside of the QM process. For example, a network facility provider recently complained about the volume of services we were denying due to lack of clinical documentation. We researched the issue and discovered that our contract with the facility required a prior authorization response within six hours. Because six hours was insufficient to collect the clinical information needed to make a determination, we met with the facility and obtained agreement to increase the turnaround time to 24 hours. This change significantly decreased the facility's overall denial rate and increased provider satisfaction.

In a different example, a provider complained because we required prior authorization for nebulizers. We removed the clinical review requirement immediately, and now nebulizers and other low-cost DME equipment are auto-approved upon receipt of the request. This process significantly reduces turnaround times (within one day) and reduces the risk of delays in care that could contribute to potentially preventable admissions, readmissions, and ED visits.

We also get regular provider feedback about our prior authorization list and requirements during peer to peer discussions, and pay close attention to trends identified in those communications. Quarterly and annually, we collect provider satisfaction data regarding our UM processes, prior authorizations, and responsiveness. We value this provider feedback, as they are our partners in improving member care, and incorporate results into our QM program. The regular delegation oversight meetings include feedback on the interactions with downstream providers and review of trending complaints including those pertaining to the UM processes.

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1.3. National Resources Available to Inform Local Decision-Making

Through our ultimate parent company, Anthem, Inc., Clear Health has access to additional UM resources and best practices across the country. Each year our national joint Medical Operations Committee (MOC) performs a review of services requiring prior authorization to determine whether changes would simplify processes for members and providers without compromising care. The MOC also evaluates whether new prior authorization requirements are needed to address changes in provider practice patterns or advancements in medical technologies related to an HIV/AIDS specialty program.

In conducting its annual review, the MOC analyzes specialty plan-specific utilization data such as:

- Top 100 procedures by volume and cost
- Top 50 denied and modified procedures
- Appropriateness reviews of all procedures that require prior authorization
- Procedures associated with specific medical policy or clinical guidelines that warrant review

The MOC's annual recommendations support the work of our local UM Committee and MAC, who take their recommendations into consideration when establishing prior authorization policy.

2. PROCESS USED TO ENSURE APPROPRIATENESS OF UM CRITERIA FOR MEDICAID BENEFITS

Clear Health's process for ensuring the appropriateness of our UM criteria involves two layers of review and approval. The first layer of review occurs at the national level. Anthem, our parent company, adopts and annually updates medical policy and clinical guidelines with input and approval by all affiliated Medicaid health plans. We then review and revise these policies and guidelines at the health plan level, through our local committee structure, which includes practicing, licensed clinicians, to ensure a flexible, local approach designed specifically to accommodate the characteristics of our care delivery system, Agency requirements, and member needs. Both the national and local layers of review involve significant input from the provider community and consider best practices and evolving standards of care for HIV/AIDS populations.

2.1. National Resources Rigorously Review Medical Policy and Clinical Guidelines

Anthem, our ultimate parent company, develops medical policy and clinical guidelines through a process that incorporates evidence-based practices from nationally recognized professional organizations, up-to-date clinical research, and input and approval from external providers in community and academic settings. We believe that scientific evidence is essential to informed decision-making and the process seeks to adopt the best of evidence-based practices and criteria.

The Medical Policy and Technology Assessment Committee (MPTAC) is a national, multidisciplinary group that includes network providers from various specialties, clinical practices, and geographies. Each year, it reviews, updates when appropriate, and approves medical policy and clinical guidelines. When reviewing and updating the medical policy and clinical guidelines, it considers information from sources that include electronic literature searches; independent technology evaluation programs; and materials published by professional associations (e.g., Blue

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Cross Blue Shield Association), technology assessment entities, appropriate government regulatory bodies, and national provider specialty societies.

2.2. Final Medical Policy and Clinical Guidelines Adopted at the Local Level

Clear Health's medical policies and clinical guidelines are based on the national criteria adopted by the MPTAC each year, but undergo a rigorous review process to ensure appropriateness in administering Florida Medicaid benefits for physical and BH services. Our Chief Medical Officer (CMO) oversees the development and review of all medical policies and clinical guidelines, and local providers on our MAC review, provide input, and approve the criteria before use. The MAC brings knowledge and perspective of the local Medicaid delivery system to help us make sure our UM criteria, including levels of care, are appropriate for administering Florida Medicaid benefits and meets the needs of our members, including the special challenges faced by individuals with HIV/AIDS.

In some cases, we must alter our coverage policy to assure its appropriateness for our HIV/AIDS specialty population. For example, women who are HIV-positive should not breastfeed due to the risk of HIV transmission via breastmilk. We updated our coverage policy, and no longer cover breast bumps due to this safety concern.

Similarly, although the Agency encourages Managed Care Plans to reduce cesarean deliveries this goal is not directly transferable to a HIV/AIDS specialty plan and our medical policy and clinical guidelines reflect the evidence-base that cesarean sections are the preferred method of delivery to prevent vertical transmission of HIV from mother to baby. Scheduled cesarean delivery, defined as cesarean delivery performed before the onset of labor and before rupture of membranes, is recommended for prevention of perinatal transmission of HIV in women with HIV RNA levels >1,000 copies/mL near delivery and for women with unknown HIV RNA levels. Our C-section rate is high at 67 percent; however, no vertical transmissions have been reported since our inception.

Our adopted medical policies and clinical guidelines become an essential tool in our provider's toolkit that help to define the most appropriate treatment and setting and assure consistency of care for all our members. In the review of medical policies and clinical guidelines through our MAC, we gather and listen to feedback from our participating providers ensuring that our UM criteria are clinically based but can also take into account member needs and clinical and environmental factors.

2.3. Clear Health's Medical Policy and Clinical Guidelines

Clear Health's current medical policy and clinical guidelines are based on the following national criteria. The criteria include a comprehensive range of level-of-care alternatives that is sensitive to the differing needs of adults, adolescents, and children. When necessary, we have adapted these criteria to strictly follow all requirements established by the Agency for administering covered Medicaid benefits, including State and federal EPSDT standards, and better accommodate our members' needs.

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- Guidelines specific to caring for HIV/AIDS populations, including the U.S. Department of Health and Human Services, Clinical Guidelines for the Treatment of HIV and the HIV Medicine Association of the Infectious Disease Society of America Primary Care Guidelines for the Management of Persons Infected with HIV: 2013 Update
- InterQual criteria for adults and pediatric members, including inpatient acute care services and inpatient skilled care
- Behavioral health (BH) criteria, developed by our subcontractor Beacon, are based on nationally recognized resources, including but not limited to those publicly disseminated by the American Medical Association (AMA), American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), Substance Abuse and Mental Health Services Administration (SAMHSA), the American Society of Addiction Medicine (ASAM), MCG (formerly known as Milliman Care Guidelines), and CMS
- American Imaging Management guidelines, for selected diagnostic imaging services, sleep studies, and genetic testing
- Milliman Care Guidelines, for therapy services
- Guidelines prepared by professional organizations, such as the American Academy of Pediatrics, American Academy of Neurology, American College of Obstetricians and Gynecologists, and other relevant, evidence-based literature or information
- Guidelines and recommendations developed by individual medical and surgical societies, the National Institutes of Health, Institute of Medicine, United States Preventive Health Services Task Force, and CDC

3. APPROACH TO ENSURE THE CONSISTENT APPLICATION OF REVIEW CRITERIA

We assure the consistent application of review criteria through our staff training program, annual inter-rater reliability (IRR) audits, and additional oversight, reporting, and resources from our national Performance Improvement and Enhancement (PIE) program.

3.1. UM Staff Training

Assuring consistent application of UM review criteria begins with our robust training program. Three to four weeks of initial classroom instruction for new UM Nurses include specific training modules for general topics such as:

- Overview of Medicaid and Medicare
- Treating the whole person (physical and BH)
- Legal and ethical issues
- HIPAA
- Review of medical policies and clinical UM guidelines, including making appropriate clinical decisions
- Day in the life of a UM Nurse
- Understanding authorizations

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We supplement these general topics with in-depth, micro-learning exercises for:

- System training
- Inpatient daily census
- Emergent and planned inpatient admissions
- Initial length of stay
- Concurrent reviews
- Authorization time frames
- Discharge planning
- Pharmacy authorizations
- Preparing for rounds

These exercises include skill practice scenarios with check points, quick reference guides, identification of available tools and resources, and error and warning messages to help guide the new employee.

One to two weeks of on-the-job training follow the intense classroom programming. During the on-the-job training, new employees work real cases under the careful guidance of preceptors, managers, and team leads. They are then closely monitored for an additional 90 days to answer questions, clarify processes, identify errors, and use errors as additional teaching opportunities. After the 90-day period, and only after they have demonstrated a thorough understanding of our UM process and procedures, can new employees work independently.

Importantly, we even reinforce our comprehensive training for seasoned staff with refresher courses and ongoing review of unique cases. The UM team meets monthly to review actual scenarios and answer questions like those included in our annual IRR audit. We then discuss the case as a team, answer questions, and make sure everyone understands how we applied the criteria. If the scenario was difficult, or produced lower-than-average scores, we forward the scenario to a Medical Director who will conduct a separate in-service on a similar case in the future, emphasizing the applicable criteria and key information to look for during a review.

3.2. Inter-rater Reliability (IRR) Audits

We conduct annual IRR audits to evaluate our consistency and accuracy in applying UM criteria, and help us assure we are treating members and providers fairly and consistently in our delivery of covered benefits and services.

We require annual IRR testing for all UM reviewers, including Medical Directors, if they have been applying UM criteria for a period of at least 90 days. The process includes hypothetical test cases or a sample of UM determination files, and uses an NCQA-approved auditing method. It helps us assure our UM reviewers:

- Make appropriate decisions based on knowledge of nationally accepted, evidenced-based guidelines, Agency-specified criteria, and our medical policies
- Apply guidelines consistently
- Have the knowledge and resources they need to identify potentially avoidable or inappropriate utilization, including potentially preventable admissions, readmissions, and ED visits

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The audits identify staff who need additional training, as well as opportunities for new training modules or refreshers that would benefit the entire UM team. We report IRR results to our Quality Management Committee (QMC), which also identify areas for improvement and develop action plans.

**** RESULTS & SUCCESSES: Our UM Team Achieved Full Compliance in 2016**

We have participated in IRR audits in Florida for the last 14 years with excellent results. The results from our most recent IRR audit indicate all our Medical Directors and UM Nurses exceeded the compliance threshold in all the guidelines used, including guidelines for adults and children. Our Medical Directors scored 90 percent, on average, and our UM Nurses scored 93.5 percent, on average. **

If a reviewer falls below our IRR compliance threshold of 90 percent, they must participate in monthly audits with a focus on clinical decision making and appropriate application of the medical policies and clinical guidelines. They remain in this increased audit cycle until they achieve 10 cases with scores above 90 percent.

Leaders also work closely with the individual until their performance improves. We develop an action plan that may include a formal training plan; one-on-one coaching by a local subject matter expert; and additional testing. Any action plan must be completed within 90 days.

3.3. Performance Improvement and Enhancement (PIE) Program

Through Anthem, our ultimate parent company, we have access to the national, multi-faceted Performance Improvement and Enhancement (PIE) program. This new initiative is a best practice and provides additional safeguards to ensure the consistent application of review criteria for authorization decisions. It continuously evaluates our UM program using monthly clinical and non-clinical audits (including call reviews), outcomes reporting, and process validation for compliance with UM policies.

The PIE program includes the following components:

- The Clinical and Non-clinical Auditing Program, which plays an integral role in driving performance improvement by continuously evaluating our staff's UM activities. The program objectively monitors and evaluates the appropriateness and quality of services provided to our members and is designed to make sure our UM processes are applied consistently. Attention is paid to adherence with new or updated processes and criteria, to make sure we catch and intervene with issues in between our annual IRR audits with one-on-one coaching or UM team retraining and the development of additional learning opportunities.
- The Reporting Program within the PIE team directly supports the work of the Clinical Audit program by regularly developing and issuing reports to our directors and managers, senior leadership, clinical leadership, and our National Program Delivery teams and Quality Committees. PIE reports summarize the clinical audit results, identify areas for improvement, and create enterprise trend comparisons that help our UM leadership prioritize necessary trainings or process changes.

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Since implementation of the PIE program, we have seen marked improvement in clinical staff adherence to process and UM criteria. These results are reflected in our recent PIE Clinical Audit compliance scores:

- Medical Directors are currently performing at 99.78 percent compliance, with approximately 1.8 percent improvement from 2015
- UM Nurses are currently performing at close to 99 percent compliance, reflecting a three year-over-year improvement trend

3.3. Clear Health Holds Subcontractors to Our Own Strict Standards

We ensure our subcontractors have processes to apply review criteria consistently during pre-delegation activities and our robust annual oversight review. No less than annually, we review the clinical criteria adopted by the subcontractor to validate that it is consistent with Clear Health's criteria. We also review subcontractor changes to review criteria as they occur. For subcontractor oversight audits, we incorporate the subcontractor's review criteria into our annual oversight review process, which includes a review of the process the subcontractor uses to audit and monitor consistency in application of their adopted review criteria.

4. REVIEW PROCESSES TO ENSURE SERVICES ARE NOT ARBITRARILY DENIED OR REDUCED

At Clear Health, there are many ways we make sure services are not arbitrarily denied or reduced. We make medical decisions only after a thorough review of the member's medical records, and base decisions on their individual needs. We never employ automatic limits on a length of stay unless required by the Agency.

Dr. Francisco Hernandez, our Medical Director, is a Florida-licensed endocrinologist and oversees all UM decisions. Other UM team members include physician reviewers in multiple specialties and our team of local, licensed UM Nurses.

Importantly, our medical policies and clinical guidelines provide a rules-based system for screening medical and BH services. They are objective, evidence-based, and include a comprehensive range of level of care alternatives sensitive to the differing needs of adults, adolescents, and children. We match the level-of-care to the member's current condition, considering individual member needs, including needs common in an HIV/AIDS population such as housing needs, the severity of illness, treatment progress, co-morbidities, home environment, episode-specific variables, and the characteristics of the local delivery system. Our overarching goal is to view members in a person-centered manner to make sure they receive the right services at the right time, in the right place.

Our local team of licensed UM Nurses use our Florida-specific coverage policies and clinical guidelines to review service authorization requests. When medical necessity is not clear, or when clinical information needed to make a decision has been requested but not received, the UM Nurse refers the case to a Medical Director for medical necessity review and determination. The Medical Director may request additional documentation and, prior to issuing a denial, may offer an opportunity for peer-to-peer consultation to discuss the case and potential care alternatives. He or she will also offer peer-to-peer consultation after any denial. We take advantage of this

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educational opportunity to reinforce applicable, evidence-based guidelines and appropriate care settings with the provider, and send the provider a copy of the medical policy or clinical guideline via fax for their future reference.

In reviewing cases for medical necessity, our Medical Directors balance the objective of supporting providers in exercising professional judgement and making informed decisions with the objective of promoting consistent use of evidence-based guidelines that have been established to be the most effective for each member's condition.

As a check to ensure services are not being arbitrarily denied or reduced, we analyze our overall denial rate. We also closely monitor the denial rate of each Medical Director and UM Nurse to look for outliers in clinical decision making. We define outliers as any individual whose denial rate is approaching 10 percent or more. When outliers are identified, we follow up with training or other interventions. Our overall denial rate is currently seven percent.

If we intend to deny a service authorization based on the test, procedure, or other service or benefit being experimental or investigational in nature, we forward the case to the Agency and request a coverage determination in accordance with rule 59G-1.035, FAC.

We never reward our UM staff or subcontractors for issuing denials of coverage, or encouraging decisions that result in under-utilization or create barriers to care and service. Members and treating providers may request a second medical opinion or appeal a denial at any time. We provide information about this process in our member and provider materials. Our Case Managers (Managed Care Coordinators) and Provider Network Managers reinforce information about the appeals process in their interactions with members and providers.

5. REVIEW PROCESSES TO IDENTIFY ABERRANT UTILIZATION PATTERNS

Maximizing the delivery of appropriate medical and BH services and minimizing occurrences of over- and under-utilization is a primary function of our UM program. We identify and address aberrant utilization patterns through a combination of powerful data analytics and focused leadership attention examining trends and implementing effective improvement strategies.

5.1. Utilization Management Data Analytics and Resources

We gather utilization data in our Core Operations System, which contains all provider, member, claims, and authorization data. Additionally, our Data Warehouse, which stores utilization data, including from our subcontractors, is an integrated repository fed directly from our Core Operations System to support data control and consistency. The Data Warehouse maximizes our capacity for data analytics.

A team of local analytics staff is dedicated to reporting utilization daily, compiling both standard and ad hoc reports. They review and monitor utilization data and identify trends. This team is supported by our national Health Care Analytics Department who provides additional resources, assistance with the data warehouse, standardized reporting and analytics, and consultation on drill down requests. They also monitor national trends and provide reports that compare utilization trends across all our affiliated health plans.

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Health plan leadership, the UM team, clinical leadership, Quality Management, Provider Relations, Financial Analysts, and the MAC use this data to implement strategies to achieve utilization targets consistent with clinical and quality indicators and to identify potential cases of fraud and abuse.

5.1.1. Our Standardized Utilization Reports Optimize Decision-making

Our analytics teams produce fully integrated over- and under-utilization monitoring reports that include administrative and incurred claims data for both physical and BH services. These reports encompass data on the full spectrum of covered services, but pay special attention to admissions, readmissions, pharmacy, specialty referrals, ED utilization, BH services, preventive services, and ancillary services such as DME and home health. They also capture critical data about preventive care utilization, including well-child and PCP visits, age-appropriate immunizations, mammograms, and blood lead testing.

The following are examples of other reports and tools that help us identify under- and over-utilization of services:

- Regional Outlier Reports include demographic information, admitting hospital, diagnosis, estimated hospital charges, number of days to exceeding the threshold for outlier length of stay, and potential additional charges for each day the member exceeds the outlier threshold. Our Medical Economics team conducts the analysis at a regional level, and these reports support our Interdisciplinary Rounds process.

**** INNOVATION: Multidisciplinary Rounds Target Outliers**

A multi-disciplinary team (MDT) of local health plan staff analyzes hospital admissions nearing or exceeding abnormal lengths of stay for the associated condition. The team includes representatives from our clinical areas, case management, Medical Directors, finance, Provider Network Managers, and Risk Analysts. The team meets weekly and reviews our inpatient census with the task of ensuring our members are getting the right level of care, in the right setting.

For complex or high-cost cases identified in our Regional Outlier Report, the MDT discusses the clinical status of each member, whether other, more medically appropriate care settings are an available option, potential financial liability at the current level of care, and other key information. The team uses this information to develop action plans where a lower level of care may be appropriate. For members identified as good cases for transfer to a lower level of care, the Concurrent Review Manager who is part of the team notifies the Concurrent Review Nurse of the decision. They then work with the attending physician, hospital case management, social services, and the discharge planning team to select the appropriate lower level of care facility. This close coordination supports a smooth, safe return for the member and reduces the risk of readmission or other potentially preventable events. **

- Our Over- and Under-Utilization Monitoring Reports identify potential over- and under-utilization patterns using incurred claims data. The report shows both standard deviation results for the current quarter/YTD as well as year-over-year changes for the following services: Non-ED physician visits; non-ED outpatient diagnostic services (including radiology, lab, etc.); non-ED outpatient therapeutic procedures (including physical therapy, occupational therapy, and speech therapy, home health, outpatient surgery, etc.); and pharmacy prescriptions. We produce and

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review this report every six months. We use this report to review a provider's utilization compared to his or her peers, year-over-year trends, and member turnover data, if available.

- Our predictive modeling tools help us identify the potential for future under- or over-utilization. Our Chronic Illness Intensity Index (CI3) tool enables us to identify individuals with the highest risk levels and coordinate the services and supports they need to achieve optimal outcomes. With this data, we can provide tailored case management, medication management, and other supports. Other predictive modeling tools include the Likelihood of Inpatient Admission (LIPA), an index that prioritizes members for outreach by predicting the probability of an inpatient admission; Statistical Obstetrical Risk (STORK) Score, for members at an elevated risk for delivering an infant who will require a NICU admission; and BH "First-Time Admitter", which spots members who have not had a BH admission in the past six months, but are likely to have one in the next 60 days.
- Our Gaps in Care Report provides information to providers about attributed members in need of specific services to close HEDIS® gaps, which can reflect potential underutilization of services. Providers use these reports to outreach to our members and encourage the member to receive the needed service. Managed Care Coordinators use the same gaps in care information, which is captured in our Case Management System, to outreach to members and work collaboratively with providers to meet our members' needs.

5.1.2. Analyzing Pharmacy Utilization to Improve Care

Clear Health also captures and analyzes pharmacy data to identify under-and over-utilization, cost, and drug trend drivers. Our review and analysis of pharmacy data supports UM, case management, medication management, clinical programs and initiatives, pharmacy restriction programs, and the identification of potential fraud, waste, and abuse.

Our pharmacy team works closely with our case management team to respond to pharmacy utilization information by developing member-specific interventions, as well as strategies and programs that address population health trends. This may include participation in care planning for members with complex medication needs such as polypharmacy and psychotropic medications, medication reconciliation for members transitioning from higher levels of care, and clinical consultation for PCPs addressing BH needs. This relationship is especially important to the Clear Health program in order to assure proper HIV treatment protocols are followed.

Our retrospective drug utilization review (RDUR) programs analyze pharmacy utilization patterns to identify opportunities for:

- Promoting appropriate prescribing
- Improving member care through medication adherence and safety
- Reducing avoidable use of ED and inpatient services
- Addressing over- and under-utilization
- Reducing the number of unique drug products prescribed per member
- Identifying potential fraud, waste, and abuse

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The following are examples of our RDUR programs:

- Medication Management Programs. Medication adherence and management is particularly important for individuals living with HIV/AIDS. Our medication management program looks for duplication of HIV medications and under-utilization of HIV medications. In the future, we will also have medication management programs for BH, diabetes, and asthma. These programs help optimize therapeutic outcomes in a safe and cost-effective manner. Through the programs, we communicate with the member, prescribers, and caregivers to close gaps in care, optimize therapies, improve medication adherence, and identify inappropriate or conflicting drug therapies.

**** INNOVATION: HAART Initiative Improves Medication Compliance**

We use special reports run by our pharmacy analytics team to provide anti-retroviral treatment (ART) compliance data to our members' PCPs. The reports identify all the medications the member is taking, as well as prescribing providers. Our Managed Care Coordinators use these reports, as well as medication history in our Case Management System, to assist when prescriptions are rejected at the point of service or require prior authorization, to ensure there are no lapses in medication adherence for our members. When members are in the hospital, Managed Care Coordinators provide UM Nurses critical information regarding the member's ART regimen to prevent lapses in medication adherence during the inpatient stay and after discharge. This program has helped increase our Highly Active Anti-Retroviral Therapy (HAART) rate by 64 percent, from 57.33 percent in 2015 to 93.85 percent in 2016. **

[REDACTED]

[REDACTED]

[REDACTED]

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5.1.3. Ad Hoc Reports Help Us Address Local Needs

Clear Health continuously pulls ad hoc reports to identify opportunities to improve utilization patterns in our provider network. For example, we recently conducted a close examination of all facility providers in our network. For each facility with a higher than average medical loss ratio (MLR), we investigated whether any specific utilization or other trends were driving the higher costs. High MLRs, especially MLRs in excess of 100 percent, can indicate difficulties in stabilizing a member's care. We are working with 10 facilities identified as a result of our analysis to address potential issues or barriers in member care, including whether we need to authorize additional services to better meet member needs.

5.2. Clear Health Mobilizes to Address Potential Cases of Over- and Under-utilization

As described above, we use many reports and tools to identify cases of over- and under-utilization. Once identified, we rely on a variety of programs and approaches to address the issue or individual case.

When patterns of over- or under-utilization present in the aggregate, results are reported to the MAC and QMC. Representatives from our clinical and QM areas work with our Medical Director to discuss intervention strategies to achieve utilization targets consistent with clinical and quality indicators.

5.2.1. Individual Provider Cases of Over- or Under-utilization

When we identify a provider with aberrant utilization patterns, our Medical Director and a Provider Network Manager review the case and, if appropriate, develop an action plan and discuss it with the provider. The action plan begins direct provider engagement in the form of a peer-to-peer discussion with the provider and our Medical Director. They discuss pertinent medical policy and clinical guidelines in the context of case examples where we have concerns about potential overutilization. In this way, we give the provider an opportunity to explain circumstances that may be unique to his or her practice or to the geographical area he or she serves. The provider may submit evidence-based data for our consideration if they disagree with our clinical guidelines.

In cases where we believe application of our current medical policy or clinical guidelines do not require change to address the provider's unique circumstances, we monitor the provider's progress in complying with our UM criteria by reviewing and trending performance over a six-month period, or shorter period if indicated. We use this information, including progress reports, during recredentialing to determine if the provider should remain in our network.

5.2.2. Individual Member Cases of Over- or Under-utilization

Clear Health members are vulnerable to many comorbidities, and we refer members identified as under- or over-utilizing services to our integrated DM and case management program for assessment, care planning, and/or member and provider education and outreach. For members with uncoordinated care patterns, excessive utilization, or suspected patterns of fraud, waste, and abuse, we may also refer them to a program tailored to their specific needs. Examples of such tailored programs include:

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- **CD4 Project.** Our CD4 project addresses members with low CD4 counts (<200 cells/mL) who typically are not fully engaged in their care. A CD4 count is a blood test to determine the strength of the immune system as measured by the presence of a type of white blood cell. A normal range for CD4 cells is between 600 and 1,500, while a CD4 count of <200 cells/mL indicates a severely compromised immune system and a clinical diagnosis of AIDS. In our CD4 project, Managed Care Coordinators must refer members to community-based programs such as Ryan White agencies when appropriate for services not available through the Plan such as support groups, legal and housing resources. We closely track labs, hospitalizations, and referrals to BH Managed Care Coordinators to identify opportunities for improvement and non-compliance patterns. Our Medical Director leads interdisciplinary rounds to discuss each case and develop specific action plans. In addition, a physician with expertise in treating HIV/AIDS populations (and our former Medical Director) lends his expertise in the cases of our most difficult members to engage. Since it began in 2014, our CD4 Project has stabilized or improved outcomes for 42 percent of the members not lost to follow-up (due to disenrollment, death, or inability to contact). Currently, we track approximately 250 members through the CD4 project.
- **Long-Acting Anti-Psychotic Injectables (LAI) program.** This program targets members who are non-adherent to prescribed LAI antipsychotic medications and aims to improve medication compliance, decrease the risk of institutionalization, and reduce potentially preventable readmissions. We assign a BH Managed Care Coordinator to members who have missed a scheduled injection; members who received an LAI during an inpatient BH stay and require their next LAI in the outpatient setting; and members with a prescription for an oral administration form of one of the target medications who missed a recent refill and may benefit from switching to an LAI.
- **Pharmacy Restriction Program.** Clear Health maintains a Pharmacy Restriction Program to identify members who demonstrate patterns of fraud, waste, or abuse resulting in unnecessary ED visits and doctor and pharmacy shopping. If appropriate, we assign the member to a single pharmacy for filling all prescriptions for a period of 12 months. By limiting members identified as potentially misusing or fraudulently obtaining controlled substances, we aim to reduce related ED and physician visits due to doctor shopping. We also refer members with potential substance use issues to a BH Managed Care Coordinator.

6. UM PROTOCOLS FOR SERVICES THAT ARE NEEDED SHORT-TERM VS. LONG-TERM

Although the protocols are the same, Clear Health follows different processes for services that are needed long-term versus short-term. For services needed long-term, we refer the case to a Managed Care Coordinator to provide coordination of all services and eliminate any gaps in care. Most importantly, the referral to a Managed Care Coordinator assures that one individual is responsible for making sure the member's services are received timely and that there are no breaks in care.

For all our members, our UM Nurses coordinate with Managed Care Coordinators and Medical Directors to obtain feedback on long-term authorization requests. Each morning, our UM Nurses receive a list of members in active case management. If the UM nurse identifies a member who may need services authorized long-term, the UM nurse checks to see if the member is in active

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case management. If the member is on the list, the UM Nurse coordinates with the assigned Managed Care Coordinator to understand what an appropriate service authorization length may be. Or, if the member does not appear on the daily list, the UM Nurse places a referral to case management.

We routinely authorize certain services, like home health services and maintenance services and therapies, for extended periods. In these cases, we approve the service as recommended in the plan of care for up to six months, and in some cases, up to a year, so long as it is medically necessary. Before the initial authorization period expires, our Case Management System notifies the Managed Care Coordinator to reassess the member, update the plan of care, and extend the authorization request as needed. This proactive approach, supported by automatic notifications in our Case Management System, facilitates continuity of care and reduces the risk of unnecessary gaps in the treatment plan.

Although we may authorize certain benefits for up to six months, or even a year, we may require that the supply be delivered in 30- to 60-day installments. We do this to reduce waste, as members may transition to commercial coverage or another Managed Care Plan, pass away, or no longer need the benefit.

When a course of treatment involves an extended period, we ask treating providers to include that information on the initial service authorization request. When the request is approved, we maintain that information in our Case Management System so that the service authorization can be extended for a longer period without filing additional paperwork or a new request. This automatically updates the claims system, and facilitates timely claims payment and eliminates the potential for delays or breaks in care.

7. APPROACH TO ENSURING CONTINUITY OF CARE

Clear Health assures continuity of care for members with special needs, as well as members who transition between various levels of care, different providers, and from enrollment in another plan into Clear Health. As described above, for members with long-term service authorizations in place, our Case Management System provides automatic notifications that trigger outreach and re-assessment by our Managed Care Coordinators to facilitate continuity of care and reduce the risk of unnecessary gaps in the treatment plan.

7.1. Thoughtful Protocol for Members with Specialized Needs

As a specialty plan serving members with HIV/AIDS, all our members have specialized needs. Our members do not need an authorization from their PCP to see a specialist. Additionally, we allow specialists, including Infectious Disease specialists, to be PCPs which is unique to our plan and increases access to care. Currently, we have 121 providers in 188 locations who have submitted specialized HIV/AIDS training attestations to achieve “Red Ribbon” PCP status. Many of these providers are also credentialed under the American Academy of HIV Medicine.

Originally, we found specialists to be somewhat reluctant to become PCPs. But we worked closely with them to bring them onboard in a partnership to better serve our members and their patients. We provide additional training to them on managed care and why it is important to have them as a PCP for populations living with HIV disease.

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We developed several policies to make sure we are not a barrier to getting necessary care for members with special needs. To begin with, our UM team works closely with our Managed Care Coordinators and is aware of each member's individualized needs.

We also developed specific protocols to assure continuity of care for particular populations. Examples of our thoughtful approach, developed over the course of 14 years of working with special needs populations in Florida Medicaid, include the following:

- We work closely with Premier Eye to reduce the risk of cytomegalovirus (CMV) disease progression in our members with HIV/AIDS. Members at risk need quick attention by experienced providers to avoid irreversible damage, including blindness. We will coordinate services, and arrange or provide transportation, to make sure our members quickly see these providers.
- We have a relationship with TEAM 1 at Jackson Memorial, a large public hospital in Miami, Florida. The on call Infectious Disease specialists have agreed to see any of our members presenting at the hospital for care. This relationship helps our members receive care from highly trained, HIV-experienced physicians who can improve member outcomes and engage them in all aspects of care.
- We have eliminated service authorization requirements for our members with sickle cell disease. We found that many members would go to the hospital for blood transfusions, through the ED, and end up in observation status. To reduce this potentially preventable hospital admission, we no longer require service authorization for blood transfusions. Our members with sickle cell disease can go straight to an outpatient infusion center to receive necessary care.
- We use HTP Woundcare, to better coordinate care and provide continuity of care for members receiving wound care at home. Upon receiving a request for wound care in the home, HTP Woundcare's certified wound care nurses work directly with the home health agency and the ordering physician to provide a comprehensive treatment plan. They visit the home and oversee progress of the wound on a weekly basis, but do not take over other home health care being provided. They supplement and help coordinate wound care.
- For our youngest members with more complex needs, we approve up to six months of private duty nursing services and therapy services based on their individualized plan of care, to keep the child in the home where they are more likely to maintain a higher level of functioning and quality of care.
- When a member receives fracture care in the ED, and is treated by an out-of-network orthopedist, we cover follow-up care with the out-of-network orthopedist until the fracture heals.
- Members needing anti-psychotic medications in a long-acting injectable form are typically authorized for 12 months.

7.2. Transitions Between Different Levels of Care

We have an inpatient case management team that reviews all members admitted to a hospital and works closely with the hospital discharge planners to assure needed services are in place, including referrals to case and/or disease management. Our UM and case management teams maintain and support open lines of communication and collaboration with hospital staff from the

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member's admission to the date of discharge. When a member is in the hospital or in any other inpatient acute care setting, our UM Nurses see that the review process incorporates use of established decision criteria to approve appropriate medically necessary care and assign the most appropriate level of care for continued medical treatment.

Our UM Nurses work closely with the hospital physicians, Managed Care Coordinators, discharge planners, other hospital staff, including therapists and nutritionists, as well as the member's PCP and other involved providers to approve and coordinate services during the inpatient stay and as the member is transitioned to the most appropriate level of care (for example, home, acute rehabilitation facility, skilled nursing facility). Our goal is to make sure all needed services are already authorized and in place when the member arrives at his or her new care setting.

UM Nurses refer all members to case management for follow-up, assistance scheduling appointments, and medication reconciliation. Automated letters also notify a member's PCP upon hospital admission and discharge to increase the likelihood of a follow-up appointment. All members identified in our daily hospital discharge report receive a phone call to identify needs and potential referral to case management.

7.2.1. Post-discharge Management (PDM) Program

We understand members are often overwhelmed when hospitalized, when returning home, and/or when there is a sudden increase in the number of people involved in their care. Lack of familiarity with the new caregivers, in addition to the sheer numbers, can be confusing. As a result, our Managed Care Coordinators initiate Post-discharge Management (PDM) activities immediately upon notification or identification of an inpatient admission for physical or BH conditions.

We assign a registered nurse or licensed BH clinician Managed Care Coordinator based on the nature of the member's admission. The Managed Care Coordinator collaborates with facility discharge planners, members, families/caregivers, providers, and UM staff to develop a safe, sustainable discharge plan. As part of the program, the Managed Care Coordinator reaches out (telephonically or face-to-face, depending on member needs) in the first 24- to 72- hours post-discharge, because that time period represents the highest risk for readmission, to make sure follow-up care was received. The Managed Care Coordinator reviews the discharge instructions with the member to make sure the member understands the plan and to confirm that needed services are received. The Managed Care Coordinator addresses any gaps identified.

The Managed Care Coordinator continues to engage the member to verify scheduled services and follow-up appointments are made, assist with arranging transportation, provide reminders, follow up to see that proper services are in place and concerns are addressed, perform medication reconciliation, identify potential issues and educate members/caregivers on how to address complications, and refer the member to our integrated DM and case management program.

7.2.2. Transitions of Care (TOC) Program

Our Transitions of Care (TOC) program, which we recently expanded statewide, improves member transitions out of the hospital by engaging members identified as having a high risk for readmission, their families, and caregivers and better meeting health care needs by providing coordination and continuity of care in the transition home.

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We target members for TOC with certain discharge diagnoses, including congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and other conditions associated with an elevated risk of readmissions. We also target members with hospital lengths of stay exceeding three days and members with at least one prior hospitalization in the past 12 months.

Managed Care Coordinators conduct home visits to provide a comprehensive health assessment, examine the home environment, and develop a person-centered plan of care with the member, family, and other caregivers using a multi-disciplinary approach. The plan of care addresses the whole person, with an emphasis on self-management, medication reconciliation and management, and closing gaps in care.

The Managed Care Coordinator continues to work with the member and his or her providers as needed over a 30-day period, providing additional support and follow-up through telephonic and in-person outreach and visits. If the Managed Care Coordinator does not believe the member is at elevated risk for readmission, he or she still provides follow-up contact at seven-, 14-, and 30-day intervals post-discharge to verify that the member's condition has not deteriorated, and to refer the member to DM or case management as appropriate.

7.2.3. More Effective Transitions to the Community with Special DME Procedures

Once a discharge is scheduled, our UM Nurse notifies the home health/DME authorization team to expedite review of the service authorization request to ensure services are in place upon the member's return home. We maintain a direct fax line for hospitals to submit discharge orders for home health/DME requests directly to our dedicated home health/DME authorization team, expediting the process, and the team works directly with the hospital's discharge planning team. These requests are prioritized and must be approved no later than 48 hours post-discharge. The average turnaround time is less than one day. We also follow up with the member on the expected delivery date to make sure the member received the services or equipment, and to answer any questions or concerns.

Any authorizations that require same day or next day turnaround are handled by a dedicated nurse who coordinates with the hospital's discharge planning nurse to see that members receive all necessary services.

7.3. Continuity of Care as Members Transition into Our Plan or Between Providers

When new members transition into our plan, we contact the prior Managed Care Plan to obtain and enter into our Case Management System any existing service authorizations and/or plans of care. We honor any service authorizations ordered as part of an ongoing course of treatment, even if the provider is not in our network, for up to 60 days after the date of enrollment. To facilitate claims processing, however, we typically input an authorization into our Case Management System. By doing this, we can reach out to the provider to verify scope and duration of services, and make sure that the provider is not an excluded provider.

In cases where the treating provider is not in our network, and after confirming licensure and lack of sanctions, we enter into a single case agreement paying the rate they received for services rendered to the member before the member's transition to our plan. We may also recruit the provider to join our network as needed to improve access, and guarantee the historical rate for at least 30 days, unless the provider agrees to an alternative arrangement.

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We have policies and procedures to address other situations requiring continuity of care. For example, when a treating provider is terminated from our network for any reason other than for cause, we allow members in active treatment to continue care with that provider when medically necessary, through completion of treatment or until the member selects another treating provider, but not longer than six months after termination of the contract.

If a provider is unavailable to deliver previously authorized services in a timely fashion, we work with the member to identify an equally qualified alternative provider in our network, or out of network if needed.

When members transition between providers, we facilitate the sharing of existing treatment plans between the providers and send the new provider the member's plan of care. Our network providers are contractually required to share treatment plans when they are transferring or coordinating care.

8. EXAMPLE OF IDENTIFYING AND ALTERING UNFAVORABLE UTILIZATION PATTERNS

Our Pharmacy Provider Engagement Program provides an excellent example of how Clear Health combines the use of data with our high-touch provider model to change utilization patterns while at the same time resulting in better outcomes for members. The program uses a "clinician- based" delivery model to provide doctors with real-time utilization metrics, comparative performance measures, and educational materials to encourage and assist them in making medically appropriate, quality based clinical decisions. The program employs clinical pharmacists to facilitate a one-on-one, clinician-to-clinician based review of medication prescribing patterns, and helps to educate clinicians on current best medical practices.

One key benefit of this program is that it offsets the marketing strategies of pharmaceutical manufacturers by making providers more aware of the economic and pharmacological features associated with specific drug therapies. Prescribers who are adequately informed can make better therapeutic selections that are both clinically effective and reduce costs.

Our Provider Pharmacy Engagement program is another example of how we use data to support performance improvement. We offer our this program as part of our Integrated Pharmacy Services Model. Clinical Pharmacy detailing complements utilization reviews and involves a focused educational exercise to encourage and assist providers in making medically appropriate and cost-effective clinical decisions.

The main goal of this program is to provide an effective means of delivering important clinical information to our network prescribers, with the primary intention of facilitating sound clinical decision making that will translate into the delivery of the highest quality medical care. The Pharmacy Provider Engagement Program provides an interactive clinical detailing platform which employs the use of four clinical pharmacists that meet regularly with network physicians, on a "one-on-one" basis, to educate, inform, review medication prescribing patterns, and communicate best clinical practice guidelines. They provide real-time utilization metrics, comparative performance measures, and educational materials focusing on cost-effectiveness and quality. Benefits associated with the Pharmacy Provider Engagement Program include the following:

- Timely reporting and utilization data places our network doctors on the "Front-line."

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- Identification of brand to generic conversions opportunities, formulation optimization opportunities, trends in the utilization of “High Risk” medications, trends in the instances of non-adherence and instances of therapeutic duplication, assists our network doctors in identifying meaningful and actionable interventions.
- Education on therapeutic drug class comparisons and related market drug pricing provides our network doctors with a means of closing the physician-drug pricing knowledge gap (i.e. Daraprim, Hep C). This promotes appropriate prescribing practices that are cost-effective and it offsets unwarranted, cost inflating prescribing behaviors that result from the persuasive marketing strategies that are employed by pharmaceutical manufacturers. An informed provider who is more cognizant of both the economic and the true relative pharmacological features of specific drug therapies can make better cost effective selections.
- Provided insight to full member medication history, and prescriptions written by other prescribers, gives our network doctors the means to identify member polypharmacy issues in a timely fashion.

Example of Improving Generic Dispensing Rates: Branded Antipsychotic Medications

At the outset of the current SMMC MMA program, Simply quickly became aware that of a significant increase in our SMI population. One of the first data points to emerge based on our daily Rx reporting was a surge in the use of branded atypical antipsychotic medications. Through the Pharmacy Provider Engagement Program the plan was able to collaborate with behavioral network providers and psych specialists to provide pharmacist-based one-on-one education on the comparative therapeutic efficacies associated with specific brand and generic antipsychotic medications in order to promote significant brand to generic treatment conversions which, ultimately, served to optimize the cost effectiveness of antipsychotic medication therapy regimens for plan members. Over 2 years, the plan has seen a 24.6 percent improvement in the generic dispensing rates of antipsychotic medications through provider collaboration efforts focusing on the utilization of generic alternatives.

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Evaluation Criteria:

1. The extent to which the respondent describes the process and data sources utilized to determine whether a service should be prior authorized, including reviewing complaints or feedback from providers regarding burdensome or unnecessary prior authorization criteria.
2. The adequacy of the processes used by the respondent to determine whether the utilization management criteria selected are appropriate and consistent with policy requirements for a Medicaid benefit.
3. The adequacy of the respondent's approach to ensure the consistent application of review criteria for authorization decisions (e.g., inter-rater reliability studies, and training for plan staff and network providers).
4. The adequacy of the review processes (data collection and analysis) deployed by the respondent to ensure services are not arbitrarily being denied or reduced.
5. The adequacy of the review processes (data collection and analysis) deployed by the respondent to identify aberrant utilization patterns (under and over utilization).
6. The adequacy of the respondent's approach in differentiating between UM protocols for authorization of services that are needed short-term (e.g., one-time authorization) vs. long-term (ongoing maintenance services/therapies).
7. The adequacy of the respondent's approach at ensuring continuity of care, particularly as it relates to special needs populations.
8. The extent to which the respondent provides a specific example of how its review processes resulted in successful interventions to alter unfavorable utilization patterns in the system.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

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SRC# 19 – Utilization Management – Ease of Use (Statewide):

The respondent shall describe the following related to its utilization management systems:

- a. A description of how the respondent will ensure that the UM processes are designed so that service authorization requests are completed efficiently and with minimum administrative burden on network providers and enrollees;
- b. A description of software capabilities that facilitate ease in requesting service authorization and support data exchanges between providers, subcontractors and the respondent (to the extent any UM functions are delegated);
- c. A description of the respondent's experience meeting timeliness standards for service authorization requests;
- d. A description of the approach that the respondent will use to educate enrollees and providers about the process for seeking authorization; and
- e. A detailed workflow of how "special service" requests are processed for enrollees under the age of 21 years. Special services are requests that are made to the plan to exceed the limit on a Medicaid covered service or to cover a medically necessary service that is not listed in the Florida Medicaid handbooks/coverage policy or the associated fee schedule.

Response:

Simply Healthcare Plans, Inc., (Simply) D/B/A Clear Health Alliance (Clear Health) designed and continues to update its Utilization Management (UM) program to improve efficiency, streamline our systems and processes, and provide fully integrated data to support UM decisions and activities. We work closely with our provider network to identify improvement opportunities and facilitate ease of use through education, innovation, and adoption of effective new technologies that save time and administrative costs.

**** RESULTS & SUCCESES: Ease of Use Reflected in High Provider Satisfaction**

Providers indicate high levels of satisfaction with Clear Health's UM process, which we continue to improve based on their feedback. Ninety percent of providers are satisfied or very satisfied with our UM program overall. **

Highlights of our UM program and systems include the following:

- An integrated Case Management System that captures claims history, subcontractor encounter claims data, physical health (PH) and behavioral health (BH) service authorizations, lab results, immunization records, case management data, and disease management (DM) data in a single system with tools for UM staff, Managed Care Coordinators, and providers to identify, manage, and coordinate enrollee (member) needs and enhance member care in real-time

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- Innovative features, both current and in the process of being implemented, such as our new provider portal that allows providers to submit service authorization requests and supporting clinical documentation electronically; our SmartPA pharmacy claims system that applies integrated medical and pharmacy data to seamlessly approve service authorizations where diagnoses are required; and our web-based tools which allows providers to easily check service authorization requirements by CPT code
- Ongoing review of our service authorization list to identify services where authorization is no longer effective, such as services we approve nearly 100 percent of the time
- A long history of supporting compliance with timeliness standards for service authorization requests, and quickly returning determinations to members and providers

1. INTEGRATED SYSTEMS SUPPORTS OUR HOLISTIC APPROACH TO CARE

Providers can submit prior authorization requests electronically, by phone, or by fax. Regardless of the method of submission, our system captures the request, the associated medical necessity criteria, and a record of all related communications with providers. It also maintains the final determination, including copies of any notices sent to members and providers. A description of our Case Management System and other key systems that support UM activities is detailed below.

1.1. Interoperable Systems Integrate Information and Support Coordinated Care

Our interoperable systems are built on a managed Medicaid model that reduces redundancies and supports integrated, coordinated care. They include our Core Operations System, data warehouses, supplemental applications, Case Management System, and provider portal.

- **Core Operations System.** Our Core Operations System is the authoritative host, or system of record, for data about members and providers. It collects and tracks data on enrollment, claims, utilization, grievances and appeals, member disenrollment, and other essential functions. Updates occur through the user interface or through application-specific data loads, such as enrollment files received from the Agency. We maintain quality through many interfacing applications that apply rules-based standardization, verification, and validation logic to data elements.
- **Data Warehouses.** Data warehouses support operational processes, analytics, and reporting. They receive data directly from the system of record, including UM subcontractors and other external sources, to promote data quality, control, and consistency. Our data warehouses deliver a comprehensive source of health information about our members and include data for medical, BH, pharmacy, dental, and vision services they receive, as well as lab results and immunizations. Our data warehouses generate member health data included in our Case Management System and supports advanced data analytics, including predictive modeling, to identify members for DM and case management; monitoring of under- and over-utilization; and operational and ad hoc reporting.

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- **Case Management System.** Our Case Management System is the system of record for case management activities. It houses member utilization data and clinical information, including claims history, encounter claims data from UM subcontractors, PH and BH service authorizations, lab results, immunization records, case management data, and DM data. With consolidated member clinical data from various sources, it delivers a comprehensive picture of the member's utilization, plan of care, and gaps in care. Our UM, DM, and case management staff use the gaps in care information to work collaboratively with providers and help members get needed services.

The Case Management System captures service authorization data, including requests and determinations, and specifically attaches the data to the member's and provider's records to provide a single source of information.

Clear Health delegates UM for BH services to Beacon Health Options, therapy services to Health Network One, Inc. (HN1), dental services to DentaQuest, optometry/ophthalmology to EyeQuest, radiology and genetic testing to AIM Specialty Health, and audiology/hearing services to HearUSA. Although our UM subcontractors do not have access to our Case Management System, it includes UM subcontractor data such as encounter claims data and BH service authorizations to provide a complete picture of our members' health.

In a provider-facing application, our Case Management System enables providers to view the following services in a user-friendly dashboard:

- Active HEDIS® alerts
- Labs with summary results
- Inpatient treatment, including admission and discharge dates, facility, and primary diagnosis
- Emergency department (ED) utilization, including primary diagnosis
- Pharmacy, including changes in medication
- Service authorizations, such as home health and medical equipment and supplies
- Outpatient primary care and specialist visits, including primary diagnosis
- BH office visits, including primary diagnosis
- Use of preventive care and immunizations

In this way, we share information about members' utilization, service authorizations, case management, including comprehensive health assessments and plan of care, with providers to enhance case management and coordination.

- **Supplemental Applications.** Supplemental applications support all our departments, including UM. A variety of dashboards, business intelligence, analytical reporting, and other applications maximize UM functionality, efficiency, and data analytic capabilities. These flexible applications enhance our ad hoc reporting capabilities and, because of the nature of our integrated systems, help us identify opportunities for improvement and make informed decisions about our UM processes and policies based on comprehensive data.

- **Provider Portal.** A login-only area gives providers a secure, HIPAA-compliant environment where information specific to their needs exists in an integrated, easy-to-use location. Providers can submit prior authorization requests and check status of pending requests through the portal.

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1.2. Systems Ensure There Are No Delays in Authorizations or Gaps in Care

Our integrated systems, including our Case Management System, seamlessly capture member clinical and other data and link service authorizations to the requesting provider and member ID. Our UM team uses this comprehensive source of information to retrieve information quickly, without asking providers for unnecessary or duplicate information that can result in delays in care. Because our UM team has access to the most comprehensive set of member data in a single application, they process UM decisions more appropriately and efficiently, based on a holistic picture of the member's overall health.

Additionally, our Case Management System houses sophisticated analytic and dashboard capabilities to see that there are no gaps in care or delays in service authorizations. UM staff view pending service authorizations in near real-time, including authorization ID, requesting provider, UM team member assigned to the case, type of service authorization, issue and due dates, and status. A variety of tools and dashboards support UM Managers and other leaders with performance metrics that help prioritize resources, make sure we meet or exceed required turnaround times for prior authorization, and efficiently address member needs.

Our Case Management System also actively supports continuity of care. For example, we routinely authorize certain services, like home health services and maintenance services and therapies, for extended periods. In these cases, we approve the service as recommended in the plan of care for up to six months, and in some cases, up to a year, so long as it is medically necessary. Before the initial authorization period expires, our Case Management System notifies the Managed Care Coordinator to reassess the member, update the plan of care, and extend the authorization request as needed. This proactive approach, supported by automatic notifications in our Case Management System, facilitates continuity of care and reduces the risk of unnecessary treatment disruptions.

Through our Case Management System, any authorized team member can access current information regarding existing or pending service authorizations, thereby reducing potential duplicated efforts, such as multiple requests for the same service for the same member.

2. REDUCING ADMINISTRATIVE BURDENS AND ELIMINATING REDUNDANCIES

Clear Health is responsive to the needs of members and providers, and we continuously assess our systems and incorporate member and provider feedback to make sure our UM program operates as intended, providing the right care, in the right place, at the right time with little administrative burden to providers or barriers to care for members. When a provider indicates that our process is administratively burdensome, we take the feedback seriously and bring it to the attention of the applicable operational areas to discuss whether we can improve our process or tools to make the UM experience more efficient and easy for providers.

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One of the primary ways we reduce administrative burden and barriers to care is by continuously reviewing our service authorization list to identify services where authorization is no longer effective. For example, we look for services we approve nearly 100 percent of the time, or services where service authorization adds little value. When we identify such services, we revise our UM policies to require that providers submit a notification only. This means that the provider must report that the service will be provided, but it will be auto-approved so long as the provider is in our network. In some cases, we may remove the service entirely from our list of those that require authorization. For example, in the previous 12 months, we identified 88 codes that could be removed from service authorization requirements or moved to the notification only process instead.

Additionally, by eliminating the requirement that PCPs authorize services and specialty referrals, we significantly reduce administrative burden and barriers to care.

**** INNOVATION: Provider portal streamlines prior authorization process**

Our innovative, new provider portal enables providers to submit service authorization requests and supporting clinical documentation electronically, without having to pick up a phone or fax documents to us. This minimizes administrative burden, and enables providers to attach clinical documentation at any time after the case is opened. Through the portal, they may also update documentation needed for us to render an appropriate decision. This information is seamlessly integrated into our Case Management System, and used by our UM Nurses and Medical Directors during the review.

The system has many unique capabilities and creates new efficiencies for providers, such as being able to approve or deny a service authorization request for common procedures immediately. Using our medical policy and clinical guidelines, combined with integrated data from our claims system, the system asks providers for the minimum amount of additional information necessary to process the request and deliver a response in real-time. It also links to our claims system and advises providers whether an authorization for a service is required or strongly recommended. When service authorization is not required, the provider can easily print the message for his or her records and future reference. **

In addition to our portal, providers may also submit authorization requests by phone or fax. To save time, and recognizing that many providers work after routine business hours, our system enables them to check on the status of a pending service authorization request through our provider portal or a telephonic voice portal at any time. All service authorization requests, regardless of method of receipt, feed into our Case Management System.

We encourage providers to use our new provider portal to submit service authorization requests in a variety of ways. We promote the portal by emphasizing its efficiencies and other benefits to providers through our routine communications, including IVR messaging, pocket guides, fax cover sheets, provider newsletters, and targeted mailings. We also conduct portal demonstrations for large provider groups, offer online tutorials, and update call scripts to reference the portal and answer any provider questions. As providers learn about the new system and its advantages, we have experienced a steady increase in its use. Electronic service authorization requests more than doubled (to 10 percent of the total) since implementation of the new UM portal; however, fax requests (47 percent) and phone requests (43 percent) remain the primary methods of submission.

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2.1. Ease of Use and Enhanced Efficiency for Pharmacy Service Authorizations

For select prescription drugs, we use SmartPA, our point-of-sale pharmacy claims processing system, to process service authorizations more quickly and reduce administrative burden for providers. SmartPA uses intelligent and automated logic to validate that a submitted claim for a drug requiring service authorization meets approved clinical criteria.

Our pharmacy claims system includes diagnosis data from member medical claims. This allows SmartPA to apply integrated medical and pharmacy data to seamlessly approve service authorizations where diagnoses are required. During adjudication, the SmartPA rules evaluate the member's medical claims diagnosis for the presence of a diagnosis code representing a condition that does not need a thorough clinical review to authorize the medication. When the algorithms confirm the diagnosis, SmartPA overrides the need for a service authorization and processes the claim. In this way, SmartPA can eliminate the need for the provider to submit a traditional service authorization request, simplifying and streamlining the process for the prescriber and eliminating delays for the member.

Smart PA improves both the member and provider experience by:

- Assuring appropriate use of medications
- Decreasing wait times and member inconvenience
- Facilitating access to prescriptions and reducing provider administration burden

**** INNOVATION:** Electronic prior authorization for pharmacy will enhance ease of use.

We are in the process of making additional improvements to our pharmacy service authorization process. We are implementing electronic prior authorization (ePA) capabilities, which will provide a new alternative for prescribing providers to initiate and manage service authorization requests for medications. The ePA process will enhance efficiency and ease of use for prescribing providers and foster a smooth member experience. For example, if the necessary information to meet clinical criteria is submitted during the ePA process, an immediate approval decision can be completed and communicated back to the provider.

The new ePA system will increase efficiency and reduce administrative burden because:

- It is faster than submitting requests by phone or by fax, plus there is no paperwork to manage
- It has automatic approval capabilities to further expedite the process and foster an improved member and provider experience
- It is easy to use, building off e-prescribing processes many providers are already familiar with
- It automatically generates approval and denial notices to members and providers in accordance with State and federal requirements ******

3. MEETING TIMELINESS STANDARDS FOR SERVICE AUTHORIZATION REQUESTS

Since 2014, we have processed nearly all standard and expedited service authorization requests within required time frames. Table 19-1 in Attachment SRC# 19-1: Service Authorization Performance illustrates our performance, as well as our low denial rate.

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Robust policies and procedures, supported by data analytics and dashboards, help us make sure we are meeting timeliness standards for service authorization requests. We have incorporated these processes into our daily operations. For example, we have separate queues in our Case Management System for service authorization requests identified as urgent or life threatening, and a dedicated team of UM Nurses processes these requests to see that we render decisions quickly. Our internal goal is to process expedited requests in one business day or less, significantly exceeding the Agency's requirement of two days.

We require our UM subcontractors to adopt and follow the same UM policies and procedures we apply internally, including compliance with service authorization turnaround times. We closely monitor the timeliness of UM subcontractors' service authorization turnaround times, member grievances and appeals, and provider complaints through a standardized monthly report. If a UM subcontractor fails to meet a timeliness standard or metric required by the Agency or under our contract, we issue a corrective action plan.

Clear Health initiated a Six Sigma process improvement project in 2016 to enhance our service authorization turnaround times. This initiative aimed to improve the member and provider experience, and several process improvement activities are now underway. These include:

- Training Fax Sorters to separate requests needing clinical review
- Streamlining forms to eliminate duplicate documentation
- Expanding training and system capabilities to help UM Nurses quickly focus on service authorizations in the clinical fax queue, more easily identify the oldest cases in inventory, and eliminate the need for UM Managers to make individual assignments
- Implementing additional UM Nurse quality audits to assure process consistency and identify improvement opportunities
- Automatically approve codes at the UM Coordinator level if no medical policy or UM guidelines are available to determine medical appropriateness, eliminating the need for UM Nurse review and shortening the time to render a decision
- Dedicating three UM Coordinators to make outbound redirection calls, enabling other staff to concentrate on production
- Asking UM Nurses to forward cases with missing clinical documentation to Medical Directors after two prior attempts to retrieve the information from the provider
- Initiating a Tuesday through Saturday work schedule for seven UM Coordinators, providing added weekend coverage and better serving our members and providers
- Establishing more aggressive internal performance standards

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**** RESULTS & SUCCESSES:** Our already strong UM turnaround times continue to improve. Clear Health's streamlined processes, and comprehensive monitoring of pending service authorization requests helps us consistently meet or exceed the required processing time frames. Our turnaround times have exceeded the 95 percent processed within seven days benchmark for the past several years. In fact, we consistently perform at two days or less for approval decisions, which account for more than 94 percent of all our authorizations. We expect to see additional improvements in 2017 from our newly adopted process improvements. Already the percentage of expedited service authorization requests processed within one day improved from 76.3 percent to 87.6 percent in a three-month period, and the percentage of our standard service authorization requests processed within three days increased from 35.2 percent to 54.5 percent during the same period. ******

At Clear Health, we meet on any case that exceeds the seven-day timeliness standard and review the case to identify root causes for the delay. We quickly act on issues before they become trends by providing additional staff education or implementing necessary process improvements.

4. PROVIDER AND MEMBER EDUCATION AND TRAINING PLAN

Through a robust provider-servicing model, we educate network providers on covered benefits and service authorization requirements. We include comprehensive information about our service authorization process and forms in our provider manual and on the provider portal.

Provider orientation also includes an overview of the process, including services that do not require authorization, time frames for processing authorization requests, our Service Authorization Form, and how to obtain further information. When we revise our service authorization process, clinical criteria, or other UM policies, we update providers through various communications, including mail, the provider portal, and fax blasts. In fact, provider portal updates are typically expedited and posted within 24 hours.

Additional resources include a toll-free UM phone number staffed from 8 a.m. to 7 p.m. We automatically route all provider-initiated UM calls to staff who guide and support the provider through the authorization process. We maintain close, collaborative working relationships with our network providers, and many view us as a clinical resource. We communicate often with providers and facilities, discussing individual cases, helping them navigate Medicaid benefits, asking for additional clinical information, and identifying alternative services that may better address the member's condition. Ninety percent of providers report that they are satisfied or very satisfied with the timeliness of our Medical Director's response to their concerns.

For members, we provide information about the process for seeking authorization in our member materials, including our member handbook and website. This includes information about services requiring prior authorization and the appeals process. Our Customer Care Representatives, Managed Care Coordinators, and UM staff reinforce information about the appeals process in their interactions with members.

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5. TRANSPARENT SERVICE AUTHORIZATION PROCESSES

Our provider portal includes our pre-certification look up tool (PLUTO), which enables providers to easily check service authorization requirements by CPT code. PLUTO also informs the provider whether the service authorization request will be reviewed by one of our UM subcontractors, such as Health Network One (HN1), or by our UM team.

In addition to clear information about our service authorization process, providers can also find our medical policies and UM criteria on our website through a user-friendly search feature. They can browse medical policies and UM criteria by category or name, obtain recent updates, and view historical information.

Our member handbook and website include valuable information about referrals and authorizations. The information identifies the difference between referrals and authorizations, how long it may take to process an authorization request, what to expect if we deny an authorization request, how to appeal a denial, what benefits never require a service authorization, and what benefits do require service authorization.

Because of our compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as it applies to Medicaid MCOs, our authorization requirements for BH services align with the State's fee-for-service program, which further enhances transparency and ease of use for providers.

6. "SPECIAL SERVICE" REQUEST WORKFLOW

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is more comprehensive than similar benefits for adults. To make sure that our youngest members receive early detection and care, and to help avert or diagnose and treat conditions as early as possible, Clear Health handles "special service" requests for members under the age of 21 differently than other requests.

Special service requests are those that exceed the limit on Medicaid covered services or request a medically necessary service not covered by Medicaid. For members under the age of 21, Clear Health does not deny services under the EPSDT benefit if they are medically necessary. If the service is covered by Medicaid but exceeds coverage limits — for instance, is listed on the Medicaid fee schedule — our UM Nurse checks for medical necessity. If medical necessity criteria are met, the UM Nurse approves the request. If it does not meet the criteria, or the service is not listed on the Medicaid fee schedule, a Medical Director reviews the case and makes the final determination.

Figure 19-1 in Attachment SRC# 19-2: Special Service Request Workflow illustrates how we process special service requests.

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Evaluation Criteria:

1. The extent to which the respondent proposes the use of interoperable systems that will seamlessly integrate information from providers to the respondent and its subcontractors (to the extent any UM functions are delegated) and the extent to which the respondent describes how that information will be used to enhance care coordination services and to ensure there are no delays in authorization or gaps in care.
2. The extent to which the respondent uses strategies to reduce administrative burdens for the provider (e.g., software capabilities) in requesting authorization and its approach is streamlined with little to no redundancies between and across departments which could contribute to delayed service authorizations.
3. The extent to which the respondent has demonstrated experience with meeting timeliness standards for service authorization requests.
4. The adequacy of the respondent's education and training plan providers on the service authorization processes.
5. The extent to which the respondent ensures transparency in service authorization processes (e.g., makes available all utilization management protocols and criteria in an accessible location for service providers).
6. The extent to which the workflow describing the respondent's process for handling "special service" requests is consistent with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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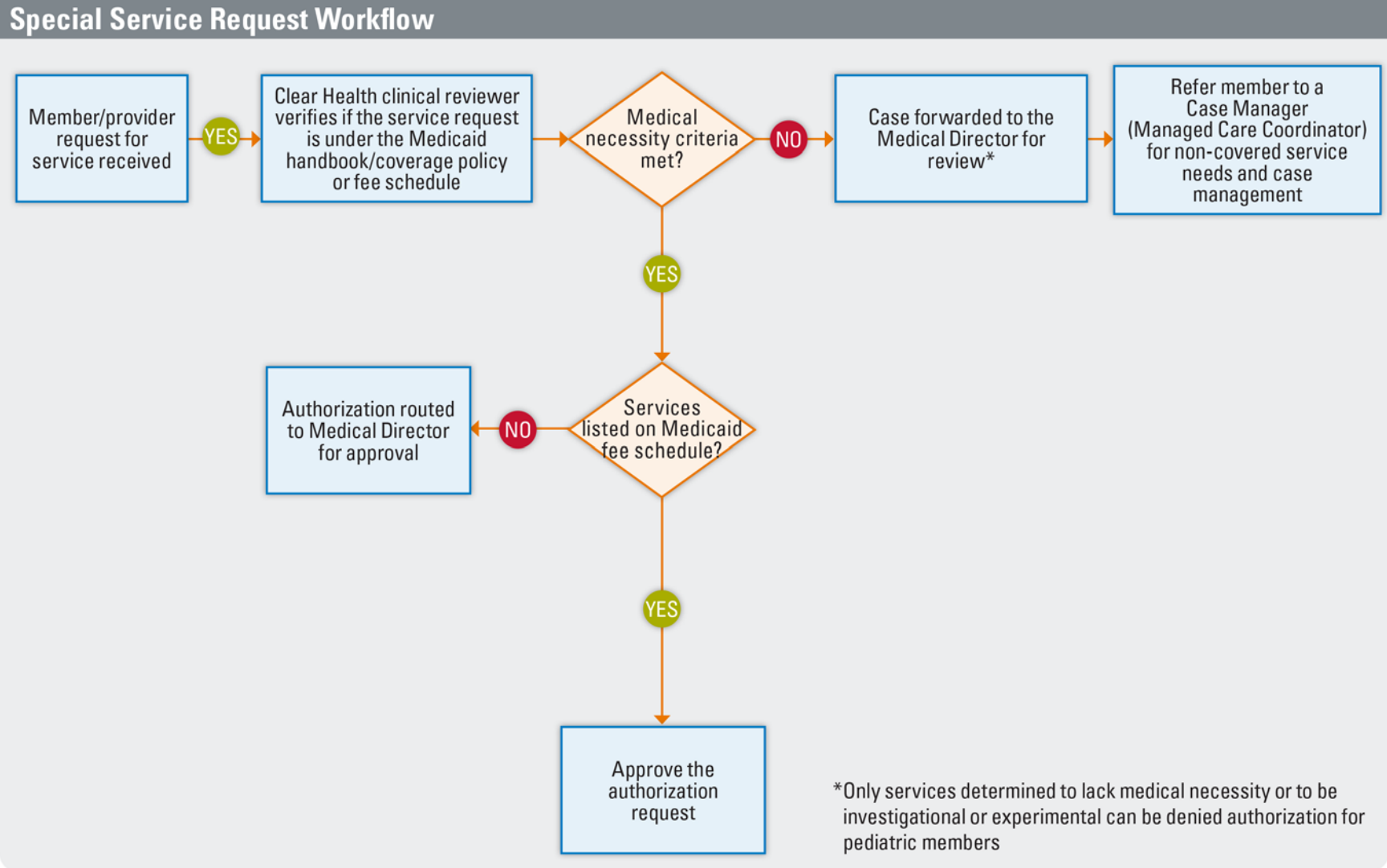
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Table 19-1. Three Years of Data Demonstrate Our Ability to Meet Timeliness Standards

Measure	2014	2015	2016
Denial Rate	5.78%	5.94%	5.50%
Standard Authorizations Processed w/in Contract Requirements	99.12%	98.89%	99.30%
Expedited Authorizations Processed w/in Contract Requirements	99.51%	98.56%	97.82%

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Figure 19-1. Workflow Assures Contract Compliance with Special Service Requests



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SRC# 20 – Care Coordination (Statewide):

The respondent shall describe its approach for identifying, assessing, and implementing interventions for enrollees that present with the following:

- Complex medical and/or behavioral health needs;
- High service utilization;
- Intensive health care needs; and
- Consistently accessing services at the highest level of care.

The respondent's approach shall include:

- a. A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level;
- b. A description of minimum contact frequencies and contact type for each severity and/or risk level;
- c. A description of the maximum caseloads for each case manager (ratio requirements) and support staff;
- d. A description of evidence-based guidelines utilized in the care coordination approach, including interventions deployed to improve enrollee engagement and improve treatment adherence; and
- e. A description of performance metrics used to evaluate the efficacy of the care coordination, including cost-savings, reduction in the use of higher cost services, etc.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Clear Health brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

The story of Clear Health over the past five years is the story of remarkable innovation, shared learning, and increased integration to respond to the our members' changing needs. Originally designed based on the Ryan White Act/Project AIDS Care (PAC) home- and community-based waiver program, the model evolved to include an enhanced medical component. The Clear Health Case Managers, called Managed Care Coordinators to differentiate from the Ryan White agency case managers with whom we collaborate, brought specialized knowledge of HIV/AIDS disease processes and treatments to our members and responded to their daily needs. While we retain this clinical expertise and responsiveness at the heart of our model of care, the current Clear Health model promotes the comprehensive health and well-being of our members using sophisticated tools, integrated care techniques, and evidence-based care protocols to proactively

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determine appropriate types and levels of service to meet each member's needs and maximize health and outcomes.

The new Clear Health model of care combines case management and disease management programs built around four key principles that characterize HIV/AIDS care today:

- HIV/AIDS is a chronic disease suitable for self-management and patient education
- HIV/AIDS is a disease that can be managed largely on an outpatient basis, thus avoiding costly inpatient care
- There is a consensus on what constitutes optimal care
- Optimal care can reduce morbidity and costs and improve outcomes

Clear Health is a state-of-the-art Medicaid HIV/AIDS program, incorporating new innovations in provider partnerships, evidence-based practices, and lessons learned working with our members around Florida.

At Clear Health, our population health management approach promotes a multidisciplinary and integrated care continuum to health care delivery, including disease management and case management approaches, to support the distinct needs of each enrolled member at different stages in their lives. As our members age, their needs change, and we change with them. Our model stratifies members based on their health status, identified risks and needs, level of engagement, member priorities, and use of health care resources to match the appropriate intensity of disease management and case management support needed. Members are supported by one Managed Care Coordinator for all needs, with some exceptions as noted below. The case management program in Florida meets all State, federal, contractual, and NCQA requirements.

We offer and encourage all members in our specialty plan to participate in case management services due to the complexity of managing HIV/AIDS disease processes and co-morbid conditions. Members who agree to participate in case management are matched with a Managed Care Coordinator who knows their community and works collaboratively with them to facilitate their care and services. Our in-house case management program is at the heart of how we ensure our members receive the right care at the right place at the right time – every time.

1. RISK STRATIFICATION METHODOLOGIES AND ALGORITHMS

The process for risk stratification and identifying needs begins soon after enrollment with Clear Health. When enrollment is confirmed, our Customer Care Representatives outreach to new members to welcome them to the plan, discuss benefits, and complete an initial health risk screening to begin to understand their urgent and ongoing health care needs. Our Customer Care Representatives speak to the member about the case management program and attempt to schedule a comprehensive assessment. These assessments provide a risk score that incorporates social determinants of health, medical conditions, behavioral concerns, cognitive concerns, emergency room (ER) and hospital utilization history, pharmacy, treatment compliance, and functional areas of concern. Other data sources for risk stratification include enrollment data provided by the Agency for Health Care Administration (AHCA), enrollee demographics, claims

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history, comprehensive health risk assessment (HRA) results, and referrals from members, family, providers, and internal staff such as Customer Care Representatives, Managed Care Coordinators and Utilization Management employees.

Clear Health Alliance uses robust methods to identify and stratify risk among our members initially and on an ongoing basis and we use the information to proactively identify gaps in care and target interventions. We prioritize information and action in these areas that may indicate high-risk behavior or utilization patterns that are sub-optimal for outcomes:

- Gaps in anti-retroviral treatment, anti-fungal or antibiotic regimens
- Utilization at facilities and of services not aligned with current member treatment plans
- Presence of diagnoses comorbid with HIV/AIDS that require special attention or management strategies (i.e. hepatitis B and C, tuberculosis, diabetes, cardiovascular disease, hypertension).
- Indications of pregnancy that would require additional intervention for anti-retroviral treatment
- Sub-optimal CD4 management
- Social determinants of health, including homelessness and food insecurity, that impact health outcomes
- Co-occurring mental health and substance use disorders
- Inconsistent medication adherence

In concert with our member engagement strategies, our data analytics resources continually mine all available information about diagnoses, past health care utilization, and demographics that will help us identify risks and anticipate the needs of our members.

This data is analyzed by our proprietary predictive modeling software, Chronic Illness Intensity Index (CI3), to produce a risk profile in one of three categories: low risk, moderate or rising risk, and high or urgent risk. We use these categories of risk as the initial basis of case management assignments and follow-up procedures.

In general terms, our stratification methodologies define levels of risk in these ways:

- Low Risk: Members who do not have urgent medical concerns and have no apparent history of inappropriate use of the ER. Members have HIV/AIDS and may have other chronic conditions but the disease(s) are well controlled and members maintain connections with a primary care provider or specialty provider. There are not major gaps in care apparent from the data review. There is no evidence of serious mental illness (SMI) or substance use disorder (SUD) in the history.

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- **Medium or Rising Risk:** Members self-identify some medical or behavioral health (BH) concerns or the claims review indicates need for additional support to manage chronic conditions which may be in moderate control. Members may have moderate ER use or recent hospitalizations. Members may have co-morbid medical and BH conditions, including SMI or SUD in remission. Members who cannot be reached and show a claims history indicating chronic conditions may be in this category to initiate follow-up.
- **High or Urgent Risk:** Members indicate or are found to have high needs or urgent issues that require follow-up by specialized, experienced Clear Health Managed Care Coordinators. They may have complex medical histories including multiple chronic conditions in poor control, including BH and medical conditions, or intensive health care needs. Members may tend to access care at the highest levels or have patterns of high utilization of the ER and a history of multiple admissions.

1.1. Members with Complex Medical and Behavioral Health Needs

We search claims and diagnosis information to identify members with significant BH conditions that may impact their overall health status as well as their management of HIV/AIDS and other chronic conditions. We also use additional analytic tools to assess enrollee risk of BH admissions when certain conditions are present, even if there is no history of past psychiatric hospitalizations. Members with complex medical and BH needs are assigned a primary Managed Care Coordinator best matched to their needs and are supported by a BH Managed Care Coordinator. Our Clear Health Managed Care Coordinators meet regularly together and complete monthly rounds supported by both a medical physician and psychiatrist to review cases and ensure that our members receive comprehensive care through difficult circumstances. Members maintain one Managed Care Coordinator as their point of contact to reduce confusion and promote building strong relationships.

1.2. Members with High Utilization

Through predictive analytics, we identify members with high utilization of pharmacy, frequent medical or BH hospitalizations, or emergency department (ED) visits and assign these members a high-risk value. Utilization at these levels may indicate that members are not connected to outpatient providers for routine management of their conditions or may indicate complex co-morbidities or challenges that require close monitoring to prevent negative outcomes. Members with high utilization are placed at the top of the queue for case management outreach after enrollment and remain a priority for Managed Care Coordinators.

1.3. Members with Intensive Health Care Needs

Clear Health has specialized integrated disease and case management programs tailored to meet the intensive needs of members with particular conditions, including members with diabetes, hypertension, asthma, major depressive disorder, heart diseases, coronary obstructive pulmonary disease, schizophrenia, SUD, bipolar disorder, and cancer. We seek to identify members with additional complex needs as early as possible through claims review, initial screening, and referrals. Our case management staff then complete condition-specific assessments with the member to define the level of risk and vulnerabilities in the member's care plan.

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1.4. Members Consistently Accessing Care at the Highest Level

Our continual data mining and service utilization review processes systematically identify members with over-utilization of health care resources, such as multiple ED visits and inpatient admissions, as well as under-utilization of preventive and wellness services such as routine primary care visits, visits to BH providers, anti-retroviral (ART) medications, and CD4 testing. Managed Care Coordinators work with members with inefficient patterns of accessing care, their families/caregivers, and providers as appropriate to identify the intervention and program that will best meet their needs. Interventions include member education on benefits and services; partnering with network providers to make them aware of gaps in care; and ongoing engagement with our case management staff to assist members with high-risk conditions to access appropriate preventive care and engagement with community resources to assist with housing, job placement, legal assistance, and other important social supports.

Clear Health case management interventions are tailored to meet the needs of the individual member and vary based on intensity of need. Based on their initial assessment results, utilization patterns, and calculated risk scores, we assign members to one of three risk levels and match them to Managed Care Coordinators based on the risk in addition to other factors such as language preferences and region. We will generate risk profiles monthly for each member and use our Managed Care Coordinators' sound clinical judgment to identify changes in status and meet members' changing needs swiftly.

We design Managed Care Coordinator assignments for the Clear Health Plan to balance members with intense care coordination needs with those with less intensive needs in a panel. This allows our Managed Care Coordinators to be flexible in responding to the needs of each of our members in a manner and level of intensity that best meets their needs at any given time. In addition, this balanced panel method allows Clear Health to support case management staff located as close as possible to the communities where our members live, building solid relationships with our members, providers and partners.

2. COMPREHENSIVE DATA SOURCES FOR RESPONSIVE RISK STRATIFICATION

To maximize the effectiveness and responsiveness of our risk stratification process, we include comprehensive data on our members to determine their risks and priorities for case management. These data sources include:

- Demographic/Enrollment Data: provided by AHCA and confirmed by our Welcome Call. Data is used as a part of the predictive analytics model to establish an initial risk score and enrollment information often contains indicators for complex and special needs members.
- Utilization Management data, including authorizations, claims and non-covered services. We monitor data in our utilization management department and flag individuals who have patterns of use or for whom there are claims for non-covered benefits. We also look at the converse -- members who have authorizations or orders but no matching claims for that service. These members are referred to case management to ensure coordination of care and to determine if there is an unmet need or members not fully accessing their health benefits.

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- Pharmacy claims data: ongoing review of Pharmacy Claims data is used to flag over-utilization of some medications indicating possible SUD, as well as under-utilization indicating lack of adherence.
- Initial Screening. Performed with all new members during the welcome call, an Initial Screening tailored to the needs of the population provides real-time information about the new member's needs. Members who answer these questions affirmatively are referred to case management for follow-up including more comprehensive assessments.
- Comprehensive Health Risk Assessment. All members engaged in case management complete a comprehensive health risk assessment including a specific HIV disease questionnaire with the Managed Care Coordinator that reviews medical and BH history, diagnoses, ongoing issues, and service needs. The Comprehensive HRA is the basis for the care plan.
- Data from providers, including referrals for case management. We work closely with our providers and encourage referrals to case management when providers have an enrollee they are concerned about or who has additional needs. In true partnership to improve health outcomes, our providers and Managed Care Coordinators regularly collaborate to address medical and psychosocial issues of our shared members .
- Input from staff working with members. Managed Care Coordinators working with members identify additional data points and concerns and can escalate or lower risk profile at any time due to changes in status, social needs, or member responses to interventions.

3. USE OF SOPHISTICATED PREDICTIVE MODELING FOR RISK STRATIFICATION

Predictive modeling tools are used monthly to identify changes in risk domain, driving possible changes in case management contact frequency and interventions. We developed our predictive model to compare the complexity of the conditions of all members in our diverse population. This allows us to stratify all members appropriately, thus identifying members with the most complex needs/conditions requiring intensive case management and follow-up.

Our CI3 is the primary component of our proprietary predictive modeling system which synthesizes data to indicate the member's overall illness burden and develop an individualized member risk profile and score. We customize the tool to the HIV/AIDS population, including prioritizing certain high-risk flags, diagnoses, and non-compliance with ART medications, to ensure that the results are helpful to our Managed Care Coordinators in coming up with a comprehensive and responsive care plan with the member.

In addition to the CI3, we use four other predictive modeling tools with this population to generate risk scores among sub-populations to stratify the member's risk level, prioritize outreach and assessment, and determine the scope and level of interventions needed.

- ER TRIAGE. Predicts the likelihood of low-level ER utilization.
- Readmission risk. Recalculates based on the inpatient daily census report to determine the likelihood of readmission.

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- BH First Time Admission. Identifies indicators of BH issues that may result in first-time admission.
- Pharmacy. Identifies indicators of over-utilization and possible substance use disorder.

Some of these members may already be thoroughly engaged with our Managed Care Coordinators and there will be limited new information. For some members who are less engaged with Managed Care Coordinators, the process may flag a new acute issue or a pattern in utilization that is actionable through case management. We identify changes in member stratification through review of their past 12 months of claims for which data is available. Additionally, the system considers member historical information, including diagnosis and demographics to predict future outcomes.

All members have a clinical profile generated monthly to track changes in status and meet members' changing needs swiftly. These individualized clinical profiles contain information about each member including: demographics, contact information, CI3 and Likelihood of Inpatient Admission (LIPA) scores, coexisting conditions, utilization data, and recent case management information.

4. FREQUENCY AND INTENSITY OF CARE COORDINATION INTERVENTIONS

Our case management protocols and expectations are tailored to meet the individual needs and goals of our members and the level of risk at their current state of disease progression. We know the needs of our members change and evolve over time, we expect that all our Managed Care Coordinators will connect with each high-risk member enrolled in case management at least once every 30 days. For members with low or medium risk profiles, Managed Care Coordinators will make contact every 60 to 90 days. Depending on case mix of risk profiles, the average caseload for a Managed Care Coordinator is 100 - 130 members although that varies based on member complexity and needs. For members with the more intensive needs, the average case load is between 40 and 80 based on member preference for communication methods (face-to-face or telephonic). In addition, Clear Health has supervisory and support staff who do not carry caseloads but support the work of the Managed Care Coordinators.

Case Management staff are reflective of the population served and are assigned to members based on several factors, including but not limited to, language (English/Spanish/Creole), gender preference (male/female), age, and cultural factors (including sexual orientation). Staff is provided training and continuing education in HIV/AIDS as well as social concerns facing this unique population. In addition, staff attend AIDS Education and Training Center webinar trainings monthly to maintain up-to-date knowledge of HIV/AIDS in addition to enhancing their knowledge of community services. The case management department subscribes to and regularly reviews top HIV treatment resources to remain abreast of new developments in care and treatment issues as well as to educate our enrollees and refer them to reliable sources for information and support.

Case Management interventions with Clear Health members are aimed to support our members in managing their HIV/AIDS diagnosis and achieve best possible health and functionality. As our members have aged, so have the number and complexity of their co-morbidities requiring a more comprehensive approach to case management. Our plans of care address co-morbid conditions and consider the whole health of the member.

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We tailor Clear Health case management interventions to meet the needs of the individual member and vary based on intensity of need and member preferences. Based on their initial risk scores, we will assign members to one of three population health risk levels (low, moderate/rising, and high/urgent) and conduct outreach to those with higher needs. The risk levels build upon one another and define the types of services, supports, and resources for members at each level. We recognize the status of members' physical or BH risks and needs will fluctuate throughout their time enrolled with us. We generate risk profiles monthly for each member and use our Managed Care Coordinators' sound clinical judgment to identify changes in status and meet members' changing needs. Members may request to join the case management program or increase the intensity of our interventions to meet their needs.

Members with low risk will have ongoing access to our Member Services line to request coordination of care and benefits, including transportation, and will receive proactive, tailored communication about self-care, management of chronic conditions (for those in our disease management program) and reminders to complete all recommended preventive services. All members can request to speak to a Managed Care Coordinator at any time by calling our Member Services line or Clear Health Care Coordination queue.



Members with high and urgent risk, who consent to enrolling in case management, are assigned to an experienced, licensed Registered Nurse or Social Worker. We determine assignment by several factors, including whether the member's primary condition of concern is a physical or BH condition; what the member's primary language is; and where the member lives. We work hard to assign members to Managed Care Coordinators who are familiar with resources in the member's local community, including the resources tailored to meet the needs of our specialty population. Many of our Managed Care Coordinators have been with the plan since our inception and bring decades of experience navigating the health care delivery system and community resources on behalf of our members. They bring passion and purpose, as well as strong technical skills, robust protocols, and service templates, to their work. Our Managed Care Coordinators receive integrated physical health and BH case management training through My Learning and co-manage members as needed to offer comprehensive, cohesive support.

The individualized plan of care will be completed in collaboration with the member, legal guardian, or other legally authorized individual based on the member's preferences. The plan includes, but is not limited to, the following based on member assessed need and priorities:

- Identified problems based on discussion with member/caregiver, HRA findings, and additional assessments (as applicable).

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- Interventions to mitigate problems, improve self-management and/or decrease health risks including, but not limited to, the following as applicable:
 - Education based on the member assessment of health risks and chronic conditions
 - Monitoring of adherence to treatment regimen
 - Co-morbid conditions and the monitoring of other health related conditions and lifestyle issues
 - Symptom management, including addressing needs such as working with the member on health goals
 - Emotional issues of the caregiver
 - Behavioral management issues of the member
 - Effective communication with providers through care coordination of appointments, primary/specialist care, transportation, and other assistance as needed to facilitate care for member
 - Medication management, including the review of medications that a member is currently taking to avoid adverse effects or interactions from contra-indicated medications
 - Referrals to formal/informal resources, including community based supports such as Ryan White programs for support groups, legal, food and/or housing assistance as needed
- Identified barriers, if any, to care or member participation in goals
- Established and measurable goals/objectives and outcomes, as well as sufficient information, to determine if goals/outcomes are met

Once the care plan is in place, the Managed Care Coordinator works with the member to support them in meeting the individual goals and responding to acute events as needed to promote health. Care plans are updated at least annually or as our members health status changes.

Partnering with our members to improve their health often involves drawing on the unique expertise of more than one Clear Health case management staff person. Thirty-four percent of our members have serious mental illness in addition to HIV. To effectively manage these members, our Managed Care Coordinators may work together to form a multidisciplinary team to engage the member, their caregivers, and the community-based providers in a holistic manner. Clear Health members maintain one main point of contact with a Managed Care Coordinator to reduce confusion, facilitate solid relationships, and streamline communication.

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5. INNOVATIVE STRATEGIES FOR ENGAGING HIGHLY RESISTANT AND DIFFICULT TO REACH POPULATIONS

Over the past four years, Clear Health learned important lessons about engaging our members that led directly to improvements in current practice. Many of our members are difficult to engage in traditional ways due to negative past experiences with health plans and healthcare providers; complex medical and BH conditions, including a high prevalence of SUD among our members; transient lifestyles; or other social determinants of health. We meet members where they are – in their homes, community centers, and shelters. We work with community partners and trusted providers to locate and engage members in their health care. We use all tools available to connect with our members initially and offer sustained, person-centered case management support and benefits.

**** REAL STORY: Connecting Hard-to-reach Member to Services and Supports Improves Health and Quality of Life**

Sometimes it helps when you have a history with someone. That's what Shay, our Managed Care Coordinator, thought when she saw Natalie's name on the new member roster. She had been Natalie's case manager under the Ryan White program at The Village in Miami, and knew she had a history of chronic homelessness, substance use, mental health issues, stroke, and criminal justice system involvement, in addition to HIV. She asked to be Natalie's Managed Care Coordinator, and, from her file, learned that Natalie had been intermittently filling medications and attending medical appointments and could not be reached.

As before, Natalie was hard to locate, so Shay referred her to one of our Outreach Care Specialists who located her at a women's shelter. By rekindling this trusted relationship, Shay was able to engage Natalie to take renewed interest in rebuilding her health and strength. She educated Natalie about her benefits, coordinated appointments with a PCP and psychiatrist, connected her to physical therapy, and helped her get approval for a motorized scooter. Natalie also began attending a support group at the clinic where her PCP and community case manager are located. She is taking her HIV and mental health medications more consistently, and is accessing a local food bank to help meet her nutritional needs. Her health and quality of life have improved dramatically, and best of all, Natalie is now living in her own apartment with financial aid from a housing program for persons living with HIV/AIDS. **

5.1. Initial Engagement of Members in Case Management

We use various methods to initially connect with all new members and offer case management support. Our Customer Care Representatives attempt to connect with the member first by phone, including attempts at different times of the day and days of the week, and will send an "unable to contact" letter if phone calls are not successful. The Member Outreach Specialist or Managed Care Coordinator may attempt additional methods of identifying contact information for the member including searching past enrollment files and claims information and leveraging publicly available data sources such as those from the Department of Corrections and Healthy Start. We may also use claims data information to connect with providers who have established

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relationships with members and can help us make the initial connections. Clear Health also purchases resources from the Homeless Management Information Services (HMIS), a local information technology service that collates information on homeless shelters that are currently or recently provided services to our members who are homeless. We will use the HMIS “client tracker” to identify the whereabouts of high risk members who are homeless.

Our Case Management teams are notified of all inpatient admissions via our daily inpatient census report and by twice-daily notifications from the Emergency Notification System (ENS). This allows our Concurrent Review nurse located at facilities and/or the assigned Managed Care Coordinator to conduct outreach to the member and facility staff prior to the member’s discharge. At this time, our staff engage the member and family/caregiver as appropriate in discharge planning, share information about our plan and the benefits and supports for member needs, update the member’s contact information, conduct the health risk screen, and explain the case management program. If the member agrees, the Managed Care Coordinator makes an appointment for the comprehensive health risk assessment and to initiate support for transition to the next level of care. Our Managed Care Coordinators also share information about the hospitalization with the member’s providers if known, closing the loop and promoting continuity of care throughout our system.

Community based organizations are a key resource in connecting with and gaining the trust of many members. Project AIDS Care (PAC) Waiver organizations, in particular, have experience working with homeless and marginalized populations that are difficult to reach and engage in care. As the PAC Waiver program ends in the 2017, we have agreements to continue to work with several of these organizations to capitalize on their established processes and relationship with our members. For example, the organizations will assist in engaging homeless members, will facilitate housing applications, will support members with housing issues, such as securing housing or shelters. Likewise, the community-based PAC waiver groups will be our “boots on the ground”, in some cases and in some communities, to engage with members in their spaces and to engage them to close gaps in care. The groups can also help our members with maintaining Medicaid eligibility which can be challenging for members who are difficult to reach. We also partner closely with County Health Departments, Ryan White providers and other community-based entities that reach our members.

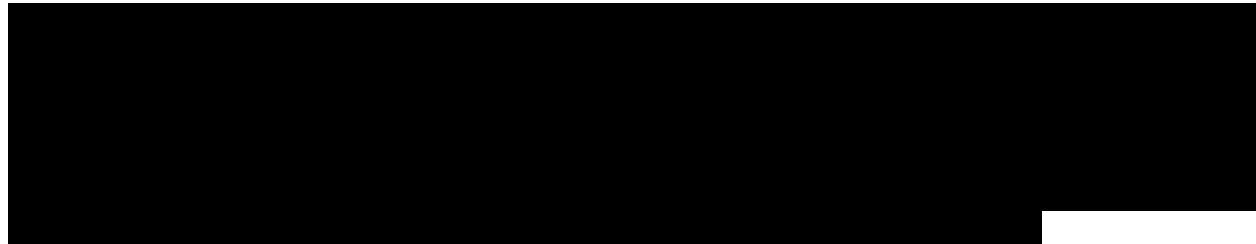
For members whom we are not able to engage in case management, our Member Outreach Specialists continue to track and monitor their care, filling gaps as needed. The Outreach Specialist will continue to reach out to members and try to engage them more fully in plan offerings.

5.2. Sustained Engagement of Difficult to Reach Members

Our approach to person-centered case management is designed to ensure maximum engagement by all our members throughout their tenure with our plan. Our Managed Care Coordinators engage members in programs using Motivational Interviewing, Recovery and Resiliency, Trauma Informed Care, and Person-Centered Care Planning techniques – evidence-based methods proven to maximize and sustain engagement. With these techniques, the member actively manages their own health care needs and improves their quality of life with the support of our clinical staff.

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We serve the needs of our members using a combination of telephonic and in-home visits for high intensity case management interventions and clinical programs, based on each member's individual assessed needs, preferences, and the experience of our Managed Care Coordinators. We take care to build trusting relationships between Managed Care Coordinators and our members including ensuring that each member has one point of contact and that there is minimal disruption of the relationship.



5.3. Specific strategies to engage challenging populations

Clear Health Managed Care Coordinators use diverse strategies, program models, and programs to meet the needs of target population defined by AHCA and address the individual needs of members.

- **Members with Complex Medical and BH Needs.** We fully integrate management and delivery of acute and primary care, BH, substance use disorder, pharmacy, social services, and supports in all clinical programs. Our Managed Care Coordinators engage interdisciplinary care teams in support of member goals and work closely with members' PCP and BH providers, and community based providers to form a comprehensive plan of care. This alignment begins during the risk stratification process, including integration of physical and mental health questions during the comprehensive assessment and review of medical and BH claims and utilization history to assess risk and gaps in care.
- **Members with High Utilization.** Our Managed Care Coordinators proactively collaborate with members to disrupt the cycle of decompensation that results in re-admissions. We accomplish this goal by leveraging existing relationships between members and Managed Care Coordinators to promote stability while intensifying the level of intervention. Managed Care Coordinators work with members through post-discharge periods to re-establish connections with outpatient providers which can be lost during frequent admissions, coach members on defining root causes of admissions, and recognize red flags and frequent medication reconciliation and follow-up.

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- **Members with Intensive Health Care Needs.** Clear Health leverages our close working relationships with community based organizations to assure that members with complex needs receive all needed supports in a coordinated fashion. For example, we collaborate with local Ryan White agencies and PAC waiver entities to support the social support needs of members. We also partner with psychiatric institutions, provider organizations, and ancillary providers to form interdisciplinary care teams to support unique member needs.
- **Members Consistently Accessing Care at the Highest Levels.** We proactively identify high utilization and risk factors for ER or admissions visits among adult and pediatric members and coordination with community-based supports to address barriers. Our case management program, emphasizes re-connecting members with their primary care providers after hospitalizations or acute exacerbations of chronic conditions and addresses the social determinants of health that can negatively impact outcomes. When appropriate, we encourage our members to select one of our Red Ribbon providers -- physicians recognized for their HIV expertise, sensitivity and competence in managing the complex medical and BH co-morbidities that are often present for members with HIV/AIDS and may drive care choices.

6. EVIDENCE BASED INTERVENTIONS THAT ACHIEVE OUTCOMES

Our Case Management program is designed to support our Managed Care Coordinators in reducing fragmentation in the care delivery system; promoting the use of evidence based guidelines in the plan of care process; supporting the navigation of transitions; and including an integrated interdisciplinary approach to assessment, planning, facilitation, and advocacy for enrollee's health needs. We rely on evidence-based standardized clinical practice guidelines (per U.S. Department of Health and Human Services (DHHS) Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents and the Primary Care Guidelines for the Management of Persons Infected with HIV published by the Florida AIDS Education and Training Center (AECT).

Recognizing that members have comorbidities, evidence based guidelines used to enhance the Case Management program and individual care planning process come from nationally recognized organizations, such as, but not limited to, the American Congress of Obstetricians and Gynecologists, United States Department of Health and Human Services (DHHS), National Heart, Lung, and Blood Institute, American Diabetes Association, and the American Heart Association.

Our Managed Care Coordinators carry out activities consistent with the case management process as defined by current Standards of Practice for Case Management (published by the Case Management Society of America). These activities include:

- Case identification/case selection
- Case initiation, including member consent for participation in case management
- Assessment
- Planning
- Monitoring and evaluation
- Case closure

All our Managed Care Coordinators use evidence-based engagement techniques, including motivational interviewing, that are shown to increase enrollee engagement and encourage adherence.

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Additional evidence-based processes within our case management approach include:

- Communicating frequently and performing follow-up with members to promote sustained engagement.
- Focusing on care coordination and ensuring that PCPs and other providers are informed about events and changes in members' status, including notification of admissions and changes of status, adherence to medications, sharing the discharge plan, and individualized care plans.
- Performing case rounds. Managed Care Coordinators meet monthly as a multi-disciplinary team supported by the Medical Director, Psychiatrist, Pharmacist, and BH specialists to review cases, determine case management interventions, resolve barriers to engaging members in the care planning process, and achieve care plan goals.
- Managed Care Coordinators have access to other licensed health care professionals for consultation of members' cases whenever needed. These include Clear Health Medical Directors and consultant HIV expert physicians.
- Performing post-discharge case management, including in-person visits to high risk members following the evidence-based Coleman model.

The recent merger between Simply, Amerigroup Florida, Clear Health and Better Health precipitated a helpful review of case management processes and best practices across entities to create a consistent standard operating procedure for the plan. This type of thorough review is rare for existing programs and contributed meaningfully to the value the combined Simply and Clear Health bring to our members and AHCA.

Some of the innovations spread during this review that contribute meaningfully to the care of our members include:

- Introduction of validated predictive models to support risk stratification.
- Expansion of intensive, "feet-on-the-street" Case Management programs for members with complex BH conditions and high utilization (Rising Star and CARES).
- Expansion of pharmacy monitoring programs, including the antidepressant late fill program and the controlled substance utilization monitoring program.

7. EFFICACY OF CARE COORDINATION PROGRAM IN ACHIEVING RESULTS

Clear Health saw dramatic improvements in quality scores over the past year due to recent enhancements in the care model to include additional staffing, coordinated training, and continuous quality improvement plans. Clear Health regularly meets and exceeds performance expectations on metrics most important to members and AHCA in terms of quality, cost avoidance, and member and provider satisfaction. We effectively translate our intimate knowledge of HIV/AIDS disease processes, wide-reaching disease management, and case management supports to improved outcomes.

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In May 2016, Clear Health Alliance earned a DecisionHealth Case in Point Platinum Award for payer-based Disease Management and Population Health programs. Recognizing organizations working across the care continuum who developed creative and innovative ways to manage patients with chronic medical conditions, they selected our program for work to best educate and empower individuals, improve adherence and wellness, manage quality of care, and contain health care costs. Our model generated interest by other states who are interested in this innovative Medicaid program.

7.1. Performance in achieving cost savings, cost avoidance and ED diversion

Despite our complex member population, Clear Health continues to perform well (relative to other plans in the state) on potentially preventable admissions, achieving the second lowest rate among plans (and lowest of all specialty plans) in 2016. By partnering closely with members and providers through diverse programs and responsive case management approaches, we are achieving improvements in the cost of care.

- 30-day all-cause re-admissions: 28.4 percent, a statistically significant improvement from the year prior (31 percent)
- Inpatient Psychiatric Admissions / 1000 Member Months: 95 (remaining stable)
- Pharmacy per-member-per-month (PMPM) Costs: Reduced \$100 PMPM since 2014 despite higher proportion of members on appropriate medications, including Highly Active Retrovirus Treatment (HAART)

7.2. Performance on metrics reflecting engagement of our members

Connecting our members to outpatient providers is important for continuity of care, medication management, and stabilization of conditions to prevent re-admission and promote good control of HIV/AIDS and other chronic conditions. We saw gains in several important HEDIS measures indicating improved engagement.

- Members on HAART – 94 percent (64 percent improvement from one year prior)
- Percent of members that had zero medical visits in 12 months – 11 percent (49 percent improvement from one year prior)
- Percent of members that had \geq two HIV-related medical visits in 12 months – 75 percent (17 percent improvement from one year prior)

7.3. Member and Provider Satisfaction with Case Management

Clear Health conducts annual surveys of members and providers to assess satisfaction with plan performance on a variety of important topics, including the core competencies of case management, engaging members and communication across settings. In 2016, results continued to show strong results.

- Percent of providers who reported that Case Management/ Disease Management had a good impact on members disease status: 95 percent

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- Member satisfaction with Coordination of Care: 95 percent

**** TESTIMONIAL:** I notified Managed Care Coordinator Dina of our difficulties finding a cardiologist in our patient's area who would take his insurance and also of our patient's difficulties with his keeping appointments due to lack of transportation, inability to read, and organizational skills. She was not only able to find a cardiologist in his area who was willing to work with Clear Health Alliance, but also arranged transportation for him and communicated effectively with him so that he kept his first and subsequent appointments with cardiology who replaced his pacemaker wires which had been unattended for years. - Jennifer Janelle, MD, Fellowship Program Director, Department of Medicine, Division of Infectious Diseases and Global Medicine, University of Florida ******

All told, Clear Health's innovative, integrated, responsive case management programs contribute meaningfully to members' health outcomes and quality of life while reducing the overall cost of care.

**** REAL STORY: Patience and Persistence Lead to Improved Outcomes**

Christine, a new member with AIDS, first met Angelina, our Managed Care Coordinator, when she was hospitalized for a severe infection. Angelina came to talk with her about remaining compliant with her medications and treatment plan, but Christine was not initially receptive.

Angelina talked with her several times, reinforcing the urgency to be compliant, and due to her patience and persistence, Christine agreed to start taking her HIV medications and enter into care with an infectious disease provider at a local community-based organization. For a time, she was compliant, but she did struggle.

When Christine relocated, Angelina helped her find a new infectious disease provider whom she is comfortable seeing; she has become medication-compliant, is scheduling her own appointments and transportation; and her latest lab tests show improvement. To show her appreciation for Angelina's help, support, and encouragement, Christine sent her a postcard saying, "Through all of my inconsistencies, you never turned me away when I came running back for help. You've impacted my life in ways you will never know, that I cannot explain. Just know I appreciate you and owe my life to you!" ******

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Evaluation Criteria:

1. The extent to which the respondent's algorithm and risk stratification approach is well-defined and incorporates data elements other than diagnosis.
2. The extent to which the respondent describes data sources that are incorporated into the risk stratification process that is used for new enrollees.
3. The extent to which the respondent's approach includes the use of predictive modeling.
4. The extent to which the frequency and intensity of the care coordination services (i.e., maximum caseload and minimum contact requirements) are aligned with the respondent's risk stratification process and proportional to the clinical and psychosocial needs of the target population.
5. The extent to which the respondent's approach includes innovative strategies for addressing the unique needs of highly resistant or difficult to serve populations.
6. The adequacy of the respondent's description of evidence-based interventions in achieving improved outcomes and enhancing enrollee engagement.
7. The efficacy of the respondent's approach in achieving cost savings, cost avoidance, emergency department diversion, increased utilization of ambulatory care settings, etc.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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SRC# 21 – Coordination of Benefits (Statewide):

The respondent shall describe the strategies utilized in care coordination with other plans and insurers (e.g., Medicare) to provide necessary services for its enrollees when the third party payer is the primary insurer. The respondent shall include information on its approach in the following circumstances:

- a. Florida Medicaid does not cover the service, but it is available through the third party payer;
- b. Florida Medicaid and the third party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses. In this scenario, the respondent shall identify any differences in its approach if the enrollee is dually eligible for Medicare and Medicaid;
- c. The third party carrier benefit limit is exhausted and the service is now a Medicaid expense. In this scenario, the respondent shall identify any differences in its approach if the enrollee is dually eligible for Medicare and Medicaid; and
- d. The service is not covered by the third party but is available through Florida Medicaid.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Efficient coordination of benefits is a central part of our integrated, person-centered approach to meeting individual needs and contributes to both provider and enrollee (member) satisfaction with the plan. We strive to reduce confusion, minimize delays, prevent gaps and coordinate care with other plans and insurers (e.g., Medicare) to provide necessary services for our members when the third party payer is the primary insurer. Our guiding principle is that member access to medically necessary services is paramount. Clear Health's cost avoidance and recovery strategies prudently manage Medicaid funds with the least impact on providers and members. Our program leverages the resources, systems, processes, and best practices from Simply's 14 years of experience in Florida, plus that of our affiliates nationally, so that Medicaid is always the payer of last resort. To achieve these goals, Clear Health has a robust process for identification of other health insurance, cost avoidance processes through coordination of benefits, post-payment recovery strategies and working with members and providers (network and out-of-network) to identify and resolve the root causes of inappropriate billing or confusion regarding benefits. In 2016, Simply's coordination of benefits processes, including processes for Clear Health members, yielded nearly \$106 million in cost avoidance, while maintaining high member and provider satisfaction with the plan. More than 90 percent of providers in our network, including Clear Health network providers, rate high satisfaction with our claims processing performance.

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We leverage experienced clinical and financial personnel, technology and automated applications, and consistent, replicable processes to assure our members receive the care they need in a compassionate and financially responsible manner.

Collecting and maintaining accurate third party payer information is central to our coordination of benefits strategy. We build this data collection in member-facing and behind the scenes processes to assure comprehensive information is available:

- Upon enrollment, we collect 834 file indicators for members with other coverage
- We have a nightly batch process that leverages the Centers for Medicare and Medicaid Services (CMS) beneficiary enrollment query (BEQ) to determine if Medicaid members have Medicare primary coverage
- Key personnel maintain MARx access to validate specific Medicare enrollment information
- We update the demographic profile in the member record when we receive third party payment information through the submission of electronic medical records or through paper and electronic claims notifications
- Customer Care Representatives and Case Managers (Managed Care Coordinators) inquire about other health insurance during the new member welcome call, the initial screening, the comprehensive health assessment, and as a part of ongoing case management reviews
- Customer Care Representatives are automatically prompted to inquire about other coverage during calls if not updated in six months
- Annual survey to dual eligible members requesting information on other potential coverage
- Clear Health's coordination of benefits staff review and verify leads of third party liability received from members and providers and electronic files received from State partners.

We provide comprehensive training in the coordination of benefits to all staff and assure the information is readily available in our Core Operations System. Whether it is Claims Representatives understanding the payment hierarchy for a claim, Customer Care Representatives understanding the benefits, or Managed Care Coordinators trying to maximize the support and care they provide; all staff are focused on navigating benefits to support our members. We also assure our subcontractors are extensively trained in coordination of benefits and receive eligibility files with dual status indicators.

1.a. Approach to Coordination of Benefits with Third Party Payers for Benefits Not Covered by Florida Medicaid

All member-facing departments have a responsibility to coordinate benefits when our member needs a service that is not covered by Medicaid but is available through their other insurer:

- We train our Customer Care Representatives under the following model: Listen, Research, Coordinate. First, they understand the member's needs and evaluate those needs against our standard and expanded benefit package. If the needs cannot be satisfied by our Medicaid benefit

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package, the Representative is responsible for exploring alternatives such as community based resources, primary insurance coverage, or other options. When found, the Representative coordinates access to services for the member.

- When Managed Care Coordinators identify member needs that go beyond our benefit structure, they engage members to develop a comprehensive, person-centered plan of care. The plan of care may include services covered by Clear Health and by third party payers, and services available through resources in communities. Throughout our case management processes, we proactively identify benefits that support the member's plan of care and goals and work collaboratively with members, third party payers, and community based resources to secure the needed services and assure coordination in delivery.
- When our Utilization Management department receives a request for authorization of a service that is not covered under our benefit package, they research the member's third party coverage options and coordinate benefits as necessary.
- When the Claims department receives a claim for a service that is not covered under the standard benefit package, they research the service requested assessing coverage guidelines, any potential authorizations on file supporting medical necessity, and third party payment coverage. For members under age 21, Clear Health follows our customized claims workflows related to EPSDT services. All claims for pediatric members undergo a retrospective medical necessity review and are covered.
- When our Grievances and Appeals department receives an appeal request, part of their response is to assist the member in obtaining the services through other avenues, which may include referring to Customer Care Representatives for assistance in coordinating the service.

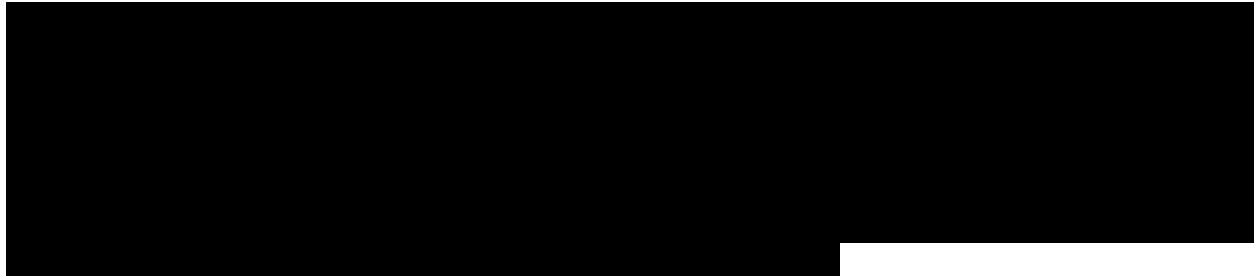


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1.b. Approach to Coordination of Benefits When Florida Medicaid is Responsible for Co-Payments

Clear Health often provides wrap-around coverage for members with more than one health plan, paying for copayments and deductibles for services covered by both plans. When members need services covered by both Medicaid and the third party payer, Clear Health proactively coordinates with member, third party payers and providers to reduce administrative burden and streamline care:

- Customer Care Representatives and Managed Care Coordinators understand the members' needs and evaluate those needs against our standard and expanded benefit packages. If the service requested by the member is covered by the primary insurer, the Customer Care Representative/ Managed Care Coordinator educates the member regarding the secondary coverage and coordinates the services with the primary provider.
- When the Utilization Management department receives a request for authorization of a covered service also covered by a third party payer, Clear Health would not require an authorization for the service unless the research concludes that the member has exhausted the benefits. In the case that the member has exhausted the benefit, Clear Health would assume the role of primary payer and process accordingly.
- When the Claims department receives a claim for a Medicaid covered service for a member with third party liability, the Claims Analyst validates that all needed documents or electronic information were submitted with the claim to coordinate benefits. The claim processes in accordance with the provider handbook, chapter 4, which outlines appropriate copayment and patient responsibilities. If the information received with the claim indicates the member's benefit has been exhausted with the third party payer, Clear Health would assume the role of primary payer and process accordingly.

The following contains more detailed information about our claims process. For example, our Core Operations System applies a series of edits to identify and prevent potential overpayments based on the member's other insurance information or indication of prior adjudication by the primary carrier. Through these edits and associated processes, we make sure that known third party payers are billed prior to paying a claim. For members with third party Medicare, Clear Health accepts the Coordination of Benefits Agreement (COBA) file that includes Medicare adjudicated claim data and automatically processes crossover claims for all our dual eligible members who are not participating in our Medicare Advantage plan, covering the Medicare deductible or coinsurance amount up to the Medicaid maximum fee, less any amounts paid.

For all other third party payers, our Core Operations System checks the claim for the presence of an Explanation of Benefits (EOB) (indicating prior adjudication) and any third party resources documented on the member's record. If an EOB is attached indicating primary carrier adjudication, we coordinate benefits automatically or the claim pends for review. An analyst reviews pended claims and attached EOBs to make sure that any copayment, coinsurance, or deductible amount does not exceed allowable amounts and approves the claim for payment.

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If no EOB is attached, our system checks for third party resources in the member's record. If present and the claim dates of service are within the effective and termination dates of the other coverage, the claim pends for analyst review. If the claim is covered by pay-and-chase rules (such as EPSDT, Title IV-D, and pregnancy related services) or State exceptions, it is paid and subject to retrospective recovery. If exceptions do not apply, the claim is returned to the submitting provider with information on the other carrier, including address, policy number, effective date, and policy holder. We include instructions to bill the appropriate third party for payment and then to resubmit a claim if there is a balance owed.

1.c. Approach to Coordination of Benefits When Third Party Benefit Limit is Exhausted

Members with another plan may exhaust benefit limits for a particular service within the defined time period. When the member needs a service and it is covered by both Medicaid and the third party payer but the third party payer benefits have been exhausted:

- Customer Care Representatives and Managed Care Coordinators understand the members' needs and evaluate those needs against our standard and expanded benefit package. When there is coverage by the primary insurer, the Customer Care Representative and Managed Care Coordinator educates the member regarding the secondary coverage and coordinates the services with the primary provider. This coordination includes proactive engagement with the primary plan to align the person-centered plan of care. If the research indicates the member exhausted the benefit with the third party payer, Clear Health would assume the role of primary payer.
- When our Utilization Management department receives a request for authorization of a service that is covered but the member has primary coverage with a third party insurer who also covers the service, Clear Health researches to determine if the member has exhausted the benefits. In the case that the member has exhausted the primary care benefit, Clear Health assumes the role of primary payer.
- When our Claims department receives a claim for a covered service that is covered under Medicaid, but the member has exhausted the primary payer benefit, Clear Health processes the claim in accordance with primary payer coverage guidelines.

For members who are hospitalized or in another facility setting, we initiate clinical support, tracking, and authorizations for that member at the time of admission before we have financial liability. Regardless of primary payer, our Concurrent Review Nurses review the case with facility staff and our Medical Directors review the cases and support member's treatment plan, as is our standard process for all members. In this way, we assure that the care is integrated in a manner that is person-centered, independent of payer, and that we can be most effective in transitioning the member between service settings when appropriate. For members with Medicare as primary payer, Clear Health staff monitor claim benefit days, supporting proactive engagement between payers to assure seamless transitions when benefits are exhausted.

Claims submitted for members with third party liability are reviewed for an EOB, which indicates prior adjudication by the primary coverage, unless our claims adjudication system is configured to pay primary for billed services. We check to see if the member has exhausted those particular benefits for the time period. If the EOB is attached, the claim pends for review by an analyst to make sure that the benefits comply with Medicaid rules and regulations. We record the EOB

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indicating exhausted benefits in the history, and manually configure the claims adjudication system to process subsequent claims appropriately.

1.d. Approach to Coordination of Benefits When the Service is Not Covered by Third Party but is Available Through Florida Medicaid

Clear Health staff work to streamline processes for members and providers when the member needs a service that is not covered by the third party but is available through Florida Medicaid:

- Customer Care Representatives and Managed Care Coordinators understand member needs and evaluate those needs against our standard and expanded benefit package. If it is identified that the service requested by the member is not covered by the primary insurer, the Customer Care Representative or Managed Care Coordinator educates the member regarding the coverage and facilitates the appropriate service per our standard processes as Clear Health assumes the role of primary payer.
- When our Utilization Management department receives a request for authorization of a service that is not covered by the primary insurer, but is covered by Clear Health Medicaid, they follow our standard authorization procedures and approve the services. Clear Health assumes the role of primary payer.
- When our Claims department receives a claim for a service that is not covered under the member's primary insurance but is covered by Medicaid, Clear Health processes the claim at the contracted rate (or Medicaid fee schedule for non-pars) in accordance with primary payer coverage guidelines.

We serve as the primary payer for all covered services listed on the Florida Medicaid benefits list not covered by other payers.

Clear Health coordinates closely with third party payers for complementary benefits when member initiates a treatment plan. For example, dual eligible members with HIV/AIDS and serious mental illnesses or substance use disorders access Medicare benefits for outpatient behavioral health care, but rely on Clear Health Specialty MMA benefits for rehabilitation or more intensive therapy. Utilization Management staff and Managed Care Coordinators are involved with the member, provider, and third party case management staff to assure appropriate authorizations are in place to facilitate seamless care delivery and claims payment.

Claims submitted for members with third party liability are reviewed for the inclusion of an EOB indicating prior adjudication by the primary coverage, including a denial of the third party claim as a non-covered benefit. If the EOB is attached, the claim pends for review by an analyst to make sure that the benefits comply with Medicaid rules and regulations. We record the EOB indicating non-covered benefits in the history, and manually configure the claims adjudication system to process subsequent claims appropriately.

If the claim does not reflect primary payer adjudication and no EOB is attached, we attempt to confirm if the benefit is covered by the third party payer or if the claim covered by pay-and-chase rules or State exceptions to simplify administrative processes for providers. For example, for Medicare, consolidated information is available on covered and non-covered codes. This information is programmed into our claims review system to streamline claims processing for dual

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eligible members. Likewise, we are aware of select exclusions from other payers, and we have proactively programmed those exclusions into our system to streamline claims payment. Claims subject to pay-and-chase rules, including EPSDT, Title IV-D, and pregnancy related services, are paid up front. Other claims are denied pending review by the primary payer and paid when returned with the EOB.

2.a. Strategies to Limit Member Confusion on Benefits

Proactive communication and education of our members regarding their benefits and their rights is a key part of our servicing strategy. We maintain communication materials in multiple modes and languages. Those modes include TTY, braille, and voice recorded materials.

Plan benefit communications occur throughout the enrollment period. Our customer-facing employees are thoroughly trained on benefits, including Customer Care Representatives, Managed Care Coordinators, Community Outreach Representatives, Grievances and Appeals Specialists, and subcontractor personnel are available to clarify any benefit questions our members may have. We provide our members an overview of their benefits and how to access them during the new member welcome calls. The unique demographics of our employee population affords us a high percentage of bilingual employees, which facilitates new member welcome calls in the member's preferred language, increasing their understanding of the benefits. We also quickly initiate telephone interpreter services in any other language by means of our language translation line which operates 24/7 and we arrange sign language interpreters for in-person meetings as needed. The new member welcome packet, available in the member's language of choice, is accessible at the time of enrollment and includes a complete list of covered benefits. The list of benefits is also available to members through our bilingual member website and mobile application.

Furthermore, Customer Care Representatives and Managed Care Coordinators proactively engage members and providers at key intervals to explain benefits and coordinate care as needed to assure appropriate access to needed services. For example, when connecting with members for our proactive post-discharge call, Customer Care Representatives confirm members are aware of benefits and discuss gaps in the plan of care that may be filled by a community-based resource or third party payer. Our Customer Care Representatives receive extensive training and are knowledgeable about both Medicare and Medicaid programs and benefit packages, as well as resources in communities to support members.

2.b. Processes to Identify Non-Covered Services by the Primary Insurer

Clear Health works collaboratively with AHCA to determine benefits on the Florida Medicaid fee schedule that are not covered by third party payers, leveraging the strength of our information technology to streamline processes when that information is available. For example, codes excluded from Medicare benefits are well documented. Clear Health edits the claims payment algorithms to reflect these exclusions, streamlining payment for related claims. We update our edits each time the CMS modifies the published benefits documents. We document all available information currently and incorporate additional information as it becomes available.

When providers submit claims for services not covered by third party payers, our Claims Analysts record the third party EOB denial in our historical record for that member to streamline future claims for the same service.

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2.c. Processes Used to Streamline Ongoing Authorization and Payment

To reduce administrative burden on providers, streamline claims payment processes, and prevent subsequent delays in care, our systems are configured to ease crossover claims from Medicare to Medicaid knowing limitations of benefit coverage. Our employees are familiar with Medicare and Medicaid and are tracking services by payer, which streamlines applying authorizations where applicable and generally assists in member care.

Clear Health's Core Operating System stores EOB submissions in history for members with commercial third party liability. When subsequent claims are submitted for the same service, manual claims adjudication reviews recognize the history, and process the claims efficiently. In cases when the service is not covered by the primary insurer, these histories may be coded into the claims adjudication system facilitating automatic processing. While annual re-sets of benefit maximums preclude automation in many cases, we remain committed to timely review of these claims and accurate payment to providers.

3. SPECIAL PROVISIONS IN COORDINATION OF BENEFITS WHEN MEDICARE IS THE PRIMARY INSURER

Clear Health works closely with members, providers, and facilities to ensure a seamless care experience for members who are dual eligible for Medicaid and Medicare and enrolled in our plan. Currently, 35 percent of our Clear Health members have Medicare coverage as primary. Our processes include:

- Collecting 834 file indicators upon receipt and leveraging the CMS beneficiary enrollment query (BEQ) to determine if Medicaid members have Medicare primary coverage
- Automatically updating systems nightly to reflect dual eligibility in the member's profile
- Transmitting dual member status within our eligibility transmissions to downstream subcontractors

Our Customer Care Representatives, Provider Relations staff, Managed Care Coordinators, and subcontractor staff receive training on how to coordinate with Medicare benefits. We prioritize actions to minimize the administrative burden on providers caring for members with Medicare and Medicaid coverage, including automating edits on non-covered benefits to reduce claims payment delays, consistent confirmation of Medicare providers including part D carriers, and proactive coordination by our Managed Care Coordinators to assure alignment of benefits and comprehensive care planning for members.

For members with our Medicare Advantage Special Needs Plan (SNP), a provider can submit a single claim that will be automatically processed through Medicare, SNP crossover, and Medicaid, regardless of whether the provider submits the claim under the member's Medicare or Medicaid identification numbers. Our claims processing system identifies the member as dual eligible and processes the claim first through Medicare.

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In line with the AHCA white paper on providing care to Medicare and Medicaid beneficiaries, examples of the specific support we provide to members includes:

- Assist members who do not have a PCP to select a PCP who accepts their Medicare coverage
- Coordinate out-of-network agreements with a PCP or other providers who have an established relationship with our dual eligible members to cover wrap-around services
- Proactively authorize services covered initially by Medicare if primary benefits may be exhausted
- Ensure Medicare providers are enrolled in Florida Medicaid to pay copayments and deductibles for dual eligible members
- Educate network providers about benefits for dual eligible members, including distributing AHCA's white paper on "Coordinating Dual Eligibles Medicare and Medicaid Managed Medical Assistance Benefits."

Our Customer Care Representatives are available to support dual eligible members who may receive bills from providers for all or part of the cost of covered services. In addition, we engage our Provider Relations team to promote coordination of benefits for dual eligible members during visits to providers. Provider education reinforces Medicaid as the payer of last resort (per 42 CFR 433.139), as well as Clear Health's and AHCA's requirements and policies. Provider Network Managers can assist with research on members' coverage to avoid potential coordination of benefits issues that can delay proper reimbursement for services.

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Evaluation Criteria:

1. The adequacy of the respondent's approach when:
 - (a) Florida Medicaid does not cover the service, but it is available through the third party payer.
 - (b) Florida Medicaid and the third party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses.
 - (c) The third party carrier benefit limit is exhausted and the service is now a Medicaid expense.
 - (d) The service is not covered by the third party but is available through Florida Medicaid.
2. The extent to which the respondent's approach includes:
 - (a) Documentation of effective communication strategies to reduce confusion for the enrollee (e.g., strategies used in enrollee materials).
 - (b) Processes used to identify non-covered services by the primary insurer for individual enrollees.
 - (c) Processes used to streamline ongoing authorization and payment of services once the initial determination has been made that a service is not covered by the primary insurer or the benefit from the third party insurer has been exhausted.
3. The extent to which respondent's description specifically addresses special processes in place to improve care coordination, including provider communications, and service provision for dual eligibles when Medicare is the primary insurer.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
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SRC# 22 – Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Statewide):

The respondent shall describe its approach to education and monitoring of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements, including:

- a. A description of outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements and to improve compliance with the periodicity schedule and treatment recommendations that are identified as a result of a screening.
- b. A training plan that includes descriptions of strategies that will be used to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the plan (case management, utilization management, provider relations, etc.) as well as subcontractors.
- c. A description of the monitoring approach that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the plan and with subcontractors.
- d. A plan for ensuring greater transparency among external stakeholders (e.g., advocacy groups) in the respondent's approach towards coverage of the EPSDT benefit.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Clear Health shares AHCA's commitment to promoting preventive screenings and health care as well as medically necessary diagnostic and treatment services for children. The EPSDT benefit is a hallmark of Medicaid coverage for children and adolescents. Without the recommended EPSDT screenings, potentially serious health conditions are more likely to go undiagnosed and untreated, resulting in poorer health status throughout childhood and into adulthood.

Our approach to ensure children receive recommended and needed services is specialized. We have approximately 300 children in Clear Health, which allows us to use a very high-touch outreach strategy. Every child enrolled in our plan has a Case Manager (Managed Care Coordinator) and may receive home-based doctor visits. For our members (children) that are HIV/AIDS positive, we understand the challenges they face and are here to support them. Some of our members who are positive for HIV/AIDS are newly diagnosed and in their teens. Many others were born with HIV. Our Peer Educators help these members – reinforcing that with the appropriate medications, they can live long, healthy lives.

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We combine our high-touch outreach tactics with traditional outreach efforts to increase participation in Florida Medicaid's Child Health Check-Up Program (CHCUP). The overall improvement in our screening and participation ratios and the 80 percent screening benchmark since 2012 is an example of the success of our outreach efforts in improving outcomes for our members under the age of 21.

We provide a variety of education and outreach materials through different mediums, such as printed materials, informational calls promoting events and programs, support and funding for community events, and partnerships with clinics, providers, Federally Qualified Health Centers (FQHCs), and school-based health clinics. We use our EPSDT Data Mart to monitor utilization to verify members are receiving timely and age-appropriate services and to follow up when needed. We encourage our members to get timely care by making it easier for them to access care and by providing incentives. Outreach to families occurs at least monthly; for children with medically complex needs, our Managed Care Coordinators are in contact with families multiple times within a month.

Recognizing the requirements unique to CHCUP, we have a non-denial of service policy for services that are medically necessary. For example, we allow therapies in the home when necessary and have provided durable medical equipment (DME) for glucose monitors and insulin pumps. We detail this policy in a Standard Operating Procedure, which is disseminated to all staff. The attached Figure 22-1 in Attachment SRC# 22-1: Special Service Request Workflow demonstrates our process for approving services. It states that only services determined to lack medical necessity or to be investigational or experimental can be denied authorization for pediatric members. To assure staff understand CHCUP, we employ a training plan that incorporates training events and resources, daily on-the-job support from EPSDT experts, and data monitoring for continuous improvement.

We routinely monitor compliance and apply interventions as needed to assure compliance goals are met. Our multi-disciplinary CHCUP work team meets bi-weekly, and sometimes more frequently, to evaluate all CHCUP measures and conduct causal/barrier analysis related to those that did not reach identified goals. Our interventions are collaborative efforts across several departments including Provider Relations, Member Services, Quality Management, and Disease and Case Management.

1. ENROLLEE OUTREACH AND COMMUNICATION

Our diverse outreach strategy makes it easy for members to find information about the recommended schedule of EPSDT visits and immunizations. We inform members of all testing/screenings due in accordance with the periodicity schedule as specified in the Medicaid Child Health Check-Up Services Coverage and Limitations Handbook. We include this information in the member handbook, newsletters, and educational materials posted on the member website.

Specifically, our CHCUP-related member outreach and education includes:

Printed and Online Resources:

Our printed and online resources are extensive, easily understood (materials are written at a fourth-grade level or below) and provided in languages our members speak. They encompass the Member Welcome packet, reminder letters and postcards, newsletters, fact sheets, and our

EXHIBIT A-4-a
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member website. These sources include reminders about timely preventive services, caregiver educational materials, and encouragement to schedule appointments, in accordance with CHCUP guidelines.

New member education includes informing parents and guardians of the importance of child health check-ups and encouragement to obtain an appointment with the child's Primary Care Provider (PCP). Members receive a new member brochure with their membership ID card that describes a simple process for updating their PCP and making an appointment. New members are also given a welcome call by our Member Services line within 30 days of enrollment. In the welcome call, members are assisted with selecting or changing a PCP if they do not have one or would like to select another, scheduling an appointment, and planning for transportation, if needed. Each month we identify members who enrolled 60 days prior and who have not had a CHCUP visit. These members are then called by Member Services to help with PCP selection as applicable and to help to arrange for appointment scheduling. We maintain a process for outreach and follow-up to EPSDT eligible members with special health care needs such as HIV/AIDS through our Member Outreach Team in Clear Health Alliance.

We reach out to members throughout the year to close gaps in care and assist members with any barriers to care. Additionally we have a targeted Q4 initiative that outreached to members who were compliant in the previous year, but who are not compliant for the current year. Forty-five days before our members' birthdays, we mail an age-specific Preventive Health Reminder. The reminder emphasizes the importance of all EPSDT services and provides a complete schedule of services. If the member is overdue for EPSDT screening, the family receives an EPSDT Overdue Service Reminder postcard. In 2016, Simply and our affiliates across the country mailed more than 9.3 million EPSDT-related items to our members, including annual preventive health reminders that coincide with each child's birthday and overdue service notifications to families that have not completed a recommended visit or service.

Postpartum Outreach for New Moms:

New mothers receive a postpartum phone call from our staff and an educational packet emphasizing well-child services for newborns, as well as the importance of the post-partum visit for the mother. New moms also receive ongoing education about the importance of Well Baby care through our My Advocate tool. My Advocate is a multi-channel communication program that provides health education by phone, text message, smartphone app, or online to pregnant members. Clear Health members are referred to HIV post-exposure screening for newborns by qualified pediatricians and counseled to not breastfeed due to the risk of HIV transmission.

Member Incentives:



EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Community-Based Outreach:

Understanding that families can be hard to reach by phone or mail, we bring services to rural and urban communities through locally-based employees and partnerships with community organizations. Clear Health, through the Miami-Dade Mobile Dental Pilot, brought dental services into communities. Managed Care Coordinators call all members under age 21, or their families/caregivers, who live near mobile sites and assist members with appointments. Enrollees who attend mobile clinics receive information regarding nearby brick and mortar clinics where they can receive ongoing dental care as well as contact information for the Dentaquest Clear Health Member Services line. For example, the summer sites include Northside Mall, where Empower U, an HIV-AIDS community health clinic, is located. Enrollees attending the mobile clinic are encouraged to use Empower U for future dental care. Going forward, we will continue using mobile units and other strategies focused on CHCUP services other than dental since dental services will not be in the new contract.

We are developing and leveraging local partnerships and contracts throughout the state to supplement adequacy of our “feet on the street” approach and abilities to find and meet members where they reside to engage them in care. We are developing partnerships and securing contracts with FHQCs, mental health centers, Ryan White providers, former Project AIDS Care (PAC) waiver entities, and housing providers that have traditionally worked with homeless or other individuals who are challenging to engage.

Telephonic and Text Outreach:

Our Florida-based Outreach team contacts and assists members who are due for EPSDT services. In 2016, Clear Health and our affiliates across the country made more than one million phone calls to members and their families with EPSDT and immunization reminders. As part of our Healthy Behaviors program, we send text message reminders to our members about their appointments, congratulate them on achieving program milestones, and more.

Case Management System:

When interacting with members and families, any member of our Member Services and Case Management teams can check the Case Management System record for EPSDT gaps and encourage the family to make an appointment. In addition, Managed Care Coordinators regularly assess compliance with CHCUP at the time of their monthly outreach. If the member is nearing the timeframe for an immunization, well-child visit, or is not in compliance with the periodicity schedule; the Managed Care Coordinator discusses this with the parent/guardian and assists in scheduling the appointment, arranging related transportation, and removing any other barriers to care. In some instances, it is not clinically appropriate for a child to receive a scheduled service. When this occurs, the Managed Care Coordinator documents the rationale in the Case Management System and the monthly State report as appropriate for pediatric complex members. Managed Care Coordinators reach out to families with medically complex children at least monthly, although it is typical that Managed Care Coordinators contact these families multiple times within a month.

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2. STRATEGIES FOR MEMBER COMPLIANCE WITH PERIODICITY SCHEDULE

Our members and their responsible parties experience unique barriers to care due to their health condition, including fear of HIV-related stigma, distrust of the health care system, homelessness/transience, lack of consistent communication means (phone or address), difficulty accessing transportation, and limited knowledge about available services. We have a specific set of interventions to address our members' complex barriers to care and to increase the number of CHCUP exams in compliance with the periodicity schedule. They include the following:

Provider Outreach:

We identify providers with the highest number of non-compliant members and then review a sample of records. We coordinate a visit, with the assistance of the Provider Network Managers to the identified providers. During the visit, we share the results of the sample review, provide additional education, and discuss strategies to increase member compliance.

Member Outreach Team:

Our Member Outreach Team or an assigned Managed Care Coordinator calls members when they are enrolled. At the time of the call, we discuss child health check-ups and dental screening, confirm the assigned PCP, and provide dental provider contact information. Members are offered assistance scheduling a child health check-up visits and dental visits as well as assistance with the coordination of transportation services and home medical visits, as needed.

Compliance Tracking:

Managed Care Coordinators keep track of compliance and engagement efforts including appointment scheduling, accuracy of member contact information, member HIV status, and claims received on the CHCUP SharePoint file. Our Quality Management Liaison meets with the Care Coordination team at least every two weeks to review progress using the information documented by Managed Care Coordinators in the CHCUP SharePoint file as well as weekly non-compliance reports.

At least semi- annually, the team reviews the CHCUP SharePoint file and updates content to facilitate the tracking process and the identification of special circumstances that could potentially impact compliance. Managed Care Coordinators prioritize contact with members who were compliant the previous year and members that are set to disenroll.

"CHCUP Act Now":

Managed Care Coordinators have dedicated time on a weekly basis to follow up exclusively with members who are non-compliant with CHCUP.

Care Coordination Home Visits:

Managed Care Coordinators conduct home visits to members who are not in compliance with CHCUP visits according to the periodicity schedule and who have been unreachable by phone or mail. During the Care Coordination Home Visits, Managed Care Coordinators:

- Complete a comprehensive health assessment and an HIV Assessment

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- Provide education on available services and Healthy Behaviors program
- Schedule appointments for CHCUP visits
- Coordinate transportation for medical visits as needed
- Complete referral for medical home visits as needed

Medical Home Visits: for members who indicate they would like to complete a CHCUP visit, but who cannot attend a clinic; we provide a medical home visit through a medical home visit vendor.

Healthy Behaviors Program:

We also offer the Healthy Behaviors program to educate and support members in choosing healthy behaviors. Our program follows established clinical practice guidelines as well as the national periodicity schedule for well-child visits and immunizations. We will send text message reminders to our members about appointments, congratulate them on achieving program milestones, and more. The Healthy Behaviors program works to encourage members to complete well-child visits and specific immunizations, including:

- A Complete Well Child Health Check-Up with the PCP per the Periodicity Schedule, based on child's age
- Preventive Dental Visit with a dentist per recommendations of the American Academy of Pediatric Dentistry
- All appropriate immunizations per Bright Futures recommendations, based on child's age
- Lead screening according to Bright Futures recommendations, based on child's age

Members earn points that they can use to redeem a range of health-related gifts from the AHCA-approved list, such as cooking essentials, scales, baby wipes, diaper rash cream, crayons, and play dough. The Well-Child Healthy Behaviors program is divided into two programs – one for babies ages 0-23 months and one for children ages 24 months to 20 years. Each program includes several milestones that are based on the Well-Child Visits in the First 15 Months of Life (W15) and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) HEDIS® measures. For example, babies ages 0-23 months are expected to attend at least six well-child visits and receive all required immunizations and a lead screening. Each milestone currently earns the member a set number of points for a total of \$50 per program, which can be used any time for up to one year after completing the program.

All new members receive an introductory packet that includes a Healthy Behaviors brochure along with the new member ID card. Each month, we send invitations to participate in the Healthy Behaviors Well Child Visits Program to parents of all members who are enrolled 60 days prior and are not yet compliant on CHCUP. The Member Services team calls families that do not have a mailing address.

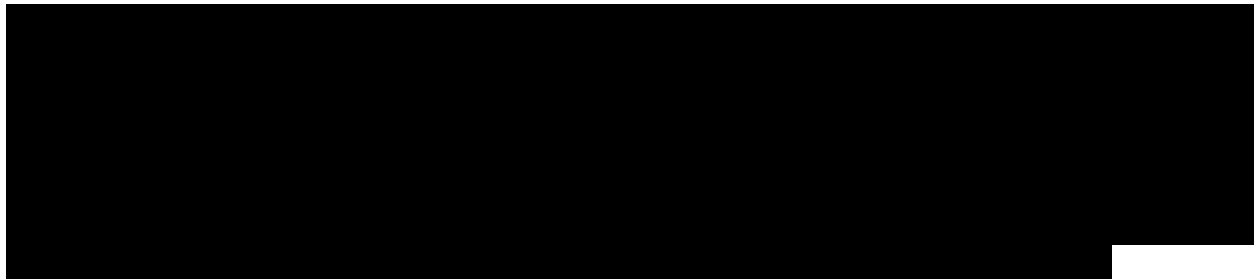
We are making improvements to the Healthy Behaviors program, including revising the milestones and simplifying the program structure. We are also transitioning to a reward card system that will allow members to select a reward card of their choice out of a list of gift cards beginning in November.

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School-based Health Clinics:

We understand that schools offer an ideal setting to engage hard-to-reach members that are sometimes disconnected to care. In response, we developed a school-based strategy that engages school-based providers across Florida, including the Miami-Dade area, Orlando, and Tampa, who offer dental and/or medical services to assure that all members are receiving the preventive care they need. For example, Jessie Trice Community Health Center an FQHC in Miami-Dade County, which operates two comprehensive school-based health centers in Liberty City and Miami Gardens, is a strong partner. In partnership with the FQHC, we have offered Clinic Days at its school-based clinics. Through this effort, we target members and their families connected with these schools who had previously been disconnected from care.

Community Resources:



3. STAFF TRAINING AND EDUCATION PLAN

Clear Health is committed to administering a compliant CHCUP and understands that staff and subcontractor education and training on CHCUP is essential to fulfilling this commitment. The EPSDT program is a locally focused program supported through national resources and experience and compliant with State and federal requirements. We assure compliance through the Clinical Quality Management Program (QMP). We built our staff training and education plan for EPSDT three core strategies: formal training events and resources, daily on-the-job support from EPSDT experts, and data monitoring for continuous improvement.

We educate all staff on the CHCUP as part of our new employee training. We also target employees in member and provider services for additional training given the high volume of direct interaction they have with members and providers. Quarterly refresher trainings are also provided. Training topics include a description of CHCUP and program goals, covered services, the periodicity schedule, well-child billing codes, compliance reports (including the CMS-416), internal EPSDT-related policies and procedures, challenges, current interventions, and potential strategies for increasing member compliance. We use the following mediums to inform and educate staff on CHCUP: in-person trainings, webinar presentations, email communications, written policies and procedures, and program guidance.

While monitoring and processing CHCUP services on behalf of members, our staff receive ongoing support from our Medical Directors who support full compliance. For example, Medical Directors routinely review denial letters, such as those related to services covered on a fee-for-service basis by the State, and confirm that such communications are accurate. If any potential issues are identified, we implement an internal improvement strategy that includes escalation to our Compliance team when applicable.

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Our training and education efforts are further enhanced by the national organization's EPSDT Program. It is governed by a Medicaid Quality Improvement Committee that comprises expert staff including Medical Directors and leaders from Quality Management, Case Management, Disease Management, Pharmacy, and other divisions. We use the national resources available to better educate and inform our staff. For example, we receive alerts when there are changes to federal and State EPSDT requirements and then initiate applicable interventions and mailings as appropriate. While we leverage our national resources to benefit our Florida plan, Clear Health remains accountable for the success of these efforts locally.

Operating under a philosophy of continuous quality improvement, the Quality Management (QM) team monitors the effectiveness and regulatory compliance of the program and acts on opportunities for improvement. Clear Health's QM program is an ongoing, comprehensive, and integrated system that defines how departments support quality objectively; systematically monitors and evaluates the quality, safety, and appropriateness of medical and behavioral care and service offered by the health network; and identifies and acts on opportunities for improvement. Conducting an effective EPSDT program is one of the QM program objectives. Leveraging our direct and extensive Florida experience, we make sure our work aligns with the State's CHCUP goals.

We will also train all subcontractors on EPSDT. In addition to new subcontractors, our Vendor Delegation Oversight Group will conduct Vendor In-Service training for subcontractors already operational when there are significant changes in programs, policy, or when there are changes in management staff and then annually thereafter.

In addition, we will use a Vendor Handbook that outlines the EPSDT requirements, expectations, and monitoring that is provided to new subcontractors. It will be updated annually, as needed, and used to conduct refresher trainings. Information materials will be disseminated throughout the year. For example, we will provide all subcontractors with the AHCA EPSDT Fact Sheet and the Medicaid Covered Services Not Provided by Managed Medical Assistance Plans guidance after they are issued by the state.

4. ADEQUACY OF RESPONDENTS MONITORING APPROACH

Clear Health monitors, evaluates, and improves the quality and appropriateness of care and service delivery to members through peer review, performance improvement projects, medical and case record audits, performance measures, surveys, and related activities. We use a number of data sources to monitor compliance, including: HEDIS® and CAHPS® data, EPSDT DataMart, Florida State Health Online Tracking System (SHOTS), medical records, and Key Performance Indicator (KPI) reports (for subcontractors).

Clear Health facilitates a formal evaluation of the effectiveness of our QM program, which has oversight of the EPSDT program, at least annually. The evaluation includes the adequacy of resources, training, scope, and content of the QM programs. Clear Health uses HEDIS® and CAHPS® data as the basis of the Quality Management Program Evaluation. In 2016, the Simply legacy plan exceeded its goal of 90 percent for appointment availability for Regular and Routine Care Appointment for Well Care visits. One hundred percent (100 percent) of providers surveyed had available well care appointments within a month. Monitoring the availability of well care appointments helps us make sure our members have access to appointments when they are needed.

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Our EPSDT Datamart tracks compliance with EPSDT service requirements including initial visits for newborns; EPSDT screenings and reporting of all screening results; and diagnosis, treatment, or referral. We pull data from across the plan, including claims data and SHOTS data, to monitor for compliance. We review medical records to determine if providers are properly documenting well-child visits. When our nurses are on site at a provider's office, they conduct an educational session on any deficiencies at that time upon the provider's request. A team of representatives from Data, Quality, Performance, Case Management, and Member and Provider Services meets monthly to discuss CHCUP, identify/resolve compliance issues, develop next steps, and determine if new program reports are required. Issues and follow-up efforts can include outreach/education to Clear Health staff, CHCUP providers, subcontractors, and members.

We require all subcontractors to report the approvals, and denial of services for under and over 21 on their monthly KPI report. Using this data, we audit their files to verify compliance with EPSDT standards. For example, when we audit the Notice of Adverse Benefit Determination (NABD), we confirm under age 21 CHCUP standards are applied and no denials are for the reason "non-covered". If during our audit we find that services are denied as "non-covered", we require the subcontractor to review the request, correctly apply CHCUP requirements, and make a new determination.

Further, we ensure the subcontractor is educated on CHCUP requirements and require the subcontract to identify the root cause of the error and provide a corrective action so there are no repeat issues. The subcontractor must also identify whether the issues was isolated or not. If the issue is not isolated, a corrective action plan is established and we increase monitoring of the subcontract until 90 days of compliance is demonstrated.

5. OPPORTUNITIES TO IMPROVE TRANSPARENCY FOR EXTERNAL STAKEHOLDERS

It is important that our members, providers, and other stakeholders understand our approach toward coverage of the EPSDT benefit. We promote transparency by making CHCUP information available in our member handbook, through provider dashboards, and our website. Additionally, we participate in a variety of partnerships at the state and local levels to give us different venues to share information about CHCUP. For example, we have partnered with the Children's Trust in Miami-Dade County, including Miami Children's Hospital, to promote health and wellness in schools and to emphasize the importance of well visits. We have also collaborated with The Children's Board to provide information about health and wellness through their Family Resource Centers in Hillsborough County.

Clear Health has a good record of collaborating with stakeholders. One way we evaluate the effectiveness of our transparency with stakeholders is through our constant monitoring of the rate of complaints/grievances, service utilization, and service denials. Nearly 85 percent of our legacy Simply plan members reported they can always or usually get needed care on the 2017 Child CAHPS® survey, a rate that exceeds the national average. The same survey also found that 87 percent of our members reported high satisfaction with Coordination of Care, a score that is in the top quarter of performance nationally. However, we recognize and believe that there is always opportunity for continuous quality improvement.

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To strengthen the relationship with one of our primary stakeholders – our providers – Clear Health seeks to collaborate with the Florida chapter of the American Academy of Pediatrics (AAP) to provide AAP-approved Continuing Medical Education (CME) courses. The courses will be given by our Medical Director on CHCUP-related topics. We are developing the following potential topics:

- Immunization Updates: following biannual Advisory Committee on Immunization Practices (ACIP) meetings, best practices for dealing with barriers to immunization such as parental refusal, follow-up appointments for series, flu vaccine updates
- AAP EPSDT Screenings: review recommended screenings and periodicity schedule and any applicable updates
- Clear Health CHCUP Services: review CHCUP services and the availability of medically necessary services and related processes.

The courses will be provided online periodically. Providers can earn CME credits and MCO points for participation.

Our plan for assuring greater transparency among external stakeholders builds on our strategy of making information about EPSDT/CHCUP easily accessible through our website and other materials and partnering with State and local organizations to promote CHCUP services. We will expand our efforts through targeted outreach to providers by offering CME courses on CHCUP-related topics. Outside of the provider community, we will continue to meet with community stakeholders and advocates, including groups like the Santiago & Friends Family Center for Autism and the Consortium for Healthier Miami-Dade, to build understanding of our approach to coverage of the EPSDT benefit and to connect families with resources that support healthy child development.

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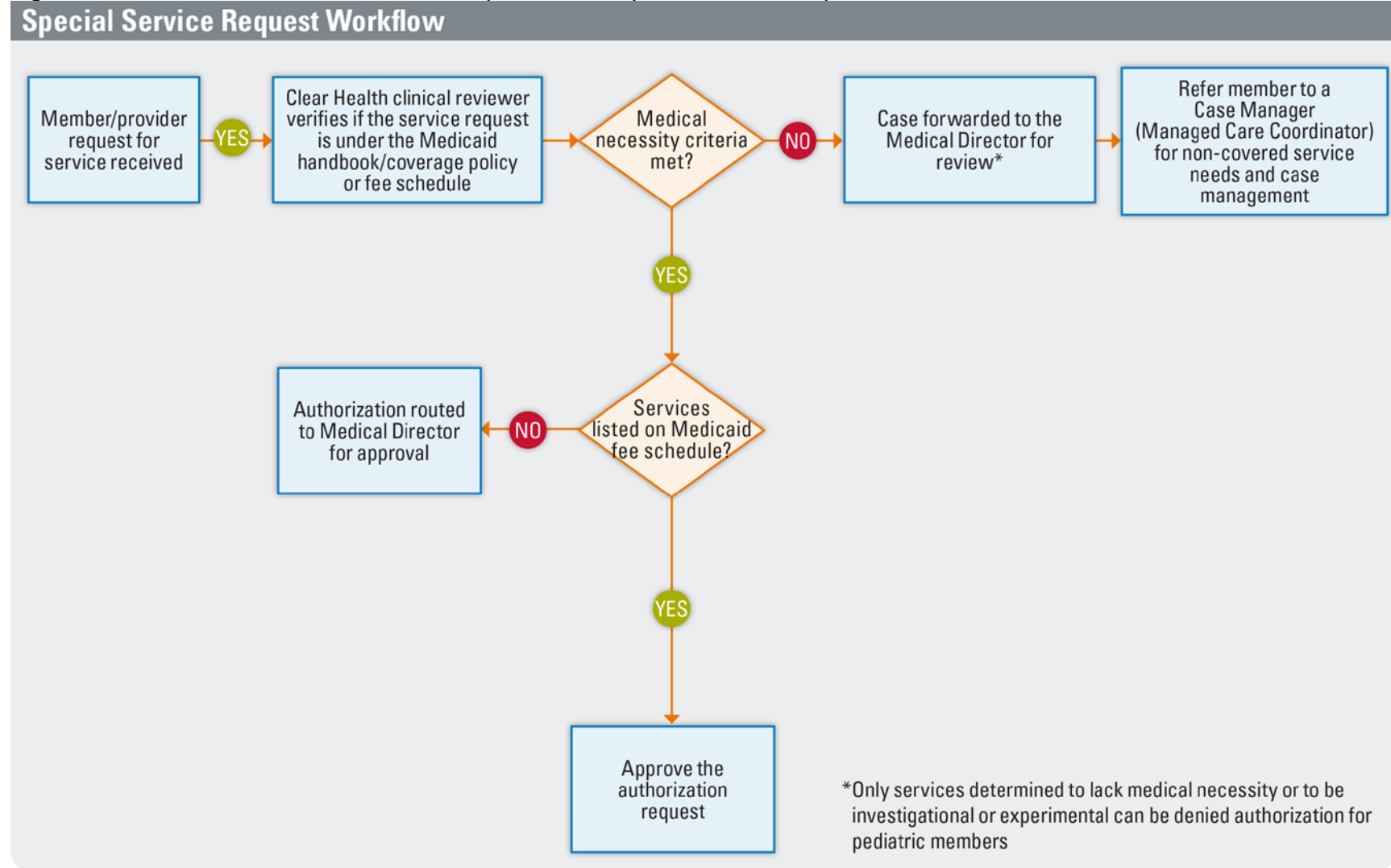
Evaluation Criteria:

1. The adequacy of the respondent's approach related to outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements.
2. The adequacy of the enrollee engagement approach and strategies that will be deployed to improve compliance with the periodicity schedule and treatment recommendations, including identification of the data sources that will be used to monitor compliance.
3. The adequacy of the respondent's training and education approach to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the plan/subcontractors. The respondent must illustrate a commitment to ongoing training and retraining of staff/subcontractors utilizing an array of mediums to earn all points for this component.
4. The adequacy of the respondent's monitoring approach, including all data sources that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the respondent and with subcontractors.
5. The extent to which the respondent's overall outreach approach identifies opportunities to improve upon the level of transparency for external stakeholders.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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Figure 22-1. Workflow Assures Contract Compliance with Special Service Requests



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GENERAL SUBMISSION REQUIREMENTS
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SRC# 23 – Behavioral Health/Primary Care Integration (Statewide):

The respondent shall describe its proposed approach in promoting integrated behavioral health and primary care models, including:

- a. Identification of integrated models in various practice settings that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness.
- b. Identification of opportunities for improvement across the respondent's system of care (e.g., care management, provider network, utilization management, enrollee services) with the goal of advancing to more integrated care models.
- c. Description of strategies the respondent will deploy to overcome the barriers/gaps identified to increase its capacity for providing integrated care models, including use of alternative payment models/financing strategies.

Response:

Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance (Clear Health) uses an integrated care model that supports delivery of seamless, integrated physical health (PH) and behavioral health (BH) care, along with social supports and pharmacy management, to decrease fragmentation across our system of care. As a pioneer organization in holistic care for members with HIV/AIDS, integration is more than just a buzz word; we build our operations specifically to promote a person-centered service model as the most effective to meet enrollee (member) needs. We recognize that many members have co-occurring PH and BH conditions that cannot be addressed in silos. Through improved case management, consistent and real-time communication, innovative multi-disciplinary partnerships, and skill-building, we are transforming health care delivery in important ways to meet our member's health goals.

Today our Clear Health plan manages approximately 9,500 members. Many of our members have BH co-morbidities in addition to HIV/AIDS and other medical conditions. Thirty-one percent of Clear Health members have a diagnosed mental illness, with mood disorders, anxiety, dissociative and other nonpsychotic mental disorders, schizophrenia, and other psychotic disorders accounting for the majority of diagnoses. In addition, 37 percent of members have an addiction disorder, including smoking and alcohol. Given this high burden of mental illness and the known impacts of co-morbid physical health and mental health conditions on the cost of care and the outcomes, we prioritize effective integration of BH and primary care for our members and reward providers for achieving improved outcomes through integration.

1. CURRENT APPROACH TO PROMOTING, INCENTIVIZING, AND REMOVING BARRIERS TO INTEGRATION THROUGHOUT OUR SYSTEM OF CARE

Clear Health roots our model of primary care and BH integration in the landmark National Council of Community Behavioral Health Care published study (2006, updated in 2009) that details strategies for effective integrated care. The study includes guidelines in a Four Quadrant Model for tailoring the design of programs to the needs of members based on the complexity of their PH and BH conditions. Widely used, evidence-based integration strategies, including depression management and screening, brief intervention, referral, and treatment (SBIRT) for the diagnosis and treatment of alcohol use disorder, incorporate the Four Quadrants Model as the foundation.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Clear Health aligns our integrated care strategy closely with the Four Quadrants to build the capacity of our provider partners and reduce barriers to integration throughout our system of care.

- Quadrant I: Members with low physical and BH acuity benefit from routine BH screening by trained providers, seamless pharmacy management, and holistic care coordination within a primary care or Patient Centered Medical Home setting. Members are incented to engage in behavior change programs they may otherwise resist to promote overall health.
- Quadrant II: Members with high physical health severity and low BH complexity receive specialized case management support, partnering and sharing information with their primary care and specialty providers to coordinate care including medical, BH, pharmacy, social service, and long-term support needs.
- Quadrant III: Members with low physical health complexity and high BH complexity (including substance use disorders) are supported by a specialized Managed Care Coordinator partnering with their BH providers at Community Mental Health Centers or other settings and members' primary care provider to manage acute crises and maintain stability. Members receive incentives to engage in treatment programs and change difficult behaviors.
- Quadrant IV: Members with high physical health and BH complexity benefit from thorough integration of systems through co-location or frequent communication and sharing information on person-centered plans of care, patterns of pharmacy utilization, and support through transitions in care.

Clear Health supports our integrated system of care with our robust risk stratification process, including our predictive analytics tool, Chronic Illness Intensity Index (CI3), as well as input from providers, members, families, and AHCA through the enrollment file. We initially stratify member needs based on PH and BH criteria and continue to look at member needs holistically through our risk review processes. We design the models to meet all members where they are and to change as needs change through their lives. At all levels and in all interventions, we incorporate the latest evidence and best practices to support members and providers in care planning, delivery, and evaluation of services, and offer meaningful choices so members access the right care at the right place at the right time.

Just as our integrated models vary based on member needs and goals, we recognize that providers are in various stages of integrated care delivery and have different barriers to integration. For this reason, we also tailor our integration strategies to the diverse needs of our providers including type of practice and where they are in the transformation toward patient-centered, integrated care. For smaller, more private practice sites including those in rural areas of the state, we support them with tools to build capacity for integrated care delivery such as identification of depression in their patients and support with mechanisms to identify service providers with whom they can connect their patients. With the larger systems and federally qualified health centers, all practices with pre-existing BH integration infrastructure, we focus on payment structures and contracting models that include reimbursing for diverse services (i.e., tele-medicine), aligning incentives, and improving coordination to provide whole-person care.

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1.1. Building Capacity for Integrated Care by Primary Care Providers

Clear Health works closely with our primary care partners to build capacity for integrated care and expand member access to routine screening and follow-up for BH conditions. Nationwide, we know that more than half of patients seek treatment for BH conditions from their Primary Care Providers (PCPs), with non-psychiatrists writing more than three-fourths of antidepressant prescriptions.

Clear Health works collaboratively with PCPs to increase rates of BH screenings. The presence of several mental health and substance abuse diagnoses are known to be common among people living with HIV/AIDS. The relative frequency of these diagnoses in Florida appears lower than has been found in published studies, suggesting that members with mental health and substance abuse conditions may not be getting screened and diagnosed, or are not being diagnosed accurately. Therefore, individuals are not being referred for services that could improve their quality of life and enhance the effectiveness of medical treatment. Clear Health requires PCPs to routinely screen members for a range of BH and substance use conditions as a part of routine, preventive care. We provide our PCPs with the tools and expertise needed to complete the screenings, and reimburse PCPs for routine screenings. Screening requirements are included in our provider contracts and provider manual. Furthermore, our interventions focus on provider education regarding accurate coding, member education regarding the importance of discussing BH with a provider, and system improvements to enhance internal reporting.

We make many valid and reliable screening tools for BH conditions easily accessible on our provider website and train PCPs on the appropriate use of them, including tools such as:

- Depression Screening: Patient Health Questionnaire-9 (PHQ-9) for depression
- ADHD Screening: Conners rating forms, Vanderbilt scale, Barkely scale
- Psychosocial Problems Screening: The Pediatric Symptom Checklist
- Mood Disorder Questionnaire
- Anxiety Screening: Generalized Anxiety Disorder-7
- SUD Screening: CAGE-AID
- Mini-Cognitive Assessment Instrument
- Comprehensive training on SBIRT
- The “5 A’s” Model for Treating Tobacco Use and Dependence

Recognizing that PCPs, upon identification of a potential behavioral health condition, may need more than these tools, we also provide an on-call BH specialist to provide consultations when they have a question about managing a member’s BH conditions including medication step-therapy and best practices.

**** REAL STORY:** Reconnecting member with behavioral and physical health providers improves health and satisfaction

Aaron’s infectious disease provider, serving as his PCP, referred him to case management to help reengage him in treatment for schizophrenia, heart problems, and infected teeth. Dina, our Managed Care Coordinator, was glad to know Aaron was consistently seeing his PCP and taking the HIV medications he received via mail order as we had been unable to reach him for many months.

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Dina talked with Aaron during her initial assessment to determine his immediate needs and learned he had not followed up with a cardiologist since his pacemaker was placed in 1997 or his psychiatrist for schizophrenia. So she got right to work arranging a cardiologist appointment. Aaron had the batteries replaced in his pacemaker which had almost stopped working and has routine checkups every six months. He is back seeing psychiatrist monthly, taking medication as prescribed, and no longer reports paranoia. She also set up a dental cleaning and assessment which revealed Aaron's many infected teeth necessitated dentures, which reestablished his ability to eat solid food. **

1.2. Targeted Network of Red Ribbon Providers Skilled at Integrated Care

Clear Health's unique model of community-centeredness and responsiveness to the distinct needs of members with HIV/AIDS includes close collaboration with select providers who are proficient in caring for our members. These providers, marked with a Red Ribbon in our provider directory, receive additional training in longitudinal management of HIV/AIDS and frequent co-morbidities and bring experience, expertise, and cultural sensitivity to our members. These providers are acutely aware of the incidence and implications of PH and BH comorbidities and have developed robust integrated processes to deliver whole-person care. Some Red Ribbon providers have co-located or integrated BH care (including many Federally Qualified Health Centers and Rural Health Centers); others established referral networks in their communities for integrated care. As a part of our support for providers and members, we engage Red Ribbon providers to identify all preferred referral networks and attempt to include those additional providers in our network. In this way, we build a circle of high-quality, trusted providers around our members.

Clear Health support for our Red Ribbon providers include efforts to build capacity and share best practices, increased compensation and ongoing communication and collaboration. When appropriate, we refer member without PCP connections to a Red Ribbon provider because of their enhanced quality and integrated care models. As noted in the real story below, the level of access our Managed Care Coordinators achieve with these providers contributes meaningfully to the integrated care delivered and to member outcomes.

** **REAL STORY:** Working together with FQHC providers leads to intensive, integrated care
When 37-year-old Roberto became a member in 2015, he was initially stratified as moderate risk due to his HIV status and psychosis. With strong family support and connections with his PCP and BH provider, Roberto remained stable for over a year. But his repeated disappearances for days at a time signaled noncompliance with his medications and possible methamphetamine use. Sophia, our Managed Care Coordinator, reached out to Roberto when he was hospitalized for exhibiting signs of psychosis.

She worked with Roberto's FQHC PCP and BH providers to increase BH services. Sophia coordinated multi-disciplinary team meetings with Roberto's BH providers, Beacon Health, our Medical Director, and Roberto's partner Steven (who has his power of attorney and is his health care surrogate) to discuss how best to help Roberto. She presented the concerns of Roberto's partner regarding noncompliance and together they brainstormed how to best address the issues. All agreed to address medication concerns with member and concerns and services to address potential substance abuse; however, Roberto's BH issues soon escalated to necessitate police involvement and several involuntary psychiatric admissions.

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In additional multi-disciplinary team discussions coordinated by Sophia, Steven requested all options available and was provided several, including criteria for the Marchman Act that allows for involuntary assessment and/or treatment of substance abuse. The family decided to pursue the Marchman Act for Roberto's safety and well-being. The court order was granted, and Roberto was enrolled in a court-mandated program with Steven assigned as supervisor. Sophia continued to provide support and continuation of care after the process.

Three months later, Steven wrote to thank our staff for their help and support in getting Roberto the care he needed, reporting that he was compliant with his psychiatric and HIV medications, attending outpatient therapy, slowly regaining his cognitive abilities, and was drug-free. Sophia will continue to provide support to the member and family and coordinate services among Roberto's providers to make sure he receives care in the appropriate settings. **

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1.4. Integration of Information Across Settings

Lack of information is a well-documented barrier to integrated care and a risk to member safety and outcomes. Primary care providers and BH providers in different systems often lack access to comprehensive medical records, including medication lists, and may not be aware when members are hospitalized or experience a change in status. Clear Health proactively engages our provider network to share important information about members' care across settings. For example, we provide our network primary care providers and BH providers with a daily census of members hospitalized at network facilities, including admissions with PH and BH diagnoses, and share information about the member ED visits through the Emergency Notification System. We also share member-level information with providers through our dashboard that includes up-to-date data on medication refills for adherence, gaps in care, and potential overutilization of services.

Our Managed Care Coordinators are at the forefront of enhancing integrated care for our high-risk members by filling the traditional information void — we proactively communicate with and engage primary care, medical specialty, obstetrics, BH providers, home- and community-based service providers, as well as all types of inpatient facilities, to promote our member's care and goals. Our case management team, including medical directors, psychiatrists, managers, pharmacists, and PH and BH staff, discuss member needs and develop real-time, comprehensive strategies and solutions to share with members and their providers. We match Managed Care Coordinators with members based on primary needs (PH or BH) and may assign a supporting Managed Care Coordinator of another discipline as needed to co-manage the member's care. This co-management is seen most often for members with high risk pregnancies where specialized OB Managed Care Coordinators partner with BH Managed Care Coordinators to address SUD issues, depression, anxiety or other BH and PH conditions that may impact birth outcomes. These Managed Care Coordinators communicate with the providers about care plans, member goals, discharge plans, and pharmacy compliance — proactively identifying any gaps in care, additional treatment options, or potential complications. In this way, the Managed Care Coordinators facilitate an integrated care experience for our members.

** TESTIMONIAL: Our patient was already receiving support from our clinic nurses and staff, myself, a pharmacy director and his Ryan White case manager for years without really making a lot of forward progress. He was maintaining a suppressed HIV viral load and was adherent to his HIV and psychiatric medications; however, he wasn't attending to his other important medical needs. Your Managed Care Coordinator, Dina, worked with our patient and convinced him of the need for dental care, something no one else on our team was able to accomplish despite numerous attempts. She found a dentist, arranged an appointment and transportation and supported him through his dental extractions. He is delighted that he no longer has oral pain and has great fitting (and looking) dentures. This has really raised his self-esteem. Dina contributed hugely to his current success! - Jennifer Janelle, MD, Fellowship Program Director, Department of Medicine, Division of Infectious Diseases and Global Medicine, University of Florida **

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All Clear Health Managed Care Coordinators receive comprehensive training on PH and BH. Our PH and BH Managed Care Coordinators are required to take the integrated case management certification program, which addresses the union between PH and BH conditions. We conduct weekly Case Management rounds in an integrated fashion — medical and psychiatric medical directors and other clinicians are available to support all Managed Care Coordinators by reviewing cases and problem solving for difficult cases. In this way, we work to improve the health and quality of life for the whole member and those that support them.

1.5. Strategies for Hard to Engage Members

Many complex members, including members with severe BH needs (quadrant III), have a difficult time engaging in traditional outpatient care due to homelessness, substance abuse, non-compliance with medications or follow-up appointments, or a history of multiple psychiatric admissions. For members with complex BH needs, the Simply CARES program, a field based case management program dedicated to serving those with behavioral and substance abuse disorders who are hard to engage, enhances the delivery of integrated care by matching members with specialized BH clinician Managed Care Coordinators for face-to-face engagement in the community, ongoing case management and care coordination with community-based and facility-based providers.

Managed Care Coordinators are trained in integrated care and work closely with members using motivational interviewing and other skills to increase medication compliance and reinforce appropriate utilization of behavioral and medical providers. Managed Care Coordinators advocate for and facilitate routine, preventive care by PCPs and BH clinicians by encouraging members to make and keep appointments and preparing for visits. We draw members back into regular care. Managed Care Coordinators in the CARES program coordinate closely with the members' BH providers and, for homeless members, Outreach Care Specialists as needed to help establish the connection, to close gaps in care and make sure the care plan is comprehensive and member-centered.

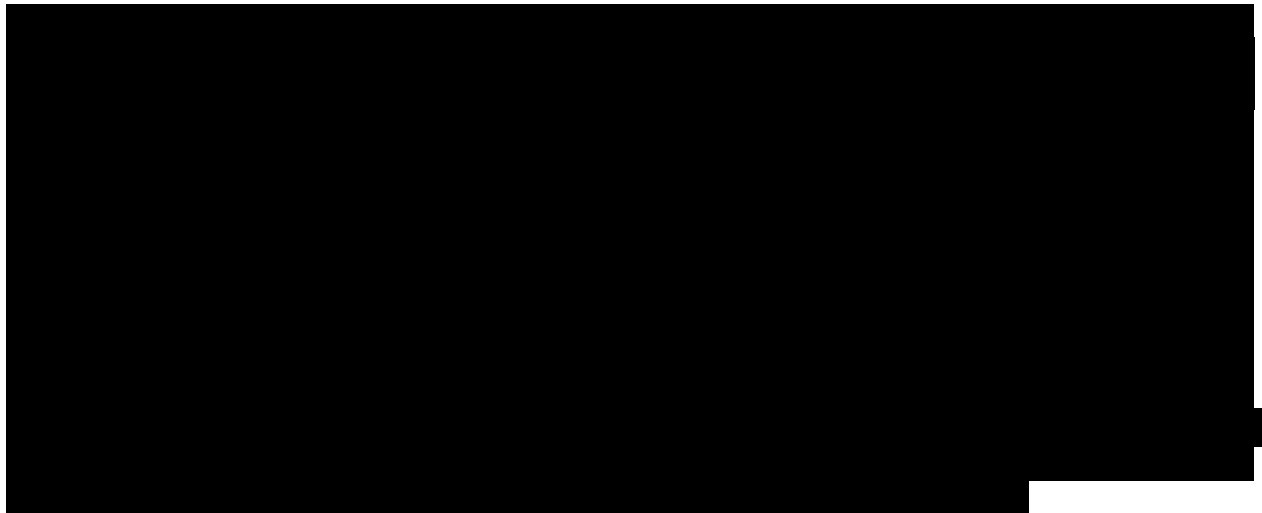


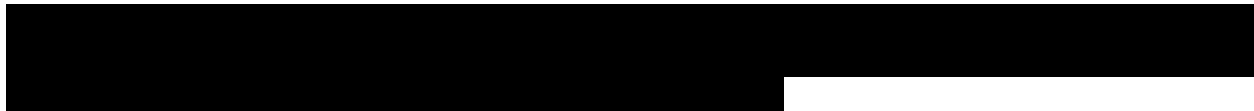
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2. EXAMPLES OF INTEGRATION IN THE NETWORK THAT SHOW IMPROVED OUTCOMES, MEMBER SATISFACTION AND COST SAVINGS

Our members consistently give our plan high ratings in satisfaction surveys on measures related to access to integrated care: satisfaction with care coordination increased to over 90 percent in 2016 and 80 percent of members reported it is easy to get needed care.

Our innovative partnerships with our network providers show positive results in terms of service to our members and cost savings. This and other strategies for network integration that have improved outcomes and member satisfaction while achieving cost savings are discussed in more detail below.

2.1. Rising Star for Members with Multiple Psychiatric Hospitalizations



2.2. Behavioral Health Medication Management Program

Clear Health's BH Medication Management Program addresses increased concerns about the safe, appropriate, and effective use of psychotropics and controlled substance medications, including opioids, across care settings. The program responds to high rates of inappropriate prescribing of controlled substance medications including in our most vulnerable populations like children and youth in foster care, individuals with intellectual and developmental disabilities, and elderly with HIV. It is a comprehensive program designed to improve effective care integration and members' quality of care through more clinically appropriate prescribing, improve member adherence to appropriate medication treatments, promote care coordination between prescribers, decrease cost of care, and improve performance on HEDIS measures. The program includes provider and member education and interventions with specific focus on building skills and sharing information across settings to inform clinical decisions in line with evidence based care.

- Controlled Substance Utilization Monitoring (CSUM) Program – surveys comprehensive claims reports to identify members receiving multiple controlled substance medications, receiving opioids from multiple providers and filled at multiple pharmacies, or combinations of controlled substances that may indicate risk. This information is relayed to the prescribing providers, including primary care and BH providers, so they can engage their patients who are at-risk for adverse events related to controlled substance and opioid misuse
- Antidepressant Late Fill Fax Program – identifies members who are more than seven days late in refilling their anti-depression medication. We notify the prescribing provider, including both BH and primary care providers, for follow-up and member engagement

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- Drug-Dose Optimization program – helps develop the skills of our primary care and BH provider partners by informing prescribers regarding members using high doses of a drug, using less than optimal dosing, and members with potential drug-drug interactions where two or more medications react to each other which can cause unexpected side effects
- Promoting Polypharmacy Reduction program – works with physicians with demonstrated polypharmacy practices by sharing written educational materials, phone calls, and outreach. Targeted members are those with multiple prescribers and multiple medications in the same class (antidepressants, stimulants, antipsychotics, sedative hypnotics) and those with higher risk of side effects. A fax is sent to prescribers to sign off that the polypharmacy is appropriate, change in therapy is needed, or they can request a clinical pharmacist contact them. In addition, outreach is conducted related to children taking 5 or more psychotropic medications regardless of class
- Antipsychotic and Bipolar Related Depression or Mania Medication Adherence program – identifies members on antipsychotic or Bipolar Depression Mania medication with a history of inconsistently filling their prescriptions. When a member falls below the Medication Possession Ratio (MPR) of 80 percent we reach out to prescribers via fax so they can follow up with members in a timely manner
- Off-label Use of Antipsychotics program – performs outreach to primary care and BH prescribers to educate and eliminate inappropriate therapy and inform them of medication's proper use. We target members taking antipsychotics without an approved indication to reduce off label use of antipsychotics, make sure safe and appropriate use of antipsychotic medications, help the prescriber select alternatives to meet member needs, and decrease cost of care

These pharmacy management programs include members from across Simply programs, including Clear Health members. The larger scale allows a depth in programs not attainable by our smaller program, while maintaining the targeted approach that contributes to effectiveness. In a recent evaluation, Simply successfully reached 94 percent of providers, including Clear Health providers, via fax with education materials to promote integration and safe prescribing practices, including prescribing psychotropic medications correctly in the primary care setting. These effective communications resulted in almost 28 percent of members having one or more of the targeted medications discontinued across Simply's programs, improving quality and member outcomes. In addition, under the CSUM program, 70 percent of eligible members reduced their claims for controlled substances to less than 10 at 180 days post intervention. Our BH medication management program also shows cost savings. Across all our markets, the program generated 43 percent higher savings than expected. Furthermore, over the past three years, Clear Health has worked closely with BH prescribing physicians in Region 11 to encourage generic prescriptions for members with serious mental illness (SMI). We have seen an annual increase in the generic prescribing rate of two percent, translating to a 26 percent reduction in the cost per scripts and PMPM for anti-psychotic drugs.

2.3. Improvements in Quality Scores from Integrated Care

In HEDIS® 2017, Clear Health Alliance achieved 54.50 percent on the measure of anti-depressant medication management — Acute Phase — exceeding the prior year's 25th percentile benchmark. Clear Health Alliance also surpassed the 90th percentile for both the IET — Initiation and Engagement of AOD — Initiation Total and Cardiovascular Monitoring for People with Cardiovascular Disease measures. These results demonstrate the extent to which people with

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BH needs are being effectively managed for BH as well as other chronic health conditions we know to be especially damaging in the population. We achieve these results through partnership with primary care and BH providers across our network supported by case management to help close care gaps.

3. OPPORTUNITIES FOR IMPROVED INTEGRATION AND STEPS TO INCREASE CAPACITY FOR INTEGRATION

Consistent with our commitment to adopt new, evidence-based care to support our members, we are introducing new supports to our provider network to enhance access to high quality, integrated care. We have heard consistently from our members and providers that access to specialized BH and SUD treatment remains a challenge in many areas of Florida, so we prioritize access to these resources through new delivery methods.

The opioid epidemic has hit the entire country hard. Clear Health launched a multi-disciplinary workgroup that meets weekly to discuss how we can contribute solutions. Our focus is to make sure members with acute pain obtain necessary treatment, reduce the likelihood of new addiction, and decrease street drugs and overdoses.

We are considering expansions to innovative Project ECHO models to address the opioid crisis. A nationally recognized team of experts with solid results, Project ECHO offers enhanced training and ongoing clinical support to our providers, including potentially providers across our network, to help physicians, nurse practitioners, BH professionals, and RNs develop skills and confidence to provide SUD care in an integrated manner in their communities. We may also provide consultations to providers through a Physician Resource Line for any questions providers may have regarding medication-assisted treatment for substance use disorder. Clear Health Alliance has an existing relationship with Project ECHO through the AIDS Education and Training Center (AETC) and the University of Miami, one of our Plan partners. The University of Miami serves more than 750 members currently, and we will scale-up its reach through innovative tele-health applications in the future.

3.1. Targeted Capacity Building with Aligned Incentives

[REDACTED]

[REDACTED]

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3.2. Expanding Focus on Integrated Providers

Clear Health works closely with provider organizations who integrate PH and BH care for our members. We currently contract with 13 Federally Qualified Health Centers (FQHCs) in our service area that include both primary care and psychiatry for members. These centers include Borinquen Health Care Center in Miami, Lee Memorial Health System in Ft. Meyers, Manatee County Rural Health Services in Palmetto, Premier Community Healthcare in Dade City, and Orange Blossom Family Health Center in Orlando. We look forward to working with additional FQHCs in new service areas through the expansion of our comprehensive model.

Achieving the quality metrics in our value-based payment arrangements with health systems and FQHCs requires effective integration of PH and BH conditions for members. These metrics include the following:

- Follow-up after hospitalization
- Anti-depressant medication management
- Initiation and engagement of alcohol and other drug dependence treatment
- Follow-up care for children accessing ADHD treatment
- Hospital re-admissions at 30, 60, 90, and 180 days.

We will continue to build capacity, share information and partner with our physical health providers to help them achieve these targets.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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These programs advance the goals of integration by aligning incentives between Clear Health, BH providers and physical health providers and encourage the investments needed in the care delivery system to achieve meaningful integration. Metrics align with AHCA goals of reducing potentially preventable events and will contribute significantly to improved outcomes for our members.

Evaluation Criteria:

1. The extent with which the respondent thoroughly describes its current approach to and readiness for promoting/incentivizing, and removing barriers to, integrating behavioral health and primary care throughout its system of care.
2. The extent to which the respondent provides examples of more effective integrated models within its provider network that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness. The respondent must also describe the data sources.
3. The extent to which the respondent identified opportunities for improvement in delivering an improved integrated care model and subsequent steps the respondent will implement across its systems to increase capacity for providing integrated care.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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SRC# 24 – Transportation (Statewide):

The respondent shall describe its experience and approach for coverage of non-emergency transportation services by providing the following:

- a. A description of the software capabilities utilized to facilitate ease in scheduling and tracking of enrollee pickup adherence;
- b. Strategies for determining the most appropriate mode of transportation; and
- c. Providing data on the following performance metrics for calendar year 2016:
 - (1) Percentage of trips where the enrollee arrived to their scheduled appointment on-time;
 - (2) Percentage of missed trip requests (failed to pick up the enrollee);
 - (3) Percentage of hospital discharge requests fulfilled within three (3) hours of the request;
 - (4) Percentage of urgent care requests fulfilled within three (3) hours of the request; and
 - (5) Number of transportation related complaints and grievances per 1,000 enrollees.
- d. A description of how the respondent uses the performance metric data above to identify areas in need of improvement and implements successful strategies that improve the provision of service.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Transportation is key to achieving the Agency's overall objective for Medicaid enrollees (members) to receive all medically necessary services in a timely manner. We understand reliable transportation is critical to the quality and continuity of the health and well-being of our members. Consistent provision of safe, reliable, appropriate, timely, easy-to-use (for members and providers), and responsive non-emergency transportation (NET) services will continue to be our goal. In 2016, Simply, including our D/B/A Clear Health Alliance, provided more than 696,000 NET trips to members throughout the state – in urban, suburban, and rural areas.

Our Experience Providing Non-Emergency Transportation Services (NET)

We recognize the challenges associated with this benefit. As in other states and with other health plans, transportation has been a challenge for members, providers, health plans, and State regulators. We have learned to work collaboratively to address transportation concerns. In planning for our future, we took a hard look at the best way to build on improvements we have made to date and to plan for future enhancements.

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As a result of this process, we decided that partnering with two subcontractors to provide high-quality transportation for our members statewide would best support our goals. We will continue our partnerships with LogistiCare Solutions, LLC (LogistiCare), which has shown a commitment to strong performance and an impressive willingness to work with us in continuous process improvement. We will also partner with MCT Express, Inc. (MCT Express), a subcontractor we have found to be very reliable and committed to timely transportation through their own fleet.

LogistiCare and MCT Express bring years of state and national experience. LogistiCare has served as a transportation subcontractor throughout the nation for more than 21 years and provides these services in 39 states and the District of Columbia. MCT Express has been a Medicaid transportation provider in Florida for more than 25 years and currently contracts with Simply through its MMA and Medicare Advantage plans, serving a membership of more than 160,000 in Regions 10 and 11. As a transportation subcontractor, the MCT Express provider network will primarily be MCT Express-employed drivers and -owned vehicles. We believe this combination of transportation subcontractors will best meet AHCA's and our own quality and time performance standards.

Our Approach to Non-Emergency Transportation

Beginning with the roll-out of the new SMMC Contract, LogistiCare will serve regions 1 through 9, and MCT Express will serve regions 10 and 11. This model also creates a competitive environment and gives us a risk mitigation strategy to migrate to one statewide subcontractor if necessary.

To supplement the services of our two delegated transportation subcontractors, we will continue to provide same-day, on-demand transportation services in all regions throughout the State. With Trip2 (an MCT Express product) and Ride2MD, Inc. (Ride2MD) statewide on-demand transportation services, our Customer Care Representatives can immediately address, through online internet access, a member's report of a late transportation provider by arranging a backup ride that meets all Medicaid credentialing standards. These on-demand services effectively expand the network of transportation providers available to our members in compliance with all Medicaid transportation policy and ITN requirements.

1. TRANSPORTATION SOFTWARE CAPABILITIES - SCHEDULING AND TRACKING OF PICKUP ADHERENCE

Both of our subcontractors have state-of-the-art software enabling members, health plan staff, and providers to access to real-time tracking and scheduling of transportation.

Transportation Software Capabilities

While LogistiCare and MCT Express each use proprietary software to manage and monitor transportation services, there are many similarities in their software. Both interface with our system to facilitate accurate and automatic eligibility verification and enable users to schedule reservations by phone, mail, email, fax, and online. Both systems facilitate efficient identification of appropriate alternative modes of transportation and level of service to meet each member's specific needs. Both software systems enable effective utilization of their transportation networks; include robust tracking and reporting tools to facilitate quality oversight and fraud, waste, and abuse detection; meet HIPAA and privacy requirements; support transportation provider claims

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processing and adjudication; and support complaints processes. The systems are flexible, scalable, enable real-time updates, and have high levels of transparency. Both companies offer users the ability to make real-time changes to their reservations.

LogistiCare's WellRyde GPS and Automatic Vehicle Locator Software enable real-time and on-time performance monitoring to determine actual trip details, such as pick-up and drop off times, journey time, wait times, and vehicle speed along the route. Using this technology, LogistiCare can immediately identify vehicles that are running late and take proactive steps to make sure members arrive in time for their scheduled appointments. LogistiCare can also use data from WellRyde to prevent fraud, waste, and abuse, and improve the member experience.

MCT Express developed their proprietary software application specifically to manage NET. Users can view detailed routes for each reservation; schedule groups of trips with one click; monitor and regulate service in real-time with a variety of devices, such as cellular phones and tablets, enabling them to instantly track cancellations, no-shows, and schedule changes; and make reservation changes in real-time. MCT Express software also offers improved passenger interfaces for booking and tracking rides; vehicle tracking; digital signatures to reduce fraud, waste, and abuse; and verify covered services.

Scheduling and Dispatch Process

Through the Member Services call center, member handbook, provider manual, newsletters, our member website, and provider portal, we inform members and providers about transportation benefits and how to schedule rides. This includes information about guidelines for requesting and using transportation services, and reporting late rides. Members, member caregivers or representatives, Managed Care Coordinators, providers, and facilities may schedule NET rides 24/7, including holidays, in a variety of ways:

- Calling the transportation subcontractor's toll-free number to talk with Call Center Representatives who speak English and Spanish and have access to language line translation services in more than 200 languages
- Through transportation subcontractors' websites
- Through MCT Express' mobile application for smartphones and tablets
- By email, triggering a call back
- For facilities, by fax, triggering a call back

The process is the same for all scheduling methods and guided by subcontractor software. Using a script displayed on monitors for subcontractor Call Center Representatives to verbally relay to phone, email, and fax applicants and on-screen for internet and mobile application applicants to read, each applicant answers a series of questions to complete the following steps of the scheduling process:

- Verify member eligibility for Medicaid, our health plan, and transportation services on the day of the requested ride through system access to current member eligibility information

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- Verify that request meets timeliness requirements of 48 hours before appointment time for covered services that are not urgent
- Confirm member contact information
- Gather information on the service, provider, appointment time, and whether the request is urgent or the member has special needs
- Determine that the member does not have other available means of transportation
- Determine the appropriate mode of transportation and level of service
- Confirm trips to and from the covered service and set up standing orders as appropriate

At the end of the scheduling process, Call Center Representatives verify and confirm trip data, including pickup time, location, and other details. Members scheduling by internet or mobile application receive electronic confirmation. All members receive a reservation number that they can use online to see an electronic summary of their reservation.

The scheduling application ties into ride dispatch for assignment of a vehicle and a driver, as described in the next section of this response. Both the scheduling and ride dispatch applications connect to a monitoring system that continually tracks provider performance, including timely pickup and other metrics.

The software supports specialized processes for scheduling short-notice, non-urgent trips; urgent trip requests; standing appointments; and facility discharges. Other tracking features include:

- Last minute requests and changes
- Member no-shows
- Late providers
- Provider no-shows
- Automated appointment reminder calls

2. DETERMINING THE APPROPRIATE MODE OF TRANSPORTATION TO MEET THE ENROLLEE'S INDIVIDUAL NEEDS

We provide a full range of transportation options to meet our members' NET needs, such as:

- Mass transit passes
- Sedan for ambulatory riders
- Van for ambulatory riders, including multi-loading
- Taxi for ambulatory riders
- Wheelchair-lift equipped vehicle
- Vehicle to accommodate stretchers
- Non-emergency ambulance

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We also provide the following levels of services by drivers:

- Curb-to-curb
- Door-to-door
- Hand-to-hand

While the caller is on the phone, software enables the representative to assign the most medically appropriate vehicle and level of service to meet the members' needs for each trip, based on information from the member regarding their mobility limitations — whether they use a cane, walker, wheelchair, or stretcher, or have other special needs. Other considerations include whether attendants, escorts, or children (with or without child car seats) will be traveling with the member. Subcontractor staff may manually override the mode of transportation recommended by system software logic if the member's medical condition requires a different level of service. Subcontractor management teams review and audit overrides to make sure each is appropriate.

The Dispatch team is responsible for identifying which driver and vehicle to schedule to complete each trip. The team contacts transportation providers to select an available provider with the appropriate vehicle and ability to provide the appropriate level of service on the date and time of the trip. Once they identify the provider, the dispatch team assigns the trip to the provider within the system.

3. ASSESSING WHETHER THE ENROLLEE HAS OTHER MEANS OF TRANSPORTATION

To determine the right means of transportation for members, subcontractor Call Center staff ask a series of questions to assess whether the rider has access to other means of transportation. Questions include "Do you have a friend or family member who can drive you to your appointment?" and "Can you walk to the nearest bus stop and take the bus to your appointment?" If the member can take mass transit, the Representative will flag him or her in the system as appropriate for mass transit and will mail a mass transit pass to him or her. If there is insufficient time to mail the pass to the member prior to the date of the scheduled appointment, the Representative will schedule a ride.

☀ Simply Helping ☀

As part of putting our Safety Plan into action, we reached out to Thomas, a 56-year-old member in Broward County who is blind and HIV-positive, to offer assistance and transportation to a shelter prior to the arrival of Hurricane Irma. Thomas needed transportation to a shelter as well as to his dialysis appointment in two days.

Stephanie, our Member Services Representative, found the shelter closest to Thomas was full, so she called the Red Cross support line to locate a shelter appropriate for persons with special needs. Stephanie contacted the church-based provider operating a shelter close to Thomas's home, and they agreed to offer shelter and provide transportation. They picked up Thomas, got him to his dialysis appointment, and transported him to their shelter during the storm. Thomas said he was very grateful for the assistance as his main concern was to be with others during the hurricane instead of home alone.

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4. PERFORMANCE METRICS

In the following sections, we provide 2016 calendar year transportation data for all legacy health plans, for all trips provided by our current subcontractors, LogistiCare and Access2Care.

4.a. Percentage of Trips Where the Enrollee Arrived to Their Scheduled Appointment On-Time

In 2016, of more than 696,000 completed rides, members arrived on or before the time of their appointment 94 percent of the time. Although we cannot entirely avoid unforeseen delays and arriving late does not always result in a missed appointment, we recognize that this is short of the State's goal that members are never late for an appointment. We have implemented several strategies to improve performance on this metric.

Improvement Strategy 1 - We contracted with two same-day, on-demand transportation programs, Trip2 and Ride2MD. We require transportation subcontractors to promptly notify our Member Services team as soon as they know a provider will likely be late to pick up a member. Our Customer Care Representatives then schedule a second driver and vehicle using the Trip2 or Ride2MD application to get the member to the appointment on time. We frequently notify and remind members to call our Member Services team or transportation subcontractors as soon as their ride is late to provide us maximum time to reschedule with Trip2 or Ride2MD.

Improvement Strategy 2 - We worked with our subcontractors to examine reasons why members arrive late. Subcontractors now have the technical capabilities to record a reason each time a member arrives late to an appointment and we require them to include reason codes in the data they send to us daily. With this data we can track and trend data on reasons such as severe weather conditions, unexpectedly heavy traffic, vehicle breakdown, inaccurate reservation information, earlier trip delays, and delays in members boarding vehicles. We work with each subcontractor to identify trends that we can address with scheduling and dispatching protocol changes and transportation provider network changes. While there will always be extenuating circumstances, we will continue to focus on making process changes to avoid delays wherever we can.

4.b. Percentage of Missed Trip Requests

It is rare that a transportation provider does not arrive to pick up a member for a scheduled ride. In 2016, this occurred for less than two-tenths (0.13) of one percent of all scheduled rides. Although a missed trip is rare, we continue to strive to have it never occur.

Improvement Strategy - As with late trips, we require very detailed trip documentation of each provider no-show incident to assure accurate trip cancellation information and identify network, staffing, and other initiatives to avoid no shows in the future. For example, to make sure we are getting accurate information on trip cancellations, a driver can no longer just indicate that the member cancelled the ride. They must now report the details of the cancellation and clearly indicate when the member rescheduled the appointment. We also now require transportation subcontractors to notify us each business day if they cannot staff a ride for the upcoming day. This gives us sufficient time to schedule a second driver and vehicle through Trip2 and Ride2MD.

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4.c. Percentage of Hospital Discharge Requests Fulfilled Within Three Hours of the Request

For hospital discharge requests fulfilled within three hours, LogistiCare achieved 91 percent in 2016 and 97 percent in the first six months of 2017. In 2016, the data metric was 82 percent for all rides from LogistiCare and Access2Care. This metric was a factor in our selection of transportation subcontractors for the future. Moving forward, as previously stated, we have selected to do business with the higher performing transportation subcontractor, LogistiCare.

Improvement Strategy 1 - Our plan for the future with two transportation subcontractors coupled with the two on-demand same-day programs will enable us to further improve on this performance.

Improvement Strategy 2 - We often get a ride request with an estimated discharge time for which the transportation provider arrives on time at the hospital to find that the member's discharge process is not complete. The member may be waiting for home health equipment or a final sign-off of his or her discharge. We will explore opportunities for working with hospitals and members when scheduling hospital and other facility discharge trips to better understand the best time to arrive and minimize wait time for the member and transportation provider.

4.d. Percentage of Urgent Care Requests Fulfilled within Three Hours of the Request

In 2016, 88 percent of all completed urgent care rides occurred within three hours of the request. While we recognize there is opportunity for improvement for this measure, we are committed to significant improvement by tracking root causes and implementing process improvements. We also recognize that the data may not accurately reflect the experience of the member. Not all member urgent care appointment times fall within the three-hour transportation pick-up window. For example, a member may call at 9:00 am for a same-day urgent care appointment at 4:00 pm. Because of the unpredictable nature of urgent care trips, it can be difficult for transportation subcontractors to appropriately plan for sufficient staff resources for all urgent trip requests.

Improvement Strategy - To address this situation, we implemented a protocol for each transportation subcontractor to notify us when they receive an urgent trip request they are not certain they can complete in three hours. In these cases, our Customer Care Representatives immediately schedule a driver and a vehicle through one of our same-day, on-demand subcontractors.

4.e. Number of Transportation Related Complaints and Grievances per 1,000 Enrollees

In calendar year 2016, we had less than one (0.83) complaint or grievance for every 1,000 member months. For all transportation complaints, we document, research, and triage to determine the level of urgency, and then respond accordingly.

Improvement Strategy - In early 2016, we implemented a process for daily reporting of transportation complaints. Our Vendor Delegation Oversight Group (VDOG) reviews a daily report of aggregated transportation complaints from members, their families, providers, and others that AHCA, our Member Services team, transportation subcontractors, and Grievance and Appeal team received. We implement strategies for addressing concerns — both global strategies, such as using same-day, on-demand transportation programs and strategies related to individual providers, regions, or circumstances. We work to address complaints before they become formal

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grievances and work to identify and address their root causes to prevent reoccurrence. These efforts coincide with significant improvement in this performance metric, going from 0.83 complaints and grievances per 1,000 member months in 2016 to 0.37 for the first six months of 2017.

5. USING PERFORMANCE METRIC DATA TO IDENTIFY AREAS IN NEED OF IMPROVEMENT AND STRATEGIES TO IMPROVE THE PROVISION OF SERVICES

Using Data in Day to Day Operations

We use data to monitor the performance of our transportation subcontractors and providers. Our proven subcontractor oversight process, led by VDOG, uses data extensively. VDOG employs a far-reaching and vigorous approach that combines various methodologies to monitor transportation subcontractor performance data. VDOG receives monthly transportation performance data from subcontractors, grievance and appeal data from plan staff, and daily ride and complaint information through direct access to subcontractor systems. Through data analysis and trending, we compare data to service level agreements for each subcontractor to identify performance issues and report them to our Quality Management Committee (QMC) and Florida Medicaid Compliance Committee at least monthly. With QMC and Compliance Committee support, we work with subcontractors to develop strategies to improve performance whether through an informal process or the more formal corrective action plan process. We make sure that improvement strategies achieve intended results by monitoring performance data to understand the impact of implemented strategies. If the data indicates that strategies are not achieving intended results, we go back to subcontractors to consider additional causes and strategies to address them. We work in partnership with subcontractors to improve processes, often applying Lean Six Sigma principles to drive change.

Each of the five performance metrics outlined in our response to Evaluation Criteria 4 above provide visibility into our members' experience with transportation services. As described above, we used data to drive improvement for these metrics. The data points we gather aid in our ability to monitor subcontractor and provider performance, identify areas of risk or concern, then develop and assess improvement strategies and their effectiveness. We gather and trend the following data for each of our transportation subcontractors:

- Trip volume, including total number of reservations, cancellations, cancellations as a percentage of reservations, total completed trips, average monthly members, average utilization percentage, and unique utilization percentage
- Level of Service – total numbers of authorized ambulatory, wheelchair, stretcher, and public transportation trips
- Mileage distribution under 10, 24, 50, or 100 miles, and more than 100 miles
- Trip reason – transportation to diagnostic center, dialysis, hospital, pharmacy, primary care or specialist, residence, skilled nursing facility, assisted living facility
- Call center operations – number of calls received and answered, average speed to answer, abandonment rate, call blockage rate, average wait time in queue, maximum hold time

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- Network development and maintenance – number of transportation providers in network by region
- Fraud, waste, and abuse – number of open cases, cases referred by health plan, closed cases

**** RESULTS & SUCCESSES:** In late 2015, an audit and an increased number of complaints from dissatisfied members exposed gaps in our transportation process. In January 2016, we initiated enhanced subcontractor oversight and set up a process for reviewing daily LogistiCare trip and complaint data. We used root cause analysis, and statistical analysis featuring the Pareto principle, by which we identify the problem areas that occur most often and address those first, to determine that five providers and five regions accounted for more than half of all late rides. We then implemented process and network changes to address the providers and regions with the most late rides first. As a result, by the end of 2016, we saw on-time performance measures increase by five percent and monthly complaints decrease by 85 percent. ******

Using Data to Select Transportation Subcontractors

We used performance data to develop our new transportation approach and select the transportation subcontractors we will work with in the future. We set detailed service level requirements and evaluated potential partners against them to make sure we selected the subcontractors that will best meet our expectations and AHCA's. We selected LogistiCare and MCT Express because they offer the best performance data to-date and a commitment to continuous improvement through use of performance data. Our same-day, on-demand services, Trip2 and Ride2MD, which meet all Medicaid credentialing standards, are also committed to the use of performance data to improve the quality of our transportation benefit. We conducted the following activities as part of our process for selecting transportation subcontractors:

- Defined our requirements for all parts of the State Contract, setting service level requirements, and detailing our expectations
- Assessed system software and technology to see that subcontractors had reliable systems and included the latest technology, such as smartphone and online ride scheduling
- Reviewed quality of care data for subcontractors, including ride volume, late and missed rides, member and provider complaints, and compliance with driver credentialing and vehicle safety requirements
- Considered each subcontractor's Medicaid and Florida experience

Beyond data, we also use subcontractor onsite visit reviews to monitor transportation services our members receive. LogistiCare sends staff to dialysis centers throughout the state to observe transportation providers as they drop off members for treatment and pick them up to take them home. They observe timeliness, customer service, and vehicle conditions to identify areas of concern that are promptly addressed.

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Evaluation Criteria:

1. The adequacy of the respondent's software capabilities to facilitate ease in scheduling transportation and tracking of enrollee pickup adherence;
2. The extent to which the respondent describes strategies for determining the appropriate mode of transportation equipped to meet the enrollee's individual needs.
3. The extent to which the respondent's approach includes an assessment of whether the enrollee has any other means of transportation, including a description of the process that will be utilized to make this assessment.
4. The adequacy of the respondent's performance related to:
 - (a) Percentage of trips where the enrollee arrived to their scheduled appointment on-time;
 - (b) Percentage of missed trip requests;
 - (c) Percentage of hospital discharge requests fulfilled within three (3) hours of the request;
 - (d) Percentage of urgent care requests fulfilled within three (3) hours of the request; and
 - (e) Number of transportation related complaints and grievances per 1,000 enrollees.
5. The extent to which the respondent uses performance metric data to identify areas in need of improvement and implements successful strategies to improve the provision of services.

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

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SRC# 25 – Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Deshea is 25 years old. She was auto-assigned to your plan and enrolled effective January 1, 2019. Deshea's enrollment information did not include a telephone number and listed a local area homeless shelter as her last place of residence. She left the shelter on December 27, 2018, and the shelter does not know her current whereabouts.

The respondent shall describe the process it will use to attempt to contact Deshea by March 29, 2019.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), provides a response for each of the Evaluation Criteria for SRC 25. We describe our process to contact the fictional new enrollee (member), Deshea, at the end of our responses that address the specific Evaluation Criteria numbers 1 through 3.

Clear Health's processes to locate, contact, and engage our members are specialized and responsive to member needs, concerns, and fears. We provide specialized sensitivity training to our Customer Care Representatives, who are often the first to establish contact with our new members, to make sure that members are welcomed into our plan with a sense of community and confidence in our ability to uphold their privacy. Privacy is a prime consideration for people with HIV/AIDS, as there is still significant stigma related to the diagnosis. Protection of health information inside and outside the care system is therefore paramount to our members. In response, we have customized our logo to "CHA" and modified member mailing protocols so that material is not readily identifiable as "Clear Health Alliance," which is recognized in the community as an HIV/AIDS Specialty Plan. In addition, we make sure that stringent HIPAA protection policies and procedures are applied.

Clear Health is aware that our member population has a higher prevalence of homelessness and mental health, substance abuse, and co-occurring disorders than members in traditional plans. We therefore designed and implemented a specialized Member Outreach Team to help us quickly locate new members so that we can fully assess their needs and promptly engage them in care. Through collaborating with providers, local shelters, and community-based organizations, as well as providing "feet on the street" outreach services, our Member Outreach Team also plays a critical role in locating and engaging new members who are homeless.

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1. STRATEGIES AND DATA WE USE TO IDENTIFY NEW MEMBERS

Clear Health understands that typical contact methods used to engage new members, such as welcome calls and mailings, often do not work with hard-to-reach members and members who are homeless or have unstable housing with no address or phone number. Therefore, we also use a combination of technology and “feet on the street” approaches through our Member Outreach Team, as well as strategic partnerships with community-based providers who incorporate innovative outreach initiatives to locate and engage Deshea, and our other members facing similar housing issues.

1.a. Innovative Strategies Help Us Identify New Members

We continually look for efficient and effective processes that will enable us to connect all of our members with the services and assistance they need. In addition to our internal Member Outreach Team, we are implementing other initiatives to help locate and engage members who are homeless or otherwise hard to reach. Innovative and best practice strategies we recently implemented or will be implementing and expanding in the near future to help locate and contact hard-to-reach members include “feet on the street” community-based partnerships and securing access to the Homeless Management Information System (HMIS). Access to real-time notifications through the Event Notification System will continue to be instrumental in helping us locate hard-to-reach members if they are admitted to a hospital or visit an emergency department. We will continue to explore additional options to obtain service notification data from other vendors we work with, like transportation providers.

Homeless Management Information System (HMIS)

We have recently secured access to the HMIS, a local information technology system that collects client-level data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. This system enables us to use the “client tracker,” a valuable application that helps us locate members experiencing homelessness. This will be a valuable new tool for our Case Managers (Managed Care Coordinators) and Member Outreach Team. This application identifies shelters and other organizations that are currently providing services or that recently provided services to a member.

Our affiliate health plan in Indiana recently began using the HMIS as a tool to successfully locate members with unstable housing. Based on total per member per month costs prior to and after engaging, our affiliate calculated that actual savings already exceed \$100,000 for the 52 homeless members they were able to locate and engage in services using the HMIS for only four-months (May through August 2017). Encouraged by early results, our affiliate will be expanding their use of the HMIS to incorporate notification alerts when a member they are searching for is identified. Clear Health will incorporate the innovative best practices that our affiliate plan is implementing to maximize the value of the HMIS.

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Clear Health Member Outreach Team

Clear Health has learned best practices for communicating and engaging with medically and behaviorally complex members. We understand that our members face significant social stigma in addition to challenges navigating their health needs. Our Member Outreach Team is strategically designed to address the barriers we encounter in contacting these hard-to-reach members. Our staff are specially trained and have years of experience supporting our members with compassion and respect. They personally reach out to and visit with other organizations and agencies that provide services to individuals who are homeless, building strong relationships and collaborations that assist us in locating and engaging our own members. This approach also involves moving outside of the walls of these organizations and agencies, directly engaging members experiencing homelessness who may be lost to care and services, living in the streets.

“Feet on the Street” Outreach through Community-based Partnerships

To support further growth and process efficiency, we are leveraging local partnerships and contracts throughout the State to supplement our “feet on the street” approach to find members where they reside to initiate engagement into care. These partnerships and contracts are being developed with Federally Qualified Health Centers, Community Mental Health Centers, Ryan White providers, former Project AIDS Care (PAC) waiver entities, and housing providers that have traditionally worked with homeless or other hard-to-reach individuals. These entities have dedicated teams comprised of skilled and trusted outreach workers who know where the homeless populations are, in shelters as well as on the streets, and when (weekdays, evenings, and weekends). These specialized field-based workers have established strong relationships over the years with key homeless leaders and individuals living on the streets. These workers can use those relationships to help our internal Member Outreach Team locate hard-to-reach members. Clear Health is in active discussions with the organizations we will partner with in Florida. After having successes with the local presence model across many of our current regions, we will be implementing these innovative partnerships to expand and supplement our “feet on the street” Member Outreach Team on a larger scale to support a scalable and sustainable local model.

Our affiliate health plan in Indiana implemented similar “feet on the street” strategies beginning March of 2017, in partnership with community health workers and entities in the community. Their program has been successful and has touched the lives of 1,230 members from March through August 2017. Actual savings through August 2017 already exceed \$440,000 based on per member per month costs prior to and after engaging members.

Real-time Data Helps Us Locate and Engage Members Certain Services

Access to the Event Notification Services will also help us locate Deshea and other hard-to-reach members through real time notification if they are admitted into a hospital or visit an emergency department at a participating facility. For example, if we are alerted through the Event Notification Service that Deshea is in a hospital, we will coordinate a Clear Health team member to meet with her face-to-face. At some hospitals, we have on-site Concurrent Review Nurses who are immediately able to make contact with Deshea. If Deshea is in a hospital where we do not have on-site team members, then we will promptly send a Managed Care Coordinator and/or Outreach Care Specialist to meet with her at the facility. We have found that face-to-face contact is an

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important tool for developing a connection and establishing rapport with our members who are homeless or difficult to engage into care and treatment for HIV/AIDS.

We will continue to explore additional options to obtain service notification data from other subcontractors. For example, our systematic process to locate hard-to-reach members includes contacting transportation vendors to obtain current pick-up addresses. Transportation data notifications will enhance our ability to locate hard-to-reach members, enabling us to meet the member where they are currently accessing transportation services. We will also ask our behavioral health vendor to search their files to share data, such as claims and provider history, which we can follow up on.

1.b. Data and Information Sources Assist in Identification of Members with Special Health Care Needs or Circumstances

We use multiple sources of information to help us locate members like Deshea, including those who we are unable to contact due to missing or outdated information in the enrollment file. We also use these information sources to identify special needs or circumstances that our new members may be experiencing (from enrollment through the first 90 days). We use the following information sources to support our new member location and identification processes:

- State enrollment files (current and past) including the 834 enrollment file and the Special Needs Supplemental File
- Historical claims data
- Face sheets from hospital emergency department visits or admissions
- Hospital and emergency department visit alerts through the Event Notification Service
- Prescriptions filled
- Health plan transportation service records and other vendor records (transportation, vision, dental, behavioral health)
- Exchange of information with local Ryan White providers and PCPs
- Weekly data exchange with Healthy Start Coalitions
- Public arrest record search (local and state level) at State of Florida, Department of Corrections, Corrections Offender Network (<http://www.dc.state.fl.us/activeinmates/search.asp>)
- Social media search tactics

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Identification of Special Circumstances and Needs using the HMIS

In addition to the above information sources, we will use the HMIS to access additional data that may assist in identifying member needs and circumstances. We will use the HMIS to help us locate members who have unstable housing or who are homeless throughout Florida, and as a resource to help us better understand member needs and circumstances. After locating a member, we will also use the HMIS to identify the organizations currently providing services to them, and to make sure that they are receiving the community-based supports we referred them to, collaborate with them as needed, and identify and fill service and support gaps. For example, our affiliate health plan in Indiana currently uses the HMIS to assess the amount of time and number of times a member has been homeless, to identify other organizations that are working with a member, and the number of past and current services utilized. This information helps our affiliate with early identification and location of the member, and also helps obtain accurate assessments, timely record sharing, identification of gaps in services or participation, and coordination of services.

Identification of Special Health Care Needs and Circumstances through Member Outreach

Once we are able to locate and establish contact with our new members, we collect additional information from them to help us identify special health care needs or circumstances. Our Customer Care Representatives conduct outreach calls to each new member to welcome them to the plan, discuss benefits, confirm demographic information including language needs and the use of interpreters, encourage them to complete an initial screening to understand their health care needs, and inquire about current or emergent needs for services. We also identify the comprehensive needs of our hard-to-reach or homeless members located by our Member Outreach Team, including Outreach Care Specialists, in collaboration with our Managed Care Coordinators and the outreach workers from the entities we partner with. All Clear Health members are referred to their assigned Managed Care Coordinator for follow up and completion of the comprehensive health assessment.

Other Strategies to Identify Special Needs and Circumstances for our Hard-to-reach Members

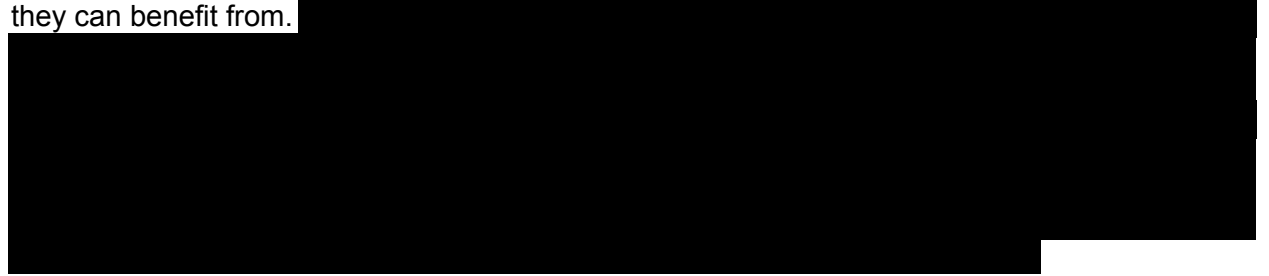
In addition to helping locate members to establish initial contact, our Member Outreach Team and the entities we partner with are also instrumental in establishing and maintaining supportive relationships, providing advice and support, and improving the likelihood that members will not only engage but will continue to access necessary services and supports for their health and well-being. We know that building strong relationships with a member is essential to establishing trust and understanding individual circumstances. We understand that there may be legitimate barriers preventing members from accessing services, including being unaware of the range of services and supports available to more complicated barriers like problematic experiences with child protection services, homeless shelters, or mental health facilities. Some members may have addictions or other barriers like pets, partners they refuse to part with, or being underage and fearful of being turned over to child protection authorities.

To support our members, we employ field-based Outreach Care Specialists as part of the Member Outreach Team and clinical Managed Care Coordinators, and have partnerships with entities that understand this population and have the “cultural competence” to know how to connect, engage, and maintain communication with members struggling with homelessness and HIV/AIDS. We educate these members on the many services and supports available to help them move off the

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streets. Our outreach workers and Managed Care Coordinators establish a trusting connection with each member, and take a holistic approach to collaborate to identify their goals, needs, and preferences for obtaining access to the services and supports they need and desire. We use a trauma informed and person-centered approach to assess each member's strengths as well as their educational, employment, nutritional, and transportation needs. We either make community connections for services or provide support such as bus cards, cell phones, or food and clothing referrals.

We carefully assess member circumstances to identify behavioral health, social, and physical health care needs, including services for sexual assault, sex trafficking, sexual or physical abuse, or sexual identity. Our holistic assessment helps us connect our members to the services that they can benefit from.



2. PROCESSES AND DATA SOURCES WE USE TO CONTACT MEMBERS

Upon our receipt of the X12-834 Enrollment File provided by the Agency, our Customer Care team mails each member a new member welcome packet, which includes member ID cards, and plan materials, including an initial screening form with a self-addressed stamped return envelope. This new member welcome packet is mailed within five calendar days of the member's enrollment. Clear Health's specially trained Customer Care Representatives also call new members to welcome them to our plan. Representatives who communicate with Clear Health members receive additional training on HIV/AIDS, including sensitivity training and training on comorbidities. The Customer Care Representatives attempt to obtain the initial screening during the welcome call, if not already completed and returned by the member. These calls are made at least twice if necessary within 30 days of a new member's enrollment. Our welcome calls are handled through our Florida-based Member Services help line. We employ bilingual Customer Care Representatives; therefore, translation services are not needed for Spanish welcome calls. If a member speaks a language other than Spanish or English, the Customer Care Representative will initiate translation services through our standard process.

If members do not respond to these initial outreach efforts, then in the second month of their enrollment we attempt four to six additional calls at different times of day and during the weekends. If the member is still not contacted and did not complete an initial screening within 60 days, our Member Outreach Team continues the process, along with further research and outreach attempts, during the third month of enrollment. Using the information we identified in evaluation criteria 1.b above, our data analytics resources simultaneously mine all available information about diagnoses, past health care utilization, demographics and other information to help us identify risks and anticipate the needs of our members, and to identify current contact information. A Member Outreach Team member also looks at external sources of information to contact a hard-to-reach member. For example, if a female member is of childbearing age, our systematic process includes review of Healthy Start Coalition enrollment files. We will also include this step if the enrollment file indicates a member is pregnant. Through our established data

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exchange agreement with Healthy Start Coalitions, we will receive these files weekly. If a member is identified in the file as pregnant, we will collaborate with the Healthy Start Coalition to locate the member and coordinate services.

Our Member Outreach Team also looks at service and visit records from our vendors, arrest records, Google searches, and other publicly available data sources that may provide updated contact information, and homelessness information using the HMIS. Clear Health conducts this type of investigation and follows up with every new member to identify any special health care needs or circumstances, and to find updated or missing contact information. In addition, if we receive returned mail with a new address, we update our records and promptly mail the new member welcome packet to the new address. We also implement “feet on the street” outreach strategies through our Member Outreach Team as well as with the entities we partner with, as we described in our response to evaluation criteria 1.a. These strategies are used to contact and engage our homeless, potentially homeless, and otherwise hard-to-reach members we are not able to contact through phone. If we identify an unreachable member goes regularly to a particular location, we may send an Outreach Care Specialist to try to meet the member at a point of contact and begin engagement while ensuring privacy and safety standards are upheld.

Additional outreach attempts are also made directly by the Managed Care Coordinator assigned to every new member. If we are unable to contact a new member, and after the Managed Care Coordinator extensively researches other sources of contact information and makes at least three call attempts is also unable to contact the new member, we will mail the new member another Unable to Contact letter asking him or her to contact our case management department.

At that time, the Managed Care Coordinator turns to the Member Outreach Team for ongoing periodic follow up. If all attempts to locate a member are unsuccessful, and if we exhaust all avenues in the first 90 days of enrollment, then our Member Outreach Team will flag the member's record in the Case Management System identifying that we have been unable to contact him or her. This flag will make sure that appropriate and immediate action, such as connecting the member directly to a Managed Care Coordinator, is taken by our Customer Care Representatives in the event the member calls us. In addition, as soon as member utilization, claims, or pharmacy usage is identified through regular reports, our Member Outreach Team pursues the new lead. If a member is hospitalized or shows up in an emergency department, we will call the hospital and visit to try to engage them. In some areas, we have special access to visit members in psychiatric facilities during discharge preparations. Our proactive search process for every member we are unable to locate will be attempted and refreshed on an annual basis.

3. ENGAGING NETWORK PROVIDERS AND COMMUNITY PARTNERS TO ASSIST NEW MEMBER IDENTIFICATION PROCESS

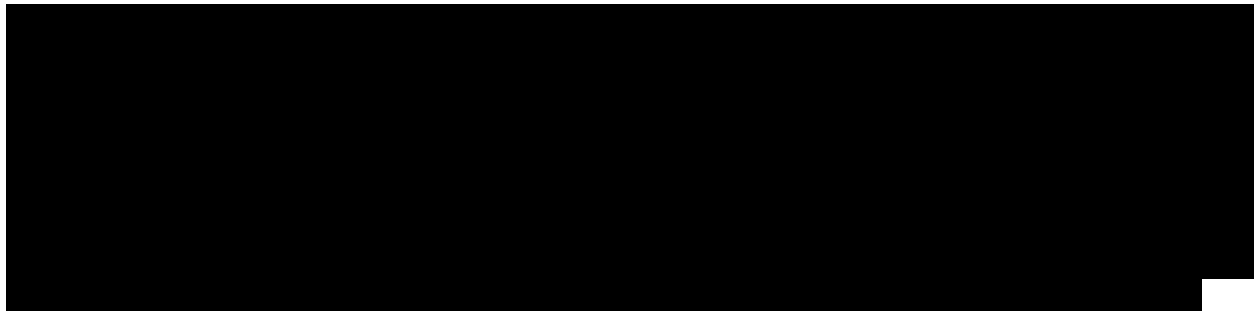
We strategically engage providers who have historically served the homeless population and are best prepared to engage and maintain meaningful contact with our members who face homelessness. The Street Outreach services we are also implementing through a provider partnership in key regions across Florida not only locate a member, but engages them in services such as health screenings, preventive care or treatment, community services, behavioral health services, peer supports, and housing services. These services effectively connect a member to resources they need in the community as well as the Continuum of Care Coordinated Entry system to help them connect with the best housing option. We are already partnering with agencies across Florida — entities such as Healthcare for the Homeless dba Orange Blossom

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Family Health (FQHC) in the Orlando area; Camillus House in the Miami area; Baley Center in St. Petersburg; Gracepoint in Tampa; the Homeless Services Network in Central Florida; and other statewide entities like the Florida Coalition for Supportive Housing.

Engaging Network Providers

We will continue to engage our provider network community and work with providers to collaboratively locate and stay in contact with our members. Our locally based Provider Relations team, Provider Network Managers, and Managed Care Coordinators work hard to build strong relationships with providers in our network, including those who provide services to hard-to-reach members, making sure they have the tools and resources they need to support each member. Our Provider Network Managers are in the community meeting face-to-face with providers to share actionable data and collaborate on optimal approaches to make sure our members receive services they need. We enlist the assistance of providers in locating specific members, and helping us connect with our members by notifying us while they are in the emergency department, hospital, or at a doctor appointment. They are instrumental in advocating on our behalf to help build trust with our members, helping us get thorough comprehensive health assessments, and maintaining contact with members that are reluctant to accept our assistance.



Community Partnerships

We have strategically developed partnerships with entities across the State that have traditionally served members with unstable housing. For example, we continue to develop partnerships with the former PAC waiver entities across every region in Florida to help us locate Clear Health's new members who may be homeless and other hard-to-reach members. The PAC waiver entities will enhance our ability to locate and engage members who are homeless because of their longstanding work with local community homeless organizations. Their role has been critical to many of these members who need a community liaison and support system to engage in care. The PAC waiver entities we partner with will also work closely with our Managed Care Coordinators to be our local "feet on the street," personally working with our members to help engage them in care.

After we locate and engage these members, we will continue to monitor member engagement and gaps in care, and coordinate with these former PAC waiver entities to further support our HEDIS® initiatives by helping us engage our members who are homeless or difficult to contact to make sure timely care and services are arranged and received.

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We will also have partnerships in specific regions in the State with other entities including FQHCs, CMHCs, and housing providers. These entities will provide additional street outreach services to locate and engage our members who are homeless.

Ongoing Collaboration with Community-based Organizations

Our Customer Care team, Managed Care Coordinators and the entities we establish partnerships with for street outreach services will collaborate with organizations such as community centers, community mental health providers, shelters, drop-in centers, faith-based organizations, senior centers, clinics, housing authorities, recovery organizations, and food banks to help us maintain contact and engage our members who are hard to reach. We will continue to conduct community outreach initiatives that extend existing social support services to these types of organizations and others serving the homeless, such as Feeding South Florida, Healthcare for the Homeless, Immokalee Friendship House, and Department of Children and Families Office on Homelessness.

Partnerships to Address Potential Justice System Involvement

We continually identify locally based resources and assess their capabilities, educate our employees about them, build mutually beneficial relationships, incorporate them into our outreach and case management activities, and customize our approach based on these resources. For example, we are collaborating with Drug Abuse Comprehensive Coordinating Office (DACCO) in Florida Regions 5 and 6 to coordinate activities for our members suffering from substance abuse. DACCO is currently a contracted provider and by working with them to integrate behavioral health and medical services, our members benefit from a wrap-around approach that can help break the cycle of substance abuse and justice system involvement.

Partnerships to Support Employment Services

To help provide additional support to members, Clear Health is working with State and local behavioral health providers as well as the Department of Vocational Rehabilitation to expand evidenced-based models such as Individual Placement and Support (IPS). Currently this model is exclusively in Broward County, and we would like to partner with the State to expand this model to other counties or regions across Florida. As we move forward with expanding this initiative, Clear Health will develop relationships with additional community-based organizations, workforce development agencies, and the Division of Vocational Rehabilitation. We will collaborate with these organizations on behalf of our members to help them enter the workforce and gain skills needed to establish self-sufficiency.

DESHEA MEMBER VIGNETTE:

CLEAR HEALTH'S PROCESS TO CONTACT DESHEA BY MARCH 29, 2019

Upon receipt of notification of Deshea as a new member effective January 1, 2019 through the X12-834 Enrollment File provided by the Agency, our Customer Care team immediately sees that Deshea's last known residence was a homeless shelter, and that her file is missing a phone number – key information we need to contact her to tell her about her benefits. We place an alert on Deshea's file in the Core Operations System to inform all plan staff who may interact with her that contact information is needed. We also mail a letter to Deshea to her last known address at the homeless shelter, requesting that she respond to a dedicated phone number designed to link

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her with specialized services. Many homeless shelters will keep mail for persons who have lived in or have a relationship with the shelter.

Since Deshea had the shelter address on file with the State, she may have previously been able to receive mail at the facility and may come by to check if any mail has been set aside for her. The new member welcome packet is also mailed to Deshea, using our modified member mailing protocols so material is not identifiable as from "Clear Health." This is mailed to Deshea at the homeless shelter's address within five days of her enrollment. We then proceed with our alternative enhanced member outreach processes.

Since we do not have a phone number to directly reach Deshea, the Customer Care Representative sends Deshea's profile to our Member Outreach Team for further research and individualized processes by a Managed Care Coordinator and an Outreach Care Specialist from our Member Outreach Team. Our Member Outreach Team uses multiple strategies and outreach attempts to locate and contact Deshea as soon as possible and no later than March 29, 2019.

The Managed Care Coordinator, Cindy, immediately contacts the local area shelter by phone to locate Deshea. Cindy learns that Deshea recently left the shelter and her location is now unknown, so Cindy attempts to identify Deshea's current homeless shelter address through the HMIS client tracker. Cindy confirms that Deshea is not currently staying in any shelter, and the shelter listed on the enrollment file was the last place she stayed. Cindy finds out that Deshea has not returned to the shelter to retrieve any of the mailings we have sent. Cindy researches any prescription refills and contacts the pharmacy that Deshea used in the past for alternative contact information. Cindy also researches any claims to contact providers and call logs to identify alternative contact information. Cindy checks back with the homeless shelters.

Cindy also engages an Outreach Care Specialist from our Member Outreach Team, Wendy, to personally visit any locations where Deshea may be. For example, if Cindy finds out that Deshea will be having a clinical appointment, she will send Wendy to the location to meet her. Wendy continues to search for Deshea by calling every shelter and organization identified through the HMIS as providing past services to Deshea. Wendy also calls all other area shelters. Wendy enlists the assistance of each shelter and organization she calls, requesting that they contact us and provide Deshea with our contact information if she chooses to seek shelter or services at their location in the future. Wendy also contacts the PCP who Deshea has been assigned to. She informs the PCP that we have not been able to contact Deshea, and requests to be notified if Deshea visits to receive services in the future.

Wendy continues to search for alternative addresses or contact numbers in all current and past information we have. She contacts the local Ryan White Agency Case Manager to determine if they have seen Deshea or have any additional information that may assist in locating her. She also identifies any past enrollment files from the State and all historical claims information we have. She finds historical information on Deshea from a prior enrollment period and identifies the providers she accessed in the past, pharmacies she used, hospitals she visited, and services she used such as transportation. Wendy reaches out to the past providers and entities for any contact information that could lead to Deshea, and follows up on each lead. Wendy asks Deshea's past providers to help us contact her and request that they give her a message to contact us if she visits them. Deshea's hospital member record is noted with an identifier that indicates she is assigned to our plan and we are unable to reach her. If she has a future hospital admission, our nurse will visit Deshea in the hospital to connect her with her benefits, case management, and

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other needed services. We will also look for information on Deshea to appear on the ENS. Wendy will also reach out to our behavioral health vendor to ask them to search for data, such as claims and provider history that we can follow up on.

Wendy also follows up on all contact leads identified by our Customer Care team identified through external data resources. For example, since Deshea is of childbearing age, Wendy continues to check the weekly Healthy Start Coalition files. Wendy continues to try to locate Deshea's current contact information by reviewing other external data resources. She searches the county and state public arrest records to rule out incarceration at the State or local level, or to find out if Deshea has a probation or parole officer who can identify her location or assist in making a connection. Wendy tries to find Deshea's contact information through other publicly available data resources and Google searches.

Cindy, Wendy, and other members from our Member Outreach Team are unable to locate Deshea through the measures described above so they collaborate with our regional partner for additional "feet on the street" outreach initiatives.

Rick, a field based team member from one of our partner organizations, helps Cindy and Wendy look for Deshea. Rick frequently searches areas surrounding the shelter where Deshea was last seen. Rick also strategically enlists the assistance of each shelter and other community-based organizations we identified through the HMIS that may provide services to Deshea, again asking them to contact us and provide her with our contact information if she receives services at their location in the future.

After using all of these methods to locate Deshea, Cindy finally made contact with Deshea with the assistance of Rick on February 21. Typically, we locate members who are homeless at the homes of family or friends, or we find them at a different shelter location. However, Deshea's situation was more complicated. Rick found Deshea living on the streets, in an alley behind a local grocery store, not far from the shelter she resided in until December 27. He learned that she was escaping from family and friends after the holidays following a dispute. She resisted all services so she could remain hidden and live in seclusion.

Strategies and Data Sources We Use to Establish and Maintain Contact

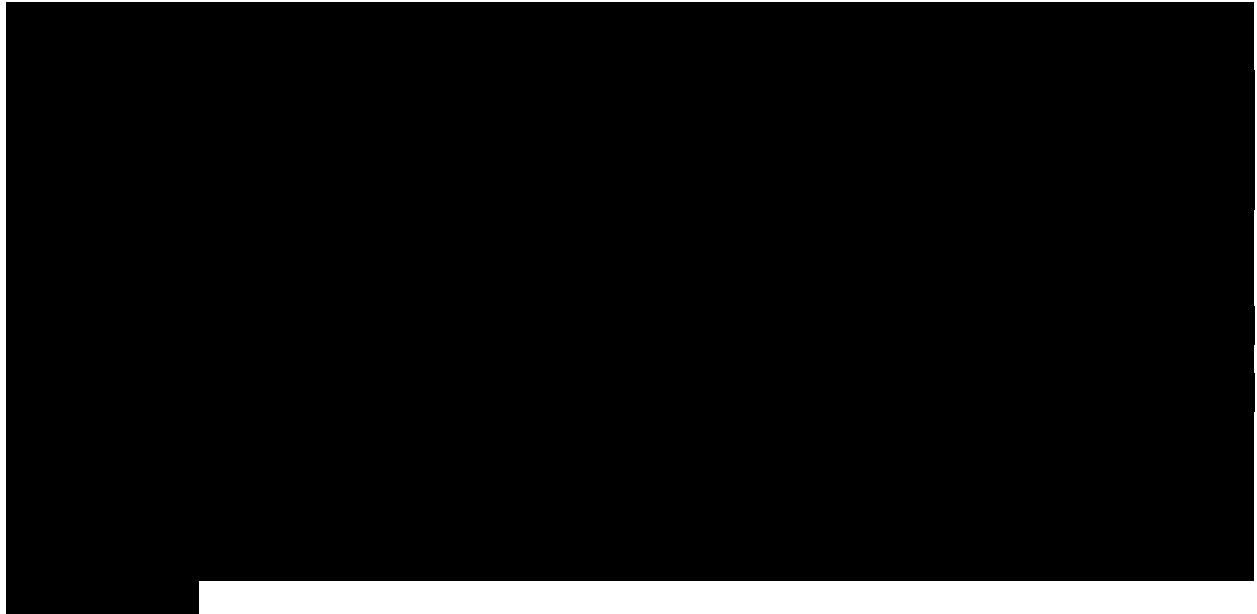
As soon as Rick finds Deshea, he shifts his priority to establishing and maintaining a supportive relationship with her to make sure that she will engage with us and will access necessary services and supports for her health and well-being. Rick understands that building strong relationships with a member is essential to establishing trust and understanding individual circumstances. He understands that there may be legitimate barriers that prevent her from accessing services. These barriers range from being unaware of services and supports available, to more complicated barriers like problematic experiences with child protection services, homeless shelters, or mental health facilities. He knows that Deshea may have addictions or other real or perceived barriers to receiving services.

Rick explains to Deshea that there are many services and support options to help her move off the streets. He provides her with multiple locations where Cindy can meet with her face-to-face to explain her benefits and connect her with services. Rick explains that they could meet her at places like the community center, shelter, or other young-adult friendly meeting spaces. He encourages Deshea to choose anywhere she feels comfortable and that he would make it work. Due to Rick's patience and persistence in gaining Deshea's trust, Deshea agreed to meet Cindy

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at a community center. Cindy immediately helped identify Deshea's barriers to returning to the shelter where she previously resided. Cindy works with Deshea to find alternative placement options and services to get her off the streets immediately.

Cindy takes a holistic approach and collaborates with Deshea to identify her goals, needs, and preferences for obtaining access to the services and supports she needs and desires. Using a trauma informed and person-centered approach, Cindy works with Deshea to assess her strengths as well as her educational, employment, nutritional, and transportation needs and makes community connections for services and provides support including a bus card, a cell phone, and food and clothing referral. She carefully assesses Deshea's circumstances to identify social and health care needs, including mental health needs; service for sexual assault, sex trafficking, or sexual/physical abuse; and sexual identity. Cindy's holistic assessment helps connect Deshea to the services that she can benefit from. Through the HMIS client tracker, Cindy identifies and monitors what community-based services Deshea receives. She uses the HMIS to make sure that Deshea is receiving the community-based supports that Sarah referred her to, collaborate with other organizations as needed, and identify and fill service and support gaps.



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[REDACTED]

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Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:
 - (a) Identification of strategies for identifying new enrollees; and
 - (b) Description of the sources of data/information that will be utilized to identify enrollees with special health care needs or circumstances.
2. The extent to which the respondent describes its process for contacting enrollees, including the data sources.
3. A description of how network providers and community partners will be engaged in the identification process.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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F. OVERSIGHT AND ACCOUNTABILITY

SRC# 26 – Subcontractor Oversight (Statewide):

The respondent shall list any proposed subcontractors to which it will delegate the management of: provision of covered services, utilization management, provider networks or paying providers. The respondent shall describe how it will oversee and monitor the performance of subcontractors in general, as well as any specific oversight planned for certain subcontractors, including any corresponding service level agreements. The respondent shall include in its response the schedule and type of monitoring and how findings are reported, remediated, and used for process improvements.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Clear Health views subcontractors as valued partners in delivering the highest quality services to enrollees (members), providers, and the Agency. Through a comprehensive vetting process, we select top-level qualified subcontractors who can best serve our members. Our subcontractors represent an extension of Clear Health and the services we deliver to our members. We build trusted, collaborative, long-standing relationships with our subcontractors to coordinate seamless delivery of services that meet AHCA requirements.

We maintain an established Subcontractor Oversight Program, refined over our 14 years of serving members in Florida Medicaid programs. We will continue to use and enhance this program to assure timely, appropriate, and quality care and services. Further, we include detailed requirements and service level agreements (SLAs) in our subcontractor agreements, set clear expectations of how we measure performance and boundaries of what is acceptable, and specify the consequences for non-compliance.

Our program enables us to continuously oversee and monitor subcontractor performance through daily collaboration, regular monitoring, and formalized auditing processes. Throughout the life of our Contract, Clear Health will retain sole responsibility for fulfilling SMMC Contract requirements and remain fully accountable for our subcontractors' performance. We will continue to oversee, monitor, supervise, and enforce Contract compliance, as well as promote frequent, open, and effective communication that emphasizes delivery of quality services to members. We monitor subcontractors to assure they meet or exceed Contract requirements.

Our Subcontractor Oversight Program leverages a dedicated local health plan team supported by national subcontractor management resources. Our dedicated Florida-based Vendor Delegation Oversight Group (VDOG) oversees and monitors subcontractor performance. Led by Judi Peterson, our Staff Vice President of Operations and System Solutions, VDOG includes four full-time dedicated staff. The VDOG team has support from executive leadership and departments

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across Clear Health, including Provider Relations, Member Services, Compliance, Regulatory, Operations, Utilization Management (UM), and Medical Management.

While we delegate some functions to subcontractors, we believe that maintaining complete visibility into the volume and topics of member grievances and appeals is a critical component of subcontractor oversight. For this reason, Clear Health maintains direct responsibility for all member grievances and appeals. We hold ourselves accountable for all aspects of our plan, and we believe that member concerns provide us with valuable insight into subcontractor performance. We do not delegate any member grievances and appeals, including for services provided by our subcontractors, such as pharmacy, dental, vision, and transportation. Our Florida-based team oversees the entire process (intake, investigation, and resolution), working closely with our subcontractors. We instruct subcontractors to forward any member grievances and appeals to Clear Health.

In the sections below, we list our proposed subcontractors and describe our Subcontractor Oversight Program, which includes three main phases:

- Selection and Pre-delegation Assessment – confirming the subcontractor can meet operational, financial, legal, compliance, regulatory, accreditation, and ethical standards
- Ongoing Oversight and Monitoring – regular, consistent, and detailed monitoring and oversight of the subcontractor’s delegated functions and financial solvency
- De-delegation or Termination
 - De-delegation – transitioning delegated functions away from the subcontractor if business needs change or if a subcontractor becomes unable to adequately perform a delegated function (such as removing subcontractor responsibility for UM)
 - Termination – activating our contingency plan in the event a subcontractor is unable to continue operations or if subcontractor becomes unable to perform the functions stipulated in the contract

1. SUBCONTRACTORS WE PROPOSE TO USE UNDER THE SMMC PROGRAM

Clear Health proposes 12 subcontractors to support our SMMC program across provision of covered services, UM, provider networks, or payment of providers, including:

- Provision of covered services, UM, provider network, and payment of providers
 - Beacon Health Options (Beacon): Behavioral health services
 - Chiro Alliance Corporation: Chiropractic services
 - DentaQuest of Florida, Inc. D/B/A EyeQuest: Vision services
 - Health Network One, Inc. (HN1): Therapy services (occupational, physical, speech)
- Provision of covered services, provider network, and payment of providers
 - Audiology Distribution, LLC D/B/A HearUSA, Inc.: Audiology/hearing services
 - DentaQuest of Florida, Inc.: Dental services
 - Express Scripts, Inc.: Pharmacy services

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- LogistiCare Solutions, LLC (LogistiCare): Non-emergency transportation services (Regions 1 through 9)
- MCT Express, Inc.: Non-emergency transportation services (Regions 10 and 11)
- Ride2MD, Inc.: Non-emergency transportation services (all regions)
- Administrative/support services and UM
 - Anthem, Inc. (Clear Health's ultimate parent company): Administrative/support services, including payment of providers and UM
 - AIM Specialty Health: UM, including radiology

All of these subcontractors already provide services under our existing Florida contracts and have demonstrated their ability to partner with us to meet the needs of members, providers, and the Agency. As we merged the health plans into one, we selected the best performing, most collaborative, most responsive, and innovative subcontractors based on our experience, and chose those that will best meet the needs of our SMMC members.

1.1. Subcontractor Selection and Pre-delegation Assessment

Our subcontractor selection process is driven by multiple data sources and clearly defined expectations. We carefully select our subcontractors only after we thoroughly evaluate and determine that they will improve the quality, efficiency, and value of services we deliver to our members and providers. Once Clear Health identifies the need for a subcontractor, Provider Relations identifies entities capable of delivering the service. They meet with each prospective subcontractor to discuss the requirements (including service levels) and capabilities. Provider Relations then executes a side-by-side comparison of the organizations and selects the entity that will best serve our Florida program.

We use a rigorous process for selecting our subcontractors and perform pre-delegation audits and reviews. Subcontractor selection and pre-delegation assessment is a collaboration between Clear Health and the national team and includes the following major tasks:

- Complete subcontractor identification, meetings, review, evaluation, and selection
- Develop agreement, including clear definition of delegated functions, expectations, and SLAs
- Conduct pre-delegation assessment
- Submit to the Agency for approval
- Implement agreement, including training, policies and procedures, and testing of interfaces

As part of the selection and pre-delegation assessment phase, we evaluate the subcontractor, which includes a written review of the subcontractor's understanding of the standards and delegated tasks, appropriate documents, staff capabilities, financial stability, performance record, and a review of State licensing and certification requirements. The process also includes an evaluation of the subcontractor's adherence to NCQA and Accreditation Association for Ambulatory Health Care (AAAHC) subcontractor standards. Evaluation often involves an on-site visit at the subcontractor's place of business.

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After determining that the subcontractor is qualified, a pre-delegation audit confirms that the proposed organization meets Clear Health's and AHCA's operational, financial, legal, compliance, regulatory, accreditation, and ethical standards. We examine items such as the organization's HIPAA privacy and security compliance, grievance and appeals history, operating procedures, staffing ratios, and financial viability. When possible, we also check credible references in the industry about subcontractor service delivery. After the subcontractor passes the pre-delegation audit, Clear Health submits information on the proposed subcontractor and the delegated functions to AHCA for approval.

Our written agreements with subcontractors comply with all Florida statutes and are subject to their provisions. Agreements define roles and responsibilities, performance standards, SLAs, quality assurance requirements, reimbursement, financial responsibilities, hold-harmless provisions, insurance requirements, privacy and security requirements, data exchange and reporting requirements, and record retention. We will continue to provide copies of subcontractor agreements to the Agency.

After subcontractor selection, functional departments across our health plan begin meeting to discuss expectations and service levels in each area. These initial discussions lead to pre-implementation meetings where functional departments confirm subcontractor compliance with detailed requirements and discuss required operational processes, including a review of policies and procedures and test files.

2. SUBCONTRACTOR OVERSIGHT STRUCTURE

Our dedicated, Florida-based VDOG team is the central component of our subcontractor oversight structure. VDOG receives support from the executive leadership of our organization as well as participation of functional departments across Clear Health, such as Provider Relations, Member Services, Compliance, Regulatory, Operations, UM, and Medical Management.

Clear Health created the VDOG team to expand and enhance our local Subcontractor Oversight Program, creating a team with diverse skills, knowledge, and expertise. To comprehensively monitor and oversee subcontractors as well as bring value to the partnership, our team includes staff with direct experience in the functions our subcontractors perform. The VDOG model represents another example of the strength that comes from combining the best practices and capabilities of three health plans. Our model combines a strong local oversight model focused on the unique needs of Florida with the significant experience of a national model that supports affiliates across the country.

Figure 26-1 in Attachment SRC# 26-1: Subcontractor Oversight shows an organizational chart of our subcontractor oversight structure, including participation of executive level staff and support delivered by other Clear Health departments as well as national subcontractor oversight teams and committees. The chart also includes short biographies of our VDOG team members, highlighting the experience and expertise they bring to our Subcontractor Oversight Program.

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VDOG assigns an Account Manager to each subcontractor to conduct day-to-day management, oversight, and performance review. This approach builds trust between our organization and our subcontractors, and also allows us to be proactive in resolving any issues that may arise, which helps mitigate any compliance issues. Account Managers possess many years of knowledge and experience that allow them to function as a subject matter expert in areas such as call center operation, provider relations, and claims processing. A dedicated Business Analyst provides the team with data analytical support.

The responsibilities of the VDOG cover all aspects of our relationship with the subcontractor. In this capacity, the VDOG team:

- Manages the relationship day-to-day at an operational level
- Identifies strategic relationship needs and issues, or addresses need for additional capacity or capabilities
- Manages daily and ongoing operational compliance according to the operational area's framework, tools, and processes
- Reviews operational performance tracking standards and measures against SLAs through monthly Key Performance Indicators (KPI) reports and other operational reports
- Requests, implements, and tracks any Corrective Action Plans (CAPs) to resolve identified deficiencies and reports to leadership, compliance, and the national team
- Maintains centralized online repository of subcontractor contact and performance data – the VDOG Dashboard – and assists with the development and planning of communications and dissemination of information
- Leads quarterly Joint Operational Committee meetings that include key business units to review subcontractor performance, KPI reports, and other issues or initiatives

The VDOG team maintains a focus on continuous improvement. Team members and leadership continuously review processes to strengthen what is working and implement change where we identify a better way. Clear Health's goal will always be to deliver the highest level of service to our members, regardless of who provides the service.

The VDOG team leverages resources from our national Enterprise Delegation Oversight and Management (EDOM) department, especially in the review of subcontractor financial stability, annual audits, and oversight of subcontractors who also serve our affiliates in other states. Due to the unique nature of administering pharmacy benefits, the national Pharmacy Performance Oversight Council (PPOC) will continue to monitor the performance of Clear Health's pharmacy subcontractor to make sure that performance meets all regulatory and accreditation standards (such as NCQA, AAAHC, CMS, URAC, State, and federal regulations).

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Key national committees deliver cross-functional management and support to our Subcontractor Oversight Program. The Delegate/Vendor Oversight and Management Committee (DVOMC) meets monthly and is the final internal approval authority for subcontractor delegation and oversight. Participation at the national level offers key benefits, including:

- Consistency in management, expectations, and remediation/corrective actions as well as a high-level review of performance across all markets/states to better identify trends
- Identification of best practices and innovations in other states that may benefit Florida
- Proactive identification and mitigation of performance variance in a single state, often avoiding impact on other markets

2.1. Executive Level Participation

Clear Health's subcontractor oversight structure includes executive-level participation from across the organization. We embrace our responsibility for the functions our subcontractors deliver under our SMMC Contract and our executives are instrumental in making sure that subcontractor services remain aligned with AHCA standards and program requirements.

Judi Peterson, the leader of the VDOG team, has direct and immediate access to our Plan President, Lourdes Rivas, to address any concerns or risks. The executive team meets every other week to discuss strategy, confirm that performance is on track, review action plans, share successes, and discuss risks and mitigation. Subcontractor strategy and performance is a component of these meetings. In addition, the entire executive leadership team is part of the Florida Medicaid Compliance and Quality Management Committees where VDOG reports on status, CAPs, and risks.

VDOG holds a quarterly Joint Operations Committee meeting with each subcontractor to review and discuss performance, issues, gaps, concerns, operational enhancements or challenges, and any upcoming new or changed policies. These meetings include key members of the executive team, including Efrain Duarte (Regional Vice President of Provider Solutions), Dr. Vincent Pantone (Chief Medical Officer), Suzanna Roberts (Chief Operating Officer), and Holly Prince (Regional Vice President of Finance).

In addition, we review with the executive leadership team and discuss any subcontractor concerns that lack commitment of improvement and directly impact the quality and care of our members. This executive review includes discussions of next steps and potential subcontractor change.

2.2. VDOG Dashboard

Our VDOG Dashboard is a comprehensive repository of detailed information on each of our subcontractors. It promotes transparency of information and consistency in management and oversight. Maintaining a centralized repository also allows other VDOG team members to easily manage the subcontractor and make sure we continue to meet day-to-day operational excellence if the assigned Account Manager is out of the office. The VDOG Dashboard contains comprehensive information, including:

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- VDOG team information, such as contact information, meeting minutes, and reference materials (including website links), documents, and other information
- A list of subcontractors, along with detailed information for each, including:
 - General information, such as legal name, physical address, and correspondence address; contact names, numbers, and e-mail addresses; delegated functions; programs and regions; VDOG Account Manager and Business Owner
 - Subcontractor agreement
 - Scorecard for the current month and historical
 - Reports submitted, including operational and KPI
 - Corrective Action Plans (current and historical)
 - Document repository, containing policies and procedures, and meeting minutes
- Reports Calendar, listing due dates for reports and information due from subcontractors
- Task Tracker, listing activities for implementation of policy changes or special projects at the team or subcontractor level and tracking progress and completion

Figure 26-2 in Attachment SRC# 26-1: Subcontractor Oversight shows several screen shots of our VDOG Dashboard, including the home page and the scorecard for one of our subcontractors.

3. USE OF SERVICE LEVEL AGREEMENTS CONSISTENT WITH THE SMMC PROGRAM

Clearly defined expectations and consistent monitoring of performance against them is a key component of our Subcontractor Oversight Program. Clear Health executes written agreements with each subcontractor that detail the delegated functions, performance standards, SLAs, and reporting responsibilities. The agreements also specify the actions we will take to address inadequate or substandard performance, such as development of a CAP, financial sanctions, and termination. If at any time performance does not meet requirements, we will take action and work closely with the subcontractor toward a resolution and a return to complete and ongoing compliance.

We outline specific SLAs for each function we delegate to the subcontractor. SLAs are never less stringent than AHCA requirements in the SMMC Program Scope of Services. If AHCA modifies a standard, we amend the subcontractor agreement to reflect the change. We currently hold our subcontractors to SLAs that meet AHCA requirements, including the following samples:

- Timely claims payment, pay or deny
 - 50 percent of all clean claims within 7 days
 - 70 percent of all clean claims within 10 days
 - 90 percent of all clean claims within 20 days

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- Timely processing of authorization requests
 - Process 95 percent of all standard authorizations within 14 days
 - Average turnaround time for standard authorization requests is seven days or less
 - Process 95 percent of all expedited authorization requests within three business days
 - Average turnaround time for expedited authorizations requests is two business days or less
- Call center performance
 - Average speed of answer of less than 30 seconds
 - Call blockage rate of less than 0.5 percent
 - Call abandonment rate of less than 3 percent

Where appropriate, Clear Health requires subcontractors to meet more stringent SLAs. For example, we require that our transportation subcontractors meet on time performance metrics for each drop-off and pick-up leg.

Our approach to subcontractor oversight is data driven. Clear Health monitors subcontractor performance against SLAs in several frequencies (daily, weekly, and monthly) and methods. One key tool is our KPI report. Subcontractors submit the KPI report each month to provide us with statistics and detailed data to document and demonstrate their performance against delegated functions. We customize the KPI report template for each subcontractor, listing performance elements specific to the services they provide. If the performance element has an SLA, the KPI report tracks performance. The report documents a rolling 13 months of statistics, allowing us to easily identify and monitor trends. Figure 26-3 in Attachment SRC# 26-1: Subcontractor Oversight provides a sample of a KPI report.

In addition to the comprehensive monthly KPI reporting, we receive daily and weekly data from some subcontractors. The VDOG team and other Clear Health functional areas use this information to support monitoring and clinical operations. For example, our behavioral health subcontractor submits a daily clinical census report and weekly clinical authorization reports related to pending appointments after discharge and pending discharge. We also receive daily member call center complaint logs from our transportation subcontractor that give us greater visibility into member needs and satisfaction levels. To confirm compliance with network access and availability requirements, we use “secret shopper” techniques to make sure providers indicated as having open panels are accepting new patients and are complying with appointment availability standards.

3.1. Working with Subcontractors on Process Improvements

Clear Health will always strive to improve the level of service we deliver, and we expect our subcontractors to do the same. During our subcontractor oversight and monitoring, we seek out opportunities to “raise the bar” and deliver better service. The VDOG team and departments across Clear Health collaborate with subcontractors to identify ways to improve performance, processes, and member care, such as the following recent examples:

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- **Beacon – Integrated Rounds on Complex Members.** To better integrate the physical and behavioral health needs of members who have complex needs, Clear Health holds monthly rounds with Beacon that include Clear Health's physical health and behavioral health Medical Directors, Beacon's behavioral health Medical Director, and the case management staff from Clear Health and Beacon. These integrated rounds help address transition and coordination of care issues and the needs of our members holistically, particularly those who may be challenging to engage or have highly complex situations.
- **LogistiCare – Improving On Time Performance.** As part of our oversight of transportation, we requested more detailed trip data. In our analysis, we discovered that one-third of late pick-ups were attributable to two specific downstream providers (transportation companies). The VDOG reviewed the findings with LogistiCare, and they worked to improve performance through driver education, performance improvement plans, and termination. LogistiCare also added increased data analysis as part of their operational processes to identify similar situations more quickly.
- **Health Network One – Cost Effective Service Delivery.** Clear Health worked with HN1 to make sure that our members obtain therapy services in the most cost-effective setting that can provide appropriate care. Since implementation of new processes, services for more than 300 members have been successfully redirected to a more appropriate care setting. Clear Health also worked with HN1 and hospitals to identify where a hospital setting is appropriate so members are not redirected to the office setting.

4. APPROACH TO MONITORING THE QUALITY OF WORK OF SUBCONTRACTORS

As discussed earlier, our Subcontractor Oversight Program begins with a thorough, rigorous evaluation process to confirm that subcontractors meet operational, financial, legal, compliance, regulatory, accreditation, NCQA/AAAHHC, and ethical standards. Our written subcontractor agreements clearly define delegated functions, expectations, all required provisions, and performance standards, SLAs, and metrics. Subcontractor training includes Clear Health policies and procedures; program-specific information; HIPAA; fraud, waste, and abuse; cultural competency; and more.

Once subcontractors are operational, our program includes activities that enable us to closely and continuously monitor their performance and financial stability to confirm members are receiving the highest quality services. We tailor our program to the functions and services each subcontractor provides, and the scope and frequency of oversight activities reflects the nature of the role, responsibilities, and service nuances.

Our program's flexibility means we can easily expand in scope or increase in frequency our oversight activities based on issues or complaints we see from members or AHCA. We often have ad hoc meetings with subcontractors throughout the month for special projects or communications that we need to discuss. Meetings may include collaborating on activities to improve performance, discussing implementation of new technology to optimize operations, or requesting updates on a new program to reduce complaints. We customize each meeting to the current activities and operations of the subcontractor.

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In the sections below, we describe the frequency (daily, weekly, monthly, quarterly, and annual) and type of monitoring activities we perform. We provide separate discussions on report and data file submissions and implementation of policy changes. Following the discussion of monitoring activities, we describe new initiatives underway to enhance our Subcontractor Oversight Program. Because of the unique nature of administering pharmacy benefits, we discuss the frequency and activities for monitoring our pharmacy subcontractor in a separate section.

4.1. Daily Management, Oversight, and Problem Solving

Account Managers communicate and collaborate with subcontractors daily. They discuss performance matters (urgent and routine), answer questions, problem solve, and identify and discuss areas of improvement, especially related to escalated member or provider concerns. With extensive experience in the operational areas critical to subcontractor performance (call center operation, provider relations, claims adjudication, and configuration), our Account Managers use their critical problem-solving skills to assist subcontractors.

This close and frequent interaction fosters a collaborative, trusting relationship between Clear Health and our subcontractors. Our subcontractors view Clear Health as part of their team, often giving us earlier insight into any management, operational, or financial changes that may affect performance.

4.1.1. Specific Oversight for Transportation

Clear Health knows that transportation and the benefits available can be a challenge for members, providers, health plans, and state regulators. Recognizing that transportation issues have been a point of concern for AHCA and stakeholders in the past, we established specific activities for overseeing our transportation subcontractors.

We use data to monitor performance of transportation subcontractors and providers. The VDOG receives monthly transportation performance data from subcontractors, grievance and appeal data from plan staff, and daily ride and complaint information through direct access to subcontractor systems. Through data analysis and trending, we compare data to SLAs for each subcontractor to identify performance issues. If we see issues, we work with subcontractors to develop strategies to improve performance whether through an informal action plan or the more formal CAP process.

In addition, we recently added additional performance measures related to on-time performance for members receiving dialysis and chemotherapy, as well as hospital and nursing facility discharge timely pick-up. We monitor these performance metrics closely and react quickly when we see issues.

Beyond data, we also use the subcontractor's onsite visit reviews to monitor transportation services our members receive. LogistiCare sends staff to dialysis centers throughout Florida to observe transportation providers as they drop off members for treatment and pick them up to take them home. They observe timeliness, customer service, and vehicle conditions to identify areas of concern for prompt follow-up.

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4.2. Weekly Scheduled and Ad Hoc Touch Base Meetings

A series of regularly scheduled weekly meetings, detailed below, are a key part of our Subcontractor Oversight Program. Having a scheduled time to discuss open items helps us address issues promptly and thoroughly. An agenda and minutes provide structure and documentation of topics discussed, decisions, and action items.

The VDOG team has an internal touch base meeting every Thursday to discuss each subcontractor's open items, concerns, and any potential risks. They also review the Task Tracker for open issues, policy changes, or special projects that affect the subcontractor (such as implementation of updates for notice of adverse benefit determination letters or quarterly waste report implementation).

We hold weekly or bi-monthly meetings with each subcontractor. Meetings include the Account Manager and representatives from other Clear Health or subcontractor teams (such as call center, grievances and appeals, claims, encounters, or information technology) based on the open items. Weekly meetings focus on a variety of topics, including performance, SLAs, member grievances, and progress on implementing policy changes.

Every other Monday, the VDOG team meets with the Compliance team to discuss open issues, trends, and any potential impacts and to monitor the subcontractor's ongoing compliance with contract requirements. These regular, small group meetings promote detailed discussions about subcontractor performance, brainstorming of interventions, and discussion of current CAPs and associated risk.

As necessary, ad hoc meetings with executive leadership and the Compliance team provide a forum to review subcontractor innovations, set expectations, review issues, and address escalated matters.

4.3. Monthly KPI Report Submissions and Review Meetings

As a critical and more formal component of our Subcontractor Oversight Program, we carefully review monthly subcontractor report and data submissions and performance against the SLAs specified in the subcontractor agreement. Open communication, collaboration, and partnership toward the service of our members remains a top priority. Monthly subcontractor oversight activity includes the following:

- Subcontractor submission of KPI report
- Internal VDOG meeting to review KPI reports
- Account Manager operational meeting with subcontractor to review KPI report
- Call center calibration meeting with subcontractors
- VDOG presentation at Compliance Committee meeting
- VDOG meeting with the Director of EDOM

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On the 15th of every month, subcontractors submit their KPI report. Upon receipt, the VDOG Business Analyst checks data integrity to document timeliness and completeness, and then scores the KPI report. Specific measures have weights, typically functions that influence the member experience/satisfaction. Scoring information is calculated and posted to the Scorecard section of the VDOG Dashboard, including a score for each component, a weighted overall score, and a final “grade” (such as A, B-, or C+). The Scorecard becomes a readily available visual representation of the subcontractor’s monthly performance.

We hold an internal VDOG team meeting to conduct a detailed review of each subcontractor KPI report and identify areas to discuss with the subcontractor. During the review, we evaluate the performance reported against standards and SLAs. We also look at trends, noting where performance is improving or still meeting requirements, but is trending down.

The Account Manager holds an operational meeting with subcontractors using online meeting technology to review their KPI report, going section by section through the report to discuss performance, trends, and any issues. The Account Manager will ask for an explanation behind any areas where there is a performance concern, and collaborate on intervention, remediation, and other opportunities for improvement. The agenda also includes review of any ongoing plans (informal action items or CAPs), discussing progress, outcomes, and continued areas for improvement. The meetings provide a forum to discuss issues and brainstorm potential solutions. Our Grievance and Appeal Director attends the meeting to review the topics of member grievances and appeals and discuss any concerns. Our experience shows that transparency and open, constructive dialogue is critical to maintaining a collaborative partnership and seamless service delivery to members.

We hold a call center calibration meeting with each subcontractor who is delegated for Member Services and include representatives from our Member Services department. The primary purpose of the meeting is to make sure we are providing consistent information and quality of service to all of our members – regardless of which organization handles the call. During the meeting, we review the call log to identify opportunities to improve service and collaborate on process improvements that would better serve member needs. The extensive call center experience of our VDOG Account Managers has proven instrumental in helping our subcontractors improve the member experience.

The Florida Medicaid Compliance Committee meeting brings together executive leadership and departmental Directors from across Clear Health and our national support services teams to present updates across functional areas, such as compliance, regulatory, operations, clinical, call center, and provider services. During the subcontractor management portion of the agenda, VDOG reports on each subcontractor, including general updates, KPI performance, issues/risk by functional area, and any CAP updates.

VDOG meets with the Director of EDOM each month to discuss our Florida subcontractors. The meeting covers a variety of topics, including subcontractor responsiveness to annual audits, progress on CAPs, and financial solvency, or other risks. VDOG also receives monthly reports from EDOM’s DVOMC meeting, and the meeting with the Director of EDOM provides an opportunity to review the report’s summary on our subcontractors. Discussions between VDOG, Compliance, and the Director of EDOM help make sure that oversight activities are aligned for appropriate follow up or collaboration.

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4.4. Quarterly and Annual Reviews

VDOG holds a quarterly Joint Operations Committee meeting with each subcontractor to review and discuss performance, issues, gaps, concerns, operational enhancements or challenges, and any upcoming new or changed policies. The meeting includes executive leadership and department directors, including the Grievance and Appeal Director. We invite EDOM to the meeting to address any outstanding items required for audit completion or deficiencies identified on the annual audit. This meeting is an open forum to ask questions or discuss trends, concerns, or expectations.

Quarterly and annual oversight activities also focus on reviews and audits. VDOG receives and reviews reports of the quarterly financial reviews and the annual audit. Quarterly and annually, delegated subcontractors submit their financial statements for a careful review (discussed in detail later in our response to this SRC).

In addition, EDOM performs an annual audit to confirm that each delegated subcontractor meets operational, financial, legal, compliance, regulatory, accreditation, NCQA/AAHC, and ethical requirements. EDOM maintains a schedule for each subcontractor's annual audit and a comprehensive set of audit tools for each type of function that may be delegated to subcontractors (such as network management, credentialing, claims processing, call center, and UM). A global tool addresses areas such as HIPAA privacy and security; fraud, waste, and abuse; cultural competency; disclosure of ownership; and record retention. Each audit tool lists a series of audit elements applicable to the function and the evidence required to assess compliance.

During the audit, EDOM reviews each element, decides whether the subcontractor is compliant or non-compliant, and documents the evidence. The audit process includes review of documents such as policies and procedures, financial statements, member complaints, employee and provider training documents, provider contract templates, credentialing committee minutes. For subcontractors with provider credentialing, authorization, and claims processing responsibilities, sample files are randomly selected for audit. EDOM presents audit findings to VDOG and the DVOMC.

4.4.1. Subcontractor Contingency Plan Review

Clear Health maintains a contingency plan for each subcontractor that we can activate if we find it necessary to terminate a subcontractor, especially in the event of financial insolvency (potential or actual) since it would compress the timeline. We perform annual activities to keep the contingency plan current and viable such as:

- Confirm the viability of the approach (bring in house, implement an alternate vendor, or a combination)
- Update the size and scope of the subcontractor (programs/lines of business, functions, regions, and number of members affected)
- Confirm contact information for alternate vendor representative (if part of the approach)

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- Analyze encounter data to create list of top providers
- Review default provider agreements

4.5. Subcontractor Report and Data File Submissions

Clear Health requires subcontractors to submit two primary types of reports: data we need to fulfill AHCA's regulatory reporting requirements and operational information to monitor their performance against standards, including the KPI report. Account Managers maintain a schedule of due dates for both types of reports (posted on the VDOG Dashboard) and reach out promptly if the submission is late, incomplete, or inaccurate.

For all reports, we identify an internal due date prior to the Agency's deadline to provide time for a thorough quality review. When we receive reports, the first step is a set of data integrity checks to confirm timely submission, completeness, and compliance. Subcontractors also submit a monthly KPI report so that we can monitor and manage their performance against a defined set of metrics and SLAs.

Clear Health also requires each subcontractor to submit data files, including member encounter data, on a specified schedule and in full compliance with AHCA requirements as described in the Medicaid Companion Guides. We document the schedule (frequency and day/time) as well as the format and secure transmission method. If we do not receive a file on its due date, an email alert notifies the Account Manager and prompts outreach to the subcontractor to ascertain the status and reason for the delay. We also maintain a schedule for data files we send to subcontractors, including member enrollment data (X12-834 enrollment file).

VDOG works with the Encounter Audit and Medical Economics teams to monitor subcontractor encounter data and submission. The Encounter Audit team uses the Clear Health Analytics business intelligence dashboard to track subcontractor encounter data. Any gaps in submission or drops in overall volume are noted, and the Encounter Audit team reaches out to the VDOG to facilitate outreach and additional training or other intervention. The VDOG participates in the weekly Encounter Task Force meetings where a cross-functional team reviews the BI dashboard monitoring reports, identifies issues, and manages the corresponding remediation.

Each subcontractor has a designated day for encounter submissions. The Account Manager receives an alert if a submission is not received according to the established schedule. Regular monitoring facilitates outreach to our subcontractors to confirm that they submit their encounters timely. Clear Health reconciles encounter submissions to subcontractor payment data as part of our oversight process. VDOG escalates non-responsive subcontractors to executive leadership for resolution. A trend of late or incomplete encounter submissions will result in a CAP or other intervention.

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4.6. Management and Oversight of Policy Changes

Our Subcontractor Oversight Program includes defined processes to make sure that new or changed AHCA policies or other information are clearly and consistently communicated, managed, implemented, and verified by our subcontractors.

For example, when AHCA issues a new or changed policy, including ineligible and sanctioned provider lists, our VDOG works with our Regulatory and Compliance teams to evaluate the policy and determine if any subcontractors are affected and to what extent. Based on the nature and complexity of the change, the team documents a plan for notification, implementation, and verification.

The team tracks each subcontractor's plan and progress in the Task Tracker portion of the VDOG Dashboard. A documented process and centralized tracking system allows us to manage on-time, accurate implementation for each subcontractor and provides a vehicle to continue to work with those facing challenges. We have the subcontractor submit an attestation and documented proof that the change or task was completed.

4.7. New Initiatives to Enhance Subcontractor Management and Oversight

Quality is fundamental to everything we do, and Clear Health operates under a culture of continuous improvement. We encourage every health plan employee to identify initiatives or process changes to help us improve efficiency and deliver better value to our members, providers, subcontractors, the Agency, and other stakeholders. The VDOG team is currently implementing two new initiatives that will deliver tangible benefits to our subcontractors, which helps them deliver better services to our members.

Our new Vendor In-Service will provide focused orientation and training for new subcontractors. We are modeling these sessions after our successful provider education program and designing modules specifically targeted to our subcontractors. We will hold Vendor In-Service programs using multiple formats: in-person, webinars, and conference calls. We will also hold sessions at a subcontractor site and invite others to participate through online conferencing technology. In addition to new subcontractors, we will hold Vendor In-Service sessions for those already operational when there are significant changes in programs, policy, or when there are changes in their leadership team. We will hold our first Vendor In-Service in January 2018.

We are also creating a Vendor Handbook, incorporating the lessons learned from developing and refining our provider handbook. The Vendor Handbook will supplement our Vendor In-Service program, giving our subcontractors a binder of important and useful information they can reference at any time. The Vendor Handbook will have sections across the spectrum of subcontractor interactions with Clear Health, including:

- Contact information
- Overview of each program: MMA, LTC, and specialty plan
- Meeting schedule
- Required report submissions with associated due dates, format, and submission process

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- Encounter submission, including submission requirements and how to correct and resubmit encounters that fail edits
- Definitions and appropriate routing for complaints, grievances, and appeals
- Description of delegated functions and AHCA's language requirements for the function
- Responsibilities for identifying, detecting, and preventing fraud, waste, and abuse
- Annual audit requirements, including process and expectations
- Process to manage issues or areas of non-compliance, including setting expectations for compliance and interventions we employ to address performance issues
- Required compliance with telecommunications regulations and the Clear Health Do Not Call policy for member outreach activities, including how to get help from Clear Health
- Useful references, including Medicaid handbooks, telephone numbers, and e-mail addresses for key external resources

We will distribute our Vendor Handbook to each subcontractor's leadership team in January 2018. Figure 26-4 in Attachment SRC# 26-1: Subcontractor Oversight shows the cover and table of contents for our Vendor Handbook.

4.8. Monitoring the Quality of Work Performed by our Pharmacy Subcontractor

Clear Health requires the same high level of performance from our pharmacy subcontractor, including agreements that specify requirements, expectations, and SLAs; regular comprehensive and detailed performance monitoring; and bi-annual audits. Our national Pharmacy Services Compliance and Audit team maintains primary responsibility for monitoring the performance of our Pharmacy Benefits Manager (PBM).

The pharmacy subcontractor must meet certain performance guarantees specified in their agreement, such as maintaining required pharmacy call center services levels, claims processing, system availability and adjudication response time, pharmacy benefit set up, mail service dispensing accuracy and timeliness, and network pharmacy access. There are required reports associated with each performance guarantee.

4.8.1. Pharmacy Oversight Activities

Responsibility for regular PBM oversight lies with the national Pharmacy Services Compliance and Audit team. The team receives regular monthly and quarterly reports and data files from the PBM. Assigned business reviewers evaluate reports and data files to determine if the PBM's performance complies with requirements and SLAs. They review each function either monthly or quarterly, depending on the function, and identify deficiencies or contractual gaps. Functions reviewed include:

- Claims processing accuracy
- Eligibility processing

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- Network access
- Prompt payment
- State or federal provider exclusions/sanctions
- Call center performance
- Network audits
- Fraud, waste, and abuse activity
- Drug utilization review
- Delegated functions such as drug recalls

We implement CAPs to address contractual issues, regulatory/compliance issues, or standing unresolved issues needing resolution. We hold meetings with the PBM every other week to review CAP status and discussion of criteria for closure.

4.8.2. Oversight Audits

In addition, pharmacy subcontractor oversight also includes conducting two formal audits each year. Audits help us verify compliance with the PBM Services Agreement and State, federal, NCQA/AAAHHC, URAC, and Medicaid regulations applicable to PBM functions. The team collaborates with other national business units, including the Reliability Team and pharmacy regulatory mandates subject matter experts, to determine the scope of the audit. National staff and/or an external auditing firm conduct audits. Audit activities may include:

- Developing audit scope in collaboration with the business areas and receiving management approval
- Creating and/or revise audit tools
- Monitoring audit progress and PBM participation/cooperation
- Determining audit deficiencies and opportunities for improvement; if applicable, reaching agreement with applicable business area and creating final report
- Collaborating with legal on final audit report
- Collecting PBM documentation for audit deficiencies, tracking until resolution, coordinating information with applicable business and approval for closure, presenting to PPOC for closure

Oversight audit results and CAPs resulting from audits are reported to our Compliance Officer.

4.8.3. Pharmacy Oversight Committees

Pharmacy subcontractor oversight and monitoring includes two main committees: the PPOC and the Joint Compliance Committee (JCC).

The PPOC monitors the overall performance of all delegated functions related to providing pharmacy operational/clinical service solutions and confirms that performance meets all applicable health plan, regulatory, and accreditation standards (such as NCQA, CMS, URAC, State, and federal regulations). The PPOC meets at least four times each year and includes

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representatives from key areas, including UM, Medical Directors, Clinical, Appeals/Grievances, Delegation, Finance, Pharmacy Operations, and EDOM). The PPOC was established to:

- Review and analyze performance metrics and information
- Provide recommendations to improve member quality of care and service
- Review and approve PBM oversight audit reports
- Review and approve the PBM's annual UM program, UM work plan, and UM annual report
- Review and approve CAPs
- Supply quarterly reports maintaining linkage between service and clinical
- Assess activities to verify that contract, accreditation, and regulatory requirements are met

The JCC meets every two weeks with the pharmacy subcontractor to discuss new and existing mandates as well as legal, regulatory, and contractual requirements; approve implementation plans to comply with these requirements; and to discuss any legal, contractual, or compliance concerns with the subcontractor and their legal team. If agreement on or resolution of an issue cannot be obtained in the JCC, the issue is escalated.

5. PROCESSES FOR ADDRESSING PERFORMANCE ISSUES

Clear Health's approach to identify and address performance deficiencies centers on establishing and maintaining a partnership with each subcontractor and regular, consistent monitoring. Throughout our relationship with each subcontractor, we maintain clear expectations of how we measure performance, boundaries of what is acceptable, and the consequences for non-compliance.

The Account Manager works daily to identify and discuss resolution of performance issues early – before they become a problem. We supplement our proactive account management structure with robust monitoring, including regular performance reporting, quarterly reviews, and annual audits.

When we identify a performance or operational problem, we immediately address our concerns with the subcontractor. We emphasize the need to evaluate and implement change as quickly as possible, and that we are here to help.

In the sections below, we discuss triggers for increased monitoring or other interventions and the types of interventions we deploy.

5.1. Triggers for Increased Monitoring Activities or Interventions

Every element of subcontractor performance can trigger increased monitoring or interventions, including review of the KPI report, submission of other required reports and data files, complaints or liquidated damages from AHCA, audit results, or a regulatory/compliance requirement. In addition to objective data, we take seriously overall information (sometimes intangible and subjective) the Account Manager and others (internal or external) gain from communication and interactions with the subcontractor. We consider all data sources as triggers to increase monitoring, including:

- Missed SLA

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- Change in performance trend, even if still meeting SLA
- Increase in the volume or change in topics of member complaints, grievances, or appeals
- Change in subcontractor management or operational staff
- Complaints or concerns from AHCA
- Complaints from the subcontractor's downstream providers
- Decrease in financial performance
- General concerns from the VDOG Account Manager (including responsiveness)
- Information gained from the field by Provider Relations staff, Case Managers, or community organizations

We review the subcontractor's KPI report and overall performance each month, first internally and then with the subcontractor. During the review, we identify any missed SLAs and ascertain the reason. We also discuss any other concerns outside of SLAs, such as staffing, responsiveness, or member satisfaction. The VDOG will determine the need for increased monitoring or other intervention.

5.2. Interventions

The VDOG applies a series of escalating interventions when we identify issues with subcontractor performance, including increased meeting frequency and data submission, development of an informal action plan, development of a CAP, and financial sanctions. We view interventions not as a punitive action; but rather, a documented process to improve performance.

The type of intervention depends on a combination of factors, including the severity of the issue and historical performance. For example, a single month of missing an SLA will likely result in increased monitoring and an action plan, while missing an SLA in two consecutive months warrants a CAP. We track information about interventions in our VDOG Dashboard.

In the event that interventions are unsuccessful in generating a sustained improvement in subcontractor performance, Clear Health will consider termination.

5.2.1. Increased Monitoring

When we identify any type of concern with the subcontractor's performance or ability to continue to provide a high level of service to our members, we increase the frequency and type of monitoring.

We may move from weekly meetings to daily meetings and may add additional participants from the subcontractor or Clear Health teams. We may also request more frequent submission of current reports or ask subcontractors to submit information (reports or data files) at a lower level of detail. The VDOG, in collaboration with the Compliance Officer, implements the type and intensity of increased monitoring that best fits the situation.

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During discussions with the subcontractor about the deficiency, we will also ask them to conduct a root cause and member/provider impact analysis and submit an informal action plan that documents the steps they will take to remedy the situation and prevent a recurrence. We review the action plan with them, asking for clarification or additional tasks, as appropriate.

5.2.2. Implementing and Monitoring a CAP

There are many situations that would prompt the VDOG to place a subcontractor on a CAP, including:

- SLA missed for more than one month (assuming first month grace period or isolated reason)
- History of the issue indicates a reoccurring trend, even if not in consecutive months
- Severity of the SLA non-compliance, even after the first occurrence
- Audit results showing non-compliance
- Other subcontractor circumstances
 - Network impact
 - Member Service impact
 - Financial impact
 - AHCA imposed CAP or liquidated damages

Additionally, if the subcontractor fails to implement new or revised policies (for example, a revised member letter) by the established due date, a CAP is developed.

When the VDOG identifies the potential need for a CAP, they meet with the Compliance Officer to discuss the areas of concern or non-compliance and make a final decision on the need to impose a CAP. If the decision supports a CAP, VDOG schedules a meeting with the subcontractor to discuss our concerns and request a complete root cause analysis and CAP. We follow this discussion with a formal written request that requests an e-mail confirmation of receipt.

We give subcontractors 15 days to develop and submit a CAP, which must include all of the corrective actions and steps needed to resolve the identified deficiencies; the name and title of responsible parties; and planned/completion dates of each action step. Upon receipt of the CAP, the VDOG and the Compliance Officer review the CAP for adequacy, collaborating with the subcontractor to make sure it addresses all identified deficiencies. VDOG presents final CAP documents to the Compliance committee and EDOM for review and approval.

During development of the CAP, the VDOG may include additional monitoring activities, dashboards to review ongoing metrics, and regularly scheduled meetings with the subcontractor to review progress. Depending on the situation, we may increase meeting frequency, including daily touch base meetings. However, we find that weekly/monthly meetings are sufficient to manage most CAPs. Progress on the action plan is recorded directly in the CAP document. The VDOG provides detailed updates on CAP progress during the monthly compliance meeting. The VDOG also updates the Compliance committee and EDOM on subcontractor progress and CAP closure.

The corrective action monitoring process ends and the CAP is closed when the subcontractor demonstrates ongoing compliance for at least 90 days. CAP information remains in the VDOG Dashboard repository for ongoing reference.

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5.2.3. Financial Sanctions

In the event that AHCA assesses liquidated damages based on subcontractor performance, Clear Health will pay the fine and seek reimbursement from the subcontractor. Our subcontractor agreements clearly document that they are responsible for any AHCA imposed liquidated damages resulting from their performance of delegated functions.

5.2.4. Escalation to our Subcontractor Contingency Plan

If interventions are unsuccessful or we see serious systemic problems, Clear Health escalates the concerns to executive leadership and may begin to activate our subcontractor contingency plan. We would initiate a set of preliminary tasks when our review of financial data or other monitoring activities gives us reason to suspect that the situation with a subcontractor may become unsustainable.

Activities are “behind the scenes” and focus on positioning Clear Health for a full activation of our contingency plan, and include the following:

- Confirm approach (such as bring functions in house, sign with alternate vendor, or combination) and contact alternate vendor representative (if applicable)
- Confirm size and scope of subcontractor (programs/lines of business, functions, regions, and number of members affected)
- Request more frequent submission of operational information (reports or data files) from the subcontractor, such as claims listings (paid or denied) and open authorizations
- Generate list of top providers, assign to Provider Network Managers, and build contact plan
- Build staffing model, including identifying positions, number needed, and hiring sources (such as external search firms, temporary agencies, and the subcontractor)
- Begin configuring system with providers, benefits, and claims history (from encounter data)

During this time, we continue to work closely with the subcontractor on remediating the situation. Clear Health will increase the frequency of monitoring and add additional focus to regular discussions.

6. MONITORING THE FINANCIAL STABILITY OF SUBCONTRACTORS

To provide services to our members, Clear Health understands the importance of subcontractors maintaining a strong financial position. Our day-to-day interactions and monthly monitoring activities give us insight into our subcontractors’ financial health. VDOG team members pay careful attention to signs that may indicate problems, such as a drop in claims payment timeliness or an increase in complaints. We discuss any concerns at internal VDOG meetings and meetings with the Compliance team. When necessary, we escalate to executive leadership.

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In addition, we regularly review the financial stability of each of our delegated subcontractors. Our Regional Vice President of Finance and national subject matter experts on our Medicaid Financial Analysis team review subcontractor financial documents each quarter. The review focuses on identifying any potential issues as early as possible and implementing any necessary action to avoid any service disruption. We leverage our keen understanding of each subcontractor's financial solvency, the risk to our operations, and ability to serve Florida members as key components in making a decision to implement our Contingency Plan.

Clear Health requires delegated subcontractors to submit unaudited financial statements quarterly and audited financial statements annually. These financial statements include the profit and loss statement, balance sheet, and statement of cash flow. Each quarterly statement is both the respective quarter and year-to-date, so that as the year progresses, the team can see how the subcontractor is performing over time.

During the review, accountants carefully review the entire submission, looking at the strengths and weaknesses and identifying if the subcontractor's financial position shows signs of deterioration. Based on this, we determine whether the subcontractor passes financial solvency. We assign a status to each subcontractor, taking into consideration this quarter's review and the prior quarter. We assign green for passed solvency, yellow for failed solvency for one quarter, and so on.

The Medicaid Financial Analysis team maintains a Financial Summary for each delegated subcontractor that documents the results of each quarterly review and contains a rolling two years of information. The Financial Summary is a key tool that allows the team to review information quarter over quarter and identify trends that may indicate an emerging issue.

Annually, the team reviews the audited financial statements prepared by the subcontractor's auditor. With more detail and the opinion of an auditor, these statements provide additional visibility into the financial stability of the subcontractor.

The team will reach out to subcontractors at any time to get additional information or clarification regarding financial stability and ability to continue serving members. If necessary, the team will request a mid-quarter financial statement from the subcontractor.

6.1. Financial Guarantee

We require a financial guarantee from all new delegated subcontractors, and we are in the process of acquiring financial guarantees on existing subcontractors. However, if a delegated subcontractor misses financial solvency for two quarters, we require a financial guarantee.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

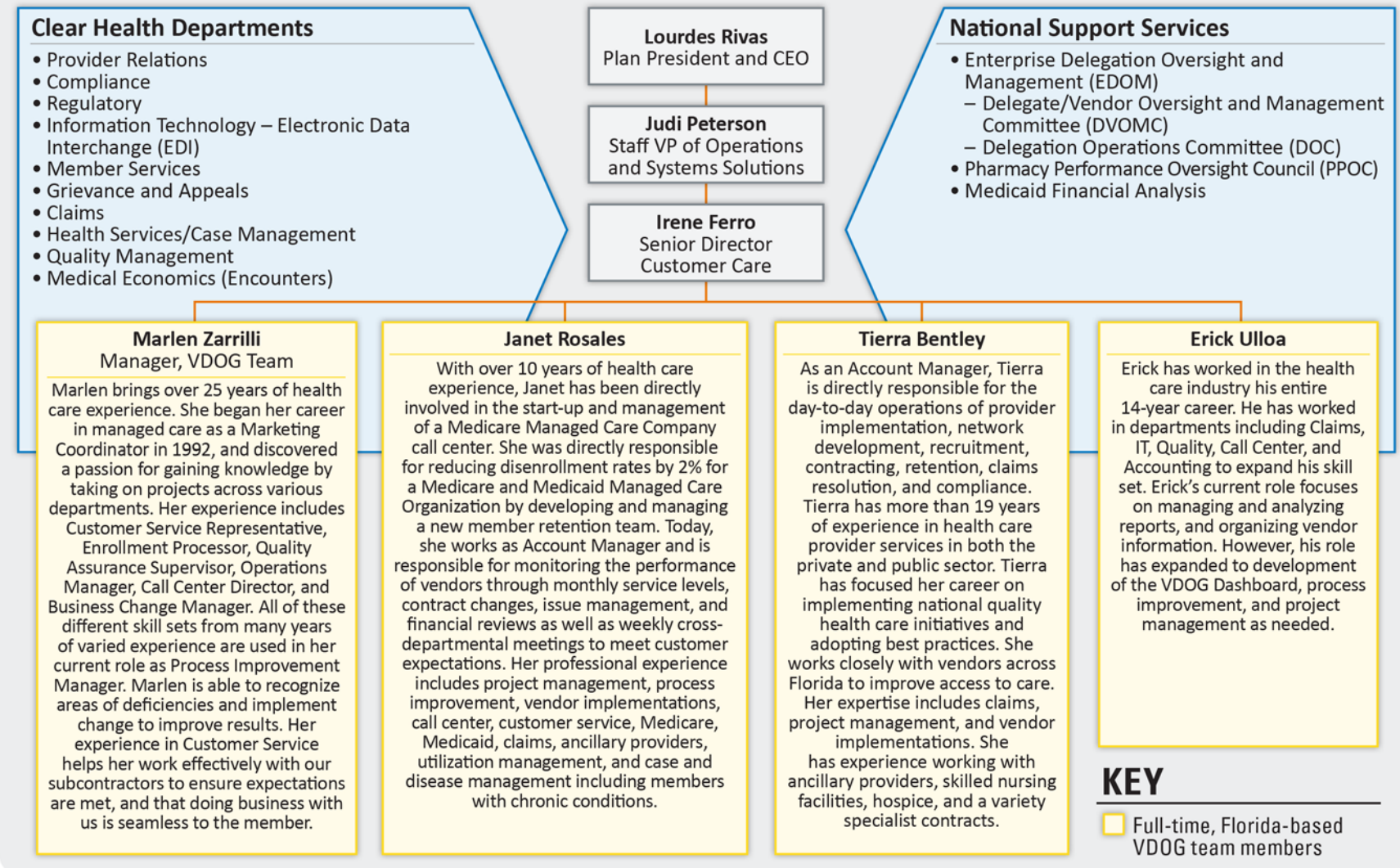
1. The extent to which the respondent provides a list of subcontractors it proposes to use under the SMMC Program for the delegation of work as described above.
2. The adequacy of the respondent's oversight structure, including the extent of executive level staff participation.
3. The extent to which the respondent uses and monitors for service level agreements consistent with the SMMC Program Scope of Services.
4. The adequacy of the respondent's approach to monitoring the quality of work performed by subcontractors, including the frequency and type of monitoring.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

5. The adequacy of the respondent's processes for addressing performance issues, including the triggers for increased monitoring activities, interventions and Contract compliance action.
6. The extent to which the respondent provides monitoring activities it will use to ensure the financial stability of the subcontractor, including the required financial reporting frequency for subcontractors.

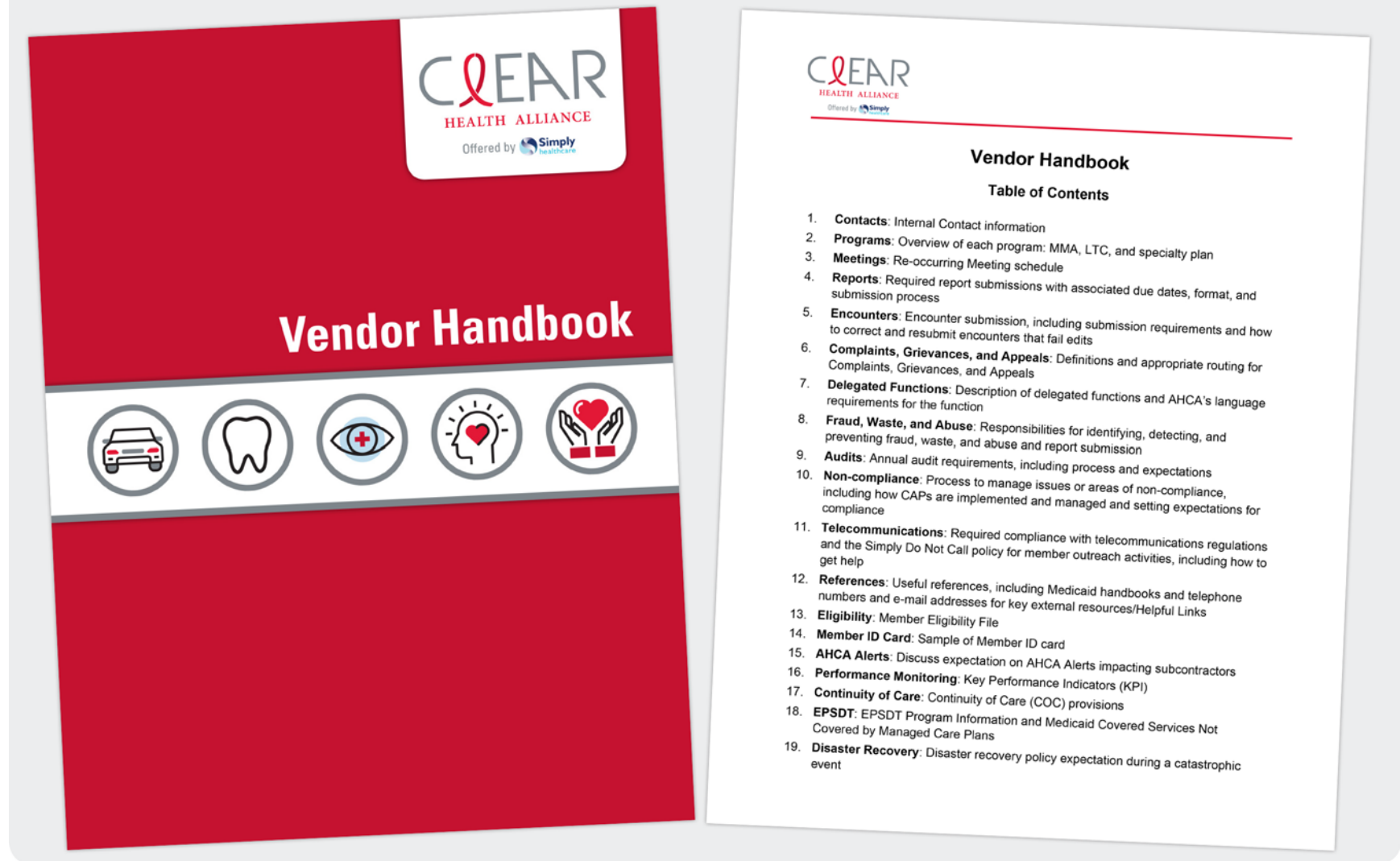
Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

Figure 26-1. Our Dedicated VDOG Team Receives Support from Key Clear Health Departments and National Resources



FL_CHA_26_VDOGOrg_62_Org_4.3

Figure 26-4. Our New Vendor Handbook will Provide Subcontractors with Ready Access to Useful Information



FL_CHA_26_VendorHbkTOC_62_MKT_2.1

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 27 – Subcontractor Oversight (Statewide):

The respondent shall submit a sample contingency plan it would enact in the event a subcontractor to which the plan has delegated authority to manage utilization and pay providers on behalf of the plan, files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Clear Health knows that a comprehensive and detailed plan is critical to any change in subcontractors. However, when an unplanned change occurs, such as one due to bankruptcy or an inability to continue operations due to a lack of financial resources, a well-thought out and documented contingency plan is even more important. Above all, we focus on making sure enrollees (members) have uninterrupted access to medically necessary services and continue to receive the care they need. We also make sure providers receive timely payment for the services they deliver. Clear, consistent, timely, and transparent communication with the Agency, as well members, providers, and other stakeholders is paramount throughout any change in subcontractors. Clear Health welcomes the opportunity to review our sample contingency plan with the Agency.

To develop our contingency plan, we combined our standard subcontractor de-delegation workflow that addresses a planned transition with the lessons learned from the Univita situation Clear Health and other Florida managed care organizations (MCOs) experienced in July 2015. We spent considerable time reviewing and analyzing what worked well and where we saw opportunities to streamline processes and communication. We also incorporated many activities focused on reducing risk. The sample contingency plan we provide in Attachment SRC# 27-1: Sample Contingency Plan leverages the strength and experience of Clear Health, our affiliates, and our national subcontractor oversight resources.

Our contingency plan includes a comprehensive set of tasks so that the functions our subcontractor was providing continue seamlessly. We customize our contingency plan for each type of subcontractor, recognizing that the contingency plan for a behavioral health subcontractor is quite different from one providing utilization management for radiology services. As such, the tasks and activities may differ in size and scope depending on the functions the subcontractor provides. Our contingency plan includes the following major components:

- General approach (such as bringing functions in house or contracting with another vendor)
- Communication strategy for members, providers, the Agency, and Clear Health employees
- Staffing plan to augment Clear Health staff to support contingency operations
- Member continuity of care and uninterrupted access to medically necessary services
- Direct outreach to providers of the prior subcontractor to add them to our network

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- Payment for services rendered by independent parties, but not reimbursed
- Prevention of potential provider fraud, waste, and abuse
- Negotiations, contracting, and implementation of alternate vendor
- Transition to a steady-state operation

The general approach includes options such as bringing the services in-house, contracting with a new vendor, or a combination of the two. Clear Health recognizes that our interim solution may differ from our final steady-state solution. Since the approach varies by subcontractor, a key part of our contingency plan is identifying our approach long before there is a problem. If the approach includes contracting with a new vendor, then our plan identifies the alternate vendor. For all current subcontractors, we have already identified potential alternate vendors. We reassess the approach for each subcontractor annually as our operations and the competitive landscape changes.

We provide information on our contingency plan in the sections below and in Attachment SRC# 27-1: Sample Contingency Plan.

1. DATA SOURCES USED TO TRIGGER IMPLEMENTATION OF CONTINGENCY PLAN

Monitoring the financial stability of our subcontractors is a key component of our Subcontractor Oversight Program, and critically important to our ability to recognize risk and trigger implementation of our contingency plan. We never want to be surprised by a subcontractor's insolvency. Early identification of problems is key. Whenever possible, we work to resolve issues as long as it is in the best interest of our members.

We know that regular, comprehensive review and analysis of the subcontractor's financial statements combined with detailed monitoring of key performance metrics that may indicate an issue – such as late claims payment, significant or notable change in management or staffing, increase in provider complaints, or a delay in responsiveness – is critical. Review of the following data sources may trigger implementation of our contingency plan in advance of the subcontractor filing for bankruptcy or becoming unable to continue operations due to lack of financial resources:

- Unaudited quarterly financial statements, including profit and loss statement, balance sheet, and statement of cash flow
- Annual audited financial statements, including profit and loss statement, balance sheet, statement of cash flow, and opinion of auditor
- Monthly Key Performance Indicator report, specifically a change that may indicate financial problems, such as:
 - A drop in claims payment timeliness
 - An increase in claims denials
 - An increase in authorization denials if delegated, or a reduction in requests if not delegated
 - A drop in call center metrics (that may be due to reduced staffing)
 - An increase in provider complaints (especially due to payment disputes)
 - For transportation, a drop in on time performance or increase in missed pick-ups
- An increase in member complaints, grievances, and appeals and/or a change in the types of topics

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- A decrease in the number and dollar value of member encounters submitted to Clear Health
- Turnover of subcontractor leadership key position or operational staff
- Requests for faster or increased payment of accounts receivable
- Information (including data analysis) from our Florida Special Investigation Unit (SIU)
- Information from the Agency, our national vendor team, our affiliate health plans using the subcontractor, or other Florida MCOs regarding subcontractor performance

In addition to objective data, we take seriously overall information (sometimes intangible and subjective) the Account Manager and others (internal or external) gain from communication and interactions with the subcontractor. Our Provider Network Managers, Case Managers (Managed Care Coordinators), and others are out in the community, and will report any comments from credible sources about subcontractor service delivery to the VDOG. Based on our experience, we consider all data sources when deciding to activate our contingency plan.

Executive leadership (Plan President and CEO, Plan Compliance Officer, Regulatory, and department directors) will make the decision to activate our contingency plan for a subcontractor. Clear Health will notify the Agency immediately.

2. COMMUNICATION STRATEGY

Clear Health understands the importance of effectively communicating any change in business operations – systems, policies, processes, or subcontractors – to our members, providers, the Agency, Clear Health employees, and other stakeholders. We take this responsibility seriously and as such, a communication strategy is an integral part of our contingency plan.

Whenever we make a change to our operations, we analyze the impact of the change to other systems, processes, and stakeholder groups. We assess the impact to all stakeholders – members, providers, Clear Health employees, subcontractors, and the Agency – and develop appropriate communication and training plans. In the unfortunate situation of a subcontractor's inability to continue to perform delegated functions, that communication is even more critical. Our communication strategy focuses on providing timely, complete, and consistent information to all affected groups through multiple channels. Simply maintains a library of communications that we can modify based on the type of subcontractor, allowing us to expedite the development and approval of member and provider communication.

In the sections below, we discuss the format and nature of our communications with the Agency, members, providers, and our employees.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

2.1. Communicating with the Agency

Clear Health will notify the Agency as soon as we make the decision to activate our contingency plan. We will be fully transparent with the Agency on our concerns about the subcontractor, our contingency plan, and our progress.

We will immediately reach out to the Agency by telephone to explain the situation, that we are activating our contingency plan, and outline any assistance we need. If the subcontractor is also providing services to other Florida MCOs, we are happy to participate in a joint meeting with the Agency and other affected MCOs to review and potentially coordinate our contingency plans, especially communication with providers related to member continuity of care and claims submission.

We will maintain regular communication and standing meetings with the Agency, following a mutually agreed upon frequency, schedule, and method (such as in person, telephone, online conferencing) to collaborate on member and provider communication, provide updates on progress, discuss concerns and challenges, and outline future arrangements for steady-state operations.

2.2. Communicating with Members

Clear, concise, and timely communication to members is a critical part of our strategy. In keeping our members informed, we will explain why we are contacting them and how they will continue to receive the services they need, even if there is a change in service provider. We will also include information on what this change means to them, continuity of care requirements, and how to get additional information or help. We will discuss the timing and approval process for member communications with the Agency during initial meetings after contingency plan implementation.

We will use a variety of methods to communicate a subcontractor change and to help make sure that we reach members. Depending on the impact of the change and the associated timeframe, we will communicate with members through the following ways:

- Written documents and notices mailed to the member
- Information and alerts posted on the member website
- Member call center staff to answer questions and deliver information about the impact the change will have on members
- Audio messages through our member call center to provide information about the change when our interactive voice response system answers the call
- Outbound member calls using an approved script that outlines the change, its impact, and how to get more information
- Direct outreach by Managed Care Coordinators

We have processes in place to capture member feedback (positive or negative) from these interactions so that we can make any necessary changes to our materials or approach.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Clear Health will analyze encounter and authorization data and prioritize outreach to members with high acuity or high utilization to make sure their needs are met. This analysis will also help us identify members with open authorizations or those that may need extra attention, as well as identify the treating provider for members with complex medical needs.

Clear Health will comply with the requirements listed in Section V.B for material information sent to members. We will work with the Agency on a process to expedite approval of member and provider communications so that we can release communication as quickly as possible.

We employ strict safeguards to verify compliance, accuracy, and ease of understanding in our member materials. We follow a well-established Collateral Materials Approval Process (CMAP) to verify compliance. Through CMAP, we review all communications to members, providers, and other external audiences to meet both legal and internal company standards. During CMAP, materials undergo review to verify cultural sensitivity, accuracy, and compliance with all Agency program requirements. CMAP confirms that our member materials are written at or near the 4th grade reading level, verified by the Flesch-Kincaid index. We use an innovative, interactive literacy software tool that replaces hard-to-read medical terms and phrases with plain language and scores documents on their general readability.

2.3. Communicating with Providers

Our provider communication strategy addresses the subcontractor's downstream providers and our network providers.

2.3.1. Downstream Providers of the Subcontractor

Since providers often have agreements with the prior subcontractor, we recognize that communicating the change to them must be clear, focused, timely, and sensitive. As with member communication, we will discuss the timing and approval process for provider communications with the Agency.

Through the provider data files subcontractors submit to Clear Health (full roster monthly and adds/terms weekly), we have provider contact information. By combining the provider data files with encounter data, we can also identify the number of our members each provider serves and the scope and volume of services provided. We will use this information to prioritize and focus outreach and communication efforts. Our communication strategy will prioritize outreach to providers who are actively rendering a high volume of services to Clear Health's members. In addition, we verify contact with all providers has been made. We will also tailor communications, as appropriate, based on the type of services the provider renders, altering information on continuity of care and claims submission, as necessary.

Our provider communication strategy will include several focused communications as we move through the process toward steady-state operations. Communication to providers will focus on apprising them of the situation as well as assuring them that they can and should continue to provide services to Clear Health members and that they will be paid for covered services provided in the future. We will outline procedures for continuity of care and new authorizations, explain claims submission guidelines, and let them know where to go and who they can call for help.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

As with member communication, we will use a variety of methods to make sure that we reach providers quickly. Depending on the situation and the associated timeframe, we will communicate with providers through the following methods:

- Written documents and notices mailed, e-mailed, and/or faxed to the provider
- Information and alerts posted on the provider portal
- Provider call center staff, who will answer questions and deliver information about the impact the change will have on providers and their members
- Direct outreach by our Provider Relations team (armed with talking points and FAQs), who will prioritize calls to high volume or specialty providers

Depending on the nature of the services the provider renders, we may also hold targeted meetings with providers and Managed Care Coordinators for members who have complex needs under the provider's care. For vulnerable populations, we make sure that providers know the Managed Care Coordinators is the point of contact for members who need heightened monitoring and support.

2.3.2. Clear Health's Network Providers

Communication to our network providers will focus on apprising them of the situation and communicating any changes that would impact them or how they support our members. As with the subcontractor's downstream providers, we will use a variety of methods to make sure that we reach providers quickly. Depending on the situation and the associated timeframe, we will communicate with providers through Agency-approved written documents and notices, information posted on our provider portal, and direct outreach by our Provider Relations team armed with talking points and FAQs. Our provider call center staff will also be available to answer questions and deliver information about how the change will impact providers and members.

2.4. Communicating with Clear Health Employees

Clear Health also recognizes the need to notify our employees of material changes to our Florida operations. For a change in subcontractor, it is critically important that our call center employees have complete and accurate information to respond to member concerns. To communicate with our employees, we will:

- Develop and distribute documents with talking points and FAQs
- Notify affected departments using regulatory alerts and/or email
- Hold meetings with affected departments to discuss the change and its impact, including employee training

As the situation progresses, we will add additional communication as necessary to make sure that our employees have the information they need to support the SMMC program, our members, providers, and the Agency and to continue to meet Contract requirements.

EXHIBIT A-4-a

GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

3. STRATEGIES FOR OPEN AUTHORIZATIONS

Clear Health remains fully accountable for our subcontractors and the quality of service they deliver. In the event of a subcontractor's financial insolvency, our priority is to minimize impact on our members and the providers who serve them. If we need to activate our contingency plan, a few critical things must happen:

- Members will continue to get the care and services they need, for open authorizations and for new services
- Providers can and should continue to serve our members, with confidence that they will be paid (including how to submit claims and how much they will be reimbursed)
- Providers will be paid for services they have already rendered and have not been reimbursed by the prior subcontractor

In the sections below, we describe the strategies we will employ to address open authorizations and provider payment. We also explain the financial guarantees we obtain and hold from our subcontractors to cover this type of contingency.

3.1. Open Authorizations and Continuity of Care

Clear Health knows that members with open authorizations need to receive uninterrupted access to approved services. So that our members can continue with their approved treatment plan, our contingency plan includes a 60-day continuity of care waiver period, for applicable services, to make sure that our members are not denied services and that providers who serve our members do not experience a delay in claims payment. Clear Health will expand the continuity of care period for certain services and for members with an active treatment plan where a transition would be clinically detrimental. The communication we send to members and providers will explain continuity of care and authorizations, providing clear instructions on what they need to do.

We will also analyze encounter data to identify members with open authorizations. Since we know what subcontractor services require authorization, we will query encounters for these services to identify the member and the rendering provider. We will also search encounter data for the presence of an authorization number. Once we know the providers currently delivering services that require authorization, we will conduct direct outreach (through letter or telephone) to explain processes.

For members in case management, the assigned Managed Care Coordinators will reach out to providers to make sure that the member continues to receive uninterrupted service.

3.2. Paying Providers for Services Rendered

Clear Health realizes that a subcontractor's downstream providers may also be greatly impacted by the situation and may have experienced delayed or denied payment for services delivered to our members. We will do everything we can to minimize the impact on providers so that our members can continue to receive the care and services that they need.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

If a subcontractor delegated for claims payment is unable to continue operations, our contingency plan includes tasks and activities for Clear Health to process and pay the claims (at least as an interim solution), including configuring providers, benefits, and claim edits and adjudication rules in our Management Information System (MIS).

Clear Health maintains a data file of the providers in the subcontractor's network at all times. We require each subcontractor to submit a full roster monthly and a weekly list of new and terminated providers. Having a provider roster that contains the information we need to configure providers in our MIS, including taxonomies (such as provider type, categories of service, and place of service), is a key step in our ability to pay providers. Our plan also includes tasks to configure benefits to support accurate claims adjudication, including covered and non-covered services, demographic limitations (such as program, age, and gender), benefit limits, prior authorization rules, and member liability. Prior to complete configuration to pay claims, we will adjust our adjudication rules to pend claims we receive for services provided previously by the prior subcontractor.

Our communications with providers will explain what they need to know, including continuity of care waivers, when and how to submit a new authorization request, where and how to submit new claims and claims not reimbursed by the prior subcontractor, and reimbursement rates. We will honor the providers' agreements with the prior subcontractor until we contract directly with them. We will also make sure that providers know who to call and where to go for help.

For new claims for services rendered to our members, Clear Health will inform providers how to submit claims (paper and electronic) and direct them to resources to gain help in clean claims practices and options for electronic claims submission. We will direct providers to the provider handbook posted on the public portion of our provider portal, which includes a section titled "Claim Submission and Adjudication Procedures." Our provider call center and Provider Relations team will be available to help. Clear Health will review claim denial reports to confirm appropriateness and to proactively reach out to providers we see may need help with claims submission.

We will also explain exactly what providers need to do if they have unreimbursed claims from the prior subcontractor. We will mail letters to all network providers, post the information on the public portion of our provider portal, and train our Customer Care Representatives on the process. The communication will clearly identify the dates of service for which unpaid claims for services rendered to our members can be submitted to Clear Health and the deadline for submission. For each claim a provider submits for payment, we will require a packet of information, including a copy of their contract (including fee schedule) with the prior subcontractor, a signed attestation that they did not receive other payment, and optionally, a copy of their authorization which would speed the claim payment process.

4. STRATEGIES TO PREVENT PROVIDER FRAUD AND ABUSE

Clear Health realizes that this type of situation could present increased opportunities for provider fraud and abuse. While we make sure that providers who rendered services to our members are compensated, we also continue to abide by our responsibility to research, investigate, and report any suspected instances of fraud, waste, or abuse. To prevent and detect provider fraud, waste, and abuse, our contingency plan includes the following strategies:

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- Configuring providers and benefits in our MIS, with the information necessary to properly adjudicate claims in accordance with Agency requirements
- Applying the standard automated pre-payment controls and post-payment analyses that are part of Clear Health's Anti-Fraud Plan and comprehensive approach to prevent and detect potential or suspected fraud, waste, and abuse and overpayment
- Implementing additional post-payment verification activities and analysis of claims data
- Requiring providers to submit documentation, including a signed attestation, to request payment for services not paid by the prior subcontractor

Clear Health maintains a list of the providers in the subcontractor's network at all times. Having a provider roster that contains the information we need to configure providers in our MIS is not only a key step in our ability to pay providers, but an important part of our strategy to prevent fraud, waste, and abuse.

Clear Health has established processes to confirm that excluded providers are not included in our network. We check the lists of providers currently excluded by State and federal governments every 30 days. We require our subcontractors and providers to comply with all federal requirements (42 CFR 1002) on exclusion and debarment screening. As another strategy to prevent provider fraud, waste, and abuse, Clear Health will confirm that the prior subcontractor's providers are not excluded by checking provider information against the Federal List of Excluded Individuals and Entities (LEIE) and the System for Award Management (SAM), and any available Florida and federal databases.

Configuring our MIS with complete information about the benefits (covered services, limits, fee schedule), and any specific claims adjudication rules will enable execution of the proactive (pre-payment and prevention) and reactive (post-payment) fraud, waste, and abuse detection methods and internal controls. Many controls are embedded in our claims adjudication logic, including code editing, duplicate claims checks, evaluating third party liability, and checking authorization requirements.

Clear Health will expand our post-payment analysis activities to look for instances of provider fraud, waste, abuse, and overpayment. We will select a random sample of claims paid and send the member a verification of services letter that will describe the services on the claim and instruct the member to contact us if the services were not rendered. We will also analyze provider claims activity (such as number of claims, dollar amount of claims, number of members served) and compare it to prior periods to identify any change in the provider's billing pattern. Monthly analysis using our claims activity dashboard supports the generation and verification of leads related to potential provider fraud, waste, and abuse. The dashboard displays a rolling 13 months of data and supports the sorting, filtering, and drill-down analysis on many elements, including county or city, provider tax ID, and top procedure codes. The ability to show a summary of billing history for a provider, including change from last month and peer comparison is a key strategy to detect and prevent provider fraud, waste, and abuse.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

In addition, Clear Health's SIU routinely collaborates with our other lines of business (Medicare and commercial) on trending schemes, provider types, and providers. In addition to the pre- and post-payment software programs, our SIU has an internal team of investigators proficient in data analysis to identify more leads for potential further development.

As discussed earlier, Clear Health will require providers with unreimbursed claims to complete a packet that includes a signed attestation. We will review the packet and pay claims, where appropriate, for covered services provided to our members when the prior subcontractor had financial responsibility, but failed to pay. Our communication will remind providers that they must comply with all applicable State and federal laws and regulations regarding requests for payment and claim reimbursement.

Evaluation Criteria:

1. The extent to which the respondent has outlined the data sources it would use to trigger the respondent to put the contingency plan into play in advance of the subcontractor filing for bankruptcy or otherwise becoming unable to continue operations due to lack of financial resources.
2. The extent to which the respondent outlines a communications strategy in the contingency plan.
3. The extent to which the contingency plan includes strategies for ensuring providers get paid for situations where there were open authorizations.
4. The extent to which the contingency plan includes strategies to prevent provider fraud and abuse in situations where a subcontractor files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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Attachment SRC# 27-1: Sample Contingency Plan

Contingency Plan For: (name of subcontractor)

Delegated Functions:

Programs and Regions:

Account Manager:

Planned Approach: (full description of interim and final steady-state approach, such as in house, alternate vendor, or combination)

Alternate Vendor: (vendor name and representative contact information, if applicable)

Size and Scope

Objective: Document the size and scope of the impact on SMMC program operations.

Programs/Lines of Business Affected	Functions Provided by Subcontractor	Regions	Approximate Number of Members Affected

Contingency Plan

Objective: Implement contingency plan to deliver uninterrupted service to members and providers for subcontractor functions.

Major Tasks (some dependent on approach):

- Activate communication plan (Agency, members, providers, and employees)
- Implement staffing plan
- Evaluate and document approach to continuity of care and utilization management
- Initiate direct outreach to downstream providers of the prior subcontractor
- Configure systems for claims processing and payment and make sure members and providers have access to customer service professionals who can assist with questions
- Tightly manage operations
- Validate or implement fraud, waste, and abuse strategies
- Initiate alternate vendor negotiations and implementation (if part of approach)
- Transition to steady-state operations

Communication Plan

Objective: Deliver clear, concise, and timely communication to affected stakeholders (Agency, members, providers, and employees).

Action	Lead Department	Begin Date
AHCA		
Notify AHCA of event	Regulatory	Day 1
Provide Plan to AHCA	Regulatory	
Establish meeting/update frequency/schedule with AHCA	Regulatory	
Provide contact information to AHCA	Regulatory	
Provide regular (weekly) updates to AHCA	Regulatory	
Members		
Extend call center hours	Call Center	
Send AHCA-approved notification letters	Regulatory	
Begin outbound call campaign (AHCA-approved script)	Call Center	
Implement notices or changes to website as needed	Marketing	
Providers		
Distribute AHCA-approved communication to downstream providers (letter, fax blast, website alerts)	Provider Relations	
Use AHCA-approved written notification to inform network providers, hospitals, skilled nursing facilities (based on impact)	Provider Relations	
Complete AHCA-approved Frequently Asked Questions (FAQs)	Provider Relations	
Conduct provider visits – immediate and ongoing	Provider Relations	
Implement notices or changes to website as needed (such as post FAQs)	Marketing	
Employees		
Hold Executive Leadership meeting to launch contingency effort	Plan President	Day 1
Launch project team – team members notified	Project Management Office	Day 1
Notify all employees of event	Plan President and CEO	
Share updates as finalized	Project Management Office	
Establish leadership and employee meeting schedule	Project Management Office	
Update online reference tools	Project Management Office	
Create and execute training for all affected departments	Training and Development	

Staffing Plan

Objective: Hire or reallocate staff necessary to support contingency operations. Recruiting source will consider employees of the subcontractor, as well as external search firms and temporary agencies.

Action	Lead Department	Begin Date
Validate pre-determined plan of areas needing additional staff	Human Resources	Day 1
Finalize resource request for short-term/contingency (including temps, shift from other departments, outsource)	Finance	
Execute contingency resource/staffing plan	Human Resources	
Determine interim plan for benefit administration (in-house or subcontracted delegated vendor)	Plan President and CEO	
Based on plan for benefit administration, prepare, finalize, and execute go-forward staffing plan	Human Resources	

Member Continuity of Care and Utilization Management

Objective: Document continuity of care provisions and review with the Agency. Include length of continuity of care waiver period (general and differences by service), components for member and provider communication, system configuration, and employee training (such as Call Center, Utilization Management, and Claims).

Action	Lead Department	Begin Date
Continuity of Care		
Identify members impacted by event (closed, open, pending authorizations/orders)	Health Care Management	Day 1
Finalize member condition stratification process	Health Care Management	
Match members to stratified outreach approach, prioritizing most vulnerable members	Health Care Management	
Communicate and train all employees involved in Plan	Training and Development	
Update all online tools and training documentation, including: VDOG, Call Centers, Claims, Provider Relations, Health Care Management, Grievances and Appeals, and Enrollment	Training and Development	
Execute Case Management Member Outreach Plan	Health Care Management	
Confirm continued employee access to accurate list of contracted providers	Provider Relations	
Utilization Management		
Validate pre-established contingency authorization process for receiving new authorization requests	Health Care Management	Day 1
Communicate fax number and phone number	Health Care Management	
Begin accepting and processing new requests for services	Health Care Management	
Establish process and script to respond to questions regarding authorizations received prior to event	Health Care Management	
Confirm UM staff can access previous and open authorization data from prior subcontractor	Information Technology	
Confirm UM reporting is in place to track volumes, variances, and verify that turn-around time is being met	Health Care Management	

Provider Network Relations and Contracting

Objective: Conduct outreach and contracting to add providers to our network, prioritizing those delivering a high-volume of services to our members. Includes scheduling meetings with providers, building additional provider agreements (from templates) to meet contracting terms, and establishing pricing for covered benefits not priced in the fee schedule. Obtain Letters of Agreement (LOAs) from providers so we can pay claims while we complete the contracting process.

Action	Lead Department	Begin Date
Communicate with the prior subcontractor's downstream providers to make sure they are aware of event, updated on decisions, and feel confident they will be made whole (so member care is not impacted)	Provider Relations	
Provide contract language related to hold harmless protection for downstream providers – create plan for LOAs as needed	Provider Relations	
Assess downstream network performance	Provider Relations	
Continue visits and communicate with providers	Provider Relations	
Define contracting strategy post contingency	Provider Relations	

Operations and Technology

Objective: Establish processes and systems to accurately pay providers for services rendered to our members. Address process differences for claims unreimbursed by the prior subcontractor. Review processes with Agency, as necessary. Include tasks to configure our MIS to pay claims for the services delegated to the prior subcontractor according to AHCA requirements. Make sure members and providers have access to staff who can answer questions. Deliver solid operational performance.

Action	Lead Department	Begin Date
Customer Service		
Expand call center hours of operation based on event	Call Center	Day 1
Determine call routing strategy and change interactive voice response (IVR) scripts/routing if needed	Call Center	
Confirm that staff are prepared to handle inquiries (training, online tools updated, provider information updated, FAQs)	Call Center	
Implement reporting and tracking tools	Call Center	
IT		
Validate file transfers to subcontractor are discontinued and confirm that access has been terminated	Information Technology	Day 1
Configuration		
Configure new contracts and LOAs; test to verify accuracy	Configuration	
Configure benefits in the MIS to include limitations, and exclusions; test to verify accuracy	Configuration	
Claim Payment		
Finalize claims processing plan	Claims	
Load prior claim history and transfer accumulators from the prior subcontractor (if applicable)	Claims	
Create Explanation of Payment (EOP) language as needed	Claims	
Implement AHCA-approved claim payment process for services received prior to the event	Claims	
Implement AHCA-approved claim payment process for services received during the continuity of care period	Claims	
Define and implement the ongoing process for the post-continuity of care period	Claims	
Implement AHCA-approved claim payment dispute/appeal process for services received before the event and during the continuity of care period.	Claims	
Reporting and Analytics		
Provide ongoing project status reports to AHCA and Executive team	Project Management Office	
Determine impact on reporting (such as PNV and encounters)	Project Management Office	
Implement project scorecard and tracking	Project Management Office	
Implement Operations flash reports	Project Management Office	
Generate upper and lower control limit reports to manage inventory and watch for trends/outliers	Project Management Office	

Fraud, Waste, and Abuse Strategies

Objective: Review and implement strategies to prevent and detect provider fraud, waste, and abuse. Include additional pre- and post-payment activities, such as additional member verification of services letters and provider claims activity over time analysis. Review strategies with AHCA.

Action	Lead Department	Begin Date
Define and implement appropriate strategies to detect and prevent any fraud, waste, and abuse	Executive Leadership and Medicaid Special Investigations Unit (SIU)	
Verify process defined to quickly escalate suspected concerns	Executive Leadership and Medicaid SIU	
Evaluate/implement pre- and post-payment activities to support fraud, waste, and abuse, as needed.	Medicaid SIU and Claims and Recovery	
Create reports and utilize analytics platform to support fraud, waste, and abuse strategy	Medicaid SIU	

Alternate Subcontractor

Objective: Initiate negotiation and contracting with alternate subcontractor (if part of approach). Includes developing agreement, completing a successful pre-delegation audit, gaining Agency approval, and full implementation (including configuration, interfaces, member and provider communication, and testing). Engage the Project Management Office to support implementation plan.

This process may begin at any point before, during, or after the contingency plan is initiated, depending on the circumstances involved.

Major Tasks	Timeframe	Responsible Owner	Completion Date
Approval to initiate new subcontractor implementation process	Begin Process	Plan President	
Validate alternate subcontractor is best option		RVP Provider Relations	
Initiate negotiation process		RVP Provider Relations	
Begin pre-delegation audit after completion of final agreement draft		Delegation Oversight	
Finalize pre-delegation audit		Delegation Oversight	
Obtain AHCA approval for subcontractor		Regulatory	
Execute final subcontractor agreement		RVP Provider Relations	
Launch project to implement new subcontractor		Project Management Office	

Transition to Steady-state Operations

Objective: Transition functions to the future steady-state operations, if different from contingency operations (for example, transitioning functions moved in-house during contingency to a new subcontractor). Includes full debrief of contingency plan implementation once transition is complete and fully operational. Also includes identifying opportunities to improve the contingency plan and documentation of an action plan with responsibilities and timeframes for completion.

Action	Lead Department	Begin Date
Finalize plan for steady-state operations (steps will vary)	Project Management Office	
Conduct project lessons learned to document successes and improvement opportunities learned throughout the event	Project Management Office	
Close out project; move to Operations	Project Management Office	

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 28 – System Modification Protocol (Statewide):

The respondent shall describe, in detail the following change control IT processes:

- a. How the respondent will initiate and coordinate internal modifications for any of its core systems (including, but not limited to, encounter submission, EDI/Clearinghouse, and financial reporting) or any potential subcontractor's core systems,
- b. How the respondent will accommodate Agency-directed IT modifications; and
- c. How the respondent will identify, track, communicate, and resolve IT production issues that affect internal or external stakeholders.

For each of the descriptions, the respondent shall also include the expected timeframes for making modifications, the prioritization process employed, the communication processes used for planned or unplanned changes, as well as status updates provided to employees, Agency staff, and providers. The descriptions shall also address testing procedures, production control procedures, and any applicable claims/encounter reprocessing for historical or retroactive system changes.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Our national Technology Services department has more than 20 years of experience with Medicaid programs and has established a comprehensive and robust Management Information System (MIS) and change management process that fully supports implementation of new systems and applications and enhancements to existing processes. Our system change management process follows a multi-level governance model with well-defined roles, responsibilities, and checkpoints and is designed according to the following guiding principles:

- All changes in scope to the production IT environment are submitted and approved using an enterprise change management tool
- An owner is defined for each change request
- Change requests must be consistent, detailed, and contain timely information that is appropriately communicated and accessible
- Change requests are approved based on change content, risk, and schedule
- Changes are scheduled to minimize business impact
- Implementation and back-out plans are required for each documented change request

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- Separate workflows are defined to accommodate Emergency and Urgent changes
- The change management process includes a protocol for resolving conflicting change requests
- Any document that is attached to requests in the change management process tool may not contain protected health information (PHI)

By promoting consistent and timely implementation of changes, and by improving visibility and communication of those changes and their impacts, we are able to minimize adverse impact to production environments and external partners and customers.

1. INITIATION AND COORDINATION OF INTERNAL MODIFICATIONS OF CORE SYSTEMS

Whether implementing new functionality, enhancing existing processes, or resolving production issues, Technology Services has established policies and procedures to manage modification to all our systems. We maintain separate development and testing environments as part of our change management protocol and verify that only systems and programs that are tested and approved are released into production. The change management function is responsible for managing and coordinating change requests and releases to the production environment. This includes infrastructure, network, system components, protocols, configurations, hardware, and software related changes.

Our IT change management process is governed by the Change Management team, Change Advisory Board (CAB), and Emergency Change Advisory Board (eCAB). The Change Management team oversees all change management processes and is responsible for maintaining the enterprise change management tool and all change management policies and procedures.

The CAB is a dynamic board comprised of Change Management team leaders, IT Managers, Project Managers, requestors, and other stakeholders who are responsible for monitoring, reviewing, and approving IT change requests. CAB meetings take place on scheduled days twice weekly and serve as a forum to discuss changes to production IT services, systems and environments, and to assess content, impact, risk, urgency, and schedule. Dockets for the CAB meetings are provided in advance with supporting documentation available for review in the enterprise change management tool. The CAB is responsible for approving, reviewing, monitoring, and governing changes for all high- and medium-risk impacts to the production environment.

The eCAB is made up of key leaders from the Change Management team and is dynamically supplemented by senior-level leaders with oversight of the impacted system or process. Due to limited or non-existent lead time, urgent and emergent changes follow a streamlined review and approval process in which all required information and documentation is collected in the enterprise change management tool, but approval is expedited through the eCAB. Key urgent and emergent changes are still reviewed, post-deployment, during the bi-weekly CAB meetings for informational purposes only.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1.1. Systems Changes and our SDLC

Our information systems change management and version control processes are tightly integrated with our Systems Development Life Cycle (SDLC) methodology. For all system changes, including encounter submission, electronic data interchange (EDI), clearinghouse, and financial reporting, Technology Services follows formal change notification policies and procedures that include standards for requirements gathering, analysis, design, tests, and implementation. The SDLC methodology, shown in Figure 28-1 in Attachment SRC# 28-1 Software Development Methodology, can be tailored to include only activities that are appropriate based on project type (new or modified system or configuration change) and whether the system is automated or manual. We have adopted the Scaled Agile Framework (SAFe) for delivering valuable capabilities to stakeholders. Our documented policies and procedures include all methodologies required to manage the life cycle of our applications and systems. We have procedures, templates, checklists, and processes that enable systems projects to move through iterative cycles, or sprints of:

- Requirements Analysis
- Design
- Development
- Testing
- Deployment

Our change management processes are documented, repeatable, monitored, and subject to continuous process improvement activities. The following sections provide details on the SDLC stages.

1.2. Requirements Analysis

Requirements analysis is the first step in the SDLC. A trained group of Business Analysts (BAs) work with business owners to identify business requirements, develop system requirements, and document results in a Requirements Review Document. This document is continuously updated and approved by the business owners and is one of the primary artifacts tracked via the enterprise change management tool. For cross-functional systems or projects, an impact assessment is part of the requirements analysis and changes to any other systems and processes will be considered as part of the overall scope.

Using the Requirements Review Document, we validate the traceability of requirements through system design, development, and testing processes. During the requirements phase, we also identify modifications to documentation, including systems documentation and user manuals, necessitated by the change. A high-level overview of the testing approach is also noted along with any training requirements. Requirements are prioritized and assigned to current sprints or backlogged for future development.

1.3. Design

While BAs collect and document the business requirements, they work collaboratively with the assigned development team so that the developers fully understand the system requirements when designing the system solution. The Requirements Review Document also includes a section for the system design details that are documented by the assigned developer. A requirements

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

traceability matrix is built as part of the design process to make sure that all requirements are accounted for in the system design. A senior-level developer or team lead is responsible for verifying the system design fully supports the business requirements and meets technical standards.

Within the Agile process, requirements are expressed as 'stories' by business experts. Stories are converted to use cases that support the design process for developers and serve as the basis for test scenarios.

1.4. Development

Developers continue to work closely with the BAs during the coding process, reaching out to the BA to obtain answers to questions regarding the requirements or additional information that is needed to support the development effort. During coding, the developer is responsible for unit testing and a senior-level developer or team lead will perform a code review, cross-checking the development against the requirements traceability matrix. A successful review indicates readiness for the testing phase.

The Agile process focuses on good communication with Agile teams holding daily 'stand-up' meetings to quickly resolve issues and weekly progress meetings with all stakeholders.

1.5. Testing

The BA works with the Business Owner and the development team to develop test scenarios and scripts for each requirement. BAs develop complete data for each test script that fully exercises system capabilities. For changes that interface with Agency systems, Agency staff, and others as appropriate, are important members of the testing team and will work with Clear Health to validate that our systems are ready for Florida operations.

System changes go through a number of testing phases to verify that they are ready for a production environment, including:

- Unit testing, which tests just the component
- System testing, which tests the component with all other components and processes it touches
- Regression testing, which confirms the change does not cause problems with existing processes
- User acceptance testing, which validates that the change satisfies user expectations

When a change affects external entities (for example, the eligibility/enrollment data exchange with the enrollment broker), we heavily engage them in the testing process to verify production readiness. If necessary, we use subsets of production data to test specific scenarios and simulate the production environment as much as possible.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

As a part of the adoption of SAFe, we have evolved our testing methodology to better support the iterative nature of Agile by adopting Acceptance Test Driven Development (ATDD). ATDD is a technique used to bring business owners into the test design process before coding has begun. It is a collaborative practice where users, testers, and developers define automated acceptance criteria. ATDD helps to ensure that all project members understand precisely what needs to be done and implemented. This is the primary technique used by Technology Services to approach sprint work with a Test-First mentality.

In addition, since the Software Development Engineer in Test (SDET) and Test Engineers are using the same test format, the SDETs can begin their test case creation early, since the steps are already defined. This helps to eliminate confusion on what needs to be automated and how it traces back to the original request. Acceptance tests define the behavior of the system and verify that requested features work as expected. These tests then become the acceptance criteria for the user story.

Our automated testing framework fully supports ATDD and gives test engineers the ability to automate their ATDD test scenarios. Jira/XRay is used for managing user stories and test scripts along with Selenium for testing web interfaces. Rational Function Tester is used to execute automated functional and integration tests against our other non-web interfaces. All reporting and defect management is centralized allowing our test engineers, developers, and stakeholders real-time visibility into the quality of the release.

1.6. Change Control and Deployment

Technology Services safeguards all systems from unauthorized modifications with systems tools and strict procedures that require a Production Code Move Sheet for every change or maintenance request, as well as an appropriate review meeting prior to deployment.

Prior to the review meeting, the development group notifies the change control group that new production code is ready for promotion. For routine maintenance requests (low risk), Technology Services conducts a desk-check procedure. For all high-risk requests, we conduct a Pre-deployment Review Meeting. Each of these reviews certifies that the change being requested has been completed according to the requirements and design documents. It validates that appropriate documentation updates have been made, testing has occurred, and business owners for the areas affected by the change have reviewed and approved the test results and agreed to implement the change.

Technology Services maintains a separate group of individuals who have the ability to promote code changes or new code to production libraries. The development group develops and tests the code, obtains approval for the completed product, and plans the implementation strategy. The change control group moves the approved code into a designated staging area. We use a release management tool to monitor and control the entire process.

Once approval is obtained from the desk-check or the Pre-deployment Review Meeting, Data Center Operations follows the instructions on the Production Code Move Sheet. This document covers promotion of code changes and detailed instructions for the introduction of new code to an application. Data Center Operations does not permit any code to be placed into a production environment without the appropriate documentation and required approvals.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1.7. Documentation and Training Requirements

Clear Health will develop, prepare, print, maintain, produce, and distribute distinct system process and procedure manuals, user manuals, and quick-reference guides, as well as any updates, for the Agency and other appropriate staff as required. Designated manuals and reference guides will be available in printed form or online and, where applicable, manuals will be published in accordance with the appropriate Agency or State standard.

Comprehensive documentation is required for all core systems and ancillary applications. Where it exists, we leverage vendor documentation to supplement internally developed documentation. Technology Services maintains a complete set of documentation, comprising:

- Vendor (third-party) software documentation, including user and system manuals, installation manuals, and release notes
- Internal technical documentation, including system process and procedure manuals, describing all manual and automated system procedures, business rules, data models and dictionaries, flow diagrams, requirement and design documents, system change logs, and change management documents
- System user and training manuals with instructions on applicable system functions and accessing system data
- Policy and procedure documentation

When a system change is subject to the Agency's written approval, Clear Health will draft revisions to the appropriate manuals prior to approval of the change. Updates to the electronic version of these manuals will occur in real time; updates to the printed version of these manuals will occur within 10 business days of the effective date of the update.

Technology Services uses change management software during implementation and maintenance of all application software and documentation. Changes to documentation begin at the initiation of systems requirements and continue through testing. We use the updated documentation as a basis to train all employees affected by the change before deployment.

Training requirements are also documented as part of the Requirements Review Document and development of training materials takes place in parallel with the system development efforts. Validation of training materials is part of the testing process and once testing is complete, training begins for all individuals affected by the change.

1.8. Case Study: Applying a System Upgrade to the Core Operations System

For system upgrades to our Core Operations System, we receive notification from the software vendor about two to three months prior to scheduled releases — typically twice annually, in February and August. A project lead is assigned and a plan is built to track all of the key deliverables and checkpoints for the upgrade project, including impact, assessment, program modifications, testing, training, and appropriate internal and external notifications. Details of the release are shared with the technical team and designated system users, who are instructed to review and complete an Impact Assessment form for their areas. A kick-off meeting is also held

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to discuss the testing timeline and answer questions. The Systems Testing Group creates a test plan and establishes the required test data in Jira, which is used to automate testing and perform defect management.

Once the release is available, it is deployed first to a development environment for initial validation and then to a quality assurance (QA) environment where we run through the full set of test cases, which generally takes about five to six weeks. Any defects found during testing are logged and tracked, working with the software vendor as needed to resolve. Weekly testing meetings are held to make sure that everyone is on track with their assigned testing efforts. Once testing is complete, we hold a Go/No-Go call with all areas to verify that there are no outstanding issues and we are confident that the release can be moved to production.

To minimize impact, the release is scheduled to occur over a maintenance weekend with the designated technical teams actively engaged in all stages of the deployment process. During the process, we maintain an open communication channel with a project lead at the ready to pull the team together to address any issues or concerns. After all deployment tasks are complete, the team holds a final Go/No-Go meeting before releasing the Core Operations System back into production.

Any post-production issues are reported via our Incident Management process and triaged according to severity and impact. The project lead monitors all logged issues and escalates as needed. If a defect has a significant impact, we escalate to the vendor, who may provide an emergency hot-fix. The hot-fix is then scheduled, deployed, and tested as quickly as possible. For system issues that impact claims batch processing, our Core Operations System has an automated recall process that tracks where failure occurred and reprocesses the affected claims batch, assuring successful completion.

1.9. Coordinating Subcontractor System Modifications

Clear Health retains sole responsibility for fulfilling SMMC Contract requirements and works with our subcontractors to identify necessary modifications to their core systems to support operations and comply with contractual obligations. Modifications to subcontractors' core systems are identified as part of their initial implementation, with additional changes as needed to support State requirements and ongoing operations.

For initial implementation, all system configuration and changes are fully reviewed by appropriate members of the Clear Health implementation team before the subcontractor is given approval to begin operations. A project plan is defined with specific milestones and checkpoints for system modifications, integration testing, and readiness review. The scope of system modifications is comprehensive and based on the subcontractors' written agreements.

Clear Health maintains an established Subcontractor Oversight Program with a Florida-based Vendor Delegation Oversight Group (VDOG) that is staffed with a dedicated team and supported by executive leadership and departments across our organization. Our Subcontractor Oversight Program includes defined processes for making sure that new or changed Agency policies, data exchanges, and system requirements are clearly and consistently communicated, managed, implemented by our subcontractors, and verified by VDOG.

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VDOG works with Clear Health's Regulatory and Compliance teams to evaluate the required change and determine if any subcontractors are affected and to what extent. Based on the nature and complexity of the change, the team documents a plan for notification, implementation, and verification. As needed, system design discussions are arranged between the subcontractor and Clear Health's VDOG and Technology Services team to review required changes, establish a timeline for development, and plan for integration and user acceptance testing as appropriate.

The team tracks each subcontractor's plan and progress against the plan in the Task Tracker portion of the VDOG Dashboard. A documented process and centralized tracking system allows us to manage on-time, accurate implementation for each subcontractor, and provides a vehicle to continue to work through open issues. Additionally we have the subcontractor submit an attestation and documented proof that the change or task was completed. Oversight and monitoring of subcontractors provides the structure necessary to apply remediation and corrective action if they are not in compliance with contractual requirements.

2. NOTIFYING THE AGENCY OF POTENTIAL SYSTEM CHANGES AND ACCOMMODATING AGENCY DIRECTED SYSTEM MODIFICATIONS

Clear Health has documented processes for implementing any system change or modification to include any Agency directed change requests. Systems availability is critical to efficient operations in Florida and we schedule all maintenance that results in systems unavailability during times that do not compromise critical business operations. Our usual practice is to schedule system downtime on maintenance weekends. If we must schedule maintenance during normal systems operational hours, we will coordinate with the Agency for scheduling and approval.

2.1. Compliance with State Mandated Changes in Less Than 90 Days

Our MIS is built on a managed Medicaid model designed to facilitate the configuration and customization needed to meet State-specific requirements, and is supported by more than 4,500 employees in our Technology Services department. If the Agency mandates changes that require system modifications, our goal is to implement those as quickly as possible without sacrificing quality and accuracy of the system modification. We evaluate the system change request and make every effort to implement changes without system downtime to core processes. We will work with the Agency to establish an implementation and testing timeline that meets the State's expectations while not exceeding 90 days from the notice date.

2.2. Notification and Discussion of Potential System Changes

If a system modification is identified that would result in system unavailability to critical business processes, we have documented protocols that will be followed. We would create and maintain a project plan with key dates for configuration, testing, end user validation, and go-live target. As our partner in Florida, the Agency is notified before major changes are made to these core processes:

- Claims processing
- Eligibility and enrollment processing
- Service authorization management
- Provider enrollment and data management

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When Clear Health executes a major conversion of a core transaction system, we will notify the Agency at least 90 days in advance. As directed by the Agency, we will discuss the proposed changes with its designated staff.

Unless otherwise agreed in advance by the Agency, scheduled system unavailability to perform maintenance, repair, or upgrade activities will not take place during hours that could compromise or prevent critical business operations.

3. IDENTIFYING, TRACKING, COMMUNICATING, AND RESOLVING IT PRODUCTION ISSUES THAT IMPACT INTERNAL OR EXTERNAL STAKEHOLDERS

Clear Health uses a single, common Incident Management process that is adhered to by all IT staff and vendors to manage all incidents within our IT environment.

The underlying objectives of Clear Health's Incident Management process are to:

- Resolve incidents within committed service level agreements (SLAs)
- Minimize duration and impact of service outages associated with an incident
- Help minimize business impact during an incident
- Minimize incident life cycles by automating tasks whenever possible, maximizing productivity of resources, and monitoring and measuring progress
- Classify incidents having a critical business impact as high priority and handle them effectively to minimize their impact

The Incident Management process defines the major activities, roles, and responsibilities for identifying, reporting, tracking, and resolving system incidents. This process improves manageability and reduces incident reoccurrence through a framework that supports consistency among all departments and provides a method for effective communication.

Clear Health's Incident Management Process:

- Establishes a common repository to be used across IT functional areas, providing visibility to all captured incident data and any actions taken to restore or provide the requested service
- Requires a single point-of-contact (SPOC) for internal end users to report all incidents; the SPOC is responsible for owning and overseeing the resolution and closing all incidents
- Provides a means for logging and assigning priority to incidents, which are then managed according to that priority and tracked to resolution throughout their life cycle (and escalated when appropriate)
- Focuses on restoring service
- Calculates priority based on impact and urgency noted on the incident record

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- Uses SLAs to identify objectives and expectations for the user and the IT support staff
- Provides Incident Management personnel with access to all appropriate tools and information databases to help address the incident
- Documents workarounds and solutions on the incident record

The scope of Incident Management includes any event that could or does disrupt a service. This includes events communicated either directly by users, through the IT Enterprise Service Desk, or through an alert from an event management system tool or command center operator.

A SWAT or Tiger team approach is often employed to address high priority events that have cross-functional impact, with multiple IT teams involved in the solution. This approach uses a round-the-clock conference call meeting to facilitate communication between the SPOC and technical resources who are addressing the issue. The conference call line remains open and resources will continue to communicate and coordinate the solution until the problem has been resolved.

3.1. Response to Events Resulting in System Unavailability

We maintain processes and procedures to make sure that critical system functions are available to enrollees (members) and providers 24/7, except during periods of scheduled system unavailability agreed upon by the Agency and Clear Health. All other system functions and information are available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m. EST/EDT, Monday through Friday.

Upon discovery of a problem that may jeopardize availability or performance of critical system functions or the availability of information from our systems, including problems affecting scheduled exchanges of data between Clear Health and the Agency or its agents, we will notify Agency staff by phone, fax, or email within one hour. We will provide hourly status updates until the problem is resolved. In the notification, Clear Health will provide details regarding the impact to critical path processes, such as enrollment management and claims submission, and will work to resolve issues and restore services within 48 hours. When requested, Clear Health will provide the Agency with full written documentation, including a corrective action plan (CAP), regarding the critical system issue and our plans for preventing recurrence. The CAP will be delivered to the Agency within five business days of the problem's occurrence.

4. COMMUNICATING ISSUES AND UPDATES

Upon discovery of any problem within our span of control that may jeopardize availability or performance of critical systems or impact the scheduled exchange of data between Clear Health and the Agency or its agents, we will notify Agency staff by phone, fax, or email within one hour. Notification will include detail regarding critical path processes and plans for restoring the system or designated functionality. Clear Health will provide the Agency with hourly updates on progress resolving the issue.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

4.1. Response to Agency Reports of System Problems not Resulting in System Unavailability

Clear Health will respond in writing to Agency reports of system problems not resulting in unavailability within seven days of notification and will make corrections or complete requirement analysis and specifications within 20 days, correcting the deficiency by the effective date determined by the Agency.

4.2. Notification of Termination of Staff with Access to the Agency's Network

Clear Health will maintain connectivity to the Agency's wide area data communications network and relevant systems attached to the network, and will notify the Agency of termination of any staff with access to the Agency's network within 24 hours.

4.3. Subcontractor Notification Process

Clear Health's subcontractors are contractually required to notify us upon discovery of a problem that jeopardizes availability or performance of critical systems or in the event that they are unable to provide data that is needed to support compliance with scheduled data exchanges between Clear Health and the Agency. Upon receiving notification from the subcontractor, Clear Health will in turn notify the Agency and continue to send hourly updates until resolved. The Plan will maintain communications with the subcontractor until the issue has been resolved.

5. INTERNAL TESTING

Clear Health fully tests all system changes prior to deployment, defining the scope of testing and all required participants as part of the requirements analysis. For changes that interface with Agency or other external systems, we will coordinate with Agency staff, and others as appropriate, to perform integration testing. Additional details on integration testing are provided in the following section.

The BA and operational owner build or identify test data to validate that all requirements have been met, and regression test and fully exercise system capabilities.

During the coding process, the developer performs component and system testing to verify that all requirements have been accounted for. Additional system testing is then performed by the BA to cross-check the developer's results.

Once the BA has confirmed all required elements have been accounted for, the full suite of test cases is executed, including regression and integration testing, if applicable. In some instances we use tools to validate control totals within data tables or comparison analyses of before and after implementation for areas like claims processing. We also deploy automated testing scripts to execute on core functions. These types of tools enable us to volume test system changes and validate accuracy efficiently. Deployment requires that all testing is complete and appropriate approvals are documented. Approval, test cases, and results are archived in the release management tool.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

5.1. Coordinating Subcontractor System Testing

Our Subcontractor Oversight Program has defined policies and processes for working with our subcontractors to make sure their systems are configured in compliance with the Agency's operational requirements. Implementation and verification plans are defined based on the nature and complexity of the required change, and testing plans are established and overseen by VDOG with final approval being required prior to initiation of production processes.

6. INTEGRATION TESTING

The BA reviews cross-functional and cross-system impact as part of the requirements analysis and documents identified impacts as part of the Requirements Review Document. The BA defines the scope and participants for each test component, as well as detailed test scenarios necessary to fully verify that all components are working as expected following the system change.

When a change affects external entities (for example, modified benefit indicators on the enrollment data exchange), the BA works with all impacted entities, such as the Enrollment Broker and subcontractors, to coordinate full end-to-end testing to verify production readiness. If necessary, we use subsets of production data to test specific scenarios and simulate the production environment as closely as possible.

Clear Health will work with the Agency on any required testing initiative, and, upon written request, will provide details of the test regions and environments for our Core Operations System, including a live demonstration of all systems, including our subcontractors systems, to enable Agency validation of system readiness.

7. CLAIMS REPROCESSING FOR RETROACTIVE SYSTEM CHANGES

Technology Services assesses all EDI and Core Operations System changes to determine impact to past claims, future claims, and those queued up for processing. If the effective date for a system change precedes the implementation date for that change, the BA includes a work plan for reprocessing any claims that meet the date of service requirements but were processed before the change implementation date. Once the system change has been made, but before production deployment, we perform regression testing by processing several batches of claims, including both impacted and non-impacted claims, for multiple providers. The BA and the Claims Operations team review the results to verify the change is working as expected.

Following deployment to production, the work plan is executed and all claims identified during the impact assessment are reprocessed and verified. Our goal is to have all claims reprocessed within 30 days of the production deployment date. Any applicable interest is paid at that time as well.

For system changes that are determined to impact claims processing by Clear Health's subcontractors, VDOG works with the subcontractor to define the scope of the change, establishing a plan for system testing and reprocessing impacted claims. The team tracks each subcontractor's plan and progress against the plan in the Task Tracker portion of the VDOG Dashboard. Once the claims are reprocessed, the VDOG team will obtain a paid claims report of the impacted claims and do a sample validation to assure accuracy of payment and any interest penalties.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
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Evaluation Criteria:

1. The adequacy of the respondent's IT processes addressing internal modifications for its core systems and subcontractor's systems.
2. The extent to which the respondent's IT processes documented for implementing Agency-directed modifications is less than ninety (90) days.
3. The adequacy of the respondent's processes documented for handling production IT system issues.
4. The adequacy of the respondent's communication process used when system issues/updates are identified and resolved by the respondent and/or its subcontractors throughout the change control process.
5. The adequacy of the respondent's approach to system internal testing to ensure the respondent's and/or subcontractors' system changes/updates are accurate.
6. The adequacy of the respondent's approach to integration testing to ensure the respondent's and/or subcontractors' system changes/updates do not adversely affect other systems, including systems operated by Florida Medicaid and subcontractors' systems.
7. The adequacy of the respondent's approach to applicable claims reprocessing for retroactive system changes, including processing performed by its subcontractor(s).

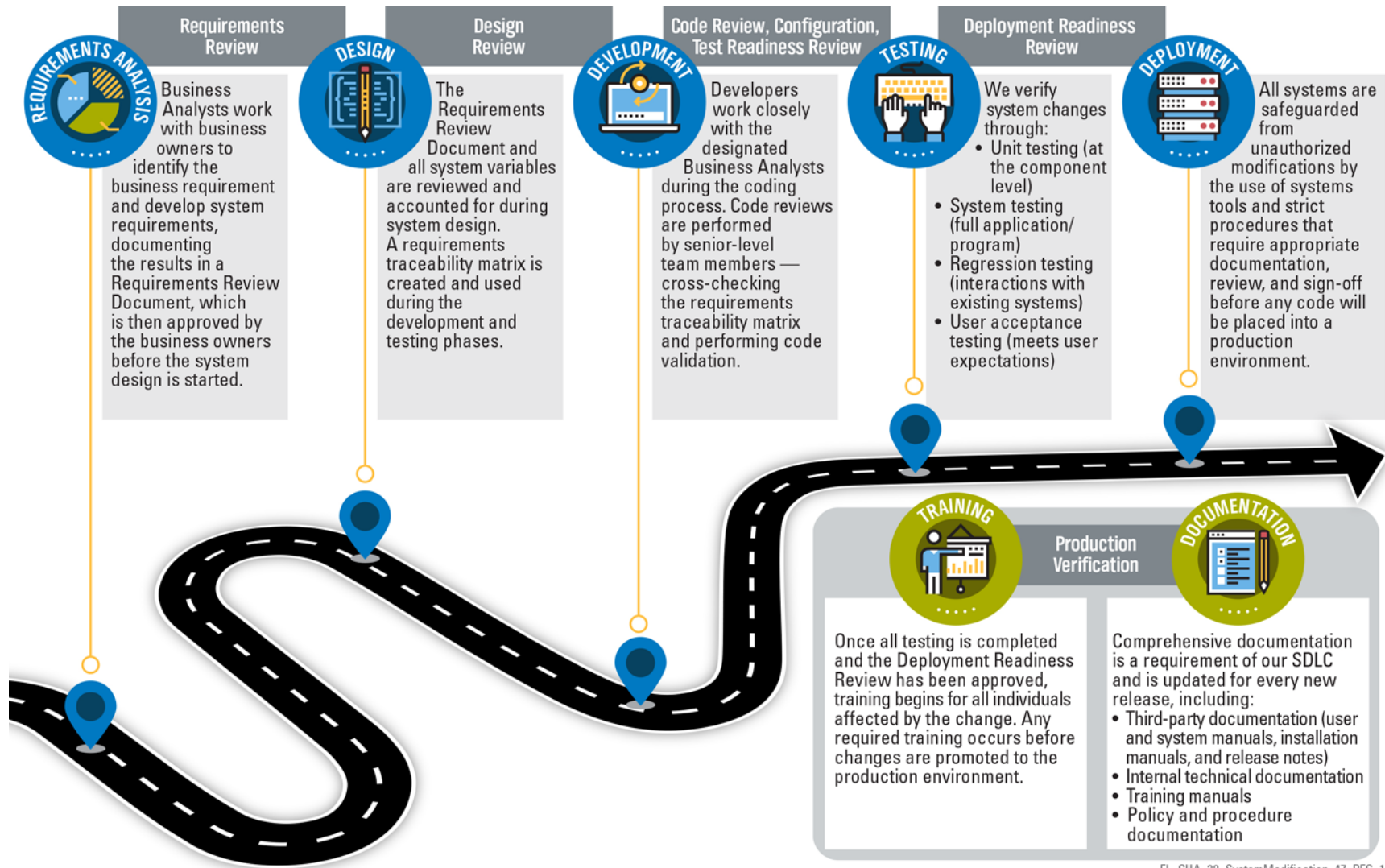
Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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GENERAL SUBMISSION REQUIREMENTS
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Clear Health's Software Development Road Map

Figure 28-1. Software Development Life Cycle (SDLC)



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GENERAL SUBMISSION REQUIREMENTS
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SRC# 29 – Encounter Data Submission (Statewide):

- a. The respondent shall submit a flow chart and narrative description of its encounter data submission process including, but not limited to, how accuracy, timeliness and completeness are ensured.
- b. Completeness of encounter submissions requires that key fields are populated accurately for every encounter submission. The respondent must describe quality control processes that will ensure key fields including, but not limited to, recipient Medicaid ID, provider Medicaid ID, claim type, place of service, revenue code, diagnosis codes, amount paid, and procedure code are accurately populated when encounters are submitted.
- c. The respondent shall demonstrate quality control procedures to ensure documentation and coding of encounters are consistent throughout all records and data sources (ASR, FMMIS, special submissions) and across providers and provider types. The description should include tracking, trending, reporting, process improvement, and monitoring of encounter submissions, encounter revisions, and methodology to eliminate duplicate data.
- d. The respondent shall include any feedback mechanisms to improve encounter accuracy, timeliness and completeness.
- e. The respondent shall include documentation of the most recent three (3) years of encounter data submission compliance ratings, corrective actions, if indicated, and timeframe for completing corrective actions for Florida Medicaid.
- f. The respondent shall submit documentation describing the tools and methodologies used to determine compliance with encounter data submission requirements.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

With extensive experience submitting encounter data, we implement best practices, including processes that focus on submitting encounter data in compliance with the requirements specified in Attachment B, Scope of Service – Core Provisions Section X, Administration and Management, E – Encounter Data Requirements, a dedicated Encounter Audit team that continuously monitors and tracks encounter submission metrics using our Clear Health Analytics business intelligence (BI) dashboard, and an Encounter Task Force that performs root cause analysis and supports cross-functional issue resolution.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

In Attachment SRC# 29-1: Encounter Workflow and Attachment SRC# 29-2: Historical Encounter Compliance, we have provided the following:

- A diagram of our encounter process that shows monitoring as integral to our workflow
- Our completeness and accuracy metrics for the previous three years

Clear Health understands that encounter data is essential to the continued success of the FL SMMC program and will continue to partner with the Agency, supporting its initiatives and collaborating on process improvements.

1. PROCESS TO ENSURE ACCURATE, TIMELY, AND COMPLETE ENCOUNTER DATA

Clear Health maintains high standards across all our systems and operations—especially in the critical areas of accurate, timely, and complete claims processing and encounter data submission. The leader of our dedicated Florida-based Encounter Audit team has over 20 years of Medicaid experience. This team is responsible for overall encounters compliance and manages our comprehensive end-to-end encounter data management operations to support our Florida SMMC program. We are supported by national teams that focus on the integrity of our claims processing and encounter data extract process. Dedicating knowledgeable resources to our Florida claims processing and encounter management promotes the following:

- Continued compliance with Agency requirements
- The highest degree of claims payment accuracy
- Provider satisfaction through prompt claims payment and focused attention to claims inquiries
- Submission of complete, accurate, and timely encounter data to the Agency
- Remediation and resubmission of rejected encounters
- Performance and scalability to support current volumes and future growth

Clear Health's encounter data submission process is designed to support complete, accurate, and timely encounter submissions to the Agency:

- Complete encounter data: We have established strict controls in our encounter process to ensure that adjudicated claims – paper and electronic, as well as subcontracted provider claims – are processed and submitted.
- Accurate encounter data: We run incoming claims and encounters against edits that check for the presence and validity of required data elements during initial processing to make sure that we have complete and accurate data for submission to the Agency. If a claim or encounter fails one or more edits, we return it to the submitter for correction and resubmission.
- Timely encounter data: We have designed our submission schedule to meet Agency submission requirements – with additional time allowed for review and remediation of any errors.

1.1. Complete Encounter Data

Clear Health will continue to submit encounter files to the Agency that contain encounter data from all claim sources – regardless of format (paper or electronic) or type of provider (network, out-of-network, sub-capitated, atypical, or subcontracted), for all services rendered to enrollees (members), including expanded benefits. We strive to achieve a 100 percent complete submission

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rate and have monitoring processes in place to assure we maintain the contractually required 95 percent completeness measure.

Our process pulls claims, claim adjustments, and encounters processed since the last submission and loads the data into our Encounters Management System. Controls validate that all retrieved claims and subcontractor encounter records load properly to the Encounters Management System for subsequent processing using comprehensive edit routines to verify all fields contain accurate and complete information.

We compile all encounters that pass the required edits into a HIPAA-compliant 837 or National Council for Prescription Drug Programs (NCPDP) file and send it to the Agency's designated fiscal agent. The Encounter Audit team uses a real-time view of claims data provided by the Clear Health Analytics Business Intelligence (BI) dashboard to review pended claims or service lines that failed edits and coordinates corrective action with the appropriate operational unit. If we determine changes to the encounter data are needed, we will work with our health care providers to require submission of an adjustment to any claims we may have paid.

The BI dashboard provides the team with the ability to drill down and view metrics and data for encounter submission and to monitor key performance indicators (KPIs) such as completeness, acceptance/rejection rates, and timeliness. The BI dashboard contains a complete view of all encounters including those from subcontractors. The system generates detailed management reports to help the team monitor timely remediation and submission of encounters that pend for incomplete or incorrect data during internal processing. Once we receive corrected information, the automated process includes the remediated encounter in a subsequent submission.

We load encounter response files from the Agency's fiscal agent and work rejections with the appropriate department or subcontractor. We also monitor rejected encounters using aging reports and manage correction and resubmission of 100 percent of encounters for which errors can be remediated by the submitting provider.

We maintain comprehensive information on each encounter submission – including claim ID, line number, type (original, adjustment, void), file path, and creation data. File retention policy exceeds the Agency 10-year requirement.

Our Encounter Audit team performs a weekly reconciliation of all adjudicated claims and submitted encounters to confirm the Completeness KPI is at 95 percent or better. During their weekly meetings, the Encounter Task Force reviews all claims and encounters that could not be submitted and engages the appropriate resources to drill down and determine the root cause. The workgroup determines appropriate action to address issues quickly to maintain the required KPI measure.

Quarterly, upon receipt of the FMMIS Encounter Data for Risk Adjustment file, we reconcile Clear Health's claims and encounters to the FMMIS file to ensure all were submitted and accepted by the Agency. If any claims/encounters are missing, we will make sure they are submitted within the timeline provided by the Agency.

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1.1.2. Encounters for Sub-capitated Providers

Sub-capitated providers present a unique challenge to complete encounter data submission due to the alternate reimbursement methodology defined in their contracts. Because of this, we have put tracking and controls in place to monitor claim submissions, identify potential submission issues, and work with sub-capitated providers to improve the completeness of their submissions. We have added focused reporting for our sub-capitated providers and use our Clear Health Analytics BI dashboard to drill down and analyze data using various criteria such as provider, claim source, claim status, region, and date (received, adjudicated, paid, or submitted). On a weekly and monthly basis, we run reports to analyze submission patterns across providers and compare claim submissions for sub-capitated providers with claim volume statistics for fee-for-service providers. Using a volume ratio based on assigned membership and total claims submitted, we identify sub-capitated providers that are not performing as expected. Provider Relations then meets with the provider to discuss any roadblocks to claim submission and sets up a monitoring program with benchmarks for that provider.

1.2. Accurate Encounter Data

Accurate encounter data requires accurate claims data and a thorough understanding of the claims data elements required for FL SMMC encounters. Clear Health bases our claim and encounter edits on Agency program requirements – ensuring the presence and validity of all required data elements — including member and provider data, date of service, diagnosis, procedure, revenue code, date of claim processing, and date of payment. We check for valid X12 format as well as the presence and validity of provider Medicaid ID and taxonomy. We promote encounter data accuracy by applying service specific edits to all incoming claim records regardless of claim format (paper or electronic) or type of provider (network, out-of-network, sub-capitated, or atypical).

We contractually require our subcontractors to comply with the Agency's claim requirements. By reviewing subcontractor encounter data against the same comprehensive edit routines as internally processed claims, we verify all fields contain accurate and complete information and follow the Agency's submission requirements.

We have built our encounter submission schedule to include time for careful review and remediation of errors. Encounter Audit closely monitors the process to support compliance with Agency requirements. Encounters Analysts monitor each encounter data file submission as it moves through the process including the use of Ramp Manager to validate all encounter files.

We have included checkpoints throughout the encounter process and use a series of internal reconciliation and certification reports to manage, monitor, and validate the integrity of the encounter data submission. If there are problems with individual records that would cause the encounter to fail, we work with the provider or subcontractor to remediate, pending the encounter for inclusion in a future submission. We closely manage remediation of pended claims and work to resolve issues quickly so that encounter submission deadlines are met. When necessary, we make program changes to enhance encounter processing and reporting, incorporating additional front-end edits to maintain compliance with the Agency's requirements.

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GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1.3. Timely Encounter Data

Our encounter data submission process is highly structured and closely monitored, using our Clear Health Analytics BI dashboard to support compliance with contractual requirements. We maintain a comprehensive schedule of system processes, review tasks, and submission dates necessary to deliver complete, accurate, and timely encounter data to the Agency. This schedule documents each step and when it needs to be completed to meet encounter data submission deadlines.

The processing and submission schedule can be easily modified to accommodate changes to the Agency's encounter data submission requirements. We have set up the current process to submit encounters according to the following timeline:

- New claims within seven days of claims adjudication
- Rejected encounter files within seven days (but most are resubmitted within 48 hours)
- Updated X12 encounters within 30 days of reversal or payment adjustment
- Updated NCPDP encounters within seven days of reversal or payment adjustment
- Corrections for rejected encounters within 30 days

We validate the submission details tracked on our BI dashboard against the Agency's weekly timeliness reports and investigate any discrepancies using the rejection details provided in the response files, identifying root cause and making corrections as needed.

2. KEY FIELDS NEEDED TO IDENTIFY SERVICES

We understand that the data we submit as encounters must be able to be linked to and integrated with Agency data and therefore have edits in place to make sure that we provide key elements such as the State assigned member and provider IDs.

We base our claim and encounter edits on Agency program requirements – ensuring the presence and validity of all required data elements to provide the Agency with the information they need to perform rate setting and meet all CMS reporting requirements, including the following:

- Billing Provider Taxonomy and NPI
- Member data including State assigned ID
- Rendering provider taxonomy, NPI, and physical location address (including zip+4)
- Date of service
- Diagnosis codes and service diagnosis pointers
- Procedure/revenue codes
- Units
- COB payer paid amount
- Amount paid
- Date of adjudication
- Date of payment/check date
- Adjustment information

We review subcontractor encounter data against the same comprehensive edit routines as internally processed claims and hold our subcontractors accountable for correctly submitting all required and key field combinations.

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3. QUALITY CONTROL PROCEDURES FOR KEY FIELDS

We maintain front-end edits as part of our claims processing to verify the presence and validity of key fields including non-PO box provider address and dispensing provider NPI as applicable. Providers are required to correct and resubmit claims and encounters with missing or invalid information.

We also perform a final validation on all encounters before submission to ensure that claims data was captured and mapped to the outbound encounter correctly. The Encounter Task Force validates and creates edits as needed to comply with system changes and any new requirements communicated by the Agency.

During orientation and training, we educate providers on claim/encounter requirements and also list those requirements in the provider handbook and on the provider portal. The Encounter Audit team monitors provider claim submission using detailed reports to identify gaps in the submission of required data, notifying Provider Relations that outreach to the provider is needed. The Network Manager then reaches out to providers to assist them in correcting their future claim submissions to include all required information.

We review subcontractor encounter data against the same comprehensive edit routines as internally processed claims to verify all key fields are included and populated correctly. Encounters that are missing required elements are rejected and must be corrected and resubmitted by the subcontractor.

4. PROCEDURES TO ENSURE ENCOUNTERS ARE CODED CONSISTENTLY ACROSS PROVIDERS AND PROVIDER TYPES

We require all providers in the network to enroll in the FMMIS as a provider or managed care registered provider to make sure encounters submitted with their provider information will not be rejected. We understand that the information submitted on the 837 encounter transaction must make a one-to-one match to a provider's Medicaid ID based on the NPI Crosswalk information (NPI, taxonomy, and Zip+4) that is provided on the Provider Master List (PML). We also check incoming claims and encounters submitted by our subcontractors to verify that valid FMMIS member ID and provider ID are present.

As a part of our comprehensive encounter submission process, we monitor and track all rejections including any provider related rejections. We check for submission compliance, including the use of required forms as applicable, and reach out to providers for education and training if they are not submitting claims information as required.

We understand the critical importance of capturing prescribing provider data on pharmacy encounters and have worked closely with Express Scripts, our Pharmacy Benefit Manager (PBM), to establish provider education regarding submitting the appropriate Medicaid ID on all prescriptions and have established monitoring to make sure that this data is supplied and captured consistently.

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5. PROCEDURE TO ENSURE ENCOUNTERS ARE CONSISTENT ACROSS DATA SOURCE

Clear Health collects all claims and encounter data received from participating and non-participating providers, sub-capitated providers, and subcontracted vendors into a central repository from which we source all scheduled encounter submissions to the Agency's FMMIS via the designated fiscal agent. We maintain all encounter details, including those that we use to facilitate tracking and validation across sources such as Claim ID, encounter submission status, and the State assigned transaction control number. Data retention for the Encounters Management System exceeds the Agency's 10-year requirement.

We verify that all submitted encounters include the amount billed and the actual amount paid to the provider for the service, including claims paid by our subcontractors. Our electronic data interchange (EDI) process verifies that billed amount is submitted and rejects any claims that are missing this and other required data elements. For pharmacy claims, our PBM reports the amount that was actually paid to the pharmacy, excluding any PBM or other administrative costs, as part of the paid claims data submitted by the vendor.

Clear Health contractually requires our subcontractors to comply with the Agency's claim requirements and reviews subcontractor encounter data against the same comprehensive edit routines as internally processed claims to verify all fields contain accurate and complete information and follow the Agency's submission requirements. We reject encounters that are missing required elements and monitor correction and resubmission by the delegated subcontractor. Our contracts hold subcontractors accountable for submission of encounters and specify penalties for non-compliance. Account Managers monitor receipt of accurate, timely, and complete encounter data and Encounter Analysts closely monitor encounters for our subcontracted vendors.

6. ENCOUNTER SUBMISSION PROCESS FLOWCHART

We have provided Attachment SRC# 29-1: Encounter Workflow Flowchart to illustrate our process from consolidation of paid claims and subcontractor encounter data through loading the response file from the Agency's fiscal agent and remediating any errors.

7. TRACKING, TRENDING, AND MONITORING ENCOUNTER SUBMISSIONS AND REVISIONS

Following a comprehensive schedule of system processes, review tasks, and submission dates, the Encounter Audit team closely tracks, trends, and monitors the full encounter process lifecycle, starting with the adjudicated claim and ending with the remediation of rejections and submission of adjustments and recoupments.

Adjunct to our Encounter Audit team, we have established a cross-functional Encounter Task Force as the front-line team to identify and remediate encounter issues as quickly as possible and to assure that we meet the following service levels and compliance standards:

- Submission of 95-100 percent of all encounter data within seven days of the claim adjudication date
- 30-day reconciliation and remediation of rejected encounters

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- 30-day submission of adjustments and recoupments for X12 encounter transactions with seven-day submission of updates for NCPDP encounter data
- 100 percent completeness against our internal check-run file

Comprised of key stakeholders and executive sponsors, the Task Force has implemented key performance measures for encounter data and established cross-functional monitoring metrics that are based on line of business requirements — including per-member-per-month averages and total volume. Responsible parties have been established throughout the encounter process, including a dedicated subcontractor oversight team — the Vendor Delegation Oversight Group — which engages delegates in the monitoring process.

The Task Force engages teams throughout the organization to quickly implement process modifications and enhancements to remediate issues and address encounter submission delays.

7.1. Monitoring Subcontractor Encounters

The Encounter Audit team maintains an internal calendar of expected submission dates for each subcontractor. The automated process checks for files and sends alerts to the designated manager if files are not received according to the calendar, triggering the manager to follow up with the subcontractor. As noted above, subcontractors are included in and monitored using the same KPI reporting tool guides that the Encounters Audit team uses. This is also presented to the Task Force and includes monitoring submission statistics, including claim volume for subcontractors and sub-capitated providers, via the Clear Health Analytics BI dashboard. Gaps in submission or drops in overall volume are noted and the Vendor Delegation Oversight reaches out to the delegate's Account Manager who works with the subcontractor to address the issue. A summary of these metrics is also reported to the Encounter Task Force for its review.

7.2. Claims and Encounters Reconciliation

Using the Clear Health Analytics BI dashboard, the Encounter Audit team reconciles incoming claim statistics to outbound encounter totals, reporting any discrepancies to the Encounter Task Force to be researched and resolved.

We maintain all encounter details in the Encounters Management System, including source Claim ID and encounter submission status. The extract process uses these details to identify initial submissions vs. replacements or adjustments to make sure the encounter is submitted appropriately. We also use sophisticated edits in the front-end claim process to evaluate the claim against processed claims data to identify duplicate claims. We automatically deny claims that are definitively identified as duplicates and pend claims for review when the system cannot make a positive determination. Eliminating duplicate claims reduces the chance of submitting duplicate encounters.

On a weekly basis, the Encounter Audit team reviews details from Agency response files to identify high volume errors that may require research, updating the encounter's status within the Encounters Management System, and tracking error correction and resubmission.

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7.3. Financial Reports and Monitoring

The Encounter Audit team monitors weekly reports that are generated via the Clear Health Analytics BI dashboard. The weekly encounter summary report shows current performance measures for completeness, accuracy, and timeliness that are based on financial claim counts and total dollars as compared to submitted encounter counts and totals. Also, on a weekly basis, we review our monthly performance on accepted encounters with detailed counts by edit code for pends and rejections. The Encounter Task Force uses these reports and metrics for its weekly review.

Our Medical Economics department performs additional monitoring through routine monthly reports. Medical Economics also reviews this data for over- and under-utilization trends, scoring providers according to their annualized encounter submission rate based on the number of assigned members. Using a green, yellow, red rating system, we identify providers for re-education and assistance in removing any barriers to timely submission. Unsuccessful remediation efforts could result in converting sub-capitated contracts to fee-for-service or terminating the provider.

7.4. Scheduled Processes and Tasks

For each encounter submission we:

- Load newly adjudicated claims to the Encounters Management System and apply encounter edits against all encounter data that has not yet been sent to the Agency
- Generate encounter error reports and distribute to corresponding departments to be worked
- Create 837 and NCPDP formatted files for all encounters that have passed the edits. Validate 837 files in Ramp Manager
- Submit 837 and NCPDP files to the Agency's fiscal agents
- Complete all attestations within the same day as submission
- Retrieve the 999, 277U, and 835 response files from the Agency's fiscal agents
- Upload the response files to the Encounters Management System
- Review encounter submission results and remediate rejected encounters
- Review daily encounter aging report

Weekly:

- Monitor and confirm the Completeness KPI is at 95 percent or better; if not, then escalate to be addressed
- Monitor and confirm the Timeliness KPI is at 9 percent or better; if not, then escalate to be addressed

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- Validate timeliness against the Agency's timeliness reports and work with internal users to resolve differences
- Monitor and confirm the Accuracy KPI is at 95 percent or better based on previous week's encounter response files; if not, then escalate to be addressed
- Weekly rejection review:
 - Review reconciliation results for comparison of claims processed against 837 encounter submission and corresponding 277U/835 files
 - Identify new rejection codes, investigate root cause, and identify and implement solutions
 - Monitor and track all rejections to gauge success and escalate issues as needed during our weekly Encounter Task Force meeting
 - Generate rejection reports for encounters to be remediated prior to the next resubmission
- Edit analysis: Identify if there are any additional edits based on new rejections
- Encounter Task Force meeting with all departments to communicate and verify the completeness, timeliness, and accuracy, and provide a resubmission status update; prioritize and follow up on all outstanding encounter issues
- Encounter Task Force meeting to review current encounter related issues, verify any Agency required changes/upgrades and create an action plan to solve any outstanding issues

8. HISTORICAL COMPLIANCE RATINGS

Clear Health has provided detailed compliance statistics in Attachment SRC# 29-2: Historical Encounter Compliance. This data represents historical ratings for both legacy Amerigroup and Simply (inclusive of Better and d/b/a Clear Health data) for the preceding three fiscal years. Our goal is to continue to improve our overall performance against these measures by applying best practices drawn from all three organizations, including our dedicated Florida-based Encounter Audit team and real-time monitoring using our Clear Health Analytics BI dashboard.

9. TIMELY CORRECTIVE ACTIONS AS NEEDED

A successful encounter process is built by regularly reviewing outcomes and learning from successes and failures. Over time and as Medicaid Managed Care has matured, encounter data reporting and the expectations around its use have changed incrementally, and we have adapted our processes to comply, building a successful and robust encounter data management process as a result.

Through our weekly monitoring processes, we have a timely view of the issues that are impacting our encounter submissions. Our cross-functional Encounter Task Force reviews all rejections and quickly works towards identifying and implementing solutions. Key leaders from various departments each bring a different perspective to the table, creating a synergy that helps us to see the broader picture and facilitates prompt resolutions to difficult problems.

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GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

By applying this strategy – monitoring rejections, reviewing, discussing, and sharing cross-functional insights – we were able to quickly resolve an issue where an edit, that we had added to our front-end claims process in compliance with an Agency encounter edit, was causing a large volume of claim rejections and provider disputes. By bringing together representation from the Encounters, Claims, and Provider Relations team at Encounter Task Force meetings, we were able to identify this as an issue that needed to be addressed quickly and had the expertise needed to determine that the Agency edit that was causing this was not in agreement with the Agency's UB-04 Claim Form Handbook. We presented our case to the Agency and were able to get the edit changed to Informational. We then quickly removed the edit from our claims system and reprocessed the impacted claims and submitted the corresponding encounters.

External collaboration is equally as important to timely corrective actions. Shortly following the implementation of the SMMC program, and at the Agency's request, Clear Health quickly established regular monthly meetings with the Agency and its fiscal agent to provide a forum for collaboration and issue resolution. For the past four years, we have faithfully hosted monthly meetings where key technical leads from our IT, EDI, and Encounters teams have come together with their counterparts at DXC to discuss new requirements or old challenges.

Our participation in these meetings has enabled us to clarify Agency policy and proactively address issues that may occur due to new requirements. One such case occurred when the Agency differentiated repairable edits from fatal (non-repairable) edits. There were two provider-related edits that were marked as fatal but based on our analysis we knew that these edits were due to events that were in fact repairable and marking them fatal would create a gap in encounters reporting. We presented our case to the Agency and these edits were switched to repairable thereby avoiding a large volume of encounters that we would have otherwise never been able to submit.

10. TOOLS AND METHODOLOGIES TO DETERMINE COMPLIANCE

As a part of the weekly rejection review process, Clear Health pulls data from the Clear Health Analytics BI dashboard and uses pivot tables to reconcile all adjudicated claims against the encounters files — including submission and response files. The BI dashboard supports the following tasks and analysis:

- Extracting data based on adjudication or submission date
- Reconciling encounter submission and response files
- Reviewing Encounters Management System edit results in total or by rejection code
- Generating summary sheets for completeness, timeliness, and accuracy for initial submission and resubmission
- Reviewing encounter details by provider to identify provider specific issues

This monitoring approach promotes contract compliance and continuous quality improvement.

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GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

11. CONVERTING PAPER CLAIMS TO ELECTRONIC ENCOUNTER DATA

The clearinghouses perform HIPAA compliant editing and submit 837 files daily to Clear Health. We have an automated process to upload 837 files into our Core Operations System for processing. The Core Operations System assigns each claim a unique internal control number to track its progress from initial entry into our system to final adjudication. We maintain an image of each electronic claim in our document management system, and real-time access to images facilitates adjudication and research tasks. The claims process applies HIPAA compliance and initial business rule edits (such as member exists in our system) to electronic and paper claims prior to adjudication. We reject claims that fail edits (prior to loading into our adjudication system) and notify the provider of the reason.

For claims we receive on paper, throughout each day, Document Services batches, scans, and exports the files for data entry. After we perform quality checks, we create 837 claims data files for processing into our claims system. On average, this cycle occurs within 48 hours of receipt, helping us process clean claims as quickly as possible.

We run daily exception reports to monitor that all claim batches are loaded into the Core Operations System. Claims are processed daily through an automated mass adjudication process after the claims upload is completed.

We currently acknowledge claims receipt according to the Agency's requirements. For claims submitted electronically we provide an electronic receipt within 24 hours after the start of the next business day and we make receipts for paper claims available through our secure provider website within 15 days of receipt.

12. IDENTIFYING AND CORRECTING ISSUES THAT COULD RESULT IN INVALID ENCOUNTER SUBMISSIONS

We understand the value of encounter data to the Agency and devote the system and staffing resources necessary to submit complete and accurate data. Accurate operational data is critical to accurate encounter data. Our operational functions contain processes and procedures designed to protect the accuracy and integrity of our member, provider, and claims data.

By applying tight controls on these processes, we are able to prevent submission of invalid encounter data to the Agency. These processes and controls include:

- Strict controls on the modification of provider and member information and regular data audits to validate accuracy
- Conversion of all paper claims into electronic format prior to claims processing
- Comprehensive and stringent compliance edits and business rule validations performed on all claims regardless of source and type of provider
- Tightly managed claims process to resolve pended claims quickly and accurately

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Our encounter data submission process contains multiple sets of edits, validations, and checkpoints designed to identify processing issues and data problems before encounters are submitted to the Agency.

When issues are discovered after submission, we perform a root cause analysis to identify changes that we can make to our processes or systems to prevent a recurrence or identify problems earlier in the cycle. Our goal is to provide the Agency with the most complete and accurate encounter data possible.

To facilitate continuous improvement, we regularly meet with the Agency and its fiscal agent to discuss solutions for current encounter submission challenges, and review policies, procedures, and systems to identify ways to streamline operations, increase efficiency, and improve overall performance. Through these efforts we have worked with the Agency to adjust the status for various encounter edits (from fatal to repairable, or repairable to informational), and have implemented several new reports to better track data through the encounters process and monitor the accuracy of data that is sent to state partners. Reports include the following:

- Source-to-target reconciliations to confirm that all claim data is loaded into the Encounters Management System, including subcontractor claims
- Full accounting of each claim within a batch to verify that all claims are present and that the number of claims loaded matches those submitted and pending
- File submission validation reports that match data written to the encounter file to the source system to validate key data elements
- FMMIS quarterly file reconciliation
- Financial reporting comparison between encounters submissions and cash disbursement journals, lag reports, and financial statistical reports

13. TOOLS TO MONITOR ENCOUNTER SUBMISSION COMPLIANCE

The Encounter Audit team monitors encounter submission status and statistics, including details for subcontractors and sub-capitated providers via the Clear Health Analytics BI dashboard. Any gaps in submission or drops in overall volume are noted and the Audit team reaches out to Provider Relations or the Vendor Delegated Oversight Group to facilitate provider outreach and training.

Using the BI dashboard, the Encounter Audit team can review encounter details by provider to monitor volume, review rejections, and identify specific edits that are issues for each provider. Summary level data is used to identify trends and isolate providers who require additional training. A summary of these metrics is also reported to the Encounter Task Force for its weekly review.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The adequacy of the respondent's process to ensure accurate, timely, and complete encounter data.
2. Demonstrated knowledge of the combination of key fields needed to identify services.
3. Adequacy of procedures, including quality control procedures, to identify key fields and ensure they are accurately populated during encounter data submission.
4. Adequacy of procedures to ensure encounters are coded consistently across providers and provider types.
5. Adequacy of procedures to ensure encounters (volume, categorization, dollar amounts, dates) are consistent across data sources, including applicable subcontractors.
6. The completeness of the respondent's flowcharts describing its encounter data submission process.
7. The adequacy of the respondent's mechanisms for tracking, trending, monitoring encounter submissions and revisions, including the type and frequency of activities, and methodology to eliminate duplicate data.
8. The adequacy of the respondent's encounter data submission historical compliance ratings.
9. The adequacy of the respondent's ability to implement timely corrective actions to compliance ratings, if indicated.
10. The adequacy of the tools and methodologies used to determine compliance.
11. The adequacy of the respondent's process for converting paper claims to electronic encounter data.
12. The adequacy of the respondent's approach to identifying and correcting specific processing/systems issues that could result in invalid data being submitted to the State.
13. The adequacy of the tool to ensure that all encounters are submitted.

Score: This section is worth a maximum of 65 raw points with each of the above components being worth a maximum of 5 points each.

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Table 29-1. Historic Encounter Compliance Percentages for Simply and Amerigroup*

		July		August		September		October	
		Simply	Amerigroup	Simply	Amerigroup	Simply	Amerigroup	Simply	Amerigroup
Jul 2016 – Oct 2016	Completeness	99.85	99.99	98.01	99.98	99.85	99.99	98.72	99.98
	Accuracy	97.69	89.12	98.48	90.82	98.76	92.4	98.72	90.64
Jul 2015 – Oct 2015	Completeness	95.37	99.99	98.14	99.99	98.48	99.97	96.61	99.99
	Accuracy	97.49	87.41	97.18	87.41	97.53	88.97	96.24	87.07
Jul 2014 – Oct 2014	Completeness	97.71	98.49	94.95	98.82	98.19	99.43	99.41	99.43
	Accuracy	94.44	93.74	95.52	92.94	96.57	94.15	96.93	94.15
		November		December		January		February	
		Simply	Amerigroup	Simply	Amerigroup	Simply	Amerigroup	Simply	Amerigroup
Nov 2016 – Feb 2016	Completeness	99.66	99.98	97.65	99.98	99.86	99.99	99.77	99.95
	Accuracy	98.12	81.39	98.48	89.56	97.93	89.3	98.07	87.98
Nov 2015 – Feb 2015	Completeness	99	99.52	97.45	99.95	98.04	99.98	99.79	99.99
	Accuracy	95.51	89.93	98.12	89.39	98.12	97.8	97.8	88.63
Nov 2014 – Feb 2014	Completeness	94.76	99.52	97.97	99.39	97.84	98.21	97.98	100
	Accuracy	95.61	93.92	97.68	92.95	97.57	97.74	97.81	92.27
		March		April		May		June	
		Simply	Amerigroup	Simply	Amerigroup	Simply	Amerigroup	Simply	Amerigroup
Mar 2017 – Jun 2017	Completeness	99.73	99.98	99.83	99.75	99.77	99.65	99.77	99.51
	Accuracy	97.69	88.39	98.55	86.5	98.14	82.73	98.06	83.56
Mar 2016 – Jun 2016	Completeness	99.79	99.98	99.6	99.98	99.66	99.99	99.72	99.97
	Accuracy	97.8	87.65	98.38	88.17	98.45	88.32	98.44	88.91
Mar 2015 – Jun 2015	Completeness	97.98	99.99	98.1	99.99	98.08	99.98	97.83	99.99
	Accuracy	97.81	92.8	97.26	89.64	97.71	90.06	97.82	89.35

*Simply and Amerigroup statistics are based on encounter submissions for all products for Simply Healthcare (Simply Healthcare, Better Health, Clear Health Alliance) and Amerigroup.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 30 – Encounter Submission for Sub-Capitated, Subcontracted, Non-Pay and Atypical (Statewide):

The respondent shall describe how it will work with providers, particularly subcapitated providers, subcontractors, atypical providers, and non-participating providers to ensure the accuracy, timeliness and completeness of encounter data.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

We understand that encounter data is critical to the continued success of the SMMC program and have established training and support for our providers and subcontractors to aid them in complete, accurate, and timely submission of claims and encounters. We also understand that providers must be eligible for participation in the Medicaid program. If a provider is currently suspended or terminated from the Florida Medicaid program whether by contract or sanction, other than for purposes of inactivity, that provider is not considered an eligible Medicaid provider and therefore is not allowed in our network, nor will we pay claims for this provider.

1. REGISTERING PROVIDERS IN THE FLORIDA MEDICAID MANAGEMENT INFORMATION SYSTEM (FMMIS)

Clear Health understands that for encounter data records to be accepted by the Agency, providers must be recognized in the FMMIS as either actively enrolled Medicaid providers or as Health Plan registered providers. We have a process in place to ensure that both out-of-network providers and network providers are registered in FMMIS prior to encounter submission to the Agency. Sub-capitated providers are network providers and follow the same enrollment and setup processes including registration in the FMMIS.

During the network contracting and credentialing process, Provider Relations and Credentialing use the most recent state Provider Master List (PML) to verify that the provider NPI is registered in FMMIS and the provider has an active Medicaid provider number or has submitted their registration form to the Agency. We also check the following exclusion lists:

- Office of the Inspector General (OIG)
- Federal List of Excluded Individuals and Entities (LEIE)
- Federal System for Award Managements (SAMS)
- CMS

If, after careful review of the PML file and designated exclusion lists, it is determined the provider is not registered with FMMIS and is not present on any exclusion list, we then review the following to make sure the provider is not ineligible to provide services:

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- AHCA MPI Monthly Ineligible Provider Reports
- AHCA MPI Terminated Providers
- Payment withhold alerts

If the provider is determined to be eligible, they are directed to begin the registration process. Our Provider Network Managers instruct each provider that claims will not be paid until they have been assigned a Medicaid ID and that claims must be billed with the appropriate ID for each designated NPI, taxonomy, and Zip+4.

We verify appropriate Medicaid ID submission as part of our claims processing using front-end edits to reject claims submitted by providers who do not have a state Medicaid ID. We then contact those providers and explain the process to acquire a state Medicaid ID. This validation step ensures that adjudicated claims pulled for encounters processing have the state Medicaid ID as required by the Agency.

For non-par providers, prior to claims payment, we use a limited provider verification/credentialing process to validate the provider's NPI, active state license, and Medicaid ID. We also check the state's Background Screening (BGS) database and query the OIG, LEIE, SAMS, Agency, and CMS provider exclusions lists as well as the Agency's provider payment suspension information received from MPI.

If the provider does not have a Florida Medicaid ID or a completed BGS record, we refer the provider to the Agency's limited provider enrollment process for the completion of a Level II background screening and to obtain a Medicaid ID. If the provider already has a Level II BGS and is not listed on any of the exclusion or suspension lists, we will submit the appropriate registration form to the State.

We enforce the same requirement with our subcontractors and require that they verify providers in their network obtain a Medicaid provider ID or a managed care plan registration number during contracting and credentialing.

2. PROVIDER EDUCATION AND TRAINING ON ENCOUNTERS REPORTING

We base our encounter edits on Agency program requirements, which ensures the presence and validity of all required data elements, including enrollee (member) demographic data, rendering/billing provider NPI and Medicaid ID (as appropriate for service), provider service address, date of service, diagnosis, procedure, revenue code, date of claim processing, date of payment, and amount paid for the service.

2.1. Initial Provider Training

Provider training is an important element in supporting providers and making sure they submit claims that include required information for encounters reporting. We provide newly contracted providers with comprehensive initial training within 30 days of their contract effective date; providing the tools and knowledge to accurately report the services they provide to our members and receive timely reimbursement for those services. Training participants are shown how to complete a paper claim and how to use our provider portal tools. We have created online training for those providers who cannot attend an onsite training session within 30 days.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

The claim specific training includes education on:

- Clear Health member ID cards and eligibility verification
- Provider help line
- Service authorizations
- Claims submission methods, including paper, provider portal, and clearinghouse
- How to complete a paper claim including specific field values and common errors
- Benefits of electronic claims submission
- Entry of a claim through our provider portal
- How to register with FMMIS
- Claims adjudication and payment
- How to check claims status
- Common claims submission errors, avoidance, and problem resolution
- Key fields needed to identify services
- Process and timing for filing an appeal
- Contact information for the Provider Network Manager
- Forms (CMS 1500, UB 04/CMS 1450)

At the end of each training session, we ask participants to complete a survey to assess their satisfaction with the presenters, training materials, content, and effectiveness, and also solicit suggestions for additional provider education topics. Over 98 percent of providers surveyed found the presentation valuable, informative, and easily understood.

At initial training, we also distribute copies of our provider manual which outlines billing procedures, claims processing timeframes, and dispute resolution process and timeframes. We also present instructions on how to use our provider portal where providers can access key provider education information.

2.2. Ongoing Provider Training

Clear Health Provider Network Managers work individually with providers in their office locations to train them on paper and electronic claims submission and guide them step-by-step through the process. They walk providers through completing a paper claim and teach them how to submit an electronic claim using the online claim entry tool on our provider portal. We stress to the provider the potential cost savings they can achieve by submitting claims electronically rather than on paper.

We have received a positive response from our providers on the value of this direct hands-on approach to claims training. Although we encourage providers to submit claims electronically, we support providers with all claim submission methods and associated benefits. We will continue to support providers who wish to submit paper claims.

We present ongoing provider training for the top five specific provider types identified by Clear Health through our monitoring and QI processes, and claims submission and payment processes. We will conduct the training monthly for a period of at least 12 months following the implementation of the SMMC Contract, covering, at a minimum, common claims submission errors and how to avoid them.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Subcontractors are required to meet the same level of training and support for our downstream providers.

2.3. Day-to-day Support for Providers

We furnish providers with a toll-free provider help line for assistance with claims submission. We make every effort to quickly and efficiently resolve claim and encounter questions from providers. Call center employees are trained to address questions, revise and reprocess claims, and provide further education while providers are on the telephone. We route any issues that require additional research to our Florida-based Internal Resolution Unit (IRU).

We use provider bulletins and blast faxes to communicate program updates, changes to policy and claims billing rules, and upcoming webinars and training events. Provider bulletins are available 24/7 via the provider portal and blast faxes are sent out as needed to the fax number designated by the provider.

Claims Operations monitors daily claims processing reports, including a review of pended claims. We focus on key fields as part of our monitoring and if a problem requires provider intervention, we proactively contact the provider to explain the error, achieve resolution, and deliver education to help prevent future errors. We also review specific claims monitoring reports to make sure providers are paid quickly and correctly. If we see specific provider problems, we work with the provider to correct the error and customize our education to reinforce correct billing procedures.

To educate and support providers who wish to submit claims electronically, we also maintain two electronic data interchange (EDI) claims submission guides, one for professional claims and one for institutional claims, that include detailed information on electronic claims submission. We publish these as tools and resources via the provider portal. These documents describe the EDI process and the benefits to providers. They provide an overview of the EDI process and include topics such as:

- Responsibilities of Clear Health and the clearinghouses
- Provider responsibilities for using the clearinghouse and our provider portal
- How to get started with EDI
- Clearinghouse fees and charges
- EDI claim requirements
- Claim rejection scenarios
- EDI report options and features

We also maintain a dedicated EDI hotline to answer specific questions related to electronic claims submission. Hotline employees can help providers with questions related to set-up, submission issues, and claim rejections.

3. PROVIDING SERVICE AMOUNT AND COST DATA

All claims data processed by Clear Health include the amount billed and the actual amount paid to the provider for the service, including claims paid by our subcontractors. Our EDI process verifies that billed amount is submitted and rejects any claims that are missing this and other required data elements. For pharmacy claims, our PBM reports the amount that was actually paid to the pharmacy, excluding any PBM or other administrative costs, as part of the claims data.

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GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

submitted by the vendor. Edits are applied to subcontractor encounter submissions to verify all required data elements are included. Encounters that are missing required elements are rejected and must be corrected and resubmitted by the subcontractor. Validation of all encounter files submitted to the Agency ensures that appropriate payment amounts are submitted as well.

4. EDUCATING AND SUPPORTING PROVIDERS WHO SUBMIT PAPER CLAIMS

Clear Health offers flexible claim submission options to providers, including paper and several electronic methods. While we accept and support providers who submit paper claims, we encourage providers to take advantage of one of our several methods of electronic claims submission, including a no-cost option for electronic claims submission via Availity. Our provider education campaign has increased the rate of electronic claims submission. Today, more than 85 percent of Florida claims are submitted electronically, and we continue to work toward increasing the number of electronic submissions. Our provider training, both initial and ongoing, covers the process for submitting paper claims, provides an overview of fields in the CMS 1500 and CMS 1450 forms, as applicable, and educates providers about key fields needed to support encounters and common errors.

Our claims processing system also supports quick and efficient paper claims processing, converting paper claims to electronic format for processing in less than 48 hours from date of receipt on average. Document Services scans and exports the files for data entry throughout each production day. After we perform quality checks, we create 837 claims data files for processing into our claims system. The electronic version of the paper claim is adjudicated with other claims received electronically and follows all of the same processing timelines and rules from that point forward.

5. ENCOURAGING PROVIDERS TO SUBMIT ACCURATE, TIMELY, AND COMPLETE ENCOUNTER DATA

To support complete, accurate, and timely encounter data to the Agency, Clear Health contractually requires providers in our network to submit complete and accurate claims within six months after the date of service or discharge. Complete, accurate, and timely encounters support payment rates, both to us from the State and from us to the provider, and allows us to monitor service utilization and calculate accurate outcome measures, such as HEDIS®.

In coordination with monitoring and oversight activities employed by our Claims Operations and Encounter Management teams, our Provider Network Managers also monitor claim submission and compliance with appropriate billing rules. The Provider Network Manager will work with providers to address compliance issues and develop CAPs for those who fail to consistently submit accurate, timely, and complete claims and encounter data. These CAPs enable us to work with the provider in a collaborative way, educating the provider on the value and necessity of complete encounter data. The cleaner the data submitted to Clear Health, the faster the provider's claim is processed, benefiting all stakeholders in the health care system: the Agency, the providers, the members, and the MCOs.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

In addition, we track completeness, timeliness, accuracy, and resubmission measures for providers and subcontractors as part of our weekly Encounter Audit process. Details on submissions are tracked using the Clear Health Analytics business intelligence (BI) dashboard, we also meet regularly with all subcontractors to review their compliance with the required completeness, timeliness, accuracy, and resubmission measures. Deficiencies are noted and corrective actions are identified.

5.1. Network Providers

Clear Health's provider contracts require all network providers, including sub-capitated and atypical providers, to submit timely and accurate claims. We contract with most providers in our network on a fee-for-service basis, which inherently drives timely claim submission and results in complete encounter data. We monitor claims activity and work closely with providers to correct errors and educate them on accurate claims submission.

Provider Network Managers educate and support providers in submitting accurate claims including delivery of hands-on paper claims training and the use of our provider portal to submit an electronic claim. Our proactive, one-on-one approach is especially valued by Florida providers in our network.

5.1.1. Sub-capitated Providers

We include language in contracts for sub-capitated providers that requires submission of encounter data as zero pay claims. Recognizing encounter capture for sub-capitated providers as a challenge for us as it is industry wide, we have added focused reporting for our sub-capitated providers and use our custom developed Simply Analytics Business Intelligence (BI) dashboard to drill down and analyze data using various criteria such as provider, claim source, claim status, region, and date (received, adjudicated, paid, or submitted). On a weekly and monthly basis, we run reports to analyze submission patterns across providers and compare claim submissions for sub-capitated providers with claim volume statistics for fee-for-service providers. Using a volume ratio based on assigned membership and total claims submitted, we identify sub-capitated providers that are not performing as expected. Provider Relations then meets with the provider to discuss any roadblocks to claim submission and sets up a monitoring program with benchmarks for that provider.

5.1.2. Subcontractors

Our contracts hold subcontractors accountable for submission of encounters and specify penalties for non-compliance. Account Managers monitor receipt of accurate, timely, and complete encounter data and Encounter Analysts closely monitor encounters for our subcontracted vendors. Clear Health works with each subcontractor to define a twice-weekly encounter submission schedule based on their adjudication schedules.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Clear Health established the Vendor Delegation Oversight Group (VDOG) to monitor and remediate any encounter data issues or gaps. The VDOG team monitors the BI dashboard weekly, based on the days of the week the subcontractor is scheduled to submit their encounter data. Alerts are sent to the Account Manager if submissions are not received according to the established schedule. This weekly monitoring facilitates outreach to our subcontractors to ensure that they submit their encounters timely. Clear Health reconciles encounter submissions to subcontractor payment data as part of our oversight process.

VDOG escalates non-responsive subcontractors to Compliance and executive leadership for immediate resolution. If there is a trend of late or incomplete encounter submissions, a CAP will be implemented for the subcontractor.

Encounters from subcontracted providers go through the same monitoring as all Simply encounters. This is monitored by the Florida-based Encounters Audit Team, which is responsible for overall encounters compliance as discussed previously and is reported up to the cross-functional Encounter Task Force and the Quality Management committee.

5.2. Out-of-network Providers

For out-of-network providers, Clear Health uses a single-case agreement that thoroughly explains the claims submission and reimbursement process. Terms and conditions in the agreement include:

- Provider agrees to follow proper billing and submission guidelines, and provider agrees to use industry standard codes for claim submissions; provider understands the billed codes denote the services or procedures performed and should be fully supported in the medical record and office notes
- Provider shall submit claims on a current CMS-1500 form for professional claims or a CMS-1450 (UB-04) form for institutional claims (or their electronic equivalent or successor formats) within 180 days of the date the authorized covered health service was provided
- Upon receipt of the provider's clean claim, Clear Health will pay the provider for the services provided within the time frame required by the SMMC Contract, or State and federal requirements, with the most stringent prevailing
- Provider will attach a copy of the agreement to any paper claim submitted

The agreement also includes an individual contact name, an address to mail paper claims, and highlights information for electronic billing.

5.3. Atypical Providers

Clear Health also works with atypical providers, or providers that do not routinely submit the industry standard claim forms. We work closely with these types of providers to assure prompt and appropriate claims submission and payment, confirming data for services rendered is captured and reported to the Agency. We use a variety of techniques to capture data from atypical providers, including standard billing for services like pest control, super-billing for in-home services, roster billing for assisted living facilities, and invoices for translation services.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
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We recognize that, while atypical providers are not traditional providers with medical billing systems and staff, they do provide services that bring a real benefit to our members. Our dedicated team works with each provider, providing the tools and training they need to bill and receive the correct payment.

5.4. Activities and Incentives or Penalties



Clear Health has created a Customer Experience Committee comprising representatives from departments across the Medicaid Business Unit and Clear Health, including Claims, National Customer Care, Provider Relations, Medical Management, and Grievances and Appeals. Customer Experience proactively gathers and analyzes data associated with the most prevalent causes of provider dissatisfaction, including claim denials, provider disputes, complaints, and grievances and appeals. They use this information to identify root causes and provides an opportunity to implement system-wide solutions which result in continuous improvement.

Accurate and complete encounter data, education, training, and improved Customer Experience activities are all designed to reduce claims denials. Reducing claims denials translates to immediate improvement in provider satisfaction and can improve member satisfaction in the long term. Most importantly, clean claims data means Clear Health submits the cleanest and most accurate encounters to the Agency.

Our contracts with our subcontractors clearly identify the requirement to submit accurate encounter data in a timely fashion. Contracts include penalties for non-compliance and Account Managers closely monitor encounter submissions to ensure that subcontractors adhere to all contract requirements.

6. CONNECTING WITH PROVIDERS TO REVISE ENCOUNTERS IN A TIMELY MANNER

Clear Health supports a number of different methods to connect with providers to revise claims or encounters in a timely manner. We staff our call center with employees who are empowered to update demographic data and adjudicate claims on the phone, working one-on-one with providers on more complex issues to coach them on correct submission and help them resolve claim errors. Clear Health approaches each situation as an educational opportunity to improve provider satisfaction and the quality of claims and encounters.

We work as a cross-departmental team. Our Encounter Management team carefully reviews problems identified during the encounter submission process. If they find issues with a specific provider or one of our subcontractors, they enlist the support of the Provider Network Manager or the VDOG Account Manager to quickly remediate errors and educate the provider or subcontractor so that we can submit complete and accurate encounters to the State's fiscal agent.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

In addition, our Provider Network Managers review weekly claims reports to proactively identify possible provider submission errors. For example, if we see a large number of claims pending, our representatives promptly reach out to providers to help facilitate correct submission and payment. Representatives also carry laptops to provide immediate claims status information during visits.

Clear Health recognizes the absolute necessity of accurate and complete health care encounter data. To that end, we are committed to making sure the data providers submit to us is accurate, complete, and represents the actual health care activity of our members, thereby supporting our submission of the cleanest, most precise data to the Agency.

Submission metrics, including timeliness measures for initial submission and resubmission of errors are monitored via the BI dashboard by the Encounter Audit team who sets performance thresholds according to the timeliness standards defined by the Agency. If the required performance threshold is not being met for any of our subcontractors, the Audit team contacts the VDOG Account Manager to coordinate outreach and remediation with the subcontractor. A twice-weekly submission schedule also facilitates timely encounter revisions.

For fee-for-service and sub-capitated providers, the Encounter Audit team uses the BI dashboard to review encounter details by provider to monitor volume, review rejections, and identify specific edits that are issues for each provider. We also use summary-level data to identify trends and isolate providers who require additional training. A summary of these metrics is also reported to the Encounter Task Force for its weekly review.

7. SUPPORTING PROVIDER COMPLIANCE WITH CORRECT CODING

Clear Health promotes correct coding by incorporating National Correct Coding Initiative (NCCI) edits into our claims processing and payment system. For our network providers (including sub-capitated and atypical), we review key fields and proper coding during initial provider training and reinforce these during subsequent interactions with each provider.

For out-of-network providers, the single-case agreement that is reviewed and signed by the provider requires them to follow proper billing guidelines and use industry standard codes, and emphasizes that billed codes denote the services or procedures performed and should be fully supported in the medical record and office notes.

8. VERIFYING SUBMISSION OF ALL ENCOUNTERS

Clear Health has established monitoring activities to identify claims issues that have the potential to impact encounter submissions. Claims Operations monitors daily claims processing reports, including a review of pended claims and our Provider Service Unit (PSU) proactively reaches out to providers to address Issues requiring provider intervention.

For our sub-capitated providers, we have added focused reporting to monitor their completeness, accuracy, and timeliness. Using the BI dashboard, we run reports to analyze submission patterns across providers and compare claim submissions for sub-capitated providers with claim volume statistics for fee-for-service providers. Using a volume ratio based on assigned membership and total claims submitted, we identify sub-capitated providers that are not performing as expected.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Provider Relations then meets with the provider to discuss any roadblocks to claim submission and sets up a monitoring program with benchmarks for that provider.

For our delegated arrangements, our VDOG actively monitors encounter data submissions to identify encounter data issues or submission gaps. In addition to monitoring for the receipt of scheduled encounter files, this team also reconciles submitted encounter data to payment data as an additional verification step. VDOG escalates non-responsive subcontractors to executive leadership for immediate resolution. If there is a trend of late or incomplete encounter submissions, a CAP will be implemented for the subcontractor.

Evaluation Criteria:

1. The adequacy of the respondent's approach to ensure that all network providers, including subcapitated providers, are known to the Florida Medicaid Management Information System (FMMIS) for the purposes of encounter data submission.
2. The adequacy of the respondent's approach to educating all providers about the importance of key field combinations in accurately identifying the service/s provided, the importance of populating all key fields, and the importance of consistency in coding across all records, providers, and provider types on encounter data submissions.
3. The adequacy of the respondent's approach to ensuring that all providers, including subcapitated providers and subcontractors, provide an amount or cost of the Medicaid service provided (including pharmacy paid amount). For pharmacy claims, this includes the adequacy of the respondent's approach to ensuring the amount or cost of the Medicaid service provided must be the amount that was actually paid to the pharmacy excluding any PBM or other administrative costs.
4. The adequacy of the respondent's approach to educating and supporting providers who submit paper claims.
5. The adequacy of the respondent's approach to encouraging providers, particularly subcapitated providers, subcontractors, atypical providers, and non-participating providers to submit accurate, timely, and complete encounter data, including the type and frequency of activities and any incentives/penalties.
6. The adequacy of the respondent's description of how it will connect with providers to revise encounter submissions in a timely manner.
7. The adequacy of the respondent's approach to work with providers to comply with correct coding.
8. The adequacy of the respondent's approach to ensure that all encounters are included in submissions.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 31 – Fraud and Abuse/Compliance Office (Statewide):

The respondent shall describe its compliance program including the compliance officer's level of authority and reporting relationships. The respondent shall describe its experience in identifying subcontractor fraud and internal fraud and abuse in managed care programs. The respondent shall include a résumé or curriculum vitae for the compliance officer. The respondent shall also include an organizational chart that specifies which staff are involved in compliance, along with staff levels of authority.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Clear Health supports a culture of ethics and compliance, including continuous improvement through an infrastructure that effectively prevents, detects, and resolves issues of conduct inconsistent with our culture and applicable federal and State laws, regulations, and contractual requirements. As a qualified health plan in Florida and under the Medicaid program, Clear Health maintains an established Florida Compliance Plan. In addition, the national Ethics and Compliance Plan provides national governance and reinforces the principles, policies, and procedures on how employees are required to conduct business and themselves.

Through our Compliance Plan, we:

- Assure compliance of our organization and employees with all federal and State laws, regulations, and regulatory and contractual requirements
- Prevent, detect, and correct overpayments as well as fraud, waste, and abuse (FWA)
- Provide employees with the knowledge and tools to perform their jobs in a compliant manner, identify potential compliance issues, and report suspected or known non-compliance, as well as FWA

Our comprehensive compliance program includes a rigorous program integrity component to identify and protect against both internal and external FWA. Working in tandem with our Compliance team, our special investigations unit (SIU) has an effective program to proactively and reactively identify and investigate suspected fraud and abuse and to help prevent payment of fraudulent, wasteful, or abusive claims.

Clear Health recognizes our responsibility to be a trusted steward of State and federal funds. Reducing improper Medicaid payments is critical to make sure that taxpayer dollars are spent on the health and well-being of our enrollees (members). We consistently demonstrate our commitment to AHCA's goals and expectations. Our compliance program and staff stand ready to continue in their efforts to meet and exceed AHCA requirements.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

We provide the résumé of our Plan Compliance Officer (Compliance Officer), Alison Cardenas, in Attachment SRC# 31-1: Compliance Officer Résumé and an organizational chart of our Compliance team in Attachment SRC# 31-2: Organizational Chart.

In the sections below, we discuss how our compliance program complies with all AHCA, State, and federal requirements; the qualifications of the Florida Compliance team; and our experience identifying subcontractor fraud and internal fraud and abuse.

1. OUR COMPLIANCE PROGRAM COMPLIES WITH ALL STATE AND FEDERAL REQUIREMENTS

Clear Health has a strong, proactive compliance program led by our local Compliance Officer and supported with the extensive resources and best practices of our national Compliance department. Our Florida Compliance team has dedicated resources and maintains a comprehensive repository of all our contractual requirements and commitments. Our Board of Directors (BOD) and Plan President and CEO conduct business in accordance with the Compliance Plan, Anthem's Standards of Ethical Business Conduct, and core values that emphasize compliance, integrity, and accountability.

Our compliance program reflects the guidelines of numerous authority sources, including the Department of Health and Human Services Office of Inspector General, CMS, and industry surveys and best practices, such as the Society of Corporate Compliance and Ethics and the Compliance and Ethics Leadership Council. Clear Health's compliance program meets the elements to demonstrate an effective compliance program, as recommended by the U.S. Sentencing Guidelines. Our Compliance and Anti-Fraud Plans comply with Florida Statutes (FS) 409.91212 and 409.967(2)(g) and 42 CFR 438.608, as well as all other applicable State and federal laws, regulations, and regulatory and contractual requirements. Additionally, our program includes other best practices such as avoidance of delegation of authority to "disqualified" individuals through, for example, new hire background checks and other screening, as well as values and ethics assessments incorporated into performance evaluations. As part of our overall program, we mandate that our employees, as well as subcontractors and providers, conduct business in accordance with our Compliance Plan.

Through the compliance program, we use robust processes and controls to prevent, identify, and mitigate potential risks. Reflective of our core values, we are trustworthy and foster open, honest communication and dialogue across our health plan and with AHCA. Further, we dedicate resources that focus on contract compliance and education, monitoring and oversight, and risk identification and mitigation. Our Florida Compliance team also benefits from oversight, guidance, and sharing of best practices across our affiliate health plans in 19 other markets across the country.

As part of our ultimate parent company's national Medicaid division and subject to the Anthem Ethics and Compliance Plan, Clear Health's Compliance team has ready access to the resources of our national Medicaid Compliance Officer and the Medicaid Compliance Program Services department. Collectively, this team manages Medicaid compliance program initiatives, including effectiveness reviews, standardized risk identification, prioritization and mitigation framework, and overall direction and guidance by sharing best practices with our Florida Compliance Officer and committees.

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Our Compliance Plan complies with Section X.F of Attachment B, Scope of Services and has been approved by the Agency's Medicaid Program Integrity (MPI) unit. We submit our Compliance Plan and Anti-Fraud Plan to the Agency each year, and our most recent submission was on September 1, 2017. If requested, we will submit an updated Compliance Plan to the Agency no later than 45 calendar days prior to implementation of the new SMMC Contract. As required by our existing contract, we maintain current information in the Compliance Plan, including new or revised contract amendment language and State and federal regulations.

1.1. Summary of How Our Compliance Program Meets AHCA Requirements

Our Compliance Plan complies with all applicable federal and State laws, regulations, and guidelines. We review and update the Compliance Plan each year to incorporate new requirements, to confirm alignment with Medicaid regulations, and to incorporate policies and procedures that address risk and assist in the detection and prevention of internal and external FWA. Updates and reviews take place at least annually or more often as required by applicable contractual and legal requirements. Clear Health's BOD reviews and approves the Compliance Plan and Anti-Fraud Plan annually.

Clear Health's Compliance Plan establishes the framework for comprehensive compliance activities to achieve the following 14 objectives:

1. Effectively enable Clear Health and our employees to comply with all applicable legal requirements, and thereby avoid legal and compliance problems
2. Effectively address compliance allegations as they arise
3. Remedy the effects of non-compliance
4. Identify and remove FWA
5. Provide employees, providers, subcontractors, and the public with an official statement of how we conduct business
6. Provide a coordinated reporting structure between impacted parties and regulatory authorities
7. Comply with obligations to AHCA, the Office of Insurance Regulation, and other regulatory agencies
8. Articulate Clear Health's commitment to comply with all applicable federal and State standards
9. Describe compliance expectations as embodied in the standards of conduct
10. Address the operation of the compliance program
11. Provide guidance to employees, contractors, subcontractors, and other applicable entities on dealing with potential compliance issues
12. Identify how to communicate compliance issues to appropriate compliance personnel

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GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

13. Describe how we investigate and resolve potential compliance issues

14. Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program including reporting potential issues; investigating issues; conducting self-evaluations, audits and remedial actions; and reporting to appropriate officials

The Compliance Plan promotes transparency and an open environment of communication that encourages everyone to view compliance as a professional and ethical requirement.

In the following sections, we summarize how our Compliance Plan directly complies with 42 CFR 438.608 including the seven elements of an effective compliance program.

1.1.1. AHCA Requirement: Written policies, procedures, and standards of conduct that articulate a commitment to comply with all applicable federal and State standards

Policies and Procedures. Clear Health maintains a robust library of written standards and policies and procedures that address our regulatory, contractual, and other program requirements. Our Compliance policies and procedures outline our commitment to integrity, ethics, and compliance and provide detail on the specific actions and activities the Compliance team will take to help Clear Health maintain an effective ethics and compliance program. They serve as a primary resource for employee guidance on conducting business activities in an ethical and compliant manner.

Functional Managers throughout the organization develop policies and procedures, and consult with our dedicated Compliance Officer and Regulatory Director, when necessary. These policies play a major role in guiding health plan activities and operations. We review policies and procedures annually, or more frequently based on new laws, regulations, contractual provisions, or compliance guidance. We publish policies and procedures on an internal website accessible to all employees.

Standards of Ethical Business Conduct (the Code). The Code articulates the company's commitment to comply with all applicable laws and regulations while providing guidance on actions, decisions, and operations that help employees safeguard our company's integrity and reputation as ethical and compliant. All Clear Health employees must acknowledge and agree to comply with the Code as a condition of employment. All new employees receive a copy of the Code, and we expect all employees to read and understand their responsibilities. In addition, employees must complete an annual compliance refresher training. The Code is also available on our public website for anyone to view.

1.1.2. AHCA Requirement: The designation of a Compliance Officer and a compliance committee accountable to senior management

Compliance Officer. We maintain a full-time Florida-based Compliance Officer, Alison Cardenas, who partners with health plan leadership to provide extensive and focused engagement on education and training; risk identification and mitigation; and development and oversight of corrective actions. She provides executive-level oversight and works collaboratively across all functional areas to infuse compliance into everything we do.

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Regulatory Director. Our Regulatory Director, Vicky Camero, is our primary liaison with AHCA for day-to-day contract management and oversight issues. Ms. Camero manages submission of all required regulatory reporting and serves as our internal subject matter expert and resource on Clear Health's contractual and regulatory obligations for all of our Florida Medicaid programs.

Florida Medicaid Compliance Committee (Compliance Committee). Chaired by our Compliance Officer, our Compliance Committee reviews compliance activities and oversees the compliance program for our MMA, LTC, and HIV/AIDS specialty plan operations. The Compliance Committee includes executive-level leadership, the Regulatory Director, as well as leaders from multiple functional areas, including Quality, Utilization Management, Case Management, LTC, Operations, Provider Relations, Member Services, Subcontractor Oversight, Finance, and Human Resources. The committee meets monthly and provides a forum to review and discuss emerging issues and upcoming activities, assess potential risks, and provide input into mitigation activities and corrective action plans.

Our Compliance Officer and Compliance Committee promote an integrated approach to assure the integrity and ethical behavior of the health plan.

1.1.3. AHCA Requirement: Effective training and education of the Compliance Officer and employees

Compliance Officer Training. The Compliance Officer receives extensive training at initial hire (or transfer into the position), as well as regular continuing education. Initial training covers a broad range of topics, including review of national compliance structure; compliance operations overview; investigations overview; one-on-one meetings with the national Medicaid Chief Compliance Officer, legal counsel, and national Privacy Officer; risk tracking overview and use of risk tool; marketing oversight; Medicaid compliance effectiveness review; regulatory services overview and partnership; project management and audit support review; enrollment initiative and cost of care overview; and an opportunity for peer interaction.

Monthly national Operational Compliance Committee meetings provide a forum for ongoing compliance education for our Compliance Officer and her counterparts at our affiliate health plans. Recent topics included the impact of the Medicaid Managed Care Final Regulations ("Mega Reg") on our organization and the impact of the Telephone Consumer Protection Act (TCPA) on processes and expectations.

Employee Compliance Training. All employees receive mandatory compliance training within 30 days of hire and annually. The Ethics, Privacy, Information Security and Compliance training program covers the requirements of current laws and regulations and includes topics such as reporting compliance concerns and suspected or actual misconduct; FWA; HIPAA; current risks related to the health care industry; and other aspects of the program, such as the Code, cultural competency, drug-free workplace policies and procedures, the federal Deficit Reduction Act, and any contractually required training. We track and monitor completion of and demonstrated understanding of all required training through our online learning systems. The Compliance team follows up directly with employees to confirm completion.

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In addition, we require all employees to complete the annual online refresher training course on Ethics, Compliance, Privacy, and Fraud and Abuse. This helps reinforce and reaffirm our commitment to fostering an ethical and compliant culture in which the top priority is always to do the right thing. Topics covered include an overview of the Ethics and Compliance Program; channels to report compliance, ethics, privacy, fraud, waste, or abuse concerns, and to ask questions; an overview of relevant policies and procedures; consequences of non-compliance; important related laws and requirements; and the Code.

Each employee confirms course completion and agrees to comply with all guidelines. After the annual refresher training, employees must complete a certification that includes questions regarding exclusion and debarment and previous felony or health care fraud convictions. Any positive response generates follow-up by the Ethics Office and investigation. We document and track training in a learning management system, allowing our Compliance team to verify completion by every employee.

Our Compliance team also conducts focused training sessions, as warranted or if requested by management. If we see trends, such as misconduct in a geographic area or business segment, enforcement, or compliance risks; our Compliance team will provide targeted training.

Continuing Education and Awareness. We conduct additional compliance education and awareness activities throughout the year to reinforce the role of all our employees in fostering a culture of compliance. An annual "Ethics, Compliance, and Privacy Awareness Week" celebration includes activities and information highlighting how employee commitment supports overall success. In addition, our SIU sponsors periodic awareness initiatives that include educational materials and activities to help employees better understand how they can help identify and prevent FWA.

We held our annual celebration from June 5-9, 2017. Our theme was "Empowering Everyone to do the Right Thing" related to ethics, compliance, and privacy. To engage staff, we included educational flyers, giveaway items, and a raffle. Compliance staff were available to meet face-to-face with employees to answer questions. We also gave employees the opportunity to nominate someone they saw "doing the right thing", making a noteworthy, ethical decision.

We also circulate monthly Medicaid bulletins that contain information on compliance and FWA updates and information, including TCPA bulletins.

1.1.4. AHCA Requirement: Effective lines of communication between the Compliance Officer, employees, subcontractors, and the Compliance committee

Awareness. Open lines of communication are essential to the compliance program. We educate all employees on the proper channels to report FWA and any other compliance concerns. Employees may use both internal and external telephone numbers to report FWA anonymously. We promote frequent and accessible interaction between the Compliance Officer and our employees, including town hall meetings, monthly e-mail reminders about compliance programs and instructions for reporting suspected violations, and prominently-placed tip sheets about reporting potential issues (such as through the anonymous hotline). We have two Compliance team members in Tampa and one in Miami, and someone is always available during core business hours. The Compliance team has an open door policy, and is accessible and available to employees in person, phone, or e-mail for questions and guidance on contracts, programs, or

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any other questions or concerns. The Compliance team participates in workgroups and meetings across our health plan, including a twice monthly meeting with the Vendor Delegation Oversight Group (VDOG).

Speaking Up. In our Florida health plan and nationally across our affiliates, we work to establish a culture that empowers employees to “speak up” to identify any potential compliance concerns or issues through multiple reporting avenues. We maintain a strict and highly publicized policy of non-retaliation for any employee who proactively comes forward to identify potential compliance risks or concerns. We publicize policies in many ways, including annual training, and our compliance intranet site.

Ethics and Compliance Hotline. Our national Ethics and Compliance Hotline supports confidential (anonymous as requested) and secure reporting of potential violations by phone or e-mail. All hotline reports are investigated and the Compliance Officer is frequently involved in the investigation of reports impacting the Florida market. Results are communicated to the national Medicaid Chief Compliance Officer.

1.1.5. AHCA Requirement: Enforcement of standards through well-publicized statutory and contractual requirements and related disciplinary guidelines

Information. We inform employees of our compliance standards, statutory and contractual requirements, and related disciplinary guidelines through online news articles/announcements, online training, the Ethics and Compliance Resource Center, screensavers, posters, newsletters, and the Compliance Committee. Employee training includes relevant scenarios and guidance. We explain our expectations to subcontractors during the contracting, pre-delegation, and annual delegation processes. We require subcontractors to have their own compliance program and fraud plan, as well as training programs for their employees and providers. Subcontractors must comply with the provisions of the Medicaid Contract.

Enforcement. Clear Health has a strong commitment to compliance and enforcement of compliance program standards, applicable laws, and regulations. The Code specifies the expectations of employees and subcontractors, as well as disciplinary actions for non-compliance. Any employee approving or participating in actions that violate the Code, the Compliance Plan, company policies, or applicable laws and regulations is subject to corrective action, up to and including termination of employment.

Subcontractors in violation of their contract, the Medicaid program provisions, or Clear Health’s compliance program are subject to corrective action up to and including contract termination. Corrective action depends upon the nature and circumstance of the violation. We consistently enforce discipline for violations through policies and procedures that address disciplinary action for employees and subcontractors who breach compliance and ethics standards. We communicate our expectations clearly and concisely, as outlined in the Code. Ethics and compliance considers factors such as previous investigations of the same or similar misconduct, information from interviews, and input from Human Resources when recommending disciplinary action.

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National Ethics and Compliance Office. The national Ethics and Compliance Office administers and advises employees on the Code, serves as an independent resource to receive and investigate allegations of employee misconduct, provides employees with training on ethics and compliance issues, and maintains high-level oversight of compliance programs across the enterprise.

1.1.6. AHCA Requirement: Provision for internal monitoring and auditing

Our Compliance team regularly monitors and audits any significant compliance issues, areas of operations with inherent compliance risk, and subcontractor performance indicators with remediation plans implemented to address them. Reviews are conducted objectively and routinely by internal and external compliance and audit personnel.

Compliance Program and Work Plan. Our Compliance team maintains the Compliance Plan and Work Plan. The Compliance Committee reviews and approves the work plan each year and receives regular progress updates. The core functions of the work plan track the elements of an effective compliance program: written standards, structured program, training and education, auditing and monitoring, reporting and investigation, enforcement and discipline, and response and prevention. The work plan is also submitted to the National Ethics and Compliance office for review.

Partnership with Internal Audit. Our compliance resources and national Internal Audit department work together to help make sure that master audit plans include key compliance issues and risks for detailed review, evaluation, monitoring, and corrective action as needed.

1.1.7. AHCA Requirement: Provisions for prompt response to detected offenses and for development of corrective action initiatives

Clear Health promptly investigates any reported potential violations and conducts investigations in a confidential, fair, and impartial manner. Our investigation, response, and prevention activities include mechanisms, processes, and resources to report compliance and ethics concerns (such as anonymous hotlines), evaluate suspected non-compliance, and report discovered violations.

Employees can use a variety of methods to ask compliance questions, review concerns, or report suspected misconduct, including a helpline, an email box, or physical mailing address. Reports can be submitted anonymously and Clear Health has a strict non-retaliation policy for compliance concerns reported in good faith. Through the Code and training, we make all employees aware that they must report any suspected misconduct. Members, providers, subcontractors, and others can also report compliance concerns and suspected misconduct.

Issues reported to the national Ethics and Compliance office are typically handled by the Ethics Office, which is primarily responsible for conducting investigations. They involve other areas as needed, such as the SIU, Human Resources, and the local Compliance team. Issues are promptly logged and tracked through to resolution.

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When the local Compliance team learns of any deficiency, whether identified by the Agency, a member, a provider, a subcontractor, or internally; our Compliance Officer, in collaboration with other internal stakeholders and department leaders, immediately logs the issue, investigates the root cause of the problem, and tracks the issue through resolution. An action plan may also be necessary for escalation and to prevent a recurrence.

1.2. Using Tools to Promote Compliance with Contract Requirements

Clear Health is committed to maintaining high performance and compliance with the Agency's expectations and requirements under our current and future Contracts. To augment our program and activities, we maintain a systematic approach to assess, track, and report compliance, using three tools: Compliance Assessment Tool (CAT), Compliance 360, and the Risk and Issues Tracking Tool.

Our Compliance Officer and Regulatory team collaboratively oversee CAT to capture contractual requirements. We load key Contract requirements into CAT and assign each one a senior-level business owner who is responsible for the functional area associated with the requirement. Business owners may designate a team member to respond and must periodically, but at least annually (as determined by the Compliance team), assess our compliance with its assigned contractual requirements.

CAT subsequently automates and tracks communications related to the business owner's compliance assessments and the Compliance team's review of them. CAT generates automatic prompts for business owners to respond within specific time frames. CAT also calculates an assessment score as a combination of compliance and monitoring – the higher the score, the greater the risk. The Compliance Officer receives notification of all responses with a non-compliant status for follow-up and resolution. The CAT process helps us identify any contractual compliance gaps and provides a system of documenting and tracking action plans that addresses these gaps to enable us to continue to meet the requirements and expectations of the Agency.

We use the Compliance 360 application to make sure that we maintain compliance with new or revised regulatory requirements. Whenever there is a new or revised requirement, such as a Contract Amendment, Reporting Manual update, AHCA alert, contract interpretation, policy transmittal, or bulletin; our Florida Regulatory team creates an alert in Compliance 360 and disseminates it to all affected employees and stakeholders who serve as assessors. Assessors evaluate alerts to determine whether the regulatory content affects their unit. If it does, the assessor must list planned tasks to reach compliance and document their completion. Our Compliance Officer monitors timely assessments and task completion. Assistance from a dedicated project management team within the national Medicaid division is available for medium-to large-scope Compliance 360 alerts such as large, cross-functional Contract amendments.

As the Compliance team identifies risks and issues within the organization, they document them in the Risk and Issues Tracking Tool. The Tracking Tool captures descriptions of risks and issues, along with root cause analysis. Risks are stratified and ranked to help determine the appropriate level of oversight and monitoring. Users enter monthly updates. The Tool tracks and trend risks and issues locally and nationally across our affiliate health plans.

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1.3. Clear Health's Anti-Fraud Plan

Our comprehensive approach to fraud, waste, abuse, and overpayments is detailed in our Anti-Fraud Plan, developed with collaboration and support from our SIU. Our Anti-Fraud Plan complies with all federal and State requirements and industry best practices. As a living document, the Anti-Fraud Plan is evaluated and updated at least annually to reflect changes in federal and State regulations, new sources of fraudulent activity, changes in business processes, and best practices.

Clear Health maintains an SIU team staffed with Florida-based employees. We have developed and implemented a FWA prevention program and policy that describe the internal controls to prevent, reduce, detect, investigate, correct, and report suspected and known cases of FWA, in compliance with 42 CFR 438.608 and ss 409.91212, 626.989, and 641.3915 F.S. Our SIU Manager provides reports and updates to the Compliance Committee, and the Compliance Officer maintains unrestricted access to our governing body for compliance reporting, including FWA reporting.

Clear Health will continue to submit our Anti-Fraud Plan to MPI by September 1 of each Contract year, with our most recent submission on September 1, 2017. Our Anti-Fraud Plan addresses all AHCA requirements as specified in Section X.F.4.c. and includes:

- A written description outlining the organizational arrangement of our employees who are responsible for the investigation and reporting of possible overpayment, abuse, or fraud
- A description of our procedures for preventing, detecting, and investigating possible acts of fraud, waste, abuse, and overpayment
- A description of our procedures for the mandatory reporting of possible overpayment, abuse, or fraud to the MPI
- A description of our program and procedures for educating and training employees on how to detect and prevent fraud, abuse, and overpayment, including new hire training within 30 days and annually thereafter; a process to verify that training occurs as required; and inclusion of Deficit Reduction Act requirements in the training curriculum
- The name, address, telephone number, e-mail address, and fax number of the individual responsible for carrying out our Anti-Fraud Plan
- A summary of the results of the investigations of fraud, abuse, or overpayment conducted during the previous year by our SIU

We will continue to build upon the strengths of our current team and the extensive compliance policies already in place. Clear Health will review and submit our Compliance Plan, Anti-Fraud Plan, and FWA policies and procedures or any changes to these items to the MPI Bureau for written approval at least 45 calendar days before we implement any change.

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1.4. Educating and Monitoring Providers and Subcontractors

Training and educating network providers and subcontractors on compliance and FWA is a critical part of our overall compliance program. Clear Health trains providers and their staff regarding the requirements of the SMMC Contract, including Contract amendments. Our provider onboarding, ongoing training, and workshops include specific modules on FWA policies and procedures and the compliance program. In addition, our provider agreements require providers to comply with program integrity requirements and applicable AHCA-approved policies and procedures, including those on FWA and all applicable laws.

Details and education provided to employees, subcontractors and providers include information as required by s. 6032 of the federal Deficit Reduction Act of 2005, including the Federal False Claims Act, the penalties and administrative remedies for submitting false claims and statements, whistleblower protections, the entity's role in preventing and detecting FWA, each person's responsibility for detection and prevention, and the toll-free State telephone numbers for reporting fraud and abuse.

In addition, our provider handbook, distributed at orientation and available on the public portion of our provider portal, includes a section titled "First Line of Defense Against Fraud" that discusses the provider's obligation to prevent, detect, and deter FWA; the importance of these activities; and examples of both provider and member FWA.

Clear Health thoroughly reviews and vets subcontractors during the pre-delegation process. During this process, we advise the subcontractor of Clear Health's expectations, require that they confirm and attest to their understanding of all contractual and operational requirements, and review evidence they provide of their ability to comply. We also review the subcontractor's organization, ownership, and management for sanctions. We confirm that they are eligible to provide services to Medicaid members and comply with the statutory and contractual requirements for ownership and management, including background screenings. The pre-delegation process confirms the existence and compliance of key requirements, including the compliance plan, fraud program, and training programs. Annual subcontractor audits confirm ongoing compliance with contractual requirements.

Our dedicated VDOG team performs ongoing oversight and monitoring of subcontractor performance, including compliance and FWA. The VDOG receives Key Performance Indicators (KPI) and other reports from the subcontractors on a regular basis and reports this information to the Compliance team and the Compliance Committee. The VDOG and Compliance teams use subcontractor data to monitor subcontractor performance and proactively identify compliance or fraud issues. The VDOG's Vendor In-Service and Handbook, both deploying in January 2018, will include discussions of subcontractor responsibilities related to compliance and FWA. The VDOG also monitors subcontractor submission of a quarterly attestation that they are identifying, monitoring, and reporting FWA.

2. QUALIFIED INDIVIDUAL TO EFFECTIVELY MAINTAIN THE COMPLIANCE PROGRAM

Our Compliance Officer, Alison Cardenas, is responsible for implementation and daily oversight of our Florida compliance program, with local oversight from our multidisciplinary Florida Compliance Committee. Ms. Cardenas has unrestricted access to our governing body for compliance reporting.

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Our Compliance Officer, the Compliance team, and the Florida Compliance Committee maintain day-to-day responsibility for our compliance program and our internal and external FWA monitoring. Our Compliance Officer serves as the organization's compliance and FWA authority with the ultimate oversight responsibility for carrying out the provisions of the plan.

We provide a résumé of our Compliance Officer in Attachment SRC# 31-1: Compliance Officer Résumé and an organization chart of our Compliance team in Attachment SRC# 31-2: Organizational Chart.

2.1. Compliance Officer Qualifications

Clear Health's Compliance Officer, Alison Cardenas, is responsible for day-to-day operations, oversight of our compliance program, and ensuring compliance with the laws, regulations, and policies that govern the Medicaid business. Ms. Cardenas is a full-time employee based in our Miami office and is 100 percent dedicated to SMMC.

Ms. Cardenas has more than 17 years of managed care plan experience in Florida, with 13 years in compliance with a focus on government contracts. She has served in regulatory and compliance roles for Florida MCOs and dental health plans. In addition, in her client services roles with DentaQuest, she worked directly with many of the major MCOs as well as AHCA and Florida Healthy Kids.

Ms. Cardenas started with Clear Health in 2012 as the Senior Manager of Medicaid Compliance and then became the Director of Medicaid Compliance. In 2015, Ms. Cardenas served as a Regulatory Manager and then became the full-time Compliance Officer in 2016.

Ms. Cardenas brings a deep understanding of Medicaid medical and dental services in Florida, and also has experience with Medicare and CHIP programs. Her operational knowledge, years of managed care experience, and significant regulatory and compliance experience fully support our organization and adherence to all State, federal, and contractual compliance requirements.

Ms. Cardenas has direct access to Clear Health's Plan President and CEO, CFO, and COO, as well as our national Medicaid Chief Compliance Officer, Chief Compliance Officer, and other compliance resources that help support Florida's compliance program and initiatives. Ms. Cardenas reports to the Florida Plan President and CEO and BOD indirectly, and reports directly to the Medicaid Chief Compliance Officer (also based in Florida). She maintains regular communication with all parties.

Ms. Cardenas chairs the Florida Compliance committee. The committee meets monthly and as needed to oversee the compliance program and includes the Plan President and CEO, the executive team, other department managers, and managers from national support services departments. As our Compliance Officer, Ms. Cardenas' primary responsibilities include:

- Confirming maintenance of policies, procedures, and standards of conduct that articulate Clear Health's commitment to comply with federal and State requirements
- Chairing, organizing, and maintaining the Compliance Committee

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- Coordinating resources and developing training programs to make sure all employees, Board members, subcontractors, and providers understand and comply with all applicable standards and requirements
- Conducting internal monitoring and audits, and participating in investigations involving violations of law or policy
- Making sure standards are well publicized and enforced
- Implementing internal and external corrective action plans
- Confirming compliance with Medicaid non-discrimination requirements
- Overseeing and collaborating with the SIU Manager in the design, implementation, and oversight of Clear Health's FWA program

2.2. Reporting Relationships

Our Compliance Officer reports dually to the Clear Health Plan President and CEO (indirectly) and our national Medicaid Chief Compliance Officer (directly) in the national Ethics and Compliance Office. Our Compliance Officer has the authority and reporting relationships to effectively implement our compliance program, and our Plan President and CEO is ultimately responsible for compliance. Our Compliance Officer, Regulatory Director and Plan President and CEO have a standing meeting, every other week to discuss Compliance issues. Our Compliance Officer is accountable for reporting FWA to the national Medicaid Chief Compliance Officer and appropriate State agencies, and making sure that employees cooperate fully with State and federal FWA investigations.

The dual reporting relationship provides accountability to our Florida leadership and to our national compliance leadership; facilitates coordination with the Ethics and Compliance Office to support ethics and compliance initiatives; and enhances communication between local senior management and national leadership regarding changes in State and federal regulations as they affect the scope and content of the national Ethics and Compliance Plan.

The Compliance Officer has primary accountability for maintaining oversight of day-to-day compliance and ethics activities for Clear Health. The Compliance Officer is also responsible for working with executives and functional areas to identify and assist in the mitigation of potential risks. She consults, advises, and implements initiatives for tracking and reporting risks; facilitates audit coordination and responses; monitors the implementation and effectiveness of integrity programs; and coordinates and assures timely responses to regulatory amendments and changes. The Compliance Officer is involved in program integrity operations and compliance with all Florida and federal requirements pertaining to FWA and overpayments.

Our Compliance Officer participates in multiple committees, reinforcing our organizational commitment to compliance, including the Quality Management, Health Plan Oversight, VDOG, Compliance and national Operational Compliance Committees.

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3. SUFFICIENT STAFF TO IMPLEMENT THE COMPLIANCE PROGRAM

We continually monitor the size, capacity, and performance of the team to verify that we continue to meet all department deliverables and will expand the staff as necessary under the new Contract. Currently, we have 16 full-time employees dedicated to supporting our Florida compliance program, with additional staff providing support. Employees fall into three main groups: compliance, regulatory, and SIU. Attachment SRC# 31-2: Organizational Chart illustrates the staff supporting our compliance program.

3.1. Compliance Staff

The Compliance Officer has two full-time Florida-based employees to provide support: the Compliance Manager and the Compliance Program Administrator. Together, the Compliance team supports our MMA, LTC, Comprehensive, and HIV/AIDS specialty plan contracts.

The Compliance Manager monitors and oversees all contractual requirements. Working with designated business owners, she reviews policies and procedures, operational guidelines, and other relevant documentation to verify alignment with our customer contracts. The Compliance Manager regularly monitors compliance through one-on-one observation with employees and desktop quality review of related documentation. This includes monitoring Contract compliance through CAT and Compliance 360.

The Compliance Program Administrator is responsible for the administrative functions of the Compliance team, which includes recording and producing all meeting minutes; tracking all training requirements; collaborating with Records Management to track all off-site document storage; and performing field audits and retrospective review of community outreach activities. The administrator also develops employee communications in collaboration with our SIU and Privacy Unit teams, including emails to reinforce HIPAA and FWA compliance. The administrator also oversees the annual review process for all Florida Operational Guidelines in support of both national and local policies and procedures.

The Florida Compliance Committee addresses compliance issues, remediation initiatives, and compliance-related risk management concerns for our MMA, LTC, and HIV/AIDS specialty plan operations. The committee includes leadership and representation across functional areas, including Compliance (local and national), Regulatory, Quality, Utilization Management, Case Management, LTC, SIU, Provider Relations, Member Services, Subcontractor Oversight, Finance, and Human Resources. The Compliance Committee also serves as a forum for the discussion of potential risk, control, and compliance issues related to health plan operations, including monitoring of action plans; completion of internal and external audit deficiencies and recommendations; and current activities in the market and legislation, including timely response to new and emerging State and federal legislation. The Plan President and CEO serves as the Executive Director of the Compliance Committee, and the Compliance Officer chairs the committee. The committee meets monthly or more frequently if necessary.

During Compliance Committee meetings, the Compliance Officer always reiterates that we foster a proactive culture centered in trust and accountability and we all share the responsibility of reporting possible violations of law, regulations, the Compliance Plan, the Code, and policies and procedures. Clear Health employees are encouraged and empowered to ask questions and report any concerns.

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3.2. Regulatory Staff

There are six full-time Florida-based employees who support the regulatory aspects of our compliance program. The Regulatory Director and Regulatory Oversight Manager oversee the regulatory implementation and compliance of our SMMC operations. Regulatory employees are the primary liaison with the Agency and facilitate communications between our local operation and the Agency on meeting contractual obligations and deliverables. They are the subject matter experts and provide education and support on our Contract, as well as rules and regulations governing our operations and AHCA expectations. They also coordinate delivery of AHCA deliverables, ensuring timely, accurate, and complete submissions of reports and data files.

Regulatory staff serve as Contract Managers for the MMA, LTC, Comprehensive, and HIV/AIDS specialty plan contracts, overseeing operational compliance and serving as the primary point of contact for State communication. Regulatory staff are responsible for: 1) communicating all contract requirements and new amendments; 2) training and communication about existing and new State and Federal regulations that impact the contract (such as the Federal Mega Reg); 3) confirming implementation of required processes and procedures for operational compliance; 4) delivering timely and compliant Agency reports and ad hoc requests; and 5) filing required Health Care Provider Certificate renewals with AHCA.

3.3. Special Investigation Unit Staff

We have seven full-time employees supporting our statewide FWA efforts, with five located in Florida. This team includes five dedicated SIU Investigators (four in Florida), an Investigative Assistant, and a Certified Professional Coder. The team receives support from the SIU Manager, three Data Analysts, and a Regulatory Compliance Consultant.

Our SIU Investigators work closely with the Compliance team and other departments. The Investigators conduct in-depth investigations of suspected fraud and promote compliance with all contractual requirements related to FWA and the SIU's investigations. Our Investigators understand the unique Florida market conditions and trends, have proximity to relevant State employees to develop relationships and share information, and can easily access Clear Health employees.

Our SIU staff bring nearly 100 cumulative years of investigative experience. Our investigators are retired FBI and Medicaid Fraud Control Unit agents who work alongside others who have experience in the health care industry with MCOs or government contractors. The investigative team holds professional designations with the National Healthcare Anti Fraud Association (NHCAA) and the Association of Certified Fraud Examiners (ACFE), and are Certified Professional Coders (CPC).

The Florida SIU meets with the MPI quarterly, with interim meetings as needed (approximately six meetings annually). The SIU participates at national conferences hosted by NHCAA and the National Association of Medicaid Program Integrity (NAMPI). The SIU also attends local meetings such as the newly formed Central Florida Healthcare Fraud Workgroup that the Central Region FBI sponsors.

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The SIU stays current with industry schemes and issues and contributes to national initiatives, such as the Federal Healthcare Fraud Prevention Partnership and the NHCAA. The SIU interacts regularly with Florida regulators and law enforcement, participating in or hosting task forces with various law enforcement and prosecuting agencies. Our Florida SIU shares information with our national Medicaid, commercial, and Medicare SIUs. This sharing of schemes and investigative techniques provides our Florida SIU with a valuable and constant supply of best practices and lessons learned from across the country.

4. EXPERIENCE IDENTIFYING SUBCONTRACTOR FRAUD AND INTERNAL FRAUD AND ABUSE IN MANAGED CARE PROGRAMS

Clear Health's compliance program includes comprehensive processes and controls to prevent, deter, and identify subcontractor and internal fraud and abuse.

4.1. Oversight of Subcontractors and Identification of Fraud

Clear Health's subcontractor selection and oversight process has controls to confirm the delivery of services to our Medicaid membership and avoid fraud. Controls begin during the contracting process and continue with regular oversight and monitoring. Activities include audits, checks for debarred or excluded individuals, and SIU investigations of potential fraud. We provide information on these activities in the sections below.

4.1.1. Contracting

Our contracting process has checks and balances to identify or help to eliminate the potential for fraud at its various stages. Clear Health's legal counsel thoroughly reviews subcontractor agreements to ensure compliance with the provisions of the Medicaid Contract, and the inclusion of required language. We hold subcontractors to the same standards that we are, including allowing us and the State access to their records and facilities for audits. During this phase, the review includes details of the subcontractor's organization, ownership, and management and the validity of their Medicaid identification and NPI numbers. Compliance and Regulatory may be involved in the review of the subcontractor agreement. Regulatory informs the Agency and submits the agreement for review as required.

4.1.2. Pre-delegation and Annual Audits

Each potential subcontractor undergoes a pre-delegation assessment and documentation review to determine ability to perform the required functions. Standardized audit tools support subcontractor evaluation prior to delegation and annually thereafter. In addition to addressing the departmental functions to be delegated, audit tools are specific to functional area and product, and include contractual, federal, State, regulatory, and accreditation standards. Risks and evidence of non-compliance or fraud (such as false statements or falsification of information) can be identified during this stage. Depending on the severity of risks or issues that arise during pre-delegation, the subcontractor may be placed on an action plan or implementation may be delayed. The audit team reports actions and delays to the VDOG and Compliance teams for tracking.

The subcontractor review process involves a team of employees. Recommendations and actions are reviewed and double-checked to avoid mistakes, bias, or employee fraud.

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4.1.3. Debarred or Excluded Individuals

Clear Health requires subcontractors to attest that they do not knowingly employ or contract with individuals or entities who are debarred or excluded from any federal health care program or who have been convicted of a crime related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs. Subcontractors must also check their own staff, subcontractors, and providers against the federal lists/databases as well as the Agency's listing of suspended, terminated, or ineligible providers. Clear Health also executes these checks when we engage a new subcontractor to confirm we do not contract with an entity that is in nonpayment status or is excluded from participation in federal health programs.

Monitoring and Reporting. Clear Health monitors subcontractor performance on an ongoing basis, including financial statements, claims and encounter data, KPI reports, and other data, where applicable. Any anomalies identified during these reviews prompt further investigation. Should the investigation identify potential fraud and abuse, we notify AHCA, DHHS OIG, and/or MIPI as appropriate. If we determine actual fraud, waste, and/or abuse occurred, we take immediate action, up to and including termination of the subcontractor.

As part of the ongoing oversight process and as required by the Contract, Clear Health requires subcontractors to disclose convictions of criminal offense, changes to owners and management, and actions taken against the subcontractor's organization or its leadership. The VDOG gathers and reports these infractions to the Compliance office for reporting to AHCA, DHHS OIG, and/or MPI.

4.1.4. SIU Review

The SIU receives and investigates all potential cases of fraud, regardless of their referral source (employees, subcontractors, members, providers, or data analysis). The SIU will continue to send a notification to MPI within 15 calendar days of receiving information about suspected fraud, waste, and overpayment and initiate investigation. If the investigative team finds evidence of possible subcontractor fraud or abuse, the case, along with documented findings, is referred to MPI and notification sent to Compliance, Regulatory, and the VDOG.

If a breach of contract, cessation of business functions, loss of required license/certification, or endangerment of members occurs, we will activate the Contingency Plan to de-delegate or terminate the subcontractor's agreement. Severe non-compliance or evidence of any fraud will lead to a cessation of the contracting process and appropriate reporting to external entities as necessary.

4.2. Identifying Internal Fraud, Waste, or Abuse

Clear Health's robust compliance program, provides a guide to ethical decision-making, covering issues that may arise with employees, providers, members, subcontractors, competitors, and the public. We mandate that all employees to read the Code and understand how it applies to their day-to-day decisions, including their responsibility to report suspected violations and to cooperate in company investigations. We take all reports seriously, and any retaliation for good faith reporting is strictly prohibited.

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GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Our compliance program helps us avoid and identify fraud within our organization. Ethics and compliance concerns may include conflicts of interest; employee dishonesty (such as intentionally falsifying expense reimbursement requests or production reports); improper disclosure/receipt of confidential or proprietary information; inappropriate access/disclosure of PHI; accepting/offering gifts or entertainment over limits; retaliation for reporting an ethical or compliance issue; accounting, auditing, or internal control irregularities; and not maintaining adequate clinical licensing.

We deter, prevent, and identify internal fraud and abuse through processes and controls embedded in our Compliance Plan that align with the seven elements of an effective compliance program, including the following:

- A strong Compliance Plan, the Code, and written standards, policies and procedures help employees understand Clear Health's ethics and compliance expectations. Employees know what they are expected to do, what they should not do, how to report suspected fraud or misconduct, and the repercussions of engaging in non-compliant activities.
- The visible presence of our local Florida Compliance team reinforces the culture of compliance and the team's open door policy gives employees direct access to ask questions and receive guidance and education. The Compliance team works with the national Ethics and Compliance department on risk identification and mitigation as well as investigation of reports of employee fraud or misconduct.
- Regular training and ongoing education reinforce the messaging. Trainings also provide specific interactive scenarios with real life examples of employee fraud to educate and discourage engagement in non-compliant activities.
- The Compliance Committee provides an excellent venue for ongoing reinforcement of the compliance program and Code expectations. Committee members share information across the organization, including their direct reports and subcontractors.
- Numerous online and written resources are available to employees related to statutory and contractual requirements, as well as disciplinary guidelines. We enforce standards promptly and consistently.
- Regular monitoring and auditing by internal and external audit and compliance personnel provide avenues for identification of potential internal fraud.
- Detected offenses are reported to the appropriate entities, including local authorities, AHCA, DHHS OIG, and MPI. We develop internal action plans in response to offenses to mitigate and prevent reoccurrence.

Effective internal controls are a significant part of Clear Health's efforts to deter internal fraud. A few examples include documentation requirements, segregation of certain responsibilities, tracking system changes, passwords/access codes, monitoring subcontractor relationships, mandatory conflict of interest disclosure, marketing oversight, prohibitions on excluded persons, and procurement integrity. We monitor these efforts regularly and escalate any potential concerns for further review. For example, if we notice that a specific employee is making more changes to claims records than his/her peers, we investigate to determine the root cause. It could be for valid

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

reasons, such as a recent configuration time and the need to reprocess previously paid claims. However, if the changes are not valid and could be due to fraud and abuse, we would take immediate action including, and up to, termination of employment.

4.3. Examples of our Program in Action

We provide two recent examples of our program in action.

Dental Provider. Identified through data analysis, the SIU investigated a dental provider for improperly billing millions of dollars against the dental and medical benefits (dental surgical procedures – extractions). The SIU submitted a referral to the State and recommended termination. The SIU worked closely with the dental subcontractor's SIU, dental surgery experts, and our Medical Directors throughout the investigation.

Behavioral Health Provider. The SIU is currently investigating a behavioral health provider referred to the State for services not rendered. Analysis of utilization reports identified the provider as submitting nearly \$1 million in claims for school-based behavioral therapy services (H2017 and H2019). The investigation was initiated after complaints for services not rendered were filed with the SIU through the hotline. The allegation was substantiated through member interviews and preliminary medical records review. Currently, the provider is not fully complying with the record review (not submitting the required parent consent forms) and was placed on 100 percent pre-payment review.

Coordination is key to everything we do at Clear Health and this includes how we combat FWA across all lines of business and all aspects of our organization. When we identify a potential FWA trend or case in our Medicaid operations, we also check Medicare and commercial lines of business across our affiliates as well, and vice versa. Our national SIU also monitors emerging industry trends and provides that information to our Florida SIU. By casting a wider net, we can identify and address emerging issues earlier and take preventive measures to protect all our members.

Our Florida SIU staff continues to expand and so does our complement of technology tools, methodologies (provider self-audits, pre-payment reviews, and field audits), and partnerships with the State and other MCOs. The Florida SIU operation is growing and poised to identify and respond to growing concerns and issues related to Medicaid oversight.

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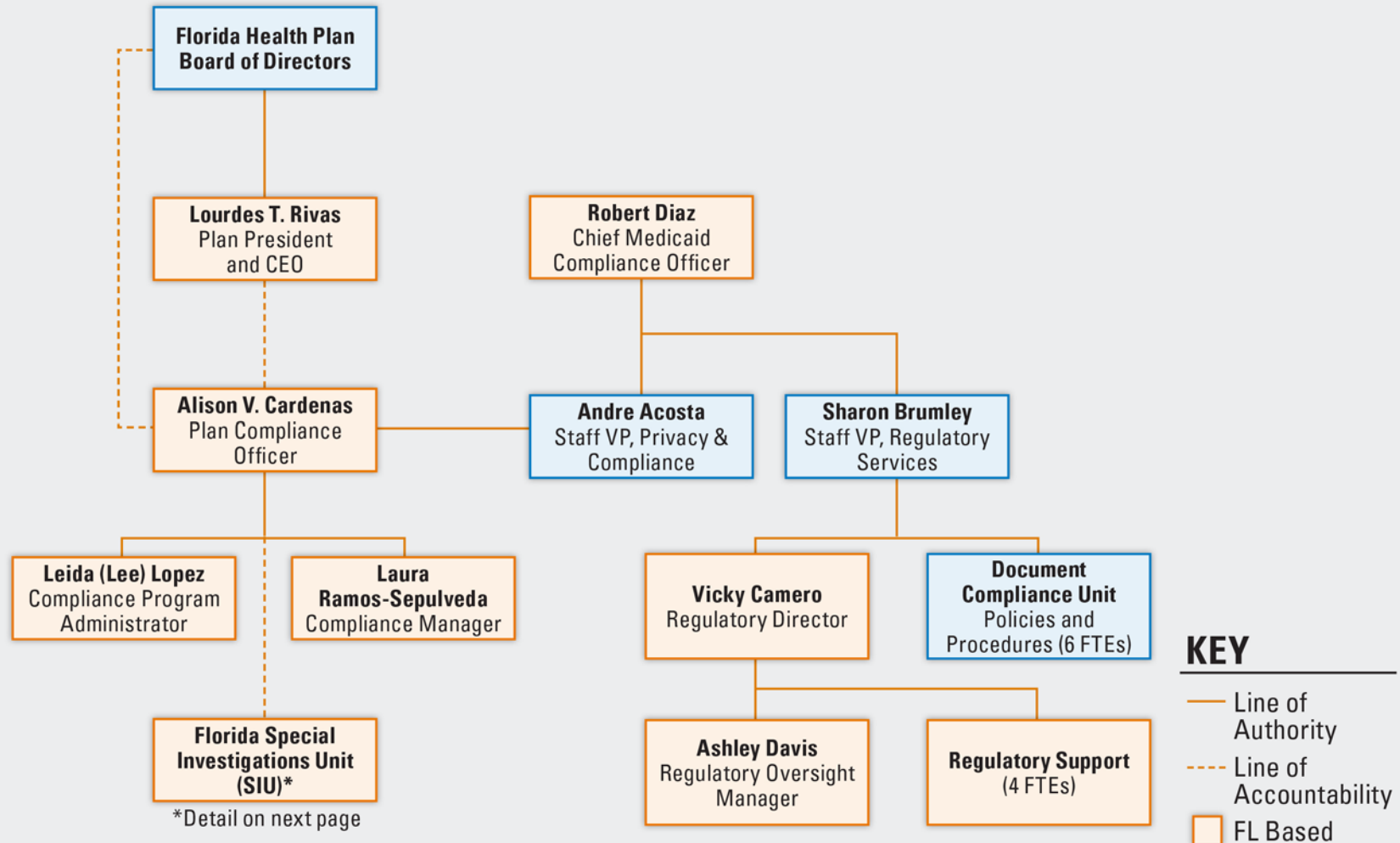
Evaluation Criteria:

1. The extent to which the respondent's compliance program complies with all State and federal requirements.
2. The extent to which the respondent has identified a qualified individual with sufficient authority and adequate corporate governance reporting relationships to effectively implement and maintain the compliance program.
3. The extent to which there are sufficient staff to implement the compliance program.
4. The extent to which the respondent's compliance program has experience identifying subcontractor fraud and internal fraud and abuse in managed care programs.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

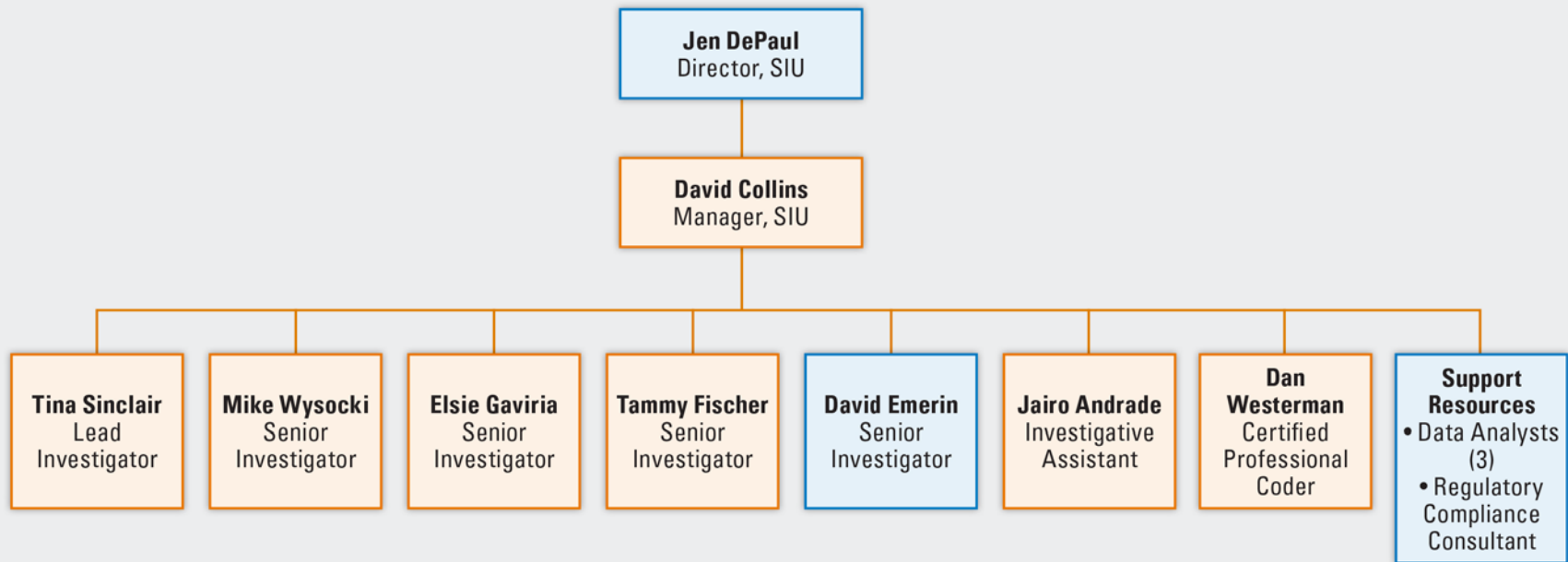
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Compliance Organization



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Florida Special Investigation Unit



KEY

 FL Based

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GENERAL SUBMISSION REQUIREMENTS
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SRC# 32 – Fraud and Abuse Special Investigations Unit (SIU) (Statewide):

The respondent shall describe its Special Investigations Unit (SIU) program and its controls for prevention and detection of potential or suspected fraud and abuse and overpayment, including the use of biometric or other technology to ensure that services are provided to the correct enrollee, including verification of home-based visits and services, to ensure those services are being appropriately provided and that services billed were received by the correct enrollee.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Clear Health recognizes the importance of preventing and investigating fraud, waste, and abuse (FWA). We are committed to protecting and preserving the integrity and availability of health care resources for our enrollees (members) and business partners by maintaining a comprehensive fraud detection program. The responsibility for the Florida fraud detection program and Anti-fraud Plan is delegated to the Special Investigations Unit (SIU) whose mission it is to combat FWA and misrepresentation perpetrated against Clear Health and the Medicaid program in Florida.

In addition to the considerable efforts of the Florida SIU team to combat FWA, our national Program Integrity team works to make sure proper payments are being made to legitimate providers for reasonable services provided to eligible members and to combat Medicaid provider FWA, which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid members. The Program Integrity team uses advanced analytics and strong enterprise governance to detect FWA.

Clear Health's comprehensive program integrity approach incorporates dedicated staff and empowers them with an integrated system of activities, processes, and controls that involve virtually every department of Clear Health's Florida operations and our national shared services team.

Special Investigations is a unique and critical part of program integrity, as it has specific resources dedicated to several key markets, including Florida. The local presence increases the effectiveness of our efforts to prevent, detect, and investigate FWA. The professional capabilities among the SIU associates are varied and diverse; experiences include retired law enforcement professionals (e.g., FBI, military, state, local, etc.), certified professional coders, claims processors, provider network, nursing, and pharmacy fraud investigations.

The Florida SIU has made two new additions to the team this year. We now have seven full-time employees for Florida to support statewide FWA efforts. This team includes five dedicated SIU Investigators (four located in Florida), an Investigative Assistant, and a Certified Professional Coder. Full-time employees receive support from the SIU Manager, three Data Analysts, and a

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Regulatory Compliance Consultant. Our growing team focuses on cultivating and growing our collaborative relationship so that we can continue meeting the Agency for Health Care Administration's (the Agency or AHCA) expectations, requirements, and standards. We have a diverse team of highly trained and experienced individuals managing program integrity at the national level to support Florida.

From July 2016 through June of 2017, the Florida SIU opened 134 cases and 89 leads with savings that totaled more than \$7 million — attributable to program recoveries, provider education, interventions to change billing behavior, and prepayment reviews.

We are proud of our long tenure as a trusted AHCA partner as well as the experience and relationships our affiliate health plans have developed with Medicaid agencies in 19 other markets over the past 26 years. Together with our affiliate health plans, we currently serve more than 6.5 million members enrolled in Medicaid and other state-sponsored programs. Our combined national and local plan Medicaid FWA experience positions us well to continue meeting all of AHCA's program integrity requirements.

We will continue to deliver superior value by combining quality health care with financial predictability. We understand that the increasingly complex Medicaid marketplace and interconnected programs require diligent monitoring and oversight to maintain program integrity, and we have the comprehensive systems in place to prevent, detect, and correct unnecessary or wasteful practices and fraudulent activities. We pride ourselves on being a good steward of public funds and working collaboratively with AHCA to assure that the public dollars entrusted to us are properly spent. We have extensive experience implementing program integrity initiatives and processes, and we will build on the best practices we are currently using in Florida. Program integrity objectives are as follows:

- Identification and implementation of system and oversight activities to reduce instances of fraudulent activities
- Increased use of advanced data analytics to expand detection capabilities across a broader spectrum of clinical services
- Deployment of improved operational performance and metrics aimed at optimizing savings for AHCA
- Combatting the diversion of funds that could otherwise be spent on or applied to safeguarding the health and welfare of our members

As illustrated in Table 32-1 of Attachment SRC# 32-1: Program Integrity Structure, our national organization's program integrity activities and responsibilities cross many functional areas with multiple departments working in collaboration, including:

- Program Integrity Strategy and Planning
- Claims Payment Integrity
- Reimbursement Policy Management
- Provider Education
- Subrogation
- Clinical Reimbursement Programs

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- Health Plan Services
- Program Integrity Analytics
- Special Investigations Unit
- Pharmacy
- Health Plan
- Long Term Services and Supports Unit

We review and update our comprehensive Florida Special Investigations Unit Antifraud Plan annually or more frequently as necessary to prevent, detect, and correct FWA. This plan will continue to include our current best practices used in Florida to monitor members and providers. We will continue to notify AHCA promptly of all potential cases of FWA and provide timely updates when any allegations are authenticated. Our SIU brings up issues and trends with AHCA in the quarterly face-to-face meetings and will continue to deploy a wide range of proven strategies and tactics that stretch from “feet on the ground” local insight to industry-leading, high-tech systems and analyses to combat FWA. Monthly analysis using our claims activity dashboard supports the generation and verification of leads related to potential provider FWA.

Overview of FWA Procedures and Examples

Our local and national staff employ a variety of program integrity tools and processes to make sure services provided to our members are effective, efficient, and safe and to make sure that payments are to legitimate providers for reasonable services to eligible members. Processes focus on avoiding and detecting FWA, encouraging reporting, investigating allegations, and implementing corrective actions. Our FWA tools and processes enable us to monitor for the following examples of provider and member fraud:

- Billing for services or goods not actually provided or for medically unnecessary services
- Billing of services under another member identification number
- Billing under another provider’s license number
- Unbundling tests, double billing, or upcoding
- Misrepresenting diagnoses, tests, provider qualifications, and/or treatments to increase reimbursement
- Soliciting, offering, or receiving kickbacks or bribes
- Failing to meet professionally recognized health care standards
- Falsifying certificates of medical necessity, plans of treatment, and medical records to justify payment
- Violating Medicaid policies, procedures, rules, regulations, and/or statutes
- Ping-ponging patients (referral of patients to other providers within the same medical group so they may benefit financially)

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- Splitting billing over a period of days (separate billings for services rendered on the same day, billed on different days, with some charges duplicated on each billing)

Examples of member fraud:

- Excessively using or overusing Medicaid
- Using another's Medicaid identification card (ID)
- Lending, altering, or duplicating a Medicaid ID
- Providing incorrect eligibility or false information to a provider to obtain treatment
- Simultaneously receiving benefits in Florida and another state
- Knowingly assisting providers in rendering services to defraud the Medicaid program
- Committing Prescription fraud

We will continue to make sure that the services provided to our members are effective and efficient and that payments are made to legitimate providers for reasonable services provided to eligible members. Our experienced Florida staff will also continue to use a variety of tools and processes to promptly investigate reports of suspected FWA by employees, subcontractors, providers, members, and others with whom we conduct business.

We protect against FWA in all we do and reinforce our commitment to prevention in new hire and annual employee trainings, focused Fraud Prevention Week initiatives, provider orientations, member handbook, and well-publicized reporting channels, such as our hotline and website. Our employee, subcontractor, and provider training and education programs address FWA signs and methods to report suspected concerns and are reinforced with monthly tips on how to identify and report FWA. Our robust FWA program complies with all applicable laws. The program includes initiatives, policies, systems, and best practices directed at FWA prevention and detection. Our Florida SIU Antifraud Plan and Compliance Plan (reviewed and updated at least annually) contain comprehensive information on our processes that guide our activities.

1. CONTROLS AND AUTOMATED METHODS TO PREVENT FWA AND OVERPAYMENT

With our extensive experience in Florida implementing program integrity initiatives and processes, we continuously gather best practices and refine our internal controls. We have refined systems and oversight activities to identify, reduce, review, recover, and report instances of fraudulent activities. Advanced data analytics and detection capabilities are established for all clinical services types. We have deployed operational performance and metrics to optimize savings across Florida. We require comprehensive annual training, which educates our employees to be on the lookout for FWA. All of these best practices combat the diversion of funds that could otherwise be applied to safeguarding the health and welfare of our members.

We conduct clinical reviews through prior authorization of select services and point-of dispensing reviews at network pharmacies and during Managed Care Coordinator contacts with members enrolled in Case Management. We refer suspected FWA to our national SIU and the Florida Compliance Officer for investigation.

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Our prior authorization process requires Utilization Management employees to comprehensively and continuously review case records and assess member needs. Managed Care Coordinators confirm member's receipt of services as authorized in the member's care plan during contact with the member, family members, or the member's representative. We conduct retrospective clinical reviews during the claims review.

1.1. Controls and Automated Approaches to Prevent and Detect Fraud

Clear Health deploys both proactive (pre-payment and prevention) and reactive (post-payment) detection methods and internal controls, including:

- Systems and oversight activities to identify, reduce, review, recover, and report fraud
- Advanced data analytics and detection capabilities across all clinical services types
- Announced and/or unannounced onsite visits to provider location(s)
- Member interviews by telephone or in-person
- Operational performance and metrics deployment to optimize savings for AHCA

Internal controls drive our program's philosophy of prevention. Pre-payment review is highly effective and efficient since it avoids suspect claim payments rather than attempting to recoup inappropriate payments. In our experience, these upstream activities account for roughly three times the savings of downstream post-payment recoveries.

Our primary tools for detecting anomalous behaviors are coding software, FWA analytics, and our internal, proprietary health care analytics. Mining claims data is the primary way investigators detect and deter FWA. Coding software and data analyses (such as exploratory, confirmatory, and predictive analytics) drive decisions in reviewing atypical provider behaviors. The SIU — staffed with coders and clinicians who review providers for miscoding concerns such as up-coding, unbundling, and billing for services not delivered — can recommend them for pre-payment review. Predictive modeling tools can analyze provider claims and billing practices against their peers and detect instances not specifically restricted to CPT codes.

In addition to pre-payment review, we use prevention tools, including:

- McKesson ClaimsXten, which automatically and comprehensively audits codes, identifying the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology, and anesthesiology procedures identified by CPT®-4 and HCPCS codes
- The Policy Administration Model, which addresses claims editing based on national reimbursement policies and national coding standards not currently available in ClaimsXten
- Cotiviti, which validates services across providers, taking claim modifiers and specialties into consideration, as well as how often the service can be performed
- FICO Insurance Fraud Manager, which is a pre- and post-payment predictive model that scores claims and providers for the likelihood of fraud, abuse, and the level of financial risk
- Credentialing and Provider Profiling, which includes review of the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), the Federal LEIE, System for Award Management (SAM) Excluded Parties List, license verification, and billing history check for fraud.

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Our Health Care Analytics team has developed benchmarking metrics for certain specialties that are used in our pre- and post-payment programs. Monthly analysis using our claims activity dashboard supports the generation and verification of leads related to potential provider FWA. The dashboard displays a rolling 13 months of data and supports sorting, filtering, and drill-down analysis on a number of elements, including county or city, provider tax ID, and top procedure codes. The ability to show a summary of billing history for a provider, including change from last month and peer comparison is a key strategy to detect and prevent provider FWA

- Quality Control and Utilization Management using information from our Utilization, Quality, and Case Management departments on member and provider over- and under-utilization is reviewed and analyzed

1.2. Additional Internal FWA Controls Outside of the SIU

Other programs and departments outside of the SIU that contribute to FWA prevention and/or collaborate with Program Integrity include: provider oversight, credentialing, medical management, member oversight, and restricted recipient programs. Clear Health screens the eligibility of our providers, and we require our subcontractors to screen their providers.

1.2.1. Provider Oversight

Contractually, participating providers must obey federal and state laws and permit our company, state, and/or federal staff to review records pertaining to members.

1.2.2. Credentialing

The Credentialing area is responsible for checking all sanction listings as well as board certifications concerning the suspension/loss/probation of provider professional licenses. In addition to federal sanctions databases in Florida, we also check AHCA Ineligible lists and the state's Provider Master List to make sure of Medicaid eligibility. SIU associates must work closely with Credentialing associates when investigating a provider and give advice to the credentialing area when issues affecting a provider's continued participation are discovered. Provider manuals include a section on requirements for physicians to notify our company of any event that changes their credentialing statutes (for example, loss of licensure or sanction).

1.2.3. Medical Management

Medical Management associates collect patient information during the prior-authorization process and identify situations that may be FWA (for example, request for authorization of an outpatient service for a member currently inpatient or request for authorization of a service not medically appropriate for the patient's condition). These associates regularly review utilization reports, including pharmacy reports, to identify any unusual patterns of utilization that may indicate FWA (for example, use of high cost pharmaceuticals medically inappropriate for the member's condition or billing for more inpatient days than authorized).

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1.2.4. Member Oversight

Member oversight occurs through the following methods:

- Member ID cards have member identifying information
- Medicaid member ID contains the phrase “Use of this card by any person other than the member is fraud”
- Primary Care Providers (PCP) receive monthly lists of the members assigned to them
- Our company provider manual urges providers to check the member ID card and call the Provider Services toll free number to confirm the member is enrolled
- Member Services, Nurse help line, and Medical Management associates verify member eligibility every time a member calls
- Medical Management obtains patient information during the pre-authorization process and identifies situations that may be FWA
- Medical Management associates obtain information during case management activities
- Fraud detection and prevention information is provided to members and providers through provider newsletters and educational updates

1.2.5. Pharmacy Restriction Program

Clear Health maintains a Pharmacy Restriction Program to identify members who demonstrate patterns of FWA that often result in unnecessary ED visits and doctor shopping. Once identified, we review the member’s case to make sure placement in the lock-in program is appropriate. If appropriate, we assign the member to a single pharmacy for filling all prescriptions for the following 12 months. We also notify the member, the member’s PCP, and the pharmacy we restricted the member to, and we encourage the member to enroll in our Substance Use Disorder Program, if indicated. Certain members, such as members with cancer and dual eligibles, are never enrolled.

By restricting members identified as potentially misusing or fraudulently obtaining controlled substances, we aim to reduce misuse of controlled substances and related potentially preventable events that result from doctor shopping. In the first half of 2017, the program resulted in a 17 percent reduction in prescriptions for controlled substances for members enrolled in the lock-in program.

Target Population: members who 1) obtained three or more controlled substance prescriptions from three or more pharmacies, 2) used more than 10 different controlled substance prescribers in 90 days, 3) obtained two or more controlled substance prescriptions written by two different prescribers from two or more different pharmacies within 180 days, if they also have a documented diagnosis of narcotic poisoning or drug abuse within the last year, or 4) violated a pain management agreement with their prescriber. We also take referrals from the AHCA, law enforcement agencies, prescribers, and pharmacies.

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2. INNOVATIVE TECHNOLOGY AT THE POINT OF SERVICE TO PREVENT FWA

Providers participating in Clear Health's network have access to our Case Management System through a secure website. Using our Case Management System, they can access a single view of member data in an easy-to-navigate dashboard, including HEDIS® care alerts, authorizations, prescriptions, and claims organized by type, such as inpatient, ER, and office visits. It also serves as our primary method for sharing member care management information, including health needs screenings and the integrated care plan. Our vendor's EVV solution deploys industry standard biometric options and accurate but flexible GPS tracking tools for caregivers. Our real-time point-of sale processing system for pharmacy claims determines, within seconds, whether to send a warning or rejection message for select alerts including refill-too-soon, excessive dosing, and severe drug interactions.

2.1. Three Part Authentication for HIPAA Verification, using iPad Mobile Technology

Our Case Management System Mobile tablet technology guides the assessment process for field-based providers, caregivers, and Managed Care Coordinators — helping collect detailed information from members, families, and caregivers to inform care planning through an in-home, face-to-face interview and assessment. Web browser and iPad mobile technology include three step HIPAA verification protocols and prompts to prevent and detect FWA. This functionality permits field-based verification of location, as well as guided tools to complete assessments, consent documents, and other critical forms while in the member's home.

Members are required to provide proof of enrollment at the point of service by showing their member ID card. This card is available in both hard copy and can be downloaded or shown on a mobile device through our app. Providers are able to verify eligibility real-time via multiple channels including through our IVR (24-7), through the Provider portal, or by speaking with a Provider Services Representative during normal business hours.

2.2. Digital Signatures, Fingerprint and Facial Recognition, and GPS-based Location Tracking

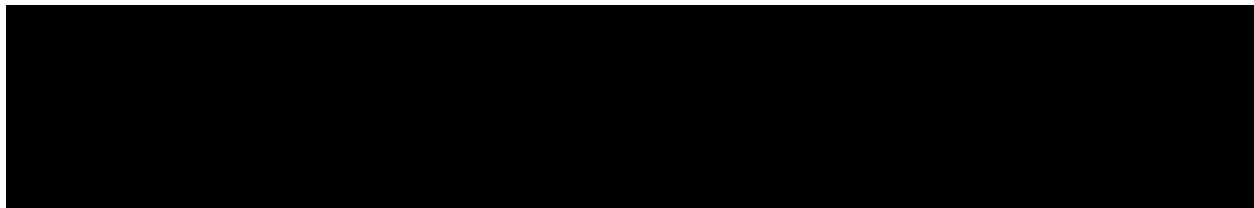


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2.3. Real-time Point-of Sale Processing System for Pharmacy Claims

Clear Health's pharmacy vendor provides network and administrative pharmacy services including a real-time point-of sale processing system for pharmacy claims. The online claims adjudication system operates 24/7. Once received, claims are verified for eligibility, drug coverage, plan design, formulary compliance, and DUR. In addition, the system applies hundreds of edits within seconds based on benefit design and eligibility requirements. Concurrently, targeted alert messaging is delivered to dispensing pharmacists. These edits may include the following:

- Member eligibility
- Benefit design edits, such as quantity, days' supply, and refill-too-soon edits
- Prospective (Concurrent) DUR edits

Within seconds, we determine whether to send a warning (passive alert) or reject message (soft-block alert) for select alerts, including refill-too-soon, excessive dosing, and severe drug interactions. Passive alerts are informational warning messages sent to the pharmacist for evaluation. Soft-block alerts are clinical warning messages sent to the dispensing pharmacist to alert him or her of a potential issue, including potential FWA. The system also provides a mechanism to track and report the member's usage, manual payments, adjustments, recoupments, and other identifying accounts receivable and claim information. This usage and claims processing data is used by our SIU department in its comprehensive data mining analysis to further identify potential FWA and overpayment.

3. REVIEWS AND INVESTIGATIONS TO DETECT SUSPECTED FWA AND OVERPAYMENT.

We maintain sophisticated FWA detection tools and systems that we apply during post-payment claim review, as part of systematic data mining, and during referral follow-up. Our experience managing and integrating these tools has been very effective in detecting FWA and in recovering inappropriate payments. Additionally, we will use post-payment reviews to assure claims have been paid in accordance with the terms of our contract and all applicable laws. Our proactive, data-analysis-driven post-payment review resources to identify erroneously billed claims and behaviors not detected by up-front edits include the following:

- Florida-based medical management staff for training and analysis, supported by national resources
- Facility site information
- Membership information

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- Medical record reviews
- Field staff information
- Information databases such as Accurint for Insurance (Public Records), CPT-Inquiry Services, National HealthCare Anti-Fraud Association Special Investigations Resource, and Intelligence System

We conduct clinical reviews through prior authorization of select services and point-of dispensing reviews at network pharmacies and during Managed Care Coordinator contacts with members enrolled in Case Management. We will refer suspected FWA to our national SIU and Florida Compliance Officer for investigation.

- Our prior authorization process requires Utilization Management employees to comprehensively and continuously review case records and assess member needs
- Managed Care Coordinators confirm member's receipt of services as authorized in the member's care plan during ongoing contact with the member, family members, or the member's representative
- We conduct retrospective clinical reviews during the claims process

While we focus heavily on pre-payment activities, we also use proactive, analysis-driven, post payment review to identify erroneously billed claims and behaviors undetectable by up-front edits. Our detection systems and resources include state-based and national medical management staff available for training and analysis, facility site data, membership information, medical record reviews, field staff information, and databases. We apply sophisticated detection tools during post-payment claim review (as part of systematic data mining) and during referral follow-up that have proven effective in detecting FWA and recovering inappropriate payments with our affiliates. Via post-payment reviews, we confirm that claims were paid pursuant to Contract terms and applicable laws.

3.1. Process for Suspected Cases of FWA

Our Compliance Officer works closely with our SIU, the staff with primary responsibility for the investigative process. When we receive a FWA referral, the SIU follows a formal process that complies with AHCA requirements. We notify the State of any proposed recoveries and report amounts collected in compliance with 42 CFR 438.608 and ss 409.91212, 626.989, and 641.3915 F.S. Our Compliance Officer maintains unrestricted access to our governing body for compliance reporting, including FWA reporting. Clear Health will continue to submit our Anti-Fraud Plan to MPI by September 1 of each Contract year, with our most recent submission on Sept. 1, 2017.

In partnership with AHCA, we take appropriate action (such as education, pre-payment review, and record audits) to address confirmed cases of FWA. For each case, actions vary based on scope, severity, and circumstances. In planning actions, we tap into our knowledge of and experience with the local community. This sets us apart from other health plans that apply a rigid, inflexible approach. Our ultimate goal is to educate, not penalize providers for aberrant practice patterns. We then monitor them to confirm compliance and report any resultant savings. If necessary, we terminate the provider when in the best interest of members and AHCA.

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3.2. Service Verification with Members (Member Verification of Services)

Our program includes strategies to verify that services billed by providers were actually provided to members. We submit our methodology and sampling process to AHCA for approval and include criteria for identifying “high-risk” services and provider types. Service verification occurs within 14 days of implementing LTC services. Monthly, we randomly select a statistically valid sampling of members from claims paid the prior month and send a member verification of services letter that instructs members to contact us if they did not receive the services. Member Services logs calls and routes them to the SIU for review and investigation.

3.3. Cooperating with State or Federal Agencies or Representatives

We embrace the goal of maximizing program efficiency, effectiveness, and integrity. Clear Health has built strong partnerships with regulatory agencies, including AHCA’s Medicaid Program Integrity Unit, the Medicaid Fraud Control Unit (MFCU), and law enforcement, to combat FWA. Our investigators work closely with AHCA and others to promptly bring provider- and member-related issues to their attention. In addition to ongoing dialogue, we meet with AHCA at least quarterly to review FWA detection efforts and results, ongoing and completed cases, and discuss future efforts. We take our role seriously as a sentinel for Florida and diligently pursue all suspected cases, regardless of size. We deliver timely reports of activities and results and assist AHCA in its investigations.

3.4. The Success of Our Program Integrity Approach

Our Florida SIU opened 134 cases and 89 leads in SFY 2016 (July 1, 2016-June 30, 2017). For calendar year 2016, program savings totaled more than \$7 million, including:

- \$1,508,735 in program savings and recoveries
- \$1,716,911 in provider education and intervention to change billing behavior
- \$3,861,594 in prepayment reviews

We routinely monitor and measure our compliance program, including FWA activities, to make sure we conduct activities and initiatives in a way that supports an effective Antifraud Plan. We also use these monitors and measures to validate that controls are in place to mitigate targeted compliance risks, including those that arise in connection with operational areas.

The oversight and support from our national SIU provides our Florida efforts with systems and best practices developed from affiliates’ experiences. When we identify a potential FWA trend or case in our Medicaid operations, we also check Medicare and commercial lines of business across our affiliates as well, and vice versa. Our national SIU also monitors emerging industry trends and provides that information to all affiliated health plans. As new processes, tools, and best practices are identified, we will adjust our program accordingly. For example, we found that allergy testing is a new scheme in Florida after data analysis identified a spike in claims for non-allergy providers. The SIU intercepted the scheme after field investigations confirmed the non-allergy providers were utilizing various non-credentialed, unapproved entities to perform allergy testing on their patients without their supervision. Medical records confirmed the suspicion and we referred several providers to the State. Additionally, the SIU placed the providers on prepayment review. Clear Health’s Medical Directors, legal, and Provider Relations teams are

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addressing this issue with actions that include cease and desist or termination. Our efforts will increase savings and quality of care.

3.5. Strategies to Adapt FWA Approach to Evolving Risks

We understand the importance of adapting our program to evolving risks and monitoring new fraud schemes identified by various organizations. We have established strong partnerships with Florida regulatory agencies and law enforcement. Our organization also participates in regional task forces aimed at reducing health care fraud, including FBI-sponsored task forces in many states. Through these relationships, we share information and best practices in avoiding and detecting FWA, allowing us to continuously enhance our program.

Our national SIU staff regularly participates in CMS-sponsored FWA outreach and education events to provide us with information on current trends and tools in health care fraud prevention. Our early relationship with the Healthcare Fraud Prevention Partnership provides a way to share data and information between public and private sectors to detect and prevent health care fraud.

The SIU also focuses on issue-driven concepts to identify multiple providers engaged in similar billing schemes across our affiliates. In addition, national "Watch Lists" identify common nationwide schemes, as well as aberrations not yet seen in certain states. Advanced data analytics evaluate paid claims across affiliates to identify local aberrations and national fraud trends.

To identify and address increasing instances of opioid FWA across the country, our organization uses a range of strategies that leverage data mining and analytics, including daily monitoring of claims; the award-winning Operation Pillbox, a collaboration with law enforcement that promotes better understanding of prescribing trends, frequently used pharmacies, and insight into possible illegal activity; data mining for top prescribers, drugs, and therapy classes; review of pharmacies when identified for high volume dispensing of controlled substances; monitoring cases of potential "doctor shopping;" and investigating "pill mills." Our affiliates also work with other MCOs in their market to share information, resources, and best practices. Activities typically include education, case and scheme sharing, and networking to identify issues and methods to reduce FWA. This collaboration optimizes efforts, minimizes redundancy, and expands efforts to reduce increased costs associated with FWA. We welcome the opportunity to collaborate with other MCOs on detecting and preventing FWA.

3.6. Experience in Action: Real SIU Cases Detect and Resolve Overpayment

A provider in Florida was referred to the SIU for billing out of scope for allergy testing. Medical record reviews revealed that the physician was not present (based on absence of signatures) for either the mixing or the injection of the serum, as required by CPT guidelines. A visit to the provider location found that the physician was not in the office; however, the mixing of allergy serums and injections was taking place. These findings were shared with the medical director who reported quality of care concerns. A subsequent request for repayment for overpayment in the amount of approximately \$150k was sent to the provider, who subsequently rebutted and refused to cooperate with the review findings and education. The provider was referred to the State for further investigation and the health plan terminated the provider from the network.

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In another case, an algorithm-rules based data analysis program detected an oral surgeon for billing excessive medical services. The SIU obtained medical records that were reviewed by the dental vendor, who determined all services billed under the medical benefit should have been billed under the dental benefit. The oral surgeon billed the dental vendor for the extractions; however, all services in conjunction with the extraction (surgical in nature) were billed to the medical plan in order to bypass incidental system edits and the dental vendor's clinical criteria. All dental services should be submitted to the vendor for possible reimbursement. In addition, services were found to be improperly documented, not rendered, or not medically necessary. An request for repayment of approximately \$1.1 million was issued to the provider who subsequently rebutted and refused to cooperate with the recovery. The SIU recommended health plan network termination and referred the provider to the Agency.

A case was opened after the SIU conducted data mining to find excessive billing units for behavioral health services and case management services (H2019 and T1017) on the same date of service. Subsequently, a complaint was received from another provider via the Health Plan Compliance Officer, stating the provider's licensed clinical social worker (LCSW) was taking assisted living facility (ALF) residents on a car ride and switching them to another ALF provider upon returning. SIU contacted the complainant who reported the LCSW admitted to recruiting activity. The medical records reviewed were found to be incomplete per state standard requirements. The records lacked documentation, including start and end times and location of services rendered. Furthermore, it appeared from the notes that the LCSW was providing mental health services AND case management services to each member on the same date of service. An overpayment for \$67,000 was identified, which the provider rebutted and submitted additional medical records. The second set of medical records reviewed also lacked necessary documentation, and it was discovered that on three separate occasions the medical records had been altered by the LCSW. Therefore, the initial overpayment was sustained for which the provider repaid and agreed to a corrective action plan. Subsequently, the provider and LCSW were referred to the state with a recommendation to terminate.

4. INNOVATIVE TECHNOLOGY FOR VERIFYING HOME-BASED VISITS AND SERVICES

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

4.3. Participant Directed Services in Florida

Clear Health oversees the use of Participant Directed (PD) services in collaboration with the FEA and Public Partnerships (PPL). PPL provides real-time reporting information for over and under-utilization of services or when an incorrect service is billed for follow-up.

The Managed Care Coordinator conducts outreach to the member and their authorized representative, as appropriate, to discuss the reasoning for the alert and to assess the ongoing appropriateness of the plan of care and determine if the PD services are still meeting the member's needs. The Managed Care Coordinator will provide education to the worker, member, and their employer of record regarding the importance of providing services as developed in the plan of care. Ongoing assessment of participant directed services continues with each contact with the member to assure that the member's needs are being met and services are being rendered as expected. Staff overseeing PD services receive extensive training regarding the oversight of such services and utilize specific tools and resources to support identification of FWA.

If the Managed Care Coordinator identifies concerns based on telephonic communication with the member, they may implement unannounced visits to the member to assess the care being provided through PD services and conduct further assessment.

PPL performs the following functions:

- Fiscal/Employer Agent Services in compliance with the IRS regulations
 - Payroll and timesheet processing
 - Tax filing and reporting

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- Criminal background checks and provider credentialing
- Development of a provider registry
- E-verification
- OIG verification checks
- Financial Management
 - Budget planning, tracking, and accounting
 - Authorization management via business rules engine
 - Claims processing and payment
 - Banking and disbursing funds
- Support, Counseling, and Customer Service
 - Telephonic customer service during business hours in English and Spanish; a language line is also available
 - Provide training for support brokers and Managed Care Coordinators
 - Provide training for other health plan staff
 - Provide training for consumers and providers
 - Offer peer trainer services
 - Help individuals understand billing and documentation responsibilities, perform payroll and employer-related duties, purchase approved goods and services, track and monitor individual budget expenditures, and identify expenditures that are over or under the budget

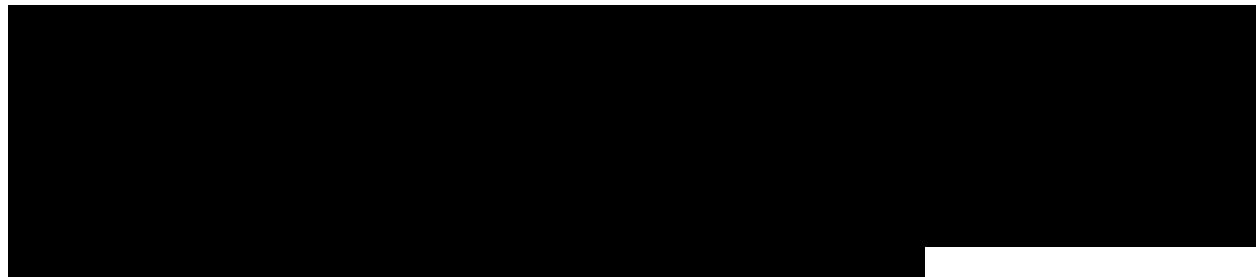


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Evaluation Criteria:

1. The extent to which the respondent uses various types of controls and automated approaches as part of a comprehensive approach to prevent and detect potential or suspected fraud and abuse and overpayment.
2. The extent to which the respondent uses biometric or other technology at the point of service delivery to prevent and detect potential or suspected fraud and abuse and overpayment.
3. The extent to which the respondent conducts clinical reviews and SIU investigations to detect potential or suspected fraud and abuse and overpayment.
4. The extent to which the respondent uses innovative technology for the purposes of verifying home-based visits and services.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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Table 32-1. National Multi-departmental Program Integrity Structure

Department	Relevant Role	Functions
Program Integrity Strategy and Planning	<ul style="list-style-type: none"> • Program Integrity Governance • Cost of Care Initiative Monitoring 	<ul style="list-style-type: none"> • Health Plan Relations • Strategic Investments
Claims Payment Integrity	<ul style="list-style-type: none"> • Issue Identification • Project Validation • Root Cause Fixes and Increased Accuracy 	<ul style="list-style-type: none"> • Provider Notification and Recovery • Coordination of Benefits/Credit Balance • Vendor Management
Reimbursement Policy Management	<ul style="list-style-type: none"> • Medical Policy and Medical Coding • Provider Billing Integrity and Education • Medical Claim Review, Record Review, and Audit 	<ul style="list-style-type: none"> • Clinical Support • Medical Director Leadership
Provider Education	<ul style="list-style-type: none"> • Educate network providers on appropriate coding practices for codes that are frequently misused 	<ul style="list-style-type: none"> • Confirm providers understand the documentation requirements for CPT codes and are billing correctly for the services rendered
Subrogation	<ul style="list-style-type: none"> • Recover medical expenses when claims are paid due to accident or injury and another party is liable 	<p>Sources include:</p> <ul style="list-style-type: none"> • Auto coverage • Workers' Compensation • Business coverage • Mass Tort
Clinical Reimbursement Programs	<ul style="list-style-type: none"> • Provider Audits 	<ul style="list-style-type: none"> • Review claims and medical charts for correct coding and proper documentation to determine appropriate payment and whether care was delivered in accordance with industry standards and payer guidelines
Health Plan Services	<ul style="list-style-type: none"> • System Edits • System Configuration 	<ul style="list-style-type: none"> • McKesson ClaimCheck • ClaimsXTen, iHealth
Program Integrity Analytics	<ul style="list-style-type: none"> • Advanced Analytics Modeling and Data Science • Prepay Claim Program 	<ul style="list-style-type: none"> • Analytic Support for Complex Audit, Data Mining, and Special Investigations Unit (SIU) • Analytic Tools • Governance
Special Investigations Unit	<ul style="list-style-type: none"> • Fraud, Waste, and Abuse Investigation • State Law Enforcement • MEDIC Referrals 	<ul style="list-style-type: none"> • Hotline, Referral, Lead Triage • Regulatory Reporting
Pharmacy	<ul style="list-style-type: none"> • Outlier Rx Medication Use Member Management • Pharmacy Coordination of Benefits Vendors 	<ul style="list-style-type: none"> • Pharmacy Outlier Claim Review
Health Plan	<ul style="list-style-type: none"> • Issue Identification • Provider Relations 	<ul style="list-style-type: none"> • Project Approvals
Long Term Services and Supports Unit	<ul style="list-style-type: none"> • Issue Identification, Provider Relations, Care Coordinators 	<ul style="list-style-type: none"> • Claims Reviews, Electronic Visit and Verification, Subject Matter Expert support

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SRC# 33 – Disaster Recovery Requirements (Statewide):

The respondent shall demonstrate its capability and approach to meet the requirements described in **Attachment B**, Scope of Services, **Section X.D.4.h**.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Clear Health believes that comprehensive disaster recovery planning, coupled with continuous readiness, are integral to our responsibility as an employer, partner to the Agency, and service provider to our enrollees (members), and providers. As a long-time Florida-based health plan, we have experienced several natural disasters, including Hurricane Matthew in October 2016 and most recently, the devastation caused by Hurricane Irma.

Our disaster recovery plan is not a theoretical document that sits on a shelf; rather, it is a vital guide to help protect the safety of our members and staff. We are proud of our response to Hurricane Irma, demonstrating the effectiveness of our preparation and Hurricane Preparedness Plan. In Attachment SRC# 33-1: Our Plan in Action: Hurricane Irma, we highlight some of the actions we took before, during, and after Irma in our efforts to recover, with priority always on the safety and well-being of our members.

Clear Health maintains and is continually ready to implement a comprehensive Business Continuity-Disaster Recovery (BC-DR) plan that meets AHCA requirements outlined in Section X.D.4.h of Attachment B, Scope of Services of the ITN Contract. We put our plan in place when we began operations in 2003 and regularly update it in response to our changing technology and systems environment, industry best practices, and AHCA requirements. Our BC-DR plan includes resources (technology and staffing) to recover and restore operation of information systems, data, and software well within AHCA's requirement to limit service interruption to 24 hours or less. Two additional plans, our Hurricane Preparedness Plan and Emergency Management Plan, supplement our BC-DR plan and support Clear Health's response to an event.

Through our national resources, we monitor and support the development and ongoing maintenance of our BC-DR plan. Employees supporting our plan have significant industry experience and hold numerous certifications, including Certified Business Continuity Professional (CBCP), Certified HIPAA Security Professional (CHSP), Certified Business Continuity Management Systems Auditor, and ITIL Foundation Certification.

With the collaboration and support of these resources, Clear Health will continue to maintain a BC-DR plan to resume normal business operations following an emergency, systems failure, or systems disruption for our Florida operations.

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1. APPROACH AND CAPABILITY TO MAINTAIN A DISASTER RECOVERY PLAN

We designed our BC-DR plan to swiftly and effectively respond to an incident or event with minimal impact on all constituencies. We have detailed disaster recovery plans for our systems and business continuity plans for operations, including operations related to our systems. Together, these plans comprise our comprehensive BC-DR plan and represent a detailed blueprint of our preparation for and planned response to any emergency or business disruption.

Our BC-DR plan is “scenario neutral” and focuses on unavailable resources, rather than the event that caused the loss. This approach allows us to respond to any event that disrupts access to necessary services or resources. Using this approach, Clear Health’s BC-DR plan supports recovery from the types of incidents outlined in the Scope of Services, as well as natural disasters, human error, computer virus, or malfunctioning network, hardware, software, or electrical supply.

Clear Health’s BC-DR plan safeguards the continuation of established services and systems and addresses our systems, applications, and platforms. Each national support business unit (such as claims, enrollment, call centers, and finance), also develops and maintains a business continuity plan specific to the operational needs of its customers and stakeholders.

In our BC-DR plan, definition of a disaster includes any type of occurrence that could jeopardize processing integrity or temporarily disable or interrupt operations, as well as catastrophic events, such as a major weather event or natural disaster, pandemic, major telecommunications outage, or computer virus.

Our disaster recovery plans protect against data loss and provide recovery from major unplanned interruptions to computing services, including system infrastructure, data, and applications. Our plans allow us to quickly recover from a situation where production systems are disabled or destroyed, through the availability of redundant systems and hardware and our disaster recovery hot site.

Several other programs also enable maintenance of critical business functions:

- The Safety program – to maintain a safe workplace for employees, contractors, and visitors
- The Emergency Management program – to detail overall response, command, and control before, during, and after an incident or event causing a business disruption
- The Business Continuity program – to document recovery strategy of critical business processes

Clear Health will continue to be ready to implement and monitor our BC-DR plan throughout operation of our Florida programs.

2. CAPABILITY OF PLAN TO LIMIT SERVICE INTERRUPTION TO 24 HOURS

We invest in the technology and equipment necessary to support our disaster recovery and business continuity needs and limit the service disruption associated with an event. Our BC-DR plan supports the ability to limit service interruption to a period of 24 hours or less and comply with the Agency’s requirements in Section X.D.4.h.

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The national Technology Services department applies industry best practices that geographically distribute data centers, back-up data centers, and off-site storage locations to support restoration and recovery efforts. Technology Services takes care to locate sites in areas with different risk profiles, including the topography of the area for vulnerability to natural disasters and malicious physical attack.

Technology Services develops and maintains hundreds of individual guides – Application Recovery Guides and Technical Recovery Guides – each with assigned resources that will execute the plan if a disaster occurs. They review and update guides at least annually as part of the recovery testing process and after major system changes. Guides employ different strategies based on criticality of the application system, including the following:

- **Dedicated Standby.** Some application systems have dedicated standby hardware in a second location that can be quickly activated if the primary site fails. Storage Area Network (SAN) replication and database log shipping keep database copies at secondary sites synchronized with production.
- **Warm Site Recovery.** Critical systems that are not replicated are protected by warm site agreements. Technical teams restore the latest production backups onto the new hardware and bring the systems up as production replacements. Redundant circuits connect to the disaster recovery warm sites and are tested regularly. In a disaster, the recovery sites become part of the production network.

Technology Services assigns employees to disaster recovery teams along with developed contingency plans to respond to worst-case scenarios. Those teams take ownership of business operations recovery by reviewing all documentation, making recommendations, alerting the disaster recovery contingency planners of system changes and upgrades, and participating in testing of the disaster recovery plans. The comprehensive disaster recovery program contains four major content areas:

- Data center recovery, including environment- and application-specific documentation
- Technology Services business unit recovery
- Telecommunications recovery, including voice and data
- Local communication room recovery

2.1. Recovery Time of Mission Critical Applications

The Recovery Time Objective (RTO) indicates how long resources can be unavailable and the Recovery Point Objective (RPO) identifies the amount of data loss that may be sustained in an unplanned event. Business units, in partnership with our national Business Continuity team, work to define the RTO for critical business processes, or how long the process can be unavailable. Critical business processes are then mapped to critical applications to establish the technology RTOs. Additionally, Technology Services has taken steps to minimize the RPO and the data loss associated with an outage.

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Our BC-DR plan supports an RTO of less than 24 hours for mission critical applications, meeting the AHCA requirement. Technology Services evaluates each new application to determine the appropriate RTO. The business units and Business Continuity team continually re-evaluate each application's RTO to assess its ongoing appropriateness. That ongoing assessment enables the team to identify additional mission-critical applications and work through the associated redundancy and replication planning.

Technology Services stages mission-critical applications in a secondary geographically distributed data center for immediate failover, and performs near real-time data replication. For example, this means that as a transaction is committed to our production systems in Virginia Beach, the same transaction is routed to our recovery hot site so that we have a duplicate copy of our production databases. The replication for these solutions delivers an RPO of 15 minutes or less, minimizing the risk of data loss in the event of a disruption. Technology Services applies this optimal recovery solution to our Core Operations System (the system of record for members, providers, claims, and authorizations), Case Management System, medical criteria, and workforce management application, among others.

2.2. Disaster Recovery Hot Site

Our primary data center in Virginia Beach hosts the majority of systems, applications, databases, and technologies that support our Florida programs. The disaster recovery site, or "hot site", for our Virginia Beach data center is in Harrisonburg, Virginia. The recovery hot site includes equipment to support our most critical medical management and member/provider contact applications, including our Core Operations System, clinical criteria, Fax II/Rightfax databases, imaging and workflow document management, and call center workforce management. There is continuous real-time replication between the production data center in Virginia Beach and the recovery hot site to keep critical applications and data in sync with production.

The Harrisonburg Data Center (HDC) is owned by our ultimate parent company, Anthem, Inc. Because Anthem owns our recovery hot site, Technology Services does not rely on a vendor for disaster recovery testing or actual recovery of operations. Rather, Technology Services fully controls the location, capacity, and resources to support a recovery event. In a regional event, this mitigates the risk of competition for shared vendor resources.

Harrisonburg is more than 220 miles from our Virginia Beach data center. The geographic distribution and different risk profiles, including the topography of the area for vulnerability to natural disasters and malicious physical attack, support the HDC's use as a recovery hot site for our Florida operations. The HDC is an Uptime Institute Tier III Certified facility. Certified in design and construction, it is one of only 50 of its kind in the country. The facility is also a Leadership in Energy and Environmental Design (LEED) Silver Certified (construction) facility.

The HDC is 102,000 gross square feet, has top-level physical security, and an electrical substation on premises that has a 33 megawatt capacity in a fully redundant, mirrored system (2N configuration). Physical security includes a perimeter fence, 24/7 onsite staffed security operations, and surveillance cameras. Access to the building, the data center, and individual data halls requires a security key card and entry of a PIN (something you have and something you know). Biometric controls provide additional security to the data center. Security systems log and track all personnel movements.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

The HDC's configuration supports maintenance, replacement, and improvement of critical infrastructure without impacting operations. The design is simple, but highly redundant. The configuration provides UPS-protected dual-path distribution to each server rack. The system has no single points of failure from the utility source to the rack level and is concurrently maintainable.

HDC has four data halls (10,000 square feet each) to allow for segregation of sensitive environments, with one hall dedicated as the recovery hot site. HDC currently has more than:

- 450 devices deployed
- 4,500 intel cores of compute with 45 terabytes of memory
- 500 Power8 cores of compute with more than 10 terabytes of memory
- 2,500 terabytes of data replicated

Persistent environments for certain mission critical infrastructure and systems (network, DNS/DHCP, security authentication, and backup and recovery) are live and in place at all times to support faster recovery

For cooling, the HDC has a high-efficiency water-cooled solution to handle peak demand conditions of 105°F. The design includes onsite back-up water storage tanks to support approximately 24 hours of operation.

For electricity, in addition to the onsite substation, the HDC has seven dedicated 2.5 megawatt generators, each with a 3,000-gallon belly tank. Two 20,000 gallon above ground storage tanks provide long-term fuel, if necessary. The generators are tested monthly.

For fire protection, all four data halls have a Very Early Smoke Detection System Apparatus (VESDA) installed. VESDA Systems are aspirating smoke detection used for early warning applications where response to a fire is critical. The VESDA detectors communicate with our security and building monitoring systems.

3. MAINTAINING RECORDS BACKUP STANDARDS AND COMPREHENSIVE DISASTER RECOVERY PLAN FOR THE ENTIRE CONTRACT PERIOD AND SUBMITTING FOR REVIEW

Clear Health will continue to submit our BC-DR plan, or certification that the approved plan is unchanged, to the Agency by May 1st each year, as specified in Section X.D.4.h. of the ITN. For 2017, we submitted our BC-DR Plan and Hurricane Preparedness Plan on May 1, 2017.

We follow a defined process to make sure that we submit our plans for review in accordance with Contract requirements. Our dedicated Regulatory team manages the review and submission of all reports and deliverables to AHCA, including our required submissions of the BC-DR, Hurricane Preparedness, and Emergency Management plans.

We maintain the requirements for each deliverable in our report tracking system, with the AHCA due date, an advance internal due date, and the business owners responsible for review and approval. Our report tracking system generates email alerts to remind business owners of upcoming report due dates and as notification that a deliverable is ready for review. Business owners and leadership review deliverables for completeness and accuracy prior to submission to the Agency.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

For records backup standards and our comprehensive BC-DR plan, the national Technology Services and Business Continuation teams are heavily involved in the development and maintenance of the plans. Since these are critical documents for the enterprise, as well as required deliverables to AHCA, these teams maintain internal processes to make sure they are consistently maintained. Clear Health will continue to collaborate with these teams to confirm that records backup standards and the BC-DR plan are maintained for the entire period of the SMMC Contract.

4. MAINTAINING A DISASTER RECOVERY PLAN FOR RESTORING DAY-TO-DAY OPERATIONS, INCLUDING ALTERNATIVE LOCATIONS FOR BUSINESS OPERATIONS

Clear Health understands that restoring day-to-day operations as quickly as possible is critical. Our BC-DR plan includes access to a substantial workspace recovery capability using a combination of resources, including network redirection of work, our national organization's worksite recovery capacity, mobile recovery resources, and secure satellite connectivity for voice and data.

Our Business Continuity program aligns the business requirements of the operating units and the deliverables of the support areas to meet stakeholder commitments following an unplanned event. The program:

- Identifies business process critical paths
- Documents the recovery strategies and resources required to support those critical paths
- Defines roles and responsibilities
- Links critical path business processes with the resources, systems, and vital records required to support response, recovery, and survival

Clear Health identifies essential business functions by looking at each process to evaluate:

- What are absolute essentials that sustain the core functions of the business?
- What triggers the implementation of the BC-DR plan?
- What resources will be required and when?

In the sections below, we describe key components of our BC-DR plan that support restoring day-to-day operations, including alternate work locations, communication protocols, continuity of service to members and providers, and employee training and awareness.

4.1. Providing Alternate Locations if Workspace is Unavailable

The ability to provide continuing business services throughout any occurrence is critical for Clear Health. Whether it is a short-term incident (such as inclement weather) or a long-term emergency (such as a pandemic or natural disaster), we have established protocols to guide business continuity and data recovery.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Technology tools enable our employees to seamlessly access necessary systems remotely to facilitate continuing operations when their primary work location is unavailable. Using our Citrix Access Gateway, employees can securely use critical applications from any location with Internet access.

To supplement worksite recovery, Clear Health can access a Mobile Recovery Solution that can be operational within 96 hours following an event that results in unavailable network connectivity. Through two owned technology vans, this solution can provide both network and Voice Over Internet Protocol (VOIP) to support up to 500 call center seats and includes the following components:

- Two mobile satellite units (data connectivity for 1,000 seats each, including servers, data switches, onboard generator, and HVAC)
- Satellite connectivity for voice and data (bandwidth equivalent to two DS-3s)
- VOIP phone switch (ACD) for 500 seats/1,000 line servers and data switches
- Two satellite ground stations
- Workstations to use with mobile recovery seat

If the building is unavailable, Mobile Workspace trailers can provide seats for employees and personal computers within 72 hours. The Mobile Workspace trailers can be deployed in conjunction with or separately from our Mobile Recovery Solution, which provides network connectivity. To confirm its continued viability, the Mobile Recovery Solution is tested every six months.

With the ability to deploy multiple protocols, our BC-DR plan will support continued operation of our SMMC program during a disruption.

4.2. Communication when Systems are Unavailable

Communicating promptly and effectively is critical in an emergency or service disruption. Our plan provides multiple methods to communicate with staff, suppliers, the Agency, members, providers, and other stakeholders.

A Virtual Command Center delivers the ability to command, control, and communicate during any event-based activity (planned or unplanned). Elements supporting communication during an event include redundant communication tools issued to key managers; automated call tree notification and management functionality; repositories for business continuity documents; employee, site, subcontractor, external partner, and other mission-critical information; and collaborative meeting tools. Our mass notification system quickly and effectively notifies employees during potential emergency situations, using a process similar to the message and alert systems in school systems and police departments nationwide. This system allows us to reach each employee impacted by an incident through multiple communications channels, both work and personal, until the employee confirms receipt.

EXHIBIT A-4-a

GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Our BC-DR plan is “scenario neutral” to address any situation that disrupts normal operations. In our plan, a recovery strategy is based on an “unavailable resource” – such as people, facilities, or systems – as an “event trigger.” The plan includes multiple event triggers related to communications systems, including data network, inbound and outbound calls, and automatic call distributor, and outlines the appropriate recovery strategy.

4.3. Notifying Members and Providers and Continuity of Services

Clear Health knows that communicating promptly and effectively with our members and providers is critical in an emergency or service disruption. Consequently, our plan includes steps to notify members or providers depending on the type of event and what services are unavailable. Our plan emphasizes proactive communication to members and providers along with reduced administrative requirements so they can focus on their health and safety.

We maintain member and provider access to information and services in any emergency. We will use our call centers, websites, and self-service voice portals to provide information and to make sure services are available before, during, and after an emergency or business disruption.

We use numerous methods to notify our members and providers of an upcoming or current emergency and to provide information on accessing services. Depending on the nature of the disruption and its impact on members and providers, notification methods may include:

- **Member and Provider Websites.** We may post alerts on our website notifying members and providers of a service disruption and how it affects their ability to access services.
- **Automated Calls, Text Messages, and Email Messages.** We can generate automated telephone calls, text messages, and emails to communicate information to our members and providers.
- **Personal Calls.** Our employees may make personal calls to vulnerable members, including those in case management.
- **Member and Provider Call Centers.** Our call center will provide up-to-date information to callers on their ability to continue to access services.
- **Local Media.** We may use local radio and television to disseminate emergency information to our members and providers.

Regardless of the nature of the emergency, redundant operations will minimize disruption for our Florida members and providers. Because redundant operations exist for key functions, we can use telecommunications and networking technology among remote sites to re-route member and provider calls to an unaffected worksite.

Our national call center maintains 10 facilities across the United States, and our telephonic technology enables them to flow calls among them as necessary, creating virtual member and provider call centers. In an emergency or service disruption, we can quickly and seamlessly route calls to another site to continue to serve our members and providers. Using our call center Integrated Desktop and Knowledge Management System, representatives in other facilities have real-time access to SMMC program requirements, covered services, eligibility, and claims data.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Access to this technology will allow them to support our Florida members and providers in the event of a disruption.

Clear Health will also mobilize our employees, including Case Managers (Managed Care Coordinators), Member and Provider Services staff, and other clinical staff, to assist members with access to information and services before, during, and after a declared incident. We can also leverage the experience of our national support services teams and affiliate health plans to augment staff in the event of a disruption.

We employed all of these strategies in our response to Hurricane Irma to minimize the disruption in service for our members and providers. Attachment SRC# 33-1: Our Plan in Action: Hurricane Irma, provides specific information about our outreach to members and providers before, during, and after the storm.

4.3.1. Emergency Planning for Vulnerable Populations

We maintain specific disaster management operating procedures and guidelines for our most vulnerable members. For these members, the guideline has three main parts: 1) emergency planning, 2) implementing the emergency plan, and 3) after the emergency. Members who reside in a facility setting will follow the facility's emergency and evacuation plan.

Emergency planning involves the Managed Care Coordinator working with members to review their emergency plan or help them develop one. The emergency plan discussion may include assisting with registration for a county special needs registry/shelter; making sure the member has at least two weeks of medications, shelf-stable food, water, and medical supplies; making a plan for their pets; registering with the county transportation, if going to a shelter; and understanding the member's desire to evacuate to a facility (based on level of care needed).

When notified of an impending emergency, the Managed Care Coordinator will reach out to members on their case load. The Managed Care Coordinator will verify and document location and contact information for the member and their representative. The Managed Care Coordinator will also talk to the member about early refill for medications and supply needs the member may have, including oxygen tanks and ventilator supplies, diabetic supplies, CPAP and BiPAP supplies, wound care supplies, as well as other essential items they need to obtain in advance of the storm.

They will also advise the member about the on-call process during the emergency, but that weather conditions may affect the ability of providers to deliver services. If during this outreach the member reports that his or her plan is not going to meet his or her needs, the Managed Care Coordinator will collaborate on other options and arrangements.

After the emergency has passed, the Managed Care Coordinator will contact all members to confirm that they are safe. If the member has unmet needs, the Managed Care Coordinator will coordinate services.

EXHIBIT A-4-a

GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

4.4. Employee Training and Awareness

Effective and efficient response to any type of emergency or business disruption requires that employees in Florida and our national shared services areas understand their roles and responsibilities. Training and awareness make sure our employees are prepared to:

- Develop components of a contingency plan
- Perform emergency tasks
- Designate off-site crisis meeting places and implement crisis communications plans

We involve employees and leadership in exercises specific to responding to an emergency. Exercises, drills, and training courses in emergency response procedures foster understanding for managers and employees with direct responsibility under the plans. Additional online courses are available to all employees, including one on Employee Safety and Emergency Response Procedures focusing on the actions employees should or should not take in emergency situations.

To help maintain awareness, employees receive regular emails and notification of internal news articles. An intranet page provides important information about what to do in emergency situations, including appropriate procedures for specific circumstances, such as weather-related events or other office emergencies, including crime or threats. Additionally, a Quick Action Guide outlines what to do in situations such as power failure, fire or smoke, or crime in progress.

5. MAINTAINING DATABASE BACKUPS THAT ELIMINATE DISRUPTION OF SERVICE OR LOSS OF DATA DUE TO SYSTEM OR PROGRAM FAILURES OR DESTRUCTION

Technology Services maintains backup and recovery plans for the types of events that could interrupt operations or cause a loss of data. A comprehensive backup strategy is a key component of our BC-DR plan and protects Clear Health from a loss of data due to system or program failures or destruction. We consistently back up systems and databases and store copies of key files in multiple locations, including secure off-site locations.

5.1. Backup Strategy

Established policies and procedures govern database and system backup, storage, and tracking. The Infrastructure team in Technology Services manages the backups, the documentation and tracking of these backups, and their secure storage. We backup our mission critical systems at our recovery hot site data center using near real-time replication. We also perform daily, weekly, and monthly full backups.

We employ a 3-2-1 backup strategy: 3 copies, 2 different types of media, and 1 copy is stored offsite. Under this strategy, we maintain the production copy (original copy) and a replicated copy within the data center. We take a backup of the replicated copy, and store it offsite.

Technology Services uses Oracle tools and software with NetApp integration to solve data management challenges, such as workload management, database cloning, and backup and recovery. Using the NetApp Snapshot technology delivers better performance and efficient use of storage. Maintaining multiple versions of the database allows for faster, near instantaneous recovery and supports more frequent testing activities.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

We store physical backup copies off-site with Iron Mountain, an industry-leader in storage and information management. Our procedures detail the rotation of backup copies to and from the Iron Mountain facility in Richmond, Virginia and the documentation and logging maintained to support tracking. In addition, we have backups and off-site storage through our business continuity and recovery solutions in our alternate data centers and our high availability solutions.

5.2. High Availability Solution

Our data center in Virginia Beach hosts the majority of systems, applications, databases, and technologies that support our Florida programs. We maintain complete redundancy for all tiers of our Core Operations System, providing a high availability instance in addition to the production and disaster recovery instances. We invest in the technology and equipment necessary to support our operational and business continuity needs.

This high availability solution is located in our primary data center in Virginia Beach. If there is a non-disaster issue with our Management Information System, we can switch to it. Likewise, we back up key hardware and communication lines that enable us to switch operations quickly from one piece of hardware to another. In most cases, we maintain mirror images of files so that if the hardware fails, a system can be quickly switched to operate from those recovery environments.

To support disaster recovery, mission critical systems in Virginia Beach have replicated backups at our recovery hot site data center in Harrisonburg, providing an additional solution during a widespread event that affects our primary data center.

6. FINALIZING THE DISASTER RECOVERY PLAN NO LATER THAN 30 CALENDAR DAYS PRIOR TO THE CONTRACT EFFECTIVE DATE

As an incumbent, Clear Health submits our BC-DR plan, or certification that the approved plan is unchanged, to the Agency by May 1st of each contract year. We will provide the Agency with a finalized BC-DR plan no later than 30 calendar days prior to the effective date of the new SMMC Contract.

7. UPDATING THE DISASTER RECOVERY PLAN IN ACCORDANCE WITH THE BEST INTERESTS OF THE AGENCY AND AT NO ADDITIONAL COST

Clear Health knows that our BC-DR plan must meet the best interests of the Agency and the members we serve. We will amend or update our plan at no additional cost to the Agency.

During our annual review, we amend or update our BC-DR plan as necessary to make sure that it aligns with applicable federal or State laws and regulations, and supports the needs of the Agency and our ability to provide service to our members, providers, and other stakeholders. After review of our plan, if AHCA requests updates or additional information, Clear Health will amend or update the plan or provide additional information as requested.

In addition to our annual review, major system upgrades or significant operational changes prompt a review to determine whether our BC-DR plan needs revision.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

8. MAKING THE DISASTER RECOVERY PLAN AVAILABLE TO THE AGENCY

Clear Health will continue to provide our BC-DR plan (or certification that it is unchanged from the prior year's submission) to the Agency by May 1st. On May 1, 2017 we submitted our BC-DR and Hurricane Preparedness plans to AHCA. We will resubmit our plan to the Agency no later than 30 calendar days prior to the effective date of the new SMMC Contract. We will continue to submit any plan changes to the Agency within 10 business days after making the change.

Clear Health will review all aspects of the BC-DR plan with the Agency, to make sure AHCA is confident in our ability to restore systems and operations and limit service interruption. We will make sure that the Agency has the information they need at all times.

9. CONDUCTING ANNUAL DISASTER RECOVERY PLAN TESTS

Every year, Technology Services and Business Continuation teams conduct tests of our BC-DR plan. We will continue to comply with the Agency's requirement to conduct comprehensive tests annually, by April 30th of each Contract year. Clear Health will submit a report of our BC-DR testing for Agency review.

During testing, we investigate and remediate any problems or situations where results do not meet expectations. We assign each item a priority (with corresponding 30-day or 60-day service level agreement) and track them to closure. We analyze test results to identify potential problem areas and improve the plans. By completing internal audits, we confirm that plans are tested regularly as well as verify that any deficiencies identified in the tests are corrected and the plans are updated accordingly.

9.1. Disaster Recovery Testing

Technology Services tests individual critical systems at least once a year and establishes recovery objectives in advance. They establish simulated disaster or recovery scenarios and lower level failures and activate plan procedures. Scenarios include testing and restoring applications at the disaster hot site recovery facility and verifying the ability of alternate locations to assume business operations for a health plan experiencing a disruption.

Each year, we conduct comprehensive data center disaster recovery exercises that require extensive planning and involve potentially hundreds of Technology Services and business unit employees. In addition to these exercises, we conduct numerous individual application recoveries and proof-of-concept activities each year to confirm the resiliency of critical technology resources across the enterprise.

The 2017 testing schedule includes three national organization data center recovery exercises and 87 application recovery exercises. Tests executed to date have been successful.

The most recent Virginia Beach data center exercise was conducted on November 20, 2016 to test the ability to bring up systems at an alternate location during a disruption in our primary data center. During the six- to eight-hour exercise, we executed a failover test of our production systems to the hot site recovery facility, tested systems and applications, and transitioned them back to Virginia Beach. During the exercise, critical production systems remained operational to

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

all users – internal and external. The exercise was successful, with two follow-up items identified, tracked, and closed within 60 days.

9.2. Business Continuity Testing

We also test business continuity at least annually using a combination of tabletop exercises and evaluating our workspace recovery capability. The team structures tabletop exercises to simulate an incident that escalates to disruption. Designated employees participate and discuss the steps to be taken in accordance with the plan. In workspace recovery testing, employees simulate an incident that requires them to telework or relocate and test access to required systems.

As part of the Safety and Emergency Management program, our Florida offices conduct two evacuation drills each year (in coordination with the landlord). A combination of planned and unplanned drills test evacuation procedures and confirm our ability to maintain the safety of employees and visitors. Evacuation drills include routing calls to another site to maintain continuity.

After each exercise or drill, we complete a formal review to compare expected and actual results to identify lessons learned and areas for improvement.

9.3. Post Incident Review

In addition to annual testing activities, when we have an incident that involves activating our BC-DR or Hurricane Preparedness Plan, Clear Health reviews what worked well and identifies areas for improvement. We highlight some of the lessons learned from Hurricane Irma in Attachment SRC# 33-1: Our Plan in Action: Hurricane Irma.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The adequacy of the respondent's proposed approach and capability to develop and maintain a disaster recovery plan for restoring the application of software and current master files and for hardware backup in the event the production systems are disabled or destroyed.
2. The adequacy of the respondent's proposed approach and capability to ensure the disaster recovery plan limits service interruption to a period of twenty-four (24) hours and ensures compliance with all requirements under the resulting Contract.
3. The adequacy of the respondent's proposed approach and capability to ensure the records backup standards and a comprehensive disaster recovery plan are developed and maintained by the respondent for the entire period of the resulting Contract and submitted for review annually by the anniversary date of the resulting Contract.
4. The adequacy of the respondent's proposed approach and capability to ensure it maintains a disaster recovery plan for restoring day-to-day operations including alternative locations for the vendor to conduct the requirements of the resulting Contract.
5. The adequacy of the respondent's proposed approach and capability to ensure it maintains database backups in a manner that eliminates disruption of service or loss of data due to system or program failures or destruction.
6. The adequacy of the respondent's proposed approach and capability to ensure the disaster recovery plan is finalized no later than thirty (30) calendar days prior to the resulting Contract effective date.
7. The adequacy of the respondent's proposed approach and capability to ensure it amends or updates its disaster recovery plan in accordance with the best interests of the Agency and at no additional cost to the Agency.
8. The adequacy of the respondent's proposed approach and capability to ensure it makes all aspects of the disaster recovery plan available to the Agency at all times.
9. The adequacy of the respondent's proposed approach and capability to ensure it conducts an annual Disaster Recovery Plan test and submits the results for review to the Agency.

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

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Our Plan in Action: Hurricane Irma

In September, Florida was hit with a Category 4 hurricane. Irma caused devastation across Florida, including widespread power outages, flooding, and substantial property damage. The impact on Clear Health Alliance members, providers, and employees was immense, and full recovery will take time.

Clear Health's Hurricane Preparedness Plan

In an emergency, nothing saves lives, time, and money, and lessens property damage like being prepared. In addition to our Disaster Recovery Plan, Simply D/B/A Clear Health Alliance maintains a Hurricane Preparedness Plan that outlines specific pre-season preparedness tasks, roles and responsibilities, and operational and post-storm activities. Our Hurricane Preparedness Plan (submitted to the Agency on May 1, 2017) guided our response to Hurricane Irma.

Our Crisis Action Team (CAT) oversees our preparedness and response to a hurricane. Led by Lourdes Rivas, our Plan President and CEO, Crisis Action Team includes 11 executives, directors, and essential employees and serves as an advisory committee to oversee activities.

We execute pre-season activities prior to June 1, the beginning of hurricane season. Tasks include reviewing hurricane policies and procedures and call trees and updating documentation, staff information, and departmental activities.

Our Hurricane Preparedness Plan outlines the responsibilities of major functional areas, including: Member Services, Health Services (clinical and non-clinical), Pharmacy, Human Resources, Information Technology, and Finance.

Our Response to Hurricane Irma

We activated our Hurricane Preparedness Plan on September 4th, as the path of Hurricane Irma was projected to impact South Florida. The following sections highlight some of the actions we took before, during, and after Irma in our efforts to recover, with priority always on the safety and well-being of our members.

Preparing for Irma

The week prior to landfall, We began working to make sure that our members were prepared. We activated our outreach protocol, identifying the most vulnerable populations, such as medically complex members. We prioritized the most vulnerable and prioritized our outreach to populations including children with complex conditions, those in long-term care (LTC), those who are ventilator or oxygen dependent, on dialysis, and our members in the highest level of case management.

We took extra measures to focus on members residing in the areas with anticipated landfall, including opening up evacuation assistance with transportation services. We implemented our

State of Emergency pharmacy protocols and expanded member access, going above and beyond to provide member access to medical and durable medical equipment (DME) supplies, as well as lifting other pharmacy edits.

Following our protocol, we initiated twice daily Emergency Response meetings with senior leadership to review and strategize member and employee contingency planning and coordinate operational communications. We also established daily clinical team meetings to coordinate and address the clinical needs of our members, including the use of a triage list to assure that members with critical needs were addressed and refer any follow up items to the “Go Team” and any post-storm activity.

We deployed a 20-person, cross-functional “Go Team” to a non-impacted location in Kentucky to address member and provider needs and concerns until normal business could resume. The “Go Team” provided support across operations, including:

- Entering service notifications into our system to facilitate claims processing
- Coordinating critically needed care for members
- Coordinating transportation needs
- Providing eligibility and payment information to out-of-state providers delivering care for evacuated members
- Handling member and provider concerns
- Processing member grievances and appeals

Supporting our Members

The following list is just a sample of the activities we performed to support our members as we prepared for Hurricane Irma:

- Our member call center and case management teams initiated outreach campaigns to members who:
 - Rely on ventilators or use oxygen to coordinate delivery of portable tanks and refills
 - Are in late stage or high-risk pregnancies
 - Undergo dialysis to assure they had pre-storm dialysis treatments and arrangements for post storm dialysis treatment and coordinate transportation or hospitalization assistance
 - Are complex, pediatric members that require a higher level of care
- Communicated with facilities to confirm that they had adequate supplies, generators, caregivers, and evacuation plans in place to protect the well-being of our members
- Suspended many of the edits restricting pharmacy access to reduce member point of sale impact, such as refill too soon, prior authorization, and step therapy
- Authorized transportation subcontractors to evacuate our members to shelters or family homes outside of an evacuation zone
- Leveraged our National Call Center footprint to assure continuity of service and expanded hours and augmented our 24/7 live answering service strategies

Simply Helping

Prior to the hurricane, our Member Services Representative, Irene, reached out to Mary, a member in the Florida Keys to check on her. When asked about her plans to evacuate, she became very emotional and stated she was afraid to be in her home during the storm, but she didn't want to leave behind her cat and two dogs. Irene identified a pet friendly shelter for Mary and her pet family to go to together.

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- Created a hurricane emergency database listing community and state resources such as FEMA, Red Cross, shelter information, and evacuation orders so that we could assist members with storm-related questions and direct them to the appropriate resources
- Included a Hurricane Irma message on our website to provide members with important storm specific information and contacts

We employed a two-pronged approach, understanding that members in LTC in a home-based setting have different needs than those that are facility based. Our goal was to meet the needs of both populations during the event.

For home-based members, actions included the following:

- Validating that they were following their pre-established emergency plan and determining if they needed assistance evacuating
- Confirming that the member had sufficient supplies, including DME, food, water, and medication
- Helping facilitate transportation and placement in an appropriate facility, for members needing evacuation assistance

For facility-based members, actions included the following:

- Confirming emergency plans with each member at the facility and offering to assist with evacuation and placement if desired
- Verifying with the facility their emergency disaster plan to include evacuation contingencies
- Offering assistance to facilities with member placement and transportation

Supporting Providers and Subcontractors

Our providers and subcontractors are critical to our ability to serve our members in the event of an emergency like Hurricane Irma, and proactive outreach is critical. Among the many activities performed, Simply D/B/A Clear Health Alliance:

- Sent a Fax Blast to all providers that outlined special hurricane protocols regarding authorizations and pharmacy access and placed notices on our website
- Coordinated with hospitals to confirm the safety and well-being of members
- Reached out to all dialysis centers to understand continuity plans and the ability for member access post storm
- Contacted DME providers to understand contingency plans and verify they had adequate supplies, such as oxygen (and the ability to issue portable tanks) and ostomy supplies
- Contacted subcontractors to understand contingency plans in place to minimize member disruption

Simply Helping

I greatly appreciate all the efforts and coordination you provided in helping us transfer two bed-bound members from our facility to the hospital before the hurricane made landfall. This shows me that you show great interest in providing quality care to their members.

– **Arnaldo Quintero**, Owner of Hogar De Abuelos (ALF)

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Supporting Employees

As Florida residents, our employees were also facing the impact of the hurricane, including evacuation. We took steps to address the safety and security of our employees, such as communicating the need to begin preparing, office closure, and flexible work arrangements. We used a mass notification system to communicate with employees, which enabled us to reach each employee through multiple channels, both work and personal, until the employee confirmed receipt.

During the Hurricane

During the hurricane, our focus was on safety. We continued twice daily Emergency Response meetings, with participation from senior management as they were able, to assure member and employee communication and safety. We also continued daily clinical team meetings to coordinate and address member clinical issues.

Some of the additional activities during the hurricane included the following:

- Updating phone messages to explain that offices were closed, while providing members and providers instructions on how to communicate throughout the storm
- Waiving administrative requirements for providers to allow clinical flexibility

In addition, the “Go Team” had daily meetings with senior management to address any new member or provider concerns, responded to member and provider needs during the storm, and continued to process grievances and appeals.

After Irma

Activities after the hurricane focused on assessing the impact on members, providers, employees, and other stakeholders and returning to normal operation. We reopened all of our offices within 48 hours with 85 percent of staff reporting for work.

Twice daily Emergency Response meetings and daily clinical meetings continued during this time to assess member, provider, and employee needs and coordinate fulfillment. We also maintained close contact with AHCA, providing proactive updates on our activities and member needs.

We continued to provide member and provider support 24/7 through our call center, with additional support from our national call center. We also implemented an “Feet on the Street” approach, encouraging staff to go out into the field to personally deliver needed supplies and assess member needs.

Supporting our Members

We conducted extensive outreach after the storm to identify member needs and get them the support they needed. We leveraged our Case Management and Member Services teams to personally reach out to our members after the storm, including following up on members from the critical populations identified pre-storm and members residing in the Keys. We supplemented efforts with an automated outreach message to all members that provided key information such as Red Cross and FEMA numbers.

Some of the many additional activities during this time included the following:

- Outreach to member, with priority on the most impacted geographic areas
- Member Services outreach to all members in case management
- Providing case management outreach to all critical care members, such as pediatric complex cases and members on a ventilator, to coordinate care, medication access, and assistance with basic needs, including food, water, and shelter
- Proactively outreaching to all dialysis members to assure their continuity of care
- Engaging our transportation subcontractor to help evacuated members return home from shelters, access food banks and temporary housing, and access FEMA emergency locations, if needed
- Leveraging our over-the-counter supplier to deliver supplies to assist impacted members
- Maintaining pharmacy edit suspension to facilitate the ability of members to replace medications lost during the storm

We began outreach to LTC home-based members after the storm. Managed Care Coordinators began communicating with members to identify needs and answer questions. If we were unable to reach members by phone, we initiated face-to-face visits.

We also started outreach to LTC facilities post storm to confirm member safety, including onsite visits to all assisted living facilities and nursing facilities. We offered assistance in placements and transportation for members that needed to relocate.

Simply Helping

Javier is 55-year-old, legally blind, diabetic member who actively participates in our diabetes disease management program. When Olga, our Case Manager, reached out to check on him post-hurricane, he told her his power had been restored, but all his food went bad, and he had no money or means to purchase additional food and no transportation. His friends, who usually take him to buy groceries and occasionally cook for him, were unavailable during the hurricane.

So Olga got right to work and placed a nutritious food order through the CVS Hurricane Emergency portal for overnight delivery. She also gave him Community Resource 311 and local food distribution centers information, and encouraged him to reach out to Miami Lighthouse for the Blind for additional assistance. But she knew he needed food right away to avoid diabetes complications, so she arranged for another Case Manager living near Javier to make a home visit that same day. She helped him get groceries to last for a few days, talked with him about his options, including assisted living facilities, and let him know we'd continue to be there for him.

FL_Simply_33_Javier_59_RS_1.3

Supporting Providers and Subcontractors

Provider Relations staff conducted outreach activities to address any concerns. We outreached to all 10,000+ providers to confirm that they had reopened and rescheduled missed appointments. Provider Relations Managers contacted facilities to check on facility and member status and offer assistance.

Our Vendor Delegation and Oversight Group worked closely with every subcontractor to understand their business resumption status and communicated updates to Member Services and Case Management departments.

Supporting Employees

The health of our employees is critical to our success and during this strenuous period, we did everything possible to assure their safety and well-being. Our support included the following:

- Managers initiated direct outreach to their employees and reported back so that Human Resources could track the status and impact of all employees.
- We used our mass notification system to send “Are you safe?” messages to employees with prompts if they had evacuated.
- We accommodated unique employee needs with flexible work arrangements including variable work schedules and work from home.
- Our Employee Assistance Program, which offers tools and resources designed to meet the challenges of our employees and their families, provided onsite counseling in our Miami and Tampa offices.
- We provided assistance through our peer-to-peer program, which coordinates employee contributions to support fellow employees in time of need with financial grants.

Additionally, our parent company’s foundation matched donations made toward disaster relief, increasing the normal 50 percent match to 200 percent.

Lessons Learned

While we are proud of our response before, during, and after Irma; we know that there are always things that we can do to better. We conducted a survey to identify best practices, lessons learned, and suggestions from employees across Clear Health and our national support areas. The “Go Team” was a great response to the situation; however, a few areas identified include the following:

- Initiating the “Go Team” earlier, as soon as the region was within the five-day cone, will help with preparation efforts (especially considering this was the largest evacuation in U.S. history)
- Expanding the “Go Team” to include other key functional areas
- Developing a menu of decision points and minimum requirements to prompt decision making during the pre- and post- event periods
- Creating a library of prepared provider communications to leverage during an incident
- Increasing leverage of the national call center to conduct outbound calls to members and providers

Over the coming months, we will continue to work on action plans to refine and expand our Hurricane Preparedness Plan. We welcome the opportunity to meet with AHCA and the other Florida Managed Care Plans to share best practices that would help us all better support our members, providers, employees, and other stakeholders.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

G. STATUTORY REQUIREMENTS

SRC# 34 – Statutory Community Partnerships (Regional):

The respondent shall describe the extent to which its organization has established community partnerships with local providers or agencies that create opportunities for reinvestment in community-based services that play a critical role in improving the health and quality of life for enrollees, including:

- a. Participation by senior executive leadership staff on local health and human service boards, councils, and commissions.
- b. Partnerships with local community organizations focused on addressing the following social determinants of health:
 - (1) Access to Food;
 - (2) Employment;
 - (3) Housing Stability;
 - (4) Education; and
 - (5) Exposure to Crime/Violence.
- c. Participation in both grass-roots and grass-tops provider initiatives.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations. Within all our programs and contracts, we recognize the critical importance of developing partnerships in the communities and among the populations we serve. We describe our partnership efforts in Region 1 related to Clear Health in this section.

Through a contract with AHCA, Clear Health has been coordinating care to individuals with HIV/AIDS since February 2012. Since then, we have expanded our program and now operate the largest Medicaid Specialty Plan for this population in Florida. During this time, we have built a comprehensive network of providers, key community partnerships, and multi-disciplinary care coordination systems that optimize care access and outcomes for our enrollees (members).

We have learned much in the past five years about coordinating care for individuals with HIV/AIDS. We have learned that the HIV community is generally tight-knit, and developing a trusting relationship between members, providers, and the health plan is critical to engaging and maintaining care for individuals in this community. Additionally, privacy is a prime consideration for individuals with HIV/AIDS, because there is still significant stigma related to the diagnosis. Protection of health information inside and outside the care system is therefore paramount to our members.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

To build trust with our Clear Health members and communities, we have engaged in consistent outreach, education, and engagement among members, providers, and subcontractors. In addition, we have established a statewide Clear Health Member Advisory Committee to make certain we stay in touch with member needs and concerns. We also continue to leverage our relationship with former NBA superstar, Earvin “Magic” Johnson, arguably the most credible and well-known advocate for people living with HIV/AIDS. Mr. Johnson serves as an ambassador for both Simply and Clear Health and is an active participant in setting strategic direction for the organization. Indeed, Magic chairs Clear Health’s Strategic Advisory Group, which makes recommendations regarding improvements to quality, operations, and community partnerships in conjunction with our Member Advisory Committee and the broader HIV/AIDS community and research experts. He recently served as keynote speaker at the 17th Annual Center for AIDS Research Scientific Symposium. The symposium was sponsored by the University of Miami and organized by Dr. Margaret Fischl, Clear Health network provider and nationally renowned AIDS researcher. Through his direct input, leadership, and the efforts of his foundation, the Magic Johnson Foundation, Magic has provided invaluable insight and entrée to minority populations and communities that have historically been difficult to reach. Moreover, in his role as plan ambassador and community advocate, Magic visits with students in local schools, pastors in local churches, with providers in our network, and our employees (see Attachment SRC# 34-1: Earvin “Magic” Johnson). In May of this year, he met with Florida lawmakers in Tallahassee, expressing support for our innovative efforts to serve Medicaid and Medicare members.

We continuously build relationships and partnerships in the communities we serve, because we understand that the needs of our Clear Health members and providers change over time, as does the availability of local resources. We also understand that the health of our members depends on resources and relationships both inside and outside the health care sector.

Within the health care sector, we work closely with Clear Health network providers and other partners such as Ryan White agencies and public health departments to reach members in need of health care services and health education. This partnership development includes sponsoring and participating in community screening events, health fairs, and workshops, as well as participating in local coalitions and collaboratives. We have found this community work complements our targeted Clear Health member outreach efforts and offers an opportunity for providers in our network and other partners to engage community members and learn more about local needs, strengths, and aspirations.

We also reach across sectors to make sure our Clear Health members have access to critical resources such as stable housing, food security, education, and gainful employment — the social determinants of health. This includes developing working relationships with a variety of social, educational, and human service organizations and assisting in key areas such as capacity building. For example, we contracted with professional grant writers and organized grant-writing workshops across multiple regions for approximately 200 non-profit organizations, which received training in obtaining funding for their missions and become more self-sustaining. We identified a need and played a leadership role by organizing the workshops — the benefits of which were multiplied across many communities.

We also collaborate with our partners and colleagues on grassroots and grass-tops initiatives that create positive change in the community, and our Community Relations staff are embedded in their communities and serve as members on many local boards, councils, and commissions in support of community goals.

EXHIBIT A-4-a

GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

We support communities in other ways as well. For instance, in 2016, Simply contributed \$102,000 to sponsor community health programs throughout Florida. In addition, over the past decade our ultimate parent company, Anthem, Inc., has invested \$7.2 million supporting low-income housing in Florida. The Anthem Foundation has also pledged \$860,000 over a five-year period to support the “Triple Play Program”, a dynamic youth wellness program. For good measure, Simply employees personally support communities throughout Florida through our Associate Giving Program (\$52,909 donated in 2016, including a Foundation match) and volunteerism (1,345 total volunteer hours in 2016). Indeed, the day after Hurricane Irma, volunteers from our Community Relations team reached out to community partners to offer assistance and pitched in to trim and clear branches, distribute food and clothing, and provide a warm, helpful presence during the post-storm crisis impacting many Florida regions.

Currently, Clear Health has an HIV/AIDS specialty contract with AHCA to coordinate care for members in Region 1, and below we describe our partnerships in support of this contract.

1. COMMUNITY PARTNERSHIPS SUPPORT THE LOCAL CARE SYSTEM

Clear Health has actively been building partnerships throughout Region 1 in support of our members’ needs and to build a more responsive and accessible care system in the region. We supported the 19th Annual Positive Living Conference held in Fort Walton Beach, organized by the Okaloosa AIDS Support and Informational Services (OASIS). A Clear Health Managed Care Coordinator who lives and works in the area was a featured speaker. The conference provided valuable information about navigating the health care system for those living with HIV/AIDS, in addition to offering advocacy training, education on treatment options, prevention services, the Affordable Care Act, and other pertinent information.

Our Provider Relations team is engaged in meetings of the Northwest Florida AIDS/HIV Consortium (NoFLAC) to support local activities to improve access to high quality HIV/AIDS care and services. We partner with the Okaloosa County Health Department in Latino AIDS Awareness Day, and we provide support for a Latino HIV testing initiative.

Our Case Managers work closely with HIV providers in the area to coordinate services and assist members in receiving immediate assistance with any care-related issues (for instance, authorizations and referrals). In Region 1, these providers include Dr. Barbara Wade, the Okaloosa County Health Department, and the HIV Care Center at Sacred Heart.

Lastly, we hold Clear Health Member Advisory Committee meetings in Region 1 to hear from members and other stakeholders about local needs, issues, and concerns. As indicated, we make adjustments in our services and policies and establish new partnerships based upon input received.

2. PARTICIPATION ON LOCAL HEALTH AND HUMAN SERVICES BOARDS, COUNCILS AND COMMISSIONS

At Clear Health, we are committed to building healthy and resilient communities, and we strive to work shoulder-to-shoulder with community members in this endeavor. This includes serving on local boards, councils, and commissions, offering a voice and resources as appropriate on behalf of our members and other underserved individuals, families, and populations.

EXHIBIT A-4-a

GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Our senior leaders, including Lourdes Rivas, President and Chief Executive Officer (CEO); Dr. Vincent Pantone, Chief Medical Officer; Suzanna Roberts, Chief Operating Officer; Judi Peterson, Staff Vice President; Holly Prince, Chief Financial Officer; and Dr. Fatimah Tahil, Medical Director for Behavioral Health are actively engaged in civic affairs, often at a statewide level, due to the nature of their positions and ability to influence policies and practices at the grass-tops level. Provided below is a listing of the committees, associations, coalitions, and councils in which they currently participate:

- Center for Leadership at Florida International University, Board of Advisors
- Florida Alcohol and Drug Abuse Association
- Florida Association for Community Mental Health
- Florida Association of Health Plans
- Florida Coalition of Supportive Housing
- Florida Council for Mental Health
- Florida HMO Consumer Assistance Board of Directors
- Florida International University Center for Leadership
- Florida Maternal Mental Health Collaborative
- Florida Policy Academy
- Hispanic Chamber of Commerce
- Miami Chamber of Commerce
- National Alliance on Mental Illness (NAMI) Florida
- St. Thomas University, Board of Trustees
- United HomeCare Services, Inc.
- United Way of Miami-Dade County

In Region 1, our Clear Health Alliance Community Relations Manager, Jose Camino, sits on the Northwest Florida AIDS Consortium. His participation and input makes certain that the HIV/AIDS prevention and treatment needs of our Clear Health members are voiced and addressed and that Clear Health resources are available, as appropriate, to assist the Consortium in meeting its goals and objectives.

3. PARTNERSHIPS WITH LOCAL AGENCIES THAT FOCUS ON ADDRESSING SOCIAL DETERMINANTS OF HEALTH

We understand that social factors such as income, employment, housing, education, and exposure to crime and violence play a critical role in health outcomes. This is particularly true for individuals living with HIV/AIDS, who are more likely to live in poverty and face challenges accessing housing, employment, and health care.

To assist Clear Health members in Region 1 with housing and access to food, our Case Managers have developed referral relationships with OASIS, Lutheran Services, and Catholic Charities. In addition, we connect members requiring housing assistance with the Housing Opportunities for Persons with AIDS (HOPWA) program, which is the only federal program dedicated to the housing needs of people living with HIV/AIDS. Under the HOPWA program, HUD makes grants to local communities, states, and nonprofit organizations for projects that benefit low-income persons living with HIV/AIDS and their families.

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

In other regions of Florida, we have developed partnerships with job training programs (CareerSource South Florida and LifeNet4Families), educational institutions (Concorde College and Buren Middle School), and violence prevention initiatives (Hillsborough Community Violence Prevention Collaborative) to improve access to social determinants such as employment, education, and violence prevention. We are particularly supportive of the St. Petersburg 2020 Task Force in Pinellas County, a poverty reduction initiative that is addressing multiple health determinants (housing, employment, and education). Our Senior Human Resources Director, Patricia Cruzalvarez, is our representative to the 2020 Task Force. These types of partnerships will serve as a blueprint for expanding our relationships in Region 1.

4. DEVELOPMENT AND INCORPORATION OF CHANGE FROM GRASSROOTS AND GRASS-TOPS INITIATIVES

Clear Health actively participates in community-based initiatives endeavoring to level the playing field so that everyone has an equal opportunity for good health. In Region 1, we are members of the Northwest Florida AIDS/HIV Consortium (NoFLAC) and work closely with consortium members to establish policies that improve access to health care services for people with HIV/AIDS and improve access to social determinants such as housing, employment, and transportation.

In other regions of Florida, we participate in grass roots dental initiatives (Tampa Bay Oral Health Coalition), substance abuse prevention initiatives (Orange County Drug Free Coalition), poverty reduction efforts (Orange County Community Action Advisory Board), and ethnic-specific coalitions (Latino Coalition of Tampa Bay). We expect to bring the best practices of these initiatives to Region 1 in areas that align with community priorities and interest.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The extent to which the respondent provides details on how their local community partnerships, activities and initiatives support the local system of care.
2. The extent to which the respondent has senior executive leadership staff who will be assigned to the resulting Contract who also participate on local health and human service related boards, councils, and commissions.
3. The extent to which the respondent has partnerships with local agencies that focus on addressing social determinants of health.
4. The extent to which the respondent jointly develops and incorporates change from grassroots and grass-tops provider initiatives.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

Figure 34-1. Earvin “Magic” Johnson Visits with Simply Employees



Figure 34-2. Magic Shares a Laugh at Simply's New Domino Room at Goodlet Park in Hialeah



Figure 34-3. Magic Gets Introduced by Our Plan President and CEO, Lourdes Rivas, at Meeting with Top Providers in Our Miami Office



Figure 34-4. Magic Visits a Local School in Miami to Speak to Kids About Importance of Being Healthy and Staying in School



EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 35 – Organization Commitment to Quality (See Section 409.966, Florida Statutes) (Statewide):

The respondent shall describe its organizational commitment to quality improvement, including active involvement by the respondent's medical and administrative leadership, and document its achievements with two (2) examples of completed quality improvement projects, including description of interim measurement and rapid cycle improvement processes, and a summary of results.

Response:

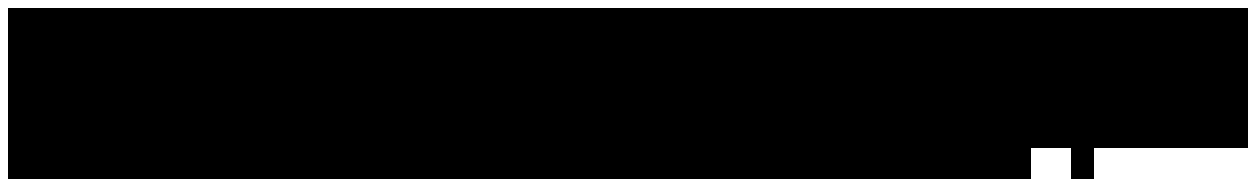
[REDACTED]

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**EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)**



Evaluation Criteria:

1. The extent to which the respondent's description demonstrates that the medical director has substantial oversight in the assessment and enhancement of quality improvement activities, and the Chief Executive Officer is actively involved in quality management.
2. The adequacy of the respondent's approach to incorporating quality improvement activities into the culture and operations of the organization.
3. The extent to which the respondent describes proactive processes and strategies that are utilized to recognize and solve problems before they occur or are exacerbated.
4. The extent to which the respondent provides two examples of completed quality improvement projects that incorporated a data-driven quality improvement cycle.
5. The extent to which the respondent provides data on the results of the quality improvement projects that demonstrates the efficacy of the interventions.
6. The extent to which one of the quality improvement projects described by the respondent is related to reducing potentially preventable events or improving birth outcomes.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 36 – Health Plan Accreditation (See Section 409.966, Florida Statutes) (Statewide):

The respondent shall specify its current accreditation status by a nationally recognized accrediting body. This shall include the name of the accrediting body, the most recent date of certification, the effective date of the accreditation, the type and/or level of accreditation, and the status of accreditation (i.e., provisional, conditional, etc.). The respondent shall attach documentation that supports this information.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Clear Health, through Simply, and each one of our legacy organizations is currently accredited by a national accrediting body. The accreditations reflect our organizational commitment to attaining the highest quality and regulatory standards in everything we do.

1.a. FULL HEALTH PLAN ACCREDITATION BY A NATIONAL ACCREDITING BODY

Our legacy health plans, Simply and Better Health, have been continuously accredited by the Accreditation Association for Ambulatory Health Care, Inc. (AAAH), a nationally recognized accrediting body, since 2013. The most recent certifications last for a period of three years, through January 2019. Simply's accreditation covers Clear Health, as reflected in Attachment SRC# 36-1: Clear Health Proof of AAAHC Accreditation.

Name of the accrediting body: AAAHC

Original date of certification: January 30, 2013 (Better Health) and January 31, 2013 (Simply/Clear Health)

Most recent date of certification: February 3, 2016 (Both)

Effective date of accreditation: January 30, 2016 (Better Health) and January 31, 2016 (Simply/Clear Health)

Type and/or level of accreditation: Full (Both)

Status of accreditation: Accredited (Both)

Attachment SRC# 36-1: Clear Health Proof of AAAHC Accreditation and Attachment SRC# 36-2: Better Health Proof of AAAHC Accreditation include a copy of the current AAAHC certificate of accreditation and the accompanying notification letter for each plan.

**** RESULTS & SUCCESSES:** High Praise in Most Recent AAAHC Survey

Clear Health, through Simply, and Better Health achieved full compliance in 11 out of 11 categories in their most recent AAAHC Survey Reports. During the onsite visit, the AAAHC auditor lauded the comprehensive programs and provided praise for the infusion of continuous quality improvement in all company activities and processes. **

EXHIBIT A-4-a GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Our other legacy organization, Amerigroup, also maintains full health plan accreditation by a national accrediting body. Amerigroup is accredited by the NCQA, and achieved full accreditation and Commendable status in 2016. Prior to obtaining NCQA accreditation, they were continuously accredited with the AAAHC starting in 2003.

Name of the accrediting body: NCQA
Original date of certification: July 29, 2016
Most recent date of certification: July 29, 2016
Effective date of accreditation: July 29, 2016
Type and/or level of accreditation: Commendable
Status of accreditation: Accredited

Attachment SRC# 36-3: Amerigroup Proof of NCQA Accreditation includes a copy of Amerigroup's current NCQA certificate of accreditation and the accompanying notification letter.

Looking forward, the recent changes in our organizational structure will provide new opportunities for Clear Health to implement NCQA-approved practices and programs to improve the health and overall experience of our members. For example:

- **NCQA Accreditation.** We are seeking full accreditation by the NCQA, through Simply, and recently initiated the process with a Letter of Intent. Due to our relationship with Amerigroup, we can undergo NCQA's Mergers, Acquisitions, and Consolidation Survey. Simply will do this in the first half of 2018 to gain full NCQA accreditation for all of its Medicaid products, including Clear Health. During this time, we will maintain our AAAHC accreditation status and therefore will have no breaks in accreditation.
- **Managed Behavioral Health Organization (MBHO) Accreditation.** Our ultimate parent company, Anthem, Inc., obtained MBHO accreditation by the NCQA in June 2017, demonstrating an organizational commitment to integrating care through evidence-based practices that improve quality and case management across medical and behavioral health (BH) systems of care.
- **Disease Management (DM) Program Accreditation.** Seven of our 12 DM programs are accredited by the NCQA, including asthma, diabetes, depression, schizophrenia, chronic obstructive pulmonary disease, coronary artery disease, and congestive heart failure.
- **Multicultural Health Care Distinction.** This distinction reflects an organizational commitment to the provision of culturally competent services and reducing health disparities. Our legacy organization, Amerigroup, was awarded this honor by the NCQA in March 2017, and is one of only two Medicaid health plans in Florida that has this distinction. Clear Health, through Simply, is currently seeking its own designation as part of the NCQA Mergers, Acquisitions, and Consolidation Survey process.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. Evidence that the respondent has:

- (a) Full health plan accreditation by a nationally recognized accrediting body; e.g., full three (3) year accreditation for the National Committee for Quality Assurance (NCQA), full three (3) year accreditation for Utilization Review Accreditation Commission (URAC), or full three (3) year accreditation for Accreditation Association for Ambulatory Health Care, Inc. (AAAHC); or
- (b) Partial/conditional health plan accreditation (e.g., provisional for NCQA, conditional or provisional for URAC, or one (1) year or six (6) months for AAAHC); or
- (c) No health plan accreditation or denied accreditation.

Score: This section is worth a maximum of 5 raw points as outlined below:

- (a) 5 points for full health plan accreditation.
- (b) 3 points for partial/conditional health plan accreditation.
- (c) 0 points if health plan accreditation denied or no accreditation.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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Congratulations!

You have been awarded a three year term of accreditation!

Your AAAHC accreditation is a significant achievement. Seeking accreditation implies a commitment to ongoing self-evaluation and continuous improvement. The dedication and effort required is substantial and I commend your staff for this approach to high-quality patient care and business practices.

Granting accreditation reflects confidence, based on evidence from this recent survey, that you meet AAAHC Standards and will continue to demonstrate the attributes of an accreditable organization. Each year of your term of accreditation, you will receive notification of release of the updated Standards. It is vital that your organization has an up-to-date copy of the *Handbook*, whether through the purchase of the annual binder, or by taking advantage of the window of opportunity to download an electronic copy free of charge.

I hope the survey experience was beneficial to your organization in identifying strengths as well as opportunities to improve, and that you found your surveyor(s) to be consultative and educational in approach.

Enclosed is your Accreditation Notification with additional details describing your award and the next steps for your organization. Your Survey Report is also enclosed. Review and use it as a periodic reference throughout your term of accreditation.

Your organization has been added to our communications mailing list. Soon you will receive our quarterly newsletter, *Triangle Times*. This publication includes news items, announcements of policy changes, review of individual Standards, and other information relevant to our accredited organizations. It will be mailed to the primary contact for your organization. You may request additional copies by providing additional names via e-mail to marketing@aaahc.org. Our e-newsletter, *Connection*, requires a subscription. It is published every other month and usually focuses on a single topic. Request a free subscription by e-mailing marketing@aaahc.org.

Again, please accept my sincere congratulations on your achievement.

Best regards,

A handwritten signature in black ink, appearing to read "Stephen A. Martin, Jr." with a stylized flourish at the end.

Stephen A. Martin, Jr., Ph.D., M.P.H.
President & CEO



ACCREDITATION
ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

grants this

CERTIFICATE OF ACCREDITATION

to

SIMPLY HEALTHCARE PLANS, INC.

DBA CLEAR HEALTH ALLIANCE

9250 W. FLAGLER, 6TH FLOOR
MIAMI, FL 33174

*In recognition of its commitment to high quality of care and substantial compliance
with the Accreditation Association for Ambulatory Health Care standards for Health Plans.*

Organization Identification Number

18589

FRANK J. CHAPMAN, MBA

Chair of the Board



The Award of Accreditation Expires on:

JANUARY 30, 2019

Stephen A. Martin, Jr., Ph.D., M.P.H.

President and CEO

ASSOCIATION MEMBERS

American Academy of Cosmetic Surgery · American Academy of Dental Group Practice · American Academy of Dermatology ·
American Academy of Facial Plastic and Reconstructive Surgery · American Association of Oral and Maxillofacial Surgeons ·
American College of Gastroenterology · American College of Health Association · American College of Mohs Surgery ·
American Congress of Obstetricians and Gynecologists · American Dental Association · American Gastroenterology Association ·
American Society of Anesthesiologists · American Society for Dermatologic Surgery · American Society for Gastrointestinal Endoscopy ·
ASCA Foundation · Association of periOperative Registered Nurses · Society for Ambulatory Anesthesia



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ACCREDITATION NOTIFICATION

February 3, 2016

Organization #	18589		
Organization Name	Simply Healthcare Plans, Inc.		
Address	9250 W. Flagler, 6th Floor		
City | State | Zip	Miami	FL	33174
Decision Recipient	Ms. Lila Labarces		
Survey Date	January 25-26, 2016	Type of Survey	Reaccreditation
Accreditation Type	Full Accreditation		
Accreditation Term Begins	January 31, 2016	Accreditation Term Expires	January 30, 2019
Accreditation Renewal Code		f4d223e418589	
Complimentary AAAHC Institute study participation code		18589FREEIQI	

As health plan that has undergone the AAAHC Accreditation Survey, your organization has demonstrated its substantial compliance with AAAHC Standards. The AAAHC Accreditation Committee recommends your organization for accreditation.

Next Steps

- Members of your organization should take time to thoroughly review your Survey Report.
 - Any Standard marked “PC” (Partially Compliant), “MC” (Minimally Compliant), or “NC” (Non-compliant) must be corrected promptly. Subsequent surveys by AAAHC will seek evidence that deficiencies from this survey were addressed without delay.
 - The Summary Table provides an overview of compliance for each chapter applicable to your organization.
- AAAHC Standards, policies and procedures are reviewed and revised annually. You are invited to participate in the review through the public comment process each fall. Your organization will be notified when the proposed changes are available for review. You may also check the AAAHC website in late summer for details.
- Accredited organizations are required to maintain operations in compliance with the current AAAHC Standards and policies. Updates are published annually in the AAAHC *Handbooks*. Mid-year updates are announced and posted to the AAAHC website, www.aaahc.org.

4. In order to ensure uninterrupted accreditation, your organization should submit the *Application for Survey* approximately five months prior to the expiration of your term of accreditation. In states for which accreditation is mandated by law, the *Application* should be submitted six months in advance to ensure adequate time for scoping and scheduling the survey. Here is the web address:

<https://application.aaahc.org/healthplan.aspx>

NOTE: You will need the Accreditation Renewal Code found in the table at the beginning of this document to submit your renewal application.

Additional Information

The complimentary AAAHC Institute study participation code on the first page of this document may be used to register for one six-month, AAAHC Institute for Quality Improvement benchmarking study.

Please visit www.aaahc.org/institute for more information or contact Michelle Chappell at 847.324.7747 or mchappell@aaahc.org.

The packet of brochures and the marketing kit in this mailing are designed to help you use your accreditation to educate and inform multiple audiences—your current and prospective patients, your payers, and your community—about AAAHC accreditation and the quality of care you deliver. Please remember that these are suggestions; tailored marketing activities with specific objectives will be most effective.

Throughout your term of accreditation, AAAHC will communicate announcements via e-mail to the primary contact for your organization. Please be sure to notify us (notify@aaahc.org) should this individual or his/her contact information change.

If you have questions or comments about the accreditation process, please contact AAAHC Accreditation Services at 847.853.6060. We look forward to continuing to partner with you to deliver safe, high-quality health care.



Congratulations!

You have been awarded a three year term of accreditation!

Your AAAHC accreditation is a significant achievement. Seeking accreditation implies a commitment to ongoing self-evaluation and continuous improvement. The dedication and effort required is substantial and I commend your staff for this approach to high-quality patient care and business practices.

Granting accreditation reflects confidence, based on evidence from this recent survey, that you meet AAAHC Standards and will continue to demonstrate the attributes of an accreditable organization. Each year of your term of accreditation, you will receive notification of release of the updated Standards. It is vital that your organization has an up-to-date copy of the *Handbook*, whether through the purchase of the annual binder, or by taking advantage of the window of opportunity to download an electronic copy free of charge.

I hope the survey experience was beneficial to your organization in identifying strengths as well as opportunities to improve, and that you found your surveyor(s) to be consultative and educational in approach.

Enclosed is your Accreditation Notification with additional details describing your award and the next steps for your organization. Your Survey Report is also enclosed. Review and use it as a periodic reference throughout your term of accreditation.

Your organization has been added to our communications mailing list. Soon you will receive our quarterly newsletter, *Triangle Times*. This publication includes news items, announcements of policy changes, review of individual Standards, and other information relevant to our accredited organizations. It will be mailed to the primary contact for your organization. You may request additional copies by providing additional names via e-mail to marketing@aaahc.org. Our e-newsletter, *Connection*, requires a subscription. It is published every other month and usually focuses on a single topic. Request a free subscription by e-mailing marketing@aaahc.org.

Again, please accept my sincere congratulations on your achievement.

Best regards,

A handwritten signature in black ink, appearing to read "Stephen A. Martin, Jr.", with a stylized flourish at the end.

Stephen A. Martin, Jr., Ph.D., M.P.H.
President & CEO



ACCREDITATION
ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

grants this

CERTIFICATE OF ACCREDITATION

to

BETTER HEALTH, LLC

9250 W. FLAGLER, 6TH FLOOR
MIAMI, FL 33174

*In recognition of its commitment to high quality of care and substantial compliance
with the Accreditation Association for Ambulatory Health Care standards for Health Plans.*

Organization Identification Number

99519

FRANK J. CHAPMAN, MBA

Chair of the Board



The Award of Accreditation Expires on:

JANUARY 29, 2019

Stephen A. Martin, Jr., Ph.D., M.P.H.

President and CEO

ASSOCIATION MEMBERS

American Academy of Cosmetic Surgery · American Academy of Dental Group Practice · American Academy of Dermatology ·
American Academy of Facial Plastic and Reconstructive Surgery · American Association of Oral and Maxillofacial Surgeons ·
American College of Gastroenterology · American College of Health Association · American College of Mohs Surgery ·
American Congress of Obstetricians and Gynecologists · American Dental Association · American Gastroenterology Association ·
American Society of Anesthesiologists · American Society for Dermatologic Surgery · American Society for Gastrointestinal Endoscopy ·
ASCA Foundation · Association of periOperative Registered Nurses · Society for Ambulatory Anesthesia



5250 OLD ORCHARD ROAD, SUITE 200 • SKOKIE, IL 60077

PHONE: 847/853.6060 • E-MAIL: INFO@AAAHC.ORG • WEB SITE: WWW.AAAHC.ORG

ACCREDITATION NOTIFICATION

February 3, 2016

Organization #	99519		
Organization Name	Better Health, LLC		
Address	9250 W. Flagler, 6th Floor		
City | State | Zip	Miami	FL	33174
Decision Recipient	Ms. Lila Labarces		
Survey Date	January 26-27, 2016	Type of Survey	Reaccreditation
Accreditation Type	Full Accreditation		
Accreditation Term Begins	January 30, 2016	Accreditation Term Expires	January 29, 2019
Accreditation Renewal Code		88d4b1ca99519	
Complimentary AAAHC Institute study participation code		99519FREEIQI	

As health plan that has undergone the AAAHC Accreditation Survey, your organization has demonstrated its substantial compliance with AAAHC Standards. The AAAHC Accreditation Committee recommends your organization for accreditation.

Next Steps

1. Members of your organization should take time to thoroughly review your Survey Report.
 - Any Standard marked “PC” (Partially Compliant), “MC” (Minimally Compliant), or “NC” (Non-compliant) must be corrected promptly. Subsequent surveys by AAAHC will seek evidence that deficiencies from this survey were addressed without delay.
 - The Summary Table provides an overview of compliance for each chapter applicable to your organization.
2. AAAHC Standards, policies and procedures are reviewed and revised annually. You are invited to participate in the review through the public comment process each fall. Your organization will be notified when the proposed changes are available for review. You may also check the AAAHC website in late summer for details.
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July 29, 2016

Rosy Cozad
Pres Medicaid Health Plan - FL
AMERIGROUP Florida, Inc.
4200 West Cypress Street Suite 900
Tampa, FL 33607

Dear Mrs. Cozad:

We are pleased to inform you that based on the information gathered during your recent HP survey, the National Committee for Quality Assurance (NCQA) Review Oversight Committee has awarded **AMERIGROUP Florida, Inc.** the accreditation status(es) listed below. The final assessment report, which incorporates relevant changes made in response to your organization's earlier comments, is now ready for your review. You may now access the final report and results online by visiting <https://iss.ncqa.org> and looking under the section entitled Survey and Results.

Product Line/ Product	Accreditation Status	Effective Date	Expiration Date
Medicaid-HMO	Accredited	July 29, 2016	July 29, 2019

The NCQA Health Plan Report Card will be updated to reflect this status by no later than the 15th of August. A certificate reflecting your accreditation status(es) is enclosed in recognition of your achievement. Also, for your convenience, you may download the NCQA accreditation seal by visiting our Web site at www.ncqa.org. Please refer to the 'Guidelines for Advertising NCQA HPA Survey Accreditation,' enclosed.

If you have reason to believe that the compliance scoring of any standard or standards does not accurately reflect your organization's compliance with the standards, you have the opportunity to request a reconsideration of compliance designations and/or accreditation outcome by the NCQA Reconsideration Committee. To proceed with reconsideration, NCQA must receive within the next 30 days a written request for reconsideration that addresses at least one of the grounds for appeal identified in the Reconsideration section of the "Administrative Policies and Procedures" of the 2015 *Standards and Guidelines for the Accreditation of Health Plans*. This request must not exceed five pages in length and must include a listing of the standards for which reconsideration is being requested. A fee, as specified in the Agreement for HP Accreditation Survey, "Pricing Methodology and Cancellation Policy" (Exhibit A), is charged for reconsideration. The fee must be paid at the time reconsideration is requested.

July 29, 2016
Page 2

In order to maintain your accreditation status(es), AMERIGROUP Florida, Inc. will need to participate in a resurvey approximately three months prior to the expiration date. Your next survey will be conducted in two stages using NCQA's Interactive Survey System (ISS) and standards in effect at the time of the survey. The first, or offsite, stage will begin immediately upon submission of your organization's completed Survey Tool. During this stage, NCQA reviews the organization against most of the standards and elements, thus reducing the duration of the second, or onsite, stage which will be scheduled to begin seven weeks after your Survey Tool is submitted to NCQA.

We have tentatively reserved **May 7, 2019** as the submission date of the completed Survey Tool to NCQA. NCQA has tentatively set **June 24 - 25, 2019** for your two-day onsite survey. If the proposed dates present a problem for you or if you have any questions regarding these dates, please contact Cindy Francis, Program Manager, Accreditation, at (202) 955-5147 or e-mail francis@ncqa.org.

If you have questions about the ISS, please contact NCQA Customer Support at (888) 275-7585 or via my.ncqa.org. You can also visit www.ncqa.org for additional information.

While it is our understanding that the results of this accreditation survey may satisfy a state regulatory requirement, NCQA assumes no responsibility for transmitting copies of this report to relevant state agencies.

We wish to acknowledge your quality improvement efforts, which were evident throughout the survey process. NCQA looks forward to working with you and your staff again in the future.

Sincerely,

A handwritten signature in black ink, appearing to read 'Gerald Stewart', with a stylized flourish at the end.

Gerald Stewart
Assistant Vice President, Accreditation

Enclosures



National Committee for Quality Assurance
has awarded

AMERIGROUP Florida, Inc.

Medicaid HMO

an accreditation status of

ACCREDITED



for service and clinical quality that meet or exceed
NCQA's rigorous requirements for consumer
protection and quality improvement.


CHAIR, BOARD OF DIRECTORS


PRESIDENT


CHAIR, REVIEW OVERSIGHT COMMITTEE

July 29, 2016
DATE GRANTED

July 29, 2019
EXPIRATION DATE



August 31, 2016

Rosy Cozad
Pres Medicaid Health Plan - FL
AMERIGROUP Florida, Inc.
4200 W. Cypress Street
Suite 900
Tampa, FL 33607

Dear Mrs. Cozad:

NCQA has completed the annual review of HEDIS® data as outlined in the *Standards and Guidelines for the Accreditation of Health Plans*. Based on your organization's HEDIS® 2016 results, the accreditation status for AMERIGROUP Florida, Inc.'s Medicaid HMO has increased to Commendable. The new score sheets are attached.

The NCQA Health Plan Report Card will be updated to reflect your new status at the time of the September release (September 15th) and will continue to reflect this status until the expiration date, or until the next review of your HEDIS® results, whichever comes first. A certificate reflecting your new accreditation status is attached.

Should you have any questions about the annual HEDIS® update process, please contact Stephanie Hoch at 202-955-3519.

Sincerely,

A handwritten signature in black ink that reads 'James A. Roney'. The signature is written in a cursive, flowing style.

James Roney
Director, Survey Support

Attachments



National Committee for Quality Assurance
has awarded

AMERIGROUP Florida, Inc.

Medicaid HMO

an accreditation status of

COMMENDABLE

for service and clinical quality that meet or exceed

NCQA's rigorous requirements for consumer

protection and quality improvement.



David Chris, MD

CHAIR, BOARD OF DIRECTORS

Margaret E. J. K.

PRESIDENT

Vicki K. H. M.

CHAIR, REVIEW OVERSIGHT COMMITTEE

August 31, 2016

DATE GRANTED

July 29, 2019

EXPIRATION DATE

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

RESPONDENT NAME: Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance

A. RESPONDENT BACKGROUND/EXPERIENCE

No SRCs in this Category for MMA.

B. AGENCY GOALS

MMA SRC# 1 – Potentially Preventable Events (Regional):

The respondent shall describe its organizational commitment to quality improvement as it relates to reducing potentially preventable events. More specifically, the respondent shall describe its overall approach and specific strategies that will be used to ensure a reduction in potentially preventable hospital admissions and readmissions, a reduction in the use of the emergency department for non-emergent/urgent visits, and a reduction in the use of unnecessary ancillary services during hospitalization and outpatient visits. The respondent's approach shall also include:

- A description of the respondent's assessment (using available data sources) of hospital utilization rates and the potential for improvement;
- A description of performance benchmarks for each area of focus;
- A description of incentives that will be implemented for providers and enrollees aimed at diverting care to more appropriate and cost-effective settings; and
- A description of evidence-based interventions and strategies that will be used to target super-utilizers, particularly related to pain management and behavioral health conditions.

Response:

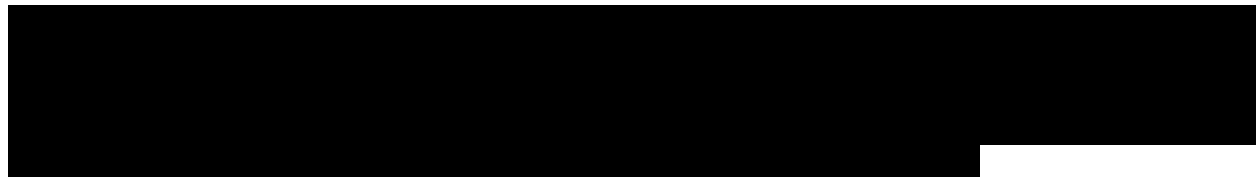
Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Clear Health shares the Agency's commitment to reducing potentially preventable events (PPEs) and utilization of unnecessary ancillary services, which increase program costs and negatively impact the overall quality of care our members receive. As recognized by the Agency in the Quarterly Statewide Medicaid Managed Care Report (Spring 2017) (the "Spring 2017 Report"), "although not all potentially preventable events can be avoided, PPE rates in populations can be used as a gauge regarding failure to access primary care and the quality of care available." When we avoid PPEs, we know we are delivering more holistic, higher quality care at the right time and in the right place.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

As defined by the Agency, PPEs include potentially preventable hospital admissions (PPAs), potentially preventable hospital readmissions (PPRs), and potentially preventable emergency department (ED) visits (PPVs). We address PPEs through a multi-faceted strategy that includes improving:

- Care transitions
- Coordination of services
- Continuity of care
- Integrated approach for members with co-occurring physical and BH conditions
- Access to primary care and other services
- Medication management and helping members and providers avoid therapeutic duplication and polypharmacy
- Self-management of chronic conditions
- Systems that monitor and analyze appropriate use of health care resources
- Health Information Exchange (HIE), including Florida Health Information Exchange's Event Notification System
- Telemedicine and telehealth
- Provider and member incentives



Our comprehensive approach of collaborating with providers and community resources to better coordinate and manage care, supported by sophisticated data analytics, an integrated disease management (DM) and case management program, focused initiatives for high utilizers, and targeted outreach, continues to demonstrate impressive results that improve outcomes while containing costs:

- Our PPA rate is the second lowest in the state. As detailed in Figure 1-1 in Attachment MMA SRC# 1-1: PPE Results, our risk adjusted PPA rate per 1,000 enrollee months is 1.3, significantly less than the statewide average of 2.14. (Spring 2017 Report).

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- Our DM programs reduce PPAs and PPRs. When we analyzed our DM programs in 2016, we found a 20 percent decrease in inpatient costs with a corresponding three percent increase in physician costs, indicating members in DM are more engaged with their PCPs and specialists, are managing their conditions, and are avoiding costly, unnecessary hospital care.
- Our value-based reimbursement strategies have a clear impact on reducing PPEs. Members assigned to providers in our value-based purchasing (VBP) programs have lower ED rates (605/1000 compared to 747/1000) and lower readmissions (12.01 percent compared to 14.6 percent) than members not assigned to providers in our VBP programs.
- As a result of focused behavioral health post-discharge management efforts, we achieved a 13.4 percent decrease in BH hospital readmissions in the last 12 months.

1. OPPORTUNITIES TO REDUCE PPEs IN REGION 1

1.1. Assessment of Region 1 PPEs and Opportunities for Improvement

We believe focusing on reducing PPVs and PPRs will have the greatest impact on reducing overall PPEs in Region 1. We reviewed the Spring 2017 Report and other available data to assess hospital utilization rates and the potential for improvement in Region 1. Because this region already has the lowest PPA rate in the state, we do not believe it offers the same opportunity for improvement (although reducing PPAs is always a priority at Clear Health).

Based on the aggregated data for all Managed Care Plans in the region, we identified many systemic and clinical factors that we believe contribute to PPVs and PPRs in Region 1:

- PPVs: Region 1 has the highest rate of PPVs in the state (32.98 in Region 1 compared to 24.08 statewide). PPVs result from lack of access, inadequate monitoring and management of chronic conditions, uncoordinated care, and poor follow-up after the initial discharge. The top three conditions leading to a PPV in Region 1 are upper respiratory infections; abdominal pain; and gastroenteritis, nausea, and vomiting. The top conditions driving PPVs at Clear Health are abdominal pain and chest pain. (Spring 2017 Report)
- PPRs: Region 1's PPR rate is slightly above the state average (88.69 in Region 1, compared to 87.11 statewide). PPRs are the result of care provided during an initial hospitalization or after discharge, reflect the continuation or recurrence of a medical condition addressed in the original hospitalization, or result from the continuation or recurrence of a BH or substance abuse condition following the original hospitalization. Inadequate follow-up care, or lack of necessary services after a hospital discharge, can also cause a PPR. The top three conditions driving PPRs in Region 1 are bipolar disorders, COPD, and pancreas disorders. Statewide, children are most commonly readmitted for bipolar disorders and major depression. For adults, schizophrenia is the most common condition resulting in a PPR. The top conditions driving PPRs at Clear Health, after HIV, are schizophrenia and COPD. (Spring 2017 Report)

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Based on our assessment, we will leverage the combined resources, effective programming, and best practices of all our legacy plans and engage or continue to use the following strategies to address PPVs and PPRs in Region 1:

- Increase access to and coordination between primary and BH care
- Expand alternatives to ED care, including telehealth and after-hours Nurse help line, and provide better access to primary care, which is a cornerstone to preventing avoidable events
- Improve identification and monitoring of members at higher risk for a PPV or PPR, especially members with asthma, COPD, and BH or substance use disorder conditions
- Enhance member engagement and follow-up post-discharge
- Provide DM, case management, and medication management programs to better manage chronic conditions, coordinate services, and improve care

1.2. Targeted Action Plans to Address Barriers and Improve Coordination of Services

Clear Health will take many steps to overcome barriers and improve coordination of care. These steps include both statewide programs and local approaches to reduce PPVs and PPRs. While many of the programs reflect activities already underway in one or more of our legacy plans, we will also implement new programs to improve our overall PPE approach (e.g., rare disease management).

- Twelve evidence-based DM programs to improve monitoring and management of chronic conditions, including our integrated HIV/AIDS DM and case management program
- High-touch case management programs to better coordinate care and overcome barriers between different systems of care
- Post Discharge Management (PDM) Program, Transitions of Care (TOC) Program, and inpatient outreach and referrals to provide adequate follow-up and coordinate necessary services after a hospital discharge
- CD4 Project and HAART Initiative
- Mobile clinic days and new telemedicine and telehealth initiatives to improve access to primary and BH services
- Complex case management rounds to develop individual action plans for super-utilizers and complex cases, including members with co-occurring BH conditions and/or multiple psychiatric admissions
- Rare Disease Management Program to improve monitoring and management of members with unique health care needs

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- Initiatives to identify and address barriers to care for homeless members
- In-home physician visits when needed as part of transitional care case management for members at high risk for readmission

Our comprehensive approach includes many local activities specific to Region 1 that overcome barriers between different systems of care.

- We will provide Mobile Clinic Days to improve access to primary care and other needed services.
- We will partner with providers through our effective VBP programs to incentivize the right care, in the right place, at the right time with a region-appropriate goal based on provider capacity
- We will use ENS to improve case management and mitigate unnecessary ED utilizations

Many of the programs and initiatives included in our comprehensive approach are described in further detail below. Additional details about tailored programs for super-utilizers is described in Section 2.2. of this SRC response, and information about our member and provider incentives is described in Section 6 of this SRC response.

1.2.1. NCQA-Accredited DM Programs

We offer integrated case management and DM services to all our members to address the unique care coordination, access, and other challenges persons living with HIV/AIDS face. We also holistically address member co-morbidities with DM programs for asthma, diabetes, cancer, hypertension, major depressive disorder, schizophrenia, substance abuse, Alzheimer's/dementia, congestive heart failure, COPD, and coronary artery disease. Seven of our DM programs are accredited by the NCQA. They all focus on closing gaps in care that contribute to PPEs and are effective because Case Managers (Managed Care Coordinators) proactively engage members in goal-setting, increasing health literacy, and improving self-care. For members with asthma and diabetes, clinical pharmacists and/or pharmacy technicians will review members' medication history and provide counseling to improve medication adherence. We also promote smoking cessation, since smoking can cause or exacerbate COPD and other lung conditions driving PPVs, and refer members to tobacco cessation programs and our Quit Smoking and Using Tobacco Healthy Behaviors Program.

1.2.2. Case Management (Care Coordination)

Our continual data mining, claims review processes, and predictive modeling tools systematically identify members with an increased risk for ED visits, inpatient admissions, including first time admissions for BH conditions, and readmissions. These processes and tools also identify members with over-utilization of health care resources, such as multiple ED visits and inpatient admissions and under-utilization of preventive and wellness services such as annual PCP visits, EPSDT services, and routine prenatal visits. Members are assigned a Managed Care Coordinator to work with them, their families/caregivers, and providers as appropriate to identify the intervention or program that will best meet their needs. Interventions include providing member education on benefits and services available in their communities, partnering with providers to

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

make them aware of gaps in care, and providing ongoing engagement to assist enrollees with high-risk conditions access appropriate preventive care. Other key interventions include removing barriers in and across systems of care, such as scheduling follow-up appointments, arranging transportation, and connecting members to providers who will accommodate any special needs.

The Clear Health Managed Care Coordinators are specifically recruited and hired based on their experience working with persons living with HIV/AIDS and/or are persons with knowledge of the disease. Many of our Managed Care Coordinators have dedicated their careers to improving the health of persons living with HIV/AIDS and are very familiar with the local resources and specialty providers who most frequently serve our members.

1.2.3. Inpatient Outreach and Referrals

We outreach to all members when they are admitted to the hospital, improving the likelihood of making contact with the member, identifying and supporting their needs, coordinating the necessary care and services, and removing administrative barriers. We start discharge planning upon admission, working with hospital staff and providers to engage members in their discharge planning. Our Managed Care Coordinators collaborate with the assigned concurrent nurse reviewer to make sure the member remains on their anti-retroviral therapy (ART) outpatient regimen while in the hospital setting.

We take this opportunity to partner with the facility to address medication adherence, post admission provider appointments, identify and address barriers that may result in a PPE, and support member self-management and risk in order to mitigate likelihood of readmission. We further support inpatient members with post-discharge outreach, following the recognized Coleman model protocols, as described below in our Post Discharge Management (PDM) and Transition of Care (TOC) Programs. When appropriate based on risk for readmission, the TOC Managed Care Coordinator will make a face-to-face visit to assist and address coordination of care issues as needed. Additionally, members are referred to our integrated DM and case management program.

During utilization review activities for facility stays, we excel at addressing post-discharge needs early by focusing on home health and follow-up appointments. If discharge to the home is not an option, we carefully review alternative, lower levels of care and facilitate a transfer. Our Inpatient Coordinators contact members and/or facility discharge planners while they are still in the facility to make sure we have the accurate contact information for case management activities post-discharge.

1.2.4. Post Discharge Management (PDM) Program

While a member is still inpatient, Concurrent Review Nurses and Inpatient Coordinators work with the member and hospital/facility discharge planners to coordinate services to be provided to assure a safe discharge. Post-discharge Customer Care Representatives call members within 48 hours of the discharge to ensure that services are in place, schedule follow-up PCP/specialist appointments, and arrange for necessary support services such as transportation. Within 3-7 days post-discharge, Managed Care Coordinators follow-up with the member to assure appointments were attended or rescheduled, discuss barriers to care, update the plan of care, conduct additional assessments and provide further interventions and follow up. Additional contacts are

EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

made as needed with at least two more follow ups within 30 days to reduce risk of readmission. This program is especially beneficial for members with inpatient admissions for acute, mental health, and substance use disorder conditions, including admissions to psychiatric residential treatment facilities. BH Managed Care Coordinators include licensed mental health and/or substance use disorder clinicians who are responsible for coordinating transition planning for members with short- and long-term behavioral health stays. These employees collaborate directly with the hospital discharge nurse and PCP, specialist, and/or home health provider to engage and assess the member prior to discharge. The clinician evaluates the member's strengths, needs, and preferences; identifies natural supports; and determines the services and resources needed to successfully transition and support the member safely in the environment he or she chooses. As a result of focused behavioral health post-discharge management efforts, we achieved a 13.4 percent decrease in hospital readmissions across all participating regions in the last 12 months.

1.2.5. Field-Based Transitions of Care (TOC) Program

We recently expanded our TOC program due to positive results in reducing PPRs in Miami-Dade and Broward counties. Our TOC program is targeted toward members who are at high risk for readmission based on predictive modeling and evidence-based criteria. The program has the dual goals of improving member outcomes and controlling costs by reducing PPRs. The program is based on the Care Transitions Intervention® developed by Eric Coleman, MD, MPH from the University of Colorado. This intervention uses best practices to reduce PPRs by engaging members, their families, and caregivers and better meeting health care needs by providing coordination and continuity of care in the transition home.

Our Managed Care Coordinators, who are licensed and cross trained in physical and BH, conduct home visits to provide a comprehensive risk assessment, examine the home environment, and support the development of a person-centered plan of care with the member and the member's family and other caregivers using a multi-disciplinary approach. The plan of care addresses the whole person, with an emphasis on self-management, medication reconciliation and management, and closure of gaps in care. It includes an emphasis on identification of risk factors that may impede the member's recovery or achievement of their goals.

The Managed Care Coordinator encourages the member's Primary Care Provider (PCP) and other providers to provide feedback into the member's plan of care and helps coordinate services across different systems of care. For example, he or she will work closely with the member's providers and community resources to make sure a seven-day follow-up visit is scheduled; the member is connected to necessary transportation, DME, home health, and therapy services; and that we identify and refer the member to effective community resources and supports.

The Managed Care Coordinator continues to work with the member and his or her providers as needed over a 30-day period, providing additional support and follow-up through telephonic and in-person outreach and visits. Even if the Managed Care Coordinator does not believe the member is at high risk for a PPR, he or she will still provide follow up at seven-, 14-, and 30-day intervals post-discharge to make sure the member's condition has not deteriorated and to refer the member to case management and/or DM as appropriate.

EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

We target members with certain discharge diagnoses, including congestive heart failure, COPD, and other conditions associated with a high risk of PPRs. We also target members with hospital lengths of stay exceeding three days and members with at least one prior hospitalization in the past 12 months. The following sources help us identify members who would benefit from the TOC program:

- Hospital discharge reports
- Claims data
- Concurrent Review Nurse referrals
- Medical Director referrals
- Propriety risk algorithm

1.2.6. HAART Initiative

We use special reports run by our pharmacy analytics team to provide antiretroviral therapy (ART) compliance data to our members' PCPs. The reports identify all the medications the member is taking, as well as prescribing providers. Our Managed Care Coordinators use these reports, as well as medication history in our Case Management System, to assist when prescriptions are rejected at the point of service or require prior authorization and to make sure there are no lapses in medication adherence for our members. When members are in the hospital, UM Nurses provide Managed Care Coordinators critical information regarding any changes to the member's ART regimen to prevent lapses in medication adherence after discharge.

1.2.7. CD4 Project.

Our CD4 project addresses members with low CD4 counts (<200 cells/mL) who typically are not fully engaged in their care. A CD4 count is a blood test to determine the strength of the immune system as measured by the presence of a type of white blood cell. A normal range for CD4 cells is between 600 and 1,500, while a CD4 count of <200 cells/mL indicates a severely compromised immune system and a clinical diagnosis of AIDS. In our CD4 project, Managed Care Coordinators must refer members to community-based programs such as Ryan White agencies. We closely track labs, hospitalizations, and referrals to BH Managed Care Coordinators to identify opportunities for improvement and non-compliance patterns. Our Medical Director leads interdisciplinary rounds to discuss each case and develop specific action plans. In addition, a physician with expertise in treating HIV/AIDS populations (and our former Medical Director) leads a discussion and lends his expertise in the cases of our most difficult members to engage. Since it began in 2014, our CD4 Project has stabilized or improved outcomes for 41 percent of the members not lost to follow-up (due to disenrollment, death, or inability to contact). Currently, we track approximately 250 members through the CD4 project.

**** Spotlight On: CD4 Project success**

Emilia's Ryan White case manager reached out to connect her with one of our Managed Care Coordinators when she was released from prison. Emilia's records showed diagnoses of neuropathy, enlarged aorta, bipolar disorder, and depression, and she already had an infectious disease specialist and a mental health provider, but needed a PCP and a cardiologist.

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With a low CD4 count, our Medical Director enrolled Emilia in our CD4 Project for members with an AIDS diagnosis and a severely compromised immune system. Celeste, a Managed Care Coordinator, met with Emilia and conducted a comprehensive assessment and depression screening and helped Emilia develop a plan of care that addressed her medical and mental health needs, and shared the plan with her new PCP. She also educated Emilia on additional behavioral health benefits available through her new Clear Health plan. Emilia actively participated in the Project and complied with the medication, lab test, appointments, and other requirements, and within four months her viral load was undetectable. She expressed her thanks to Celeste for her support, help navigating the health care system, and connections to her new PCP and heart specialist to address her other health issues. **

1.2.8. Complex Case Management Rounds

We hold a variety of interdisciplinary care team rounds that dedicate resources to developing specific interventions for our super-utilizers, medically complex cases, recent admissions and discharges, BH admissions, and members with coordination of care concerns. These rounds occur bi-weekly or monthly, depending on the area of focus. We solicit feedback and expertise in these meetings from a variety of disciplines, including Medical Directors, Concurrent Review Nurses, Managed Care Coordinators, Psychiatrists, Outreach Specialists, Peer Educators, and BH Managed Care Coordinators. They discuss member needs, resolve challenging coordination of care issues, and break down barriers across systems of care. For example, members identified as high-risk for PPEs due to BH conditions or multiple psychiatric admissions in the month prior would be covered in our monthly Medical/BH Interdisciplinary Care Team Rounds. In the future, our Medically Complex Interdisciplinary Care Team Rounds will include an invitation to the member and their PCP.

1.2.9. Mobile Unit

Our Mobile Unit address gaps in care and improve access. In Region 1, we will host asthma-focused clinic days to provide education and preventive services to help our members manage their condition and avoid unnecessary ED visits. The Mobile Clinic Days program began in October 2014. Since its inception, the number of clinic days held statewide and the number of members who attended has increased by 50 percent between 2015 and 2016. Similar attendance is expected in 2017, and we anticipate a 20 percent increase in the number of clinic days in the first year of the new Contract based on this experience. In 2017, we have held 145 clinic days statewide and 1,248 members have attended.

1.2.10. Telemedicine and Telehealth

We use telemedicine to expand access to specialty care and BH services for members in rural areas, as well as to provide an effective alternative to the ED for care that can be provided in another setting. We are working with GlobalMed to provide pediatric and adult primary care, NICU, cardiology, pulmonology, endocrinology, and internal medicine through a secure internet connection on a computer, tablet, or smartphone.

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If approved by the Agency, we will also offer our LiveHealth Online (LHO) solution, which will provide urgent care telemedicine through two-way audio/video technology to Florida licensed, board-certified physicians for consultations on clinically appropriate conditions (such as upper respiratory infections or the flu as well as BH conditions). Members can access LHO through a secure internet connection or an application on their smartphones.

We are also conducting a pilot study with telemonitoring for members with COPD, CHF, diabetes, and hypertension. This program offers remote monitoring of vital signs and symptoms related to the member's condition, which is tracked by a central station nurse who is in communication with the member and physician. Telemonitoring enables the identification of minor fluctuations in health that, left untreated, lead to acute exacerbations and unnecessary hospital and ED visits. If the pilot is successful, we will expand this program to all regions including Region 1.

1.2.11. Rare Disease Management

This program, called Accordant, is an adjunctive, telephonic rare disease program designed to help members find the additional answers and support they need to manage their unique health care needs and maximize their overall health status. It targets members with specific conditions such as sickle cell disease, epilepsy, rheumatoid arthritis, multiple sclerosis, and cystic fibrosis, among others. A Nurse Managed Care Coordinator who specializes in rare conditions provides a health risk assessment to identify risk factors, gaps in care, knowledge deficits, and self-management skills to develop a personalized plan of care. The Nurse Managed Care Coordinator provides ongoing support and education to prevent complications and optimize medication management, co-morbidity support, and psychosocial support.

1.2.12. Addressing Barriers to Care Caused by Homelessness

We have recently secured access to the Health Management Information System (HMIS), a local information technology system that collects client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. This system enables us to use the "client tracker" — a valuable application that helps us locate members experiencing homelessness. This application identifies shelters and other organizations that are currently providing services or that recently provided services to a member. We will use service need information collected through the HMIS as another source of information to help us identify organizations and services currently being provided to our members who are or have been homeless, so that we can identify and fill service gaps and make sure that member needs are being met.

2. OUR TAILORED CASE MANAGEMENT INITIATIVES AND PROTOCOLS REDUCE PPES FOR SUPER-UTILIZERS

When we identify a super-utilizer or potential super-utilizer, our general coordination of care approach involves motivational interviewing and identification of social determinants of health and barriers to access care, followed by specific interventions to address those barriers according to an individualized plan of care. We refer members to appropriate providers, arrange transportation, schedule appointments, and address care and service needs that may be preventing a member from seeking care.

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As described below, we also have very targeted programs for super-utilizers, which include their own coordination of care protocols.

2.1. Identification of Super-Utilizers

Our Chronic Illness Intensity Index (CI3) is the primary component of our proprietary predictive modeling system, which synthesizes data from a variety of sources to indicate the member's overall illness burden and develop an individualized member risk profile. This includes diagnosis, demographics, hospitalizations, readmissions, ED visits, over- and under-utilization of services, and expenditures. The CI3 algorithm results in each member being stratified in low, moderate/rising, and high/urgent risk levels.

We use CI3 to identify super utilizers, based on which members are stratified in our high/urgent risk category. These members have complex medical histories including multiple chronic conditions in poor control, co-occurring BH and medical conditions, or intensive health care needs. They access care at the highest levels or have patterns of high utilization of the ED and/or a history of multiple admissions.

Six other predictive modeling tools also generate risk scores to stratify the member's risk level, prioritize outreach and assessment, and determine the level or type of intervention needed. Many of these tools are particularly useful in identifying super-utilizers and emerging super-utilizers to prioritize member outreach, assessment, and engagement:

- Likelihood of Inpatient Admission (LIPA): Predicts the likelihood of an inpatient admission within 60 days and helps us identify members at risk of a PPA
- ER TRIAGE: Predicts likelihood of ED utilization and helps us identify members at risk of a PPV
- Readmission Risk: Recalculates based on the inpatient daily census report to determine the likelihood of readmission and helps us identify members at risk of a PPR
- Behavioral Health First Time Admission: Identifies indicators of BH issues that may result in a first-time admission and helps us identify members at risk of a PPA for a mental health condition or substance abuse disorder
- Pharmacy: Identifies indicators of over-utilization and possible substance use disorder
- STORK: Assesses for a poor pregnancy outcome or NICU admission based on results of our OB High Risk Screener

In addition to predictive modeling tools, our targeted programs for super-utilizers, such as our CARES Program, may have other unique algorithms to identify members for outreach and enrollment in the specific program.

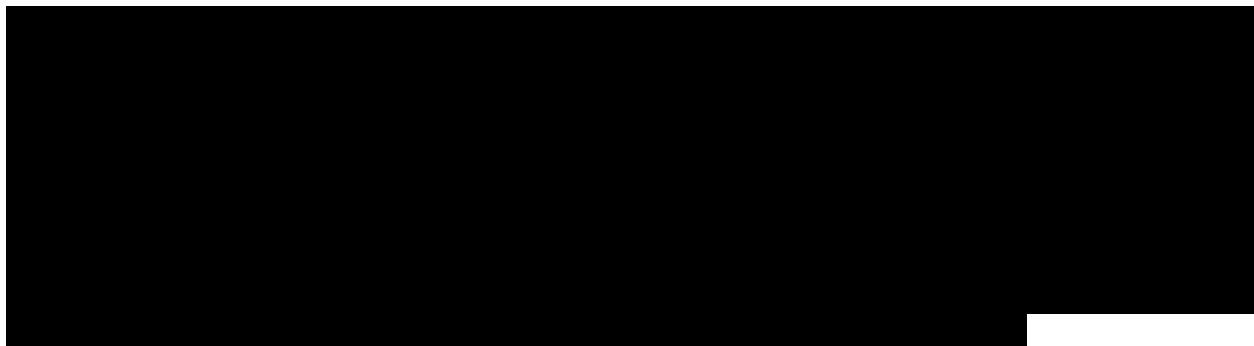
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2.2. Interventions Designed to Avoid PPEs and Target Super-Utilizers

We recognize the pressure high rates of ED utilization, avoidable hospitalizations, readmissions, and other PPEs are having on Florida's Medicaid program. In addition to increasing costs, they limit access by consuming limited resources, interfere with the development of medical home relationships, and negatively impact the quality of care our members receive. We use data mining with our predictive modeling tools to flag members with a high likelihood of a PPE and reach out to them and their providers to identify case management and service coordination needs and eliminate barriers to care.

In addition to the comprehensive programs we already highlighted, including our PDM and TOC programs, we also have a number of programs specifically designed to address super-utilizers. Many of these programs focus on BH conditions because we have identified members with complex and co-occurring BH and substance use disorder conditions as driving many of our PPEs. A description of the program, as well as any applicable algorithm used to identify super-utilizers is included.

- **ED Diversion Program.** To address the root causes of unnecessary and frequent ED use, our ED Case Management Program assists members and their families or caregivers manage the member's symptoms in alternative settings. We exchange information about ED "frequent flyers" with all our network hospitals and educate members on proper utilization of services, discuss the importance of primary and preventive care, provide information on nearby resources such as urgent care, and determine whether the member should be referred to case management.



Target Population: Members with three or more admissions in the prior six months, or at least 45 days of inpatient BH services in the prior six months (excluding state institutions)

- **Clear Health CARES Program.** Our field-based Case Management program helps us engage hard to reach members and address the behavioral and social barriers that negatively affect their health outcomes. Compared to a more traditional case management approach, this program locates hard to find members, addresses non-clinical needs and barriers through frequent, face-to-face contact (i.e., daily, weekly), and uses paraprofessionals to focus on social determinants of health by connecting members to community resources and social services such as housing, child care, and educational services. Managed Care Coordinators coordinate PCPs and BH providers and other specialists. They also schedule provider visits, arrange transportation, and accompany the member to the appointment. If the member is admitted to a hospital, the Managed

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Care Coordinator provides onsite inpatient discharge coordination to improve the transition home and avoid a PPR.

Target Population: CI3 Group 3, psychiatric or substance abuse condition, age 18 or older, and not in case management

- Long-Acting Anti-Psychotic Injectables (LAI) Program. Schizophrenia is the top condition contributing to PPRs statewide. Our Behavioral Health LAI program targets members who are non-adherent to prescribed long acting injectable antipsychotic medications and aims to improve medication compliance, decrease the risk of institutionalization, and reduce PPRs.

Once a member is enrolled in the LAI program, he or she is assigned a BH Managed Care Coordinator for outreach, engagement, and ongoing case management. The BH Managed Care Coordinator also works with the member and the prescribing provider to ensure the member receives the next scheduled LAI dose. When appropriate, the BH Managed Care Coordinator facilitates in-home administration of the LAI, including accompanying the home health care agency to the member's home to improve success of the injection, working with the local pharmacy to ensure home delivery, and working with a Provider Network Manager to locate a nearby home health care agency to provide the injection.

We recently initiated this program to help the Agency meet its goals of reducing PPEs and keeping members in the community for a greater length of time. Although it is too early to evaluate program outcomes, we plan to measure the following outcomes at six-month intervals:

- Reduction in PPRs
- Proportion of members LAI-adherent for at least three consecutive injections
- Proportion of members becoming LAI-adherent due to in-home LAI administration
- Reduction in overall medical costs

Target Population: Members currently prescribed an LAI form of one of the target medications who have missed a scheduled injection, members who received an LAI during an inpatient behavioral health stay and require their next LAI in the outpatient setting, and members with a prescription for an oral administration form of one of the target medications who missed a recent refill and may benefit from switching to an LAI. Haldol, Abilify, Invega, Prolixin, Risperdal, and Invega are the target medications.

- Controlled Substance Utilization Management (CSUM) Program. Clear Health will implement a new program that uses several retrospective drug utilization reviews designed specifically to decrease controlled substance over-utilization, including opioids. Our Medicare Opioid Overutilization Management program, which includes similar components, received an Excellence Award for Care Management Strategies from the Pharmacy Benefit Management Institute.

Target Population: Members receiving multiple controlled substance medications, receiving opioids from multiple providers and filled at multiple pharmacies, or combinations of controlled substances that may indicate risk.

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- Behavioral Health Substance Use Disorder Program. This Case Management program is based on the principles of recovery, harm reduction, and motivational interviewing. Behavioral Health Managed Care Coordinators connect the member to a network of treatment and recovery services, including detoxification services, rehabilitation services, intensive outpatient services, partial hospitalization services, outpatient therapy, pain management, and peer services. Managed Care Coordinators also coordinate care across different providers, including medical providers. They refer members to additional supports such as peer services and 12-Step programs, as well as other resources that can address the occupational, housing, and relationship consequences of their disorder. Initially, contact with the member occurs at least weekly. Some members may be referred to our Pharmacy Restriction Program. We have evidence-based protocols providers can use when managing chronic pain in members with substance use disorders.

Target Population: C13 identified substance use disorder as primary or secondary diagnosis, prescription drug outlier behavior (i.e., enrolled in our Pharmacy Restriction Program), or referred by providers or internal or external sources (e.g., Case Management, Behavioral Health Crisis Line)

- Opioid Workgroup. Our ultimate parent organization, Anthem, Inc., has taken a leadership role in addressing the national opioid epidemic. Pharmacy is at the core of this commitment, building an integrated strategy with our medical, BH, provider, and fraud, waste, and abuse (FWA) partners. Anthem's multi-faceted strategy established a goal to reduce the number of opioids dispensed to members by 30 percent from 2012 to 2019. By May 2017, they had cut opioid prescriptions by 31 percent. Because it met its goal to reduce the number of opioid prescriptions early, Anthem updated its goal to achieve a 35 percent reduction in opioids dispensed by 2019.

At Clear Health, we recently initiated an interdisciplinary Opioid Workgroup following the Governor's recent declaration that Florida is in a state of emergency due to the opioid epidemic. We are in the process of expanding member access to medication-assisted treatment (MAT) for opioid abuse. We are working toward more accurately identifying those at risk for opioid abuse and non-adherence to MAT for more targeted case management and will be expanding our substance use disorder (SUD) program in the future. We have pulled representatives from Utilization Management, Pharmacy, Case Management, Quality Improvement (QI), Data and Analytics, and other areas to develop and execute a global strategy focused on:

- Pain management
- Addiction prevention
- Overdose prevention
- Addiction treatment

As responsible stewards of tax payer dollars, we anticipate implementation of new initiatives to not only improve member outcomes but reduce costs related to PPEs. In implementing these initiatives, we will borrow the best practices of our affiliated health plans, who in the past year alone have demonstrated large decreases in opioid use, including a 29 percent reduction in Virginia and a 22 percent reduction in Maryland.

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Target Population: Members with patterns of either overutilization of opiates or other evidence of possible abuse

- Pharmacy Restriction Program. Clear Health will implement a Pharmacy Restriction Program to identify members who demonstrate patterns of FWA that often result in unnecessary ED visits and doctor shopping. Once identified, we review the member's case to make sure placement in the lock-in program is appropriate. If appropriate, we assign the member to a single pharmacy for filling all prescriptions for the following 12 months. We also notify the member, the member's PCP, and the pharmacy we restricted the member to, and encourage the member to enroll in our Substance Use Disorder Program, if indicated. Certain members, such as members with cancer and dual eligibles, are never enrolled.

By limiting members identified as potentially misusing or fraudulently obtaining controlled substances, we aim to reduce misuse of controlled substances and related PPEs that result from doctor shopping. In the first half of 2017, the program resulted in a 17 percent reduction in prescriptions for controlled substances for members enrolled in the lock-in program.

Target Population: Members who 1) obtained three or more controlled substance prescriptions from three or more pharmacies, 2) used more than 10 different controlled substance prescribers in 90 days, 3) obtained two or more controlled substance prescriptions written by two different prescribers from two or more different pharmacies within 180 days, if they also have a documented diagnosis of narcotic poisoning or drug abuse within the last year, or 4) violated a pain management agreement with their prescriber. We also take referrals from the Agency, law enforcement agencies, prescribers, and pharmacies.

3. DATA EXCHANGE IMPROVES COORDINATION OF SERVICES

Through our secure Provider portal, all Providers can access our provider-facing Case Management System. The provider-facing Case Management System supports our strategy of using health information exchange to promote the right care, at the right time, and in the right place. It offers access to a single view that displays member-specific data in an easy-to-navigate dashboard, including HEDIS® care alerts, authorizations, prescriptions, and claims organized by type such as inpatient, ED, and office visits. It is also our primary method for sharing members' case management information, including health risk assessments and the plan of care, with providers.

In addition to member data available to providers in our provider-facing Case Management System, our Provider Relations team uses a suite of reports to discuss with providers individually which specific members who may need attention. For example, we use a pharmacy profile report that identifies for provider outliers the complete prescription fill history of each of the provider's members and calls attention to potential drug to drug conflicts.

For providers participating in our Value Based Purchasing (VBP) programs, which are described in detail below, we offer additional tools and data exchanges to improve care coordination for members, including high-risk members. This information sharing includes data about ED utilization, inpatient admissions, gaps in care, readmission rates, and cost of their member population.

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- APM Provider Scorecards. Clear Health provides periodic scorecards with performance data, including cost and utilization data, for providers participating in our VBP programs.
- Provider Care Management Solution (PCMS). For providers participating in our VBP programs, additional PCMS access allows providers to see actionable, member-specific information to help identify members who need outreach and engagement, as well as care gaps. PCMS provides real-time information; including alerts, icons, hover overs, drop downs, and drill-throughs to support population health management. PCMS has the ability to filter patient populations by key conditions, risk factors, gaps in care, and visit history. PCMS is updated daily and provides real-time availability for providers on demand.

4. CLEAR HEALTH LEVERAGES FLORIDA'S EVENT NOTIFICATION SYSTEM

In 2017, we enrolled in the Florida Health Information Exchange's Event Notification System (ENS). ENS provides real-time notification when our members have an admission, discharge, or transfer (ADT) from a participating hospital, including ED discharges. We receive ENS data twice a day. These notifications are built into our case management workflow and provide important notifications to our Managed Care Coordinators about when to intervene in a member's care and start preparing for discharge or other outreach. For example, we use ENS notifications to identify members upon admission, so we can successfully contact the member, especially hard to reach members, while they are at the facility. We also use ENS notifications to identify members being discharged from the hospital who may have questions about their discharge plans or medications or who need assistance setting up appointments. When members are being transferred to another facility, this early notification helps us expedite necessary authorizations for needed services.

5. EVALUATING IMPACT OF OUR SUPER UTILIZER INTERVENTIONS

We have many interventions for super-utilizers, as described above. Example measures we use to evaluate the impact of these interventions include:

- Inpatient admissions
- Readmissions
- ED visits
- Medical and pharmacy utilization metrics
- Follow-up after hospitalization for mental illness – seven days (HEDIS)
- Initiation and engagement of alcohol and other drug dependence treatment – initiation total (HEDIS)
- Adherence to antipsychotic medications for individuals with schizophrenia (HEDIS)
- Diabetes monitoring for people with diabetes and schizophrenia
- Follow-up after ED visit for alcohol and other drugs of abuse or dependence

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- Follow-up after ED visit for mental illness
- Antidepressant medication management

6. ENCOURAGING APPROPRIATE CARE THROUGH INCENTIVES

6.1. Provider Incentives

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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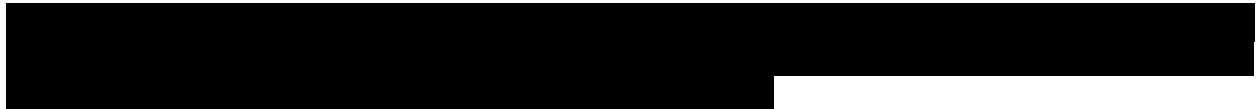
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7. PROPOSED BENCHMARKS FOR REDUCING REGION 1 PPES

Clear Health's PPA rate is already the second lowest in the state (Spring 2017 Report). In Region 1, we will drive further reductions in PPEs by setting ambitious goals related to our experience in existing regions instead of using state averages, which we already exceed.

7.1. Reducing PPAs and PPRs

We propose to attain a ranking in the top 20 percent of health plans for both PPAs and PPRs by the end of the third year of the new contract, and sustain this level for subsequent years.

7.2. Reducing PPVs

We propose to attain a ranking in the top 20 percent of health plans for PPVs by the end of the third year of the new contract, and sustain this level for subsequent years.

7.3. Reducing the Use of Unnecessary Ancillary Services

Health plans are not currently ranked on this metric. We will collaborate with the Agency to determine a feasible measurement approach, as well as benchmarks for all health plans to use.

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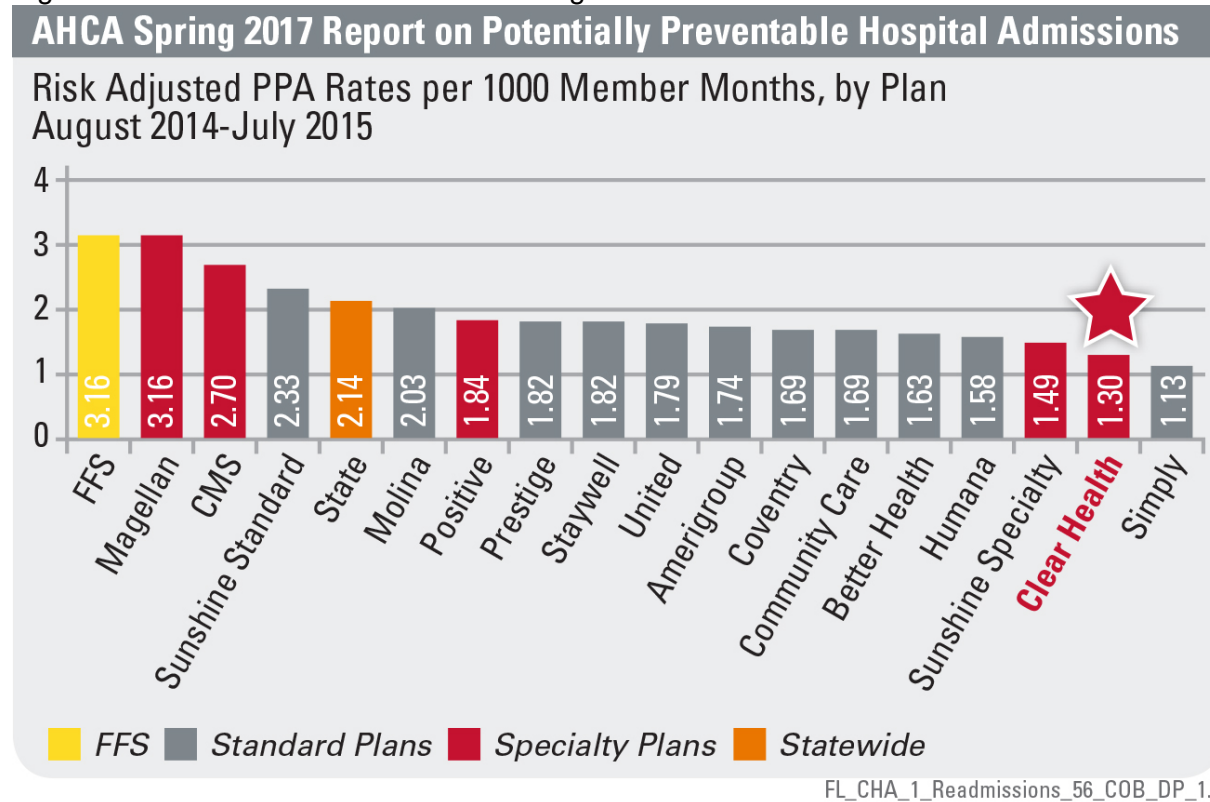
Evaluation Criteria:

1. The extent to which the respondent identified specific localized opportunities for improvement in achieving a reduction in potentially preventable events and subsequent steps the respondent will implement to overcome any barriers across and within different systems of care (i.e., medical, behavioral health).
2. The extent to which the respondent describes specific care coordination protocols, including a description of the risk stratification algorithm used to identify super-utilizers.
3. The extent to which the respondent describes strategies to improve data exchanges and communications between practitioners to improve care coordination efforts for high-risk enrollees, using specific local examples.
4. The extent to which the respondent plans to include the use of the Agency's Event Notification System as a means to extract relevant data from hospitals.
5. The adequacy of the respondent's description of specific indicators or measures that will be used to evaluate the effectiveness of evidenced-based programs and interventions that target super-utilizers.
6. The extent to which the respondent describes financial and non-financial provider and enrollee incentives that are aimed at diverting care to more appropriate and cost-effective settings (e.g., incentives for primary care providers that agree to extended or after-hours clinic care for their Medicaid patients).
7. The extent to which the respondent proposed local performance benchmarks for:
 - (a) Reducing potentially preventable hospital admissions and readmissions;
 - (b) Reducing use of the emergency department for non-emergent/urgent visits; and
 - (c) Reducing the use of unnecessary ancillary services during hospitalization and outpatient visits.

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

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Figure 1-1. Clear Health Excels at Reducing PPAs



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MMA SRC# 2 – Birth Outcomes (Statewide):

The respondent shall describe its organizational commitment to quality improvement as it relates to pregnancy and birth outcomes. More specifically, the respondent shall describe its overall approach, and specific strategies, that will be used to address prematurity prevention, improve perinatal outcomes, and reduce unintended pregnancies, including:

- A description of performance benchmarks for reducing non-medically indicated cesarean sections and early elective deliveries;
- A description of incentives that will be implemented for providers and enrollees aimed at improving birth outcomes; and
- A description of strategies to decrease unintended pregnancies (e.g., increase in the use of long acting reversible contraceptives).

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Clear Health is committed to working with the State to meet its goal of improving birth outcomes. In addition to our Case Management program, we offer our comprehensive Maternal Child Health Program, Taking Care of Baby and Me®, to our enrollees (members) who are pregnant. We recognize that our members experience normal pregnancies, and many also have complex conditions and benefit from high-risk case management to obtain the best outcomes form mom and baby.

Taking Care of Baby and Me® addresses maternal and newborn health risks by providing members with access to the information, care, and support needed to stay healthy before, during, and after pregnancy. We encourage pregnant women to take action to optimize the outcome of their pregnancies, prepare for the delivery and homecoming of their infants, and participate in their infants' care should a Neonatal Intensive Care Unit (NICU) stay be required.

Taking Care of Baby and Me® makes sure that our members have access to appropriate obstetrical, medical and behavioral health (BH) care services. We engage members in care management as advocates for their own health care and by assisting with the essential elements of personal responsibility and health care that lead to a healthy pregnancy and newborn. We strive to identify pregnant women as early as possible, conduct a thorough clinical and psycho-social assessment to assess each woman's risk, then develop an individualized care management plan based on the member's risk. Our approach for improving birth outcomes focuses on:

- Promoting preconception care
- Promoting prenatal care

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- Increasing the number of prenatal care visits
- Increasing compliance with an anti-retroviral treatment (ART) regimen through pregnancy to delivery to decrease chance of vertical transmission or other adverse outcomes
- Reducing infant mortality
- Reducing premature births
- Reducing incidence of low birth weight
- Reducing NICU admissions and lengths of stay
- Improving identification of perinatal depression and access to treatment
- Promoting education and access to treatment for smoking cessation and substance use disorders
- Improving access to and completion of postpartum care visits
- Educating on breastfeeding and the risk of transmission of HIV and alternative baby nutrition options
- Encouraging compliance with administration of ART prophylaxis to the newborn and all appropriate follow-up screening for HIV

We use our Simply, Better Health, and Amerigroup collective Florida experience to best meet our members' needs. For example, through the breadth and depth of our local experience, we quickly recognized the serious risk Zika poses for our members and the communities we serve. In response, we developed various tools to make sure we provide timely and accurate information to our members and providers. These tools include:

- Zika Virus Associate Resources Guide
- Member and Provider Resources Guide
- Medical Policy for Zika diagnostic testing (which parallels the Centers for Disease Control and Prevention and the American Congress of Obstetricians and Gynecologists guidelines)
- Coverage for commercially-available insect repellent when prescribed by a provider.

Additionally, we are part of a national organization that represents nearly 10 percent of the nation's births. We are stronger with the support of our national organization, Anthem, Inc. (Anthem), and the experience of our affiliate plans in 18 other states and the District of Columbia. We draw on our experience in Florida to determine how best to leverage our national and affiliate plan resources for the advantage of our members.

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For example, we are using the expertise of Dr. Susan Brown to support our local efforts to collaborate with Florida on collecting Neonatal Abstinence Syndrome (NAS) rates and developing initiatives to combat the impact of opioid use and reduce the rate of babies born with NAS. Dr. Brown is a board-certified Anthem Medical Director specializing in Neonatal-Perinatal medicine and serves as Anthem's Enterprise Medical Director and Neonatal Lead for NAS. She has sponsored a NAS study, pairing mothers with their babies to identify maternal risk factors, medications, and outcomes for infants identified with NAS.

Clear Health is advantaged by its combination of a strong, local presence in Florida and access to recognized experts and resources through its national organization. This combination exemplifies our organizational commitment to quality improvement for pregnancy and birth outcomes. Our members have access to the most innovative practices that best support healthy moms, babies, and families in Florida.

1. OPPORTUNITIES FOR IMPROVEMENT IN ACHIEVING BENCHMARKS

1.1. Establishing Performance Benchmarks

Despite considerable evidence of increased risk for adverse health outcomes for women and newborns, rates of unnecessary medical interventions in labor and delivery remain high. This includes low-risk cesarean (C-section) deliveries, elective inductions, and scheduled deliveries before 39 weeks gestation. In our population of members with HIV/AIDS, C-section may be the preferred method of delivery to prevent vertical transmission of the virus. Scheduled C-section delivery is recommended for prevention of perinatal transmission of HIV in women with HIV RNA levels >1,000 copies/mL near delivery and for women with unknown HIV RNA levels. Our C-section rate is 67 percent; however, no vertical transmissions have been reported since our inception.

Clear Health's comprehensive Maternal Child Health Program, Taking Care of Baby and Me® program, with its focus on improving birth outcomes, is working. In 2016, our rate for early elective deliveries was lower than the national average at 3.3 percent. Looking forward, we will utilize the Leapfrog Group target for early elective deliveries (5 percent) and for C-sections for all hospitals (23.9 percent), where applicable, based on national guidelines. We propose to attain these benchmarks in current and new regions by the end of the third year of implementation and sustain this level subsequently.

1.2. Programming and Tools to Achieve Targets and Overcome Barriers

Taking Care of Baby and Me® addresses maternal and newborn health risks by assuring members of access to the information, care, and support needed to stay healthy before, during, and after pregnancy. The program sees that our members have access to appropriate obstetrical, medical and BH care services. We engage members in care management as advocates for their own health care and by assisting with the essential elements of personal responsibility and health care that lead to a healthy pregnancy and newborn.

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All pregnant members with HIV/AIDS are stratified as high risk for OB case management. Frequency of contact is at least monthly, and focuses on adherence to ART in addition to normal high-risk OB protocols. We advocate for healthy deliveries through member engagement, provider and stakeholder collaborations, innovative payment models, and performance-based incentives:

- My Advocate — In an effort to effectively screen for risk factors and engage our members during and after pregnancy, Clear Health employs My Advocate, a multi-channel communication program that provides health education by phone, text message, smartphone app, or online to pregnant members in our Medicaid markets. In addition to promoting healthy habits, My Advocate:

- Enables members to complete our High-Risk OB Screener by phone or online to determine level of risk and need for case management or care coordination services

- Alerts Case Managers (Managed Care Coordinators) to reach out to members when they experience a change in risk level

- Allows members to ask questions and get a prompt callback from a Managed Care Coordinator



- Maternal Postpartum Outreach Program (MPOP) — MPOP is an all-inclusive (member, provider, and data collection) call outreach program focused on improving access to care and assuring the timeliness of a mother's visits with a practitioner after delivery of her baby. Outreach is completed by providing experienced, compassionate Outreach Care Specialists and a state-of-the-art web-based system to help members with postpartum visits, refer at-risk members to care providers and community resources, and educate members about recommended newborn checkups and Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Program components include:

- MPOP System — A state-of-the-art, web-based system that identifies moms who have just delivered a baby and may need assistance with scheduling their postpartum visit. It captures all components of the outreach process, including appointments, mailings, and outreach attempts.

- Outreach Care Specialists — Experienced Outreach Care Specialists attempt to contact new mothers assigned in the MPOP system to help with appointment scheduling, reminders (five days prior to the postpartum appointment), and appointment coordination and verification (contact OB provider to schedule an appointment for moms and verify that they kept their postpartum appointments).

- Postpartum Packet — New mothers receive a postpartum packet that includes a flyer congratulating them on their newborns, a booklet on caring for the infant, a brochure on baby blues vs. postpartum depression, and "Making a Family Life Plan."

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- **Programs Integrating Comorbid Conditions** — To identify existing health risks for pregnant women and prevent future health problems, we developed specific programs to integrate comorbid conditions such as diabetes, depression, hypertension and heart disease, and SUD, including tobacco. We include a registered dietician/certified diabetes education in the members' multi-disciplinary care team who assist (co-manage) these members. Screening of pregnant members for BH issues is conducted as early as possible. The early screening has helped to successfully identify perinatal depression, substance use, and intimate partner violence, and helped members connect to resources and supports.

- **Post-Traumatic Stress Disorder Program (PTSD)** — We offer targeted postpartum help for our families with babies in the NICU through our PTSD program. We know that children cared for by mothers with (PTSD) and depression are at significantly higher risk for psychological aggression, child abuse, and neglect. The stress of having a critically ill infant in a NICU can result in PTSD symptoms. Incorporating this screening into our care for mothers, infants and families, and referring parents to support programs may mitigate the impact of PTSD, decrease NICU length of stay, and improve the health of our member and her child.

**** RESULTS & SUCCESSES:** Innovative PTSD program helps parents of NICU babies
We are pleased to offer our PTSD program, which was recognized as an innovative and promising best practice by the Institute for Medicaid Innovation and the Medicaid Health Plans of America. With PTSD symptoms reported in 20-50 percent of NICU parents, our Indiana affiliate incorporated a PTSD screening tool into its care for mothers and infants' families and referred parents with positive screening to support programs.

- 11.5 percent of families of NICU patients screened positive for PTSD symptoms
- 77 percent accepted referrals for treatment
- At a one month follow-up, 80 percent remained engaged in the health care system ******

- **OB Practice Consultants** — Provider education and collaboration efforts are enhanced by OB Practice Consultants, Registered Nurses who meet regularly with provider partners to build and maintain a coordinated approach to caring for women before, during, and after pregnancy. Our OB Practice Consultants will be based out of Miami, Orlando, and Tampa.

- **Early Elective Delivery (EED) Pre-Payment Claim Edit** — In 2018, we will enhance our program by implementing an EED pre-payment claim edit to help reduce the number of EEDs. We will roll out an initiative to educate providers on EEDs — scheduled births (induction or cesarean) without a medical reason between 37 and 39 weeks of pregnancy. Hard stop policies and mandatory reporting have helped, but we see the greatest decline in EED rates in states that have implemented medical necessity criteria with non-payment policies through their state's Medicaid agency. Following recognized Milliman and Interqual EED criteria, and requiring professional delivery claims be submitted with a code that defines the gestational age, we match 37- and 38-week delivery claims with a medically necessary diagnosis code and deny EED claims that do not meet medical necessity.

At times, locating members can be a challenge. For this reason, we have a close working relationship with the Healthy Start Coalition as well as the TOPWA (Targeted Outreach to Pregnant Women Act) program, referring members for outreach. TOPWA was created in 1999 to reach HIV-infected pregnant women or high risk pregnant women who are not receiving services.

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Recognizing the special risks for pregnant women with HIV, we also engage our Member Outreach Team Case Managers (Managed Care Coordinators) and Outreach Care Specialists for any ongoing efforts as needed. This reduces duplication while making sure that all avenues are exhausted to bring these members into care.

Other barriers we encounter relate to social determinants of health. In response, we will pilot a program targeting healthy birth outcomes for women with gestational diabetes mellitus (GDM). Compared to women without it, those with gestational diabetes had higher rates of emergency C-section, infants with higher rates of NICU admissions, and 34 percent higher costs of care.



In addition to our collaboration with Florida on collecting NAS rates, developing initiatives to combat the impact of opioid use, and reducing the rate of babies born with NAS, we are considering piloting a Women's Health Peer Support Program. Our affiliate health plans are piloting this program and it may be expanded into Florida if its design and goals align with the needs of our members.

We also plan to integrate our Women's Wellness and Recovery program aims to support and empower women of reproductive age who have substance use disorders by providing non-clinical peer support to promote wellness and recovery. Wellness and Recovery Specialists will conduct field-based and telephonic outreach to members in an effort to connect members to care, recovery, and social support services; engage them in reproductive life planning; and enhance care management services by adding a layer of peer-based social and emotional support.

We continually make enhancements to our Taking Care of Baby and Me® program by improving existing components and integrating new ones. The program is effectively helping improve birth outcomes. We focus on the whole person and her well-being before, during, and after pregnancy.

2. CARE COORDINATION PROTOCOL AND IDENTIFYING HIGH-RISK PREGNANCIES

Clear Health understands the importance of identifying high-risk pregnancies and assuring appropriate care for mom and baby. We use a Maternal Child Services model — preconception, prenatal, postnatal, and infant health — to deliver a seamless, coordinated approach to the continuum of care for our childbearing aged members and their infants. From initial identification of a pregnant member through targeted outreach and education, case management and care planning, trained staff seeks to improve the overall quality of life, functional status, and health outcomes for pregnant members and their newborns.

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The goal of our program is to promote healthy pregnancies and delivery of HIV-negative babies through early identification of potential risk complications with appropriate referrals and interventions. To help achieve that goal, each pregnant member is assigned a Nurse Case Manager (experienced in obstetrics) in addition to a Clear Health Managed Care Coordinator who follows the member from pregnancy through birth.

2.1. Identification of High Risk Pregnancies

To assure the broadest range of identification, several avenues are used to identify members for OB case management. These include identification through State enrollment files, claims data, medical management data, and manual referral. Most pregnant members are identified through State enrollment data and claims data. Pregnant Clear Health members, by their enrollment in the Plan, are automatically identified as high risk.

Clear Health providers can also use our web portal, Availity, to identify pregnant members and collect data on HEDIS® prenatal and postpartum measures. We implemented a daily feed from Availity into our Case Management System when newly pregnant members are identified by their providers, which supports our goal of early identification. It also identifies the date of the first prenatal visit, date of delivery, notifications of preterm births, and postpartum visits.

Upon identification of a pregnant member, an obstetrical (OB) risk screening tool is completed — either by the automated My Advocate program, specially trained associates, or Case Managers — to determine the need for further assessment for case management services. The OB risk screener was developed through a comprehensive analysis of pregnant women who were screened for OB case management services. It has been designed to predict the likelihood of a NICU admission. The tool prioritizes pregnant members in need of education and case management. We conduct a periodic review of the risk screening tool to improve its effectiveness.

Following screening, the member is assigned to a risk group based on the results. Based on the member's responses, the screener generates the following scores:

- Statistical Obstetrical Risk Score (STORK Score), which is based on a predictive model and will indicate the increased risk of a NICU admission. A scored benchmark of > 12.57 is “referral point” for OB case management (NCQA Compliance). Health Plans will continue to assess lower scored members for their case management needs.
- STORK Score benchmarks will be:
 - Urgent ≥ 12.57
 - High 9.99 -12.56
 - Medium 8.36 - 9.98
 - Low ≤ 8.35

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- Group Level is based on the member's responses to the screener. A tally of each scored question and its predictive value will group the member into one of the following case management Groups:

- Urgent
- High
- Medium
- Low

All cases will be designated as "potential referrals."

2.2. Care Coordination Protocols

Clear Health considers case management (care coordination) based on the following protocol:

- Members are educated regarding required frequency of screening and prenatal visits.
- The OB Case Manager works with Healthy Start for referral of high-risk pregnancies. In addition, bi-directional data is exchanged regarding member risk and Healthy Start interventions.
- Members are educated regarding T-DAP (tetanus, diphtheria, and pertussis) immunizations for every pregnancy.
- Members are introduced to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program and other State and local resources available to pregnant women, new mothers, infants, and young children.
- Members who are pregnant and infected with HIV are counseled and offered the latest ART regimen recommended by the federal Department of Health and Human Services and referred to HIV-experienced OB providers.
- Members in My Advocate have access to its IVR, text, or smartphone app program; they may choose to opt-out of it at any time.

All pregnant members with HIV/AIDS are stratified as high risk for OB case management. Frequency of contact is at least monthly and focused on adherence to ART in addition to normal high-risk OB protocols.

Our Case Managers are in our members' communities, often speak their languages, and are licensed clinicians – a Registered Nurse (RN) or a social worker, based on the member's needs. The Case Manager conducts an initial visit when possible, completes a comprehensive assessment, and works with the member to create a person-centered plan of care. The person-centered plan of care is finalized within five business days of the initial visit.

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After finalizing the person-centered plan of care, the Case Manager makes sure all services are authorized, coordinated, and initiated within 14 days or less, as appropriate for the member. The Case Manager follows up with members residing in their home or their authorized representative within 14 days of the initial visit to confirm that services were initiated as described in the person-centered plan of care. The Case Manager will contact the member at least monthly or more frequently when issues arise.

We have a maternity-specific health assessment that screens for co-occurring disorders, as well as additional assessments triggered by positive responses that help us identify the need for BH case management. Assessments result in a risk score (STORK) and members are placed accordingly in the appropriate case management level.

2.3. How High-Risk Case Management Helps Moms and Babies

Providing case management to women experiencing high-risk pregnancies can decrease complications and prevent disease transmission to babies. Case management makes a real difference to our members, including Krysten, who delivered a full-term, healthy baby girl.

**** REAL STORY: High-risk OB Case Management Helps Mother Deliver Healthy Baby Girl**
When Carmen, our OB Case Manager, offered 36-year-old Krysten high-risk OB case management services based on her HIV status, she was reluctant to discuss her status, but she accepted help managing her pregnancy. Happily, although Krysten had not sought prenatal care in the first months of her pregnancy, she welcomed Carmen coordinating services and referrals for her, including WIC, Healthy Start, and an OB/GYN. Carmen also worked with the Orange County Department of Health Ryan White case manager to coordinate education on prenatal and postpartum care, nutrition, baby feeding, and the signs and symptoms of pre-term labor and postpartum depression.

Carmen was there for Krysten throughout her pregnancy, answering her questions, providing support, and reinforcing the importance of medication, lab work, and appointment compliance to keep her and her baby healthy. By keeping her appointments and taking her medications, Krysten avoided complications, including pre-term labor and transmitting the virus to her full-term baby girl, Andrea. And she kept her OB/GYN follow-up and pediatrician appointments, too. Krysten expressed her gratitude to Carmen and delivered a healthy baby girl. ******

3. STRATEGIES TO IMPROVE DATA EXCHANGE AND PROVIDER COMMUNICATION

Clear Health understands the importance of data exchange and provider communication to improve case management for pregnant members who are identified as high-risk. We apply several strategies to see that our providers are equipped with the best information to render the best care to our members. We focus on simplifying data exchange, engaging providers where they work, and offering tools to easily access information.

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3.1. Improve Data Exchange

Clear Health is leading efforts with Healthy Start to outline options for a file exchange that will notify health plans of Prenatal Risk Screening tools received for members, improving timeliness of notification for newly pregnant moms. This will enable Clear Health to initiate prenatal programs earlier for members.

Clear Health and Healthy Start are also discussing the development of a program for exchanging information through data files regarding referrals, referral status, and notification of enrollment for new pregnant mothers to streamline communication, improve tracking and increase efficiencies for both organizations. The discussions have centered on a centralized solution, but could begin at the county level with agreement from Healthy Start.

3.2. Provider Engagement

Clear Health's OB Practice Consultant helps strengthen our relationships with OB providers, make sure they understand our programs, and help enhance maternity-related quality scores. The OB Practice Consultant serves as a liaison between us and the provider, to either answer their questions or direct them to someone at Clear Health who can respond. We will have three OB Provider Practice Consultants (RNs) for Florida based out of Miami, Orlando, and Tampa.

The Practice Consultants will meet face-to-face with OB providers and promote our Taking Care of Baby and Me Program and address any questions they have. Through the Practice Consultants, we will receive pregnancy notifications, due dates, and other key information direct from the provider. This enables us to learn about a member's pregnancy earlier than if we only relied on claims data.

Practice Consultants will meet face to face with OB Providers to discuss their group profile report and discuss best practices to enhance their maternity HEDIS® or other quality-oriented results. The OB Practice Consultant will also coordinate with Health Plan Quality Representatives on other quality gaps in care that should be raised in the already scheduled provider visits.

3.3. Availity for Providers

Another strategy for improving provider communication is the use of Availity. Clear Health providers have long used Availity to verify member benefits and eligibility across all health plans; now they can also use it to identify pregnant members and collect data on HEDIS® prenatal and postpartum measures. Availity gives providers another opportunity to connect with urgent and high-risk OB providers via care planning and coordination activities.

Clear Health also communicates with providers through clinical watch newsletters, the provider portal, and peer-to-peer consults made available with OB medical directors. These are important mechanisms for communicating with our providers. For example, we used the clinical watch newsletter during the Zika outbreak to educate providers on what supports and services were available to members.

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4. REDUCE UNINTENDED PREGNANCIES

Clear Health and its affiliate health plans currently provide family planning services as a covered benefit across 20 Medicaid markets. We understand that Florida's rate of unintended pregnancies is well above the national average, that most unplanned births in the state are publicly funded, and that 41 percent of all unintended pregnancies result from inconsistent or incorrect use of contraceptives, according to the Guttmacher Institute.

Members in Florida receive information at enrollment on family planning benefits and services available to them through our member handbook and portal. We also provide this information at community events and through our Customer Care Representatives during telephonic contact and Care Managers during member interactions.

The CDC identifies long-acting reversible contraceptives (LARCs) as the most effective in preventing pregnancy. The use of LARCs in the United States has increased — but the rate of utilization is still low at only 11.6 percent.

CDC, through its 6|18 initiative, also identifies three payment interventions to reduced unintended pregnancies:

- Reimburse providers for the full range of contraceptive services, including the actual cost of LARC or other contraceptive devices
- Reimburse for immediate postpartum insertion of LARCs by unbundling payment from other postpartum services
- Remove administrative and logistical barriers to LARC contraception

Clear Health applies all three of these interventions to prevent unintended pregnancies, and includes LARCs as a benefit to members. We educate our members on LARCs through educational materials, such as brochures, and through our OB Case Managers, who are trained on them.

5. PROVIDER AND MEMBER INCENTIVES

[REDACTED]

[REDACTED]

[REDACTED]

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[REDACTED]

[REDACTED]

— Pre-term Birth Rate: Percentage of all attributed member deliveries at less than 37 weeks

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

6. PROPOSE PERFORMANCE BENCHMARKS FOR REDUCING NON-MEDICALLY INDICATED C-SECTIONS AND EARLY ELECTIVE DELIVERIES

In 2016, 67 percent of our births were via C-section. Based on the federal Department of Health and Human Services guidelines, C-section may be the preferred method of delivery to prevent vertical transmission of HIV. However, vaginal delivery is recommended for women with HIV Disease who are adherent to ART and whose HIV viral load is below 1,000 copies/ml. The latest guidelines, updated on October 26, 2016, recommend:

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- Scheduled C-section at 38 weeks' gestation to minimize perinatal transmission of HIV for women with HIV RNA levels >1,000 copies/mL or unknown HIV levels near the time of delivery, regardless of administration of antepartum ART. Scheduled C-section delivery performed solely for prevention of perinatal transmission in women receiving ART with HIV RNA ≤1,000 copies/mL is not routinely recommended because of the low rate of perinatal transmission in this group. In women with HIV RNA levels ≤1000 copies/mL, if scheduled C-section or induction is indicated, it should be performed at the standard time.
- In women with an HIV RNA >1,000 copies/mL or unknown HIV RNA level who present in spontaneous labor or with ruptured membranes, there is insufficient evidence to determine whether C-section reduces the risk of perinatal HIV transmission. Management of women originally scheduled for C-section because of HIV infection who present in labor must be individualized at the time of presentation.
- In women on ART with HIV RNA ≤1,000 copies/ml, duration of ruptured membranes is not associated with an increased risk of perinatal transmission, and vaginal delivery is recommended. National benchmarks for individuals with HIV/AIDS are not available. In lieu of national benchmarks, we will monitor deliveries by C-section to establish benchmarks going forward. For members where vaginal delivery is recommended, we will apply the Leapfrog Group benchmarks. The Leapfrog Group, a national leadership organization in measuring and promoting positive outcomes in the hospital setting, and the Healthy People 2020 program set a target on C-sections of 23.9 percent for all hospitals. Similarly, the Leapfrog Group target rate for EED is five percent. Clear Health proposes to attain these benchmarks within current and new regions by the end of the third year after implementation and to sustain this level subsequently.

We will also review trends and relative performance each year to determine if goals need to be adjusted up or down to meet quality improvement expectations.

7. SUCCESSFUL STRATEGIES IN REDUCING NON-MEDICALLY INDICATED C-SECTIONS AND EARLY ELECTIVE DELIVERIES

In our population of members with HIV/AIDS, C-section may be the preferred method of delivery to prevent vertical transmission of the virus. Scheduled C-section delivery, defined as cesarean delivery performed before the onset of labor and before rupture of membranes, is recommended for prevention of perinatal transmission of HIV in women with HIV RNA levels >1,000 copies/mL near delivery and for those with unknown HIV RNA levels. Since our inception, no vertical transmissions have been reported. Vaginal delivery is recommended for women with HIV Disease who are adherent to ART and whose HIV viral load is below 1,000 copies/ml. We adhere to these guidelines.

We will continue to work closely with our HIV-experienced provider network, consultants, and case management staff to provide education on the guidelines and promote best practices to reduce risk of transmission. Our efforts center on encouraging strict adherence to ART and compliance with prenatal visits, as well as postpartum care and HIV screening/exposure protocols for all newborns.

EXHIBIT A-4-b
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The Clear Health rates for early elective deliveries and C-sections will be higher than standard health plans due to Department of Health and Human Services guidelines. The guidelines recommend providers schedule cesarean delivery at 38 weeks of gestation for women with HIV RNA levels of over 1,000 copies or for those with unknown levels near the time of delivery in order to minimize the risk of transmission from mother to child. As such, our results are reflective of Clear Health's comprehensive maternal child health strategy. It incorporates comprehensive education, support, and case management programs and tools to members during and after pregnancy. We start with early identification of pregnancy and prompt screening for risk factors, then follow with quality, culturally-competent case management to pregnant Medicaid members during the prenatal and postpartum periods.

In 2018, we will implement an EED pre-payment claim edit. Clear Health affiliate plans in six states have EED payment rules. Five out of the six with EED payment rules saw a reduction in rates from 2015 to 2016.

Clear Health continues to invest in innovative solutions and collaborations to increase the use of safe, evidence-based practices in maternity care, and reduce unnecessary medical interventions in labor and delivery.

**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
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Evaluation Criteria:

1. The extent to which the respondent identified opportunities for improvement in achieving the benchmarks and subsequent steps the respondent will implement to overcome any barriers across and within different systems of care.
2. The extent to which the respondent describes specific care coordination protocols, including a description of the risk stratification algorithm used to identify high-risk pregnancies (including enrollees with co-occurring behavioral health conditions).
3. The extent to which the respondent describes strategies to improve data exchanges and communications between practitioners to improve care coordination efforts for pregnant enrollees that are determined to be high-risk.
4. The adequacy of the respondent's description of specific evidenced-based programs and interventions that will be used to decrease the number of unintended pregnancies and the associated indicators or measures that will be used to determine their effectiveness.
5. The extent to which the respondent describes financial and non-financial provider and enrollee incentives for evidence-based practices that will contribute to hitting the benchmarks.
6. The adequacy of the respondent's proposed performance benchmarks for reducing non-medically indicated cesarean sections and early elective deliveries.
7. The extent to which the respondent describes its experience implementing successful strategies that resulted in a reduction in non-medically indicated cesarean sections and early elective deliveries. In order to receive all points for this component, the respondent must include outcome data on specific performance metrics.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
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MMA SRC# 3 – Patient Centered Medical Homes (Regional):

The respondent shall describe its experience with patient centered medical homes (PCMHs) including the respondent's efforts toward the solicitation of PCMH-recognized practices to improve access, facilitate care integration and improvement in quality measures. Specifically, the respondent shall describe programs and initiatives utilizing PCMHs to promote the Agency's goals.

Response:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

EXHIBIT A-4-b

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[REDACTED]

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EXHIBIT A-4-b

**MMA SUBMISSION REQUIREMENTS
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**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)**

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EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS
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EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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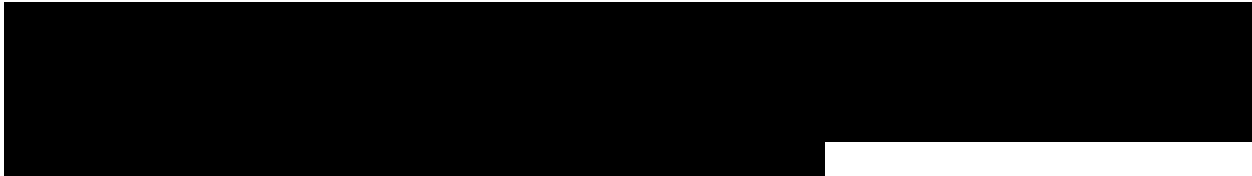
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MMA SUBMISSION REQUIREMENTS
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Evaluation Criteria:

1. The extent to which the respondent's description demonstrates experience that includes contracts with patient centered medical homes in the network serving populations similar to the target population of this solicitation and demonstrates:
 - (a) Enhanced access;
 - (b) Coordinated and/or integrated care; and
 - (c) Achievement of improved quality outcomes.
2. The extent to which the respondent's description of recognizing PCMHs addresses the reduction of potentially preventable events for enrollees assigned to a PCMH for their PCP.
3. The extent to which the respondent's description of recognizing PCMHs addresses methodologies and processes to improve prenatal care and birth outcomes for enrollees assigned to a PCMH as their PCP.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
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MMA SRC# 4 – Telemedicine (Regional):

The respondent shall describe its overall approach to utilizing telemedicine services to promote the Agency's goals, in particular as it relates to enhanced access to the following providers within the plan's network:

- a. Primary Care;
- b. Licensed mental health clinicians;
- c. Psychiatrists;
- d. Cardiologists;
- e. Pulmonologists;
- f. Endocrinologists; and
- g. Internists.

The respondent shall describe any limitations placed on telemedicine services within its network and the percentage of providers with the network that are authorized to provide telemedicine services for the specialty types referenced above and those actually providing telemedicine.

Response:

[REDACTED]

[REDACTED]

[REDACTED]

EXHIBIT A-4-b

**MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)**

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EXHIBIT A-4-b

**MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)**

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EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Evaluation Criteria:

1. The extent to which the respondent describes an approach on the use of telemedicine services within its provider network that supports achievement of the Agency's goals.
2. The extent to which the respondent describes the methodology it will use to identify providers eligible for participation, limitations/barriers in its proposed use of telemedicine and proposed strategies to overcome those limitations/barriers.
3. The extent to which the respondent has already made significant achievements in the deployment of telemedicine within its network as evidenced by:
 - (a) The percentage of providers authorized to provide telemedicine services for the provider types referenced; and
 - (b) The percentage and type of authorized providers that provided telemedicine services during the 2016 calendar year.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 5 – Provider Network Development (Statewide):

The respondent shall submit a draft network development and management plan demonstrating how it will ensure timely access to primary and specialty care services, necessary to promote the Agency's goals, including:

- a. Identification of network gaps (time/distance standards, after-hours clinic availability, closed panels, etc.);
- b. Strategies that will be deployed to increase provider capacity and meet the needs of enrollees where network gaps have been identified;
- c. Strategies (including a description of data sources utilized) for measuring timely access to appointments with the following provider types:
 - (1) Cardiologists (pediatric and adult);
 - (2) Pulmonologists (pediatric and adult);
 - (3) Endocrinologists (adult);
 - (4) Internists (adult);
 - (5) Psychiatrists (pediatric and adult);
 - (6) Obstetricians/Gynecologists (adult); and
 - (7) Licensed mental health clinicians (pediatric and adult).
- d. Strategies for recruitment and retention efforts planned for each provider type, including the quality and/or performance metrics that will be used to determine a provider's success in making progress towards the Agency goals.

Response:

We submit our annual network plan and corresponding policies and procedures (including supporting documents such as data analytics, reports, graphs, identified trends, and patterns of care) to the Agency each year for approval. We make sure covered services are available and accessible for all members and develop and monitor network development plans that assure the provision of covered services for the maximum number of members for each region.

Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance (Clear Health) acknowledges that we have read and will comply with all contract provisions as identified in Attachment B, VIII Provider Services, and B.2 Annual Network Development Plan. A draft network development and management plan is included as Attachment MMA SRC# 5-1: Network Development and Management Plan (Statewide).

1. IDENTIFYING AND RESOLVING BARRIERS AND NETWORK GAPS

As Florida's largest HIV/AIDS specialty plan, Clear Health has extensive experience and qualifications in contracting and servicing networks designed to meet the special needs of this population. We recognize that to develop and maintain a high quality network to serve the HIV/AIDS Medicaid population, our company must have the respect and trust of the community. Our management team has a combined 105 years of experience serving the Florida Medicaid community.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Clear Health has built an extensive HIV/AIDS Medicaid network in Florida, establishing close relationships with PCPs, specialists, county health departments (CHDs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and teaching institutions. We have recruited PCPs and specialists in infectious disease, cardiology, dermatology, rheumatology, gastroenterology, endocrinology, and all other specialties who have experience in treating patients with HIV disease to become Medicaid providers and contract with us. We have developed a provider recruitment strategy and message of inclusivity and collaboration and actively provided education and support for the providers who serve our population.

Our ongoing recruitment efforts specifically target specialists who are experienced in working with people living with HIV/AIDS. It is our practice to work closely with our PCPs and determine who they most commonly refer enrollees to so we can make every attempt to include those providers in our network. We have been successful in contracting with most physicians who have traditionally not accepted Medicaid enrollees from other plans and/or direct MediPass recipients.

Based on our experience in providing services to the specialty population proposed, we have identified that the following specialties are critical due to the most commonly seen comorbidities in the HIV/AIDS population: Infectious Disease, Cardiology, Hematology/Oncology, Dermatology, Pulmonology, Endocrinology, Gastroenterology, Ophthalmology, and Behavioral Health. We meet the required access standards in all regions for all of these specialties.

We maintain an annual network development and management plan (annual network plan), including policies and procedures for assuring covered services are available, accessible, and provided promptly. In our response, we describe the various tools and methods we use to monitor our network and identify gaps including time/distance standards, after-hours clinic availability, and open/closed panels.

Our statewide provider network for the provider types identified above includes:

- Cardiologists (pediatric and adult)
- Pulmonologists (pediatric and adult)
- Endocrinologists (adult)
- Internists (adult)
- Psychiatrists (pediatric and adult)
- Obstetricians/Gynecologists (adult)
- Licensed mental health clinicians (pediatric and adult)

To assure our network of PCPs meets member needs, we have expanded our definition of primary care physicians to include family practice, general practice, pediatrics, internal medicine, and infectious disease providers. We designate providers with specialized HIV/AIDS training with a red ribbon beside their name in the Provider Directory, informing members of the provider's additional specialized HIV/AIDS care and treatment competency. This "Red Ribbon" program is nationally recognized and testament to our patient-centered model of service and support. In addition, many of our physician assistants, nurse practitioners, and pharmacists are also credentialed as HIV experts/specialists. Based on our experience, we believe that these physicians have the best understanding of the underlying condition of the member.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

**** SPOTLIGHT ON: Maintaining Access for Clear Health Members**

We recently faced the loss of providers when a large group decided to disband. We immediately reached out to their entire underlying network of providers to recruit them. We individually contracted PCPs with assigned members including a large number of infectious disease providers and endocrinologists. This assured continuity of care for our members and no erosion of access for Clear Health members. **

Clear Health considers the following elements (as required by 42 CFR 438.206) when establishing the provider network:

- Anticipated number and types of members
- Expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented
- Numbers and types (in terms of training, experience, and specialization) of providers required to furnish the covered services
- Number of network providers with open panels
- Geographic location of providers and members, considering ratios, time and distance
- After-hours availability
- Travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid members with disabilities. We provide transportation across counties. Additionally, Clear Health offers a medically-related lodging and food benefit for enrollees and caregivers needing to travel in excess of 120 miles for medically necessary care.

1.1. Ongoing Network Monitoring

Clear Health knows that a network composed of high quality providers is key to improved member outcomes, positive member experience, and appropriate utilization of services. We review data from various sources (such as Quest Analytics, Member Services data, satisfaction survey results, and provider feedback) and take action based on analysis of data as well as provider or membership changes. In addition, while comprehensive network data plays an important role in the ongoing management of our network, our hands-on collaborative approach to provider engagement is a critical source of information allowing us to best meet the needs of our members and providers.

1.1.2. Quest Analytics

To assure we are adequately monitoring contract requirements, we use Quest Analytics, the same software currently used by the Agency and the Centers for Medicare and Medicaid Services (CMS), to verify ratios and confirm we meet time and distance standards on assigned enrollment files and participating providers submitted in the PNV file. The Quest Analytics software includes contract-defined access standards to assure we review the network against AHCA standards. This allows for the consistent monitoring and reporting of our network. Analysis is run bi-weekly

EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

and reported to Provider Relations for investigation and resolution of any gaps. Additionally, we report it every quarter to the Gap Committee and before a significant provider termination to ensure adequate coverage. A standard Quest report includes the following features:

- **Geographical Overview Maps:** Overview maps display the provider locations in the geographical area requested. We can shade the service area by ZIP code, county, or state for easier interpretation by the end-user.
- **Provider and Member Location Maps:** Provider/member maps plot members and providers of any or all specialty/specialties – or combinations of both. These maps overlay the provider network against the membership base, with the appropriate radius encompassing each provider to identify geographical coverage in the service area.
- **Member Accessibility Summary:** The Member Accessibility Summary is a data sheet that provides an overview of the entire analysis displayed in the report. It shows the number and percentage of members with or without access. In addition, the Summary displays the top 10 key geographic areas and summary information. The top 10 key geographic areas are determined by the greatest number of members in that area.
- **Access Standard Comparison:** The Access Standard Comparison graph demonstrates the point at which the percentage of members attains compliant status with the specified provider type and defined access standard. The information from this graph can provide a quick evaluation of the strength-of-network in conjunction with the membership.
- **Accessibility Detail:** The Accessibility Detail data sheet provides an in-depth look at the summary information contained on the Accessibility Summary Page. We assess this data on a ZIP code level and display counts of members with and without access to care under the defined access standards. The detail provides the total number of members and providers along with a member-to-provider ratio for the demographic/geographic area analyzed. Additionally, the report continues this detailed analysis of a member's choice of up to five providers and the average distance to achieve that access.

1.1.3. Member and Provider Feedback

We monitor provider adherence to access standards through trending of member and provider complaint data. This is accomplished through real-time communication from our Member Services and Clinical teams to the Provider relations team to address the issue and provide immediate resolution. We assess these actions at monthly staff meetings. We also use annual member and provider satisfaction surveys to monitor access standards.

We continually monitor and act on information obtained through our Provider Relations, Case Management, Quality Management, and Marketing departments. We discuss this information at Gap Committee and QMC meetings. Member Advisory Committee (MAC) meetings, where members are invited to attend, are held on a regular basis to gauge member needs specific to the region. We relay data collected from the MAC to the different departments to inform process improvements.

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MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1.1.4. Additional Data Sources

Additional methods we use to monitor access standards include:

- Member Services data, which helps us identify potential compliance issues. For example, for each call regarding a provider's inaccessibility, we contact the provider to investigate.
- Quality of Care and access concerns are investigated as part of our Quality Management program. We review the outcomes of Quality of Care reviews, including Peer Review Committee actions.
- HEDIS® scores and our HEDIS® hybrid process enables collaboration with providers to improve access and outcomes. Our staff reviews medical records for documentation, access to care, and quality of services during provider visits.
- Administrative data review and annual comprehensive analysis of access and availability includes analysis of administrative complaints, after-hours availability, survey information, appointment access statistics, Provider Call Center reports, Quest Analytics® reports, and provider satisfaction survey results. We use data from departments such as Provider Contracting and Database Administration, Operations, Medical Management, and Quality Management in the analysis.
- Grievance and appeals data identify trends at an individual provider level.
- Annually, our Quality Management Department engages a qualified organization to administer the most current version of the Consumer Assessment of Health Care Providers and Systems (CAHPS®) survey that queries members on access to care among other key questions.

Once we identify a network gap, we identify prospects in the affected area and work to close the gap and/or address the barrier by negotiating a contract with specialty providers in the geographic area as a long-term intervention. During the contracting and negotiation process, we execute a letter of agreement (LOA) or single-case agreement to assure care for a specific member in that region that may require immediate access to specialty services. This is a short-term intervention as the ultimate goal is to fully contract and credential the provider(s). We monitor any future membership changes and our capacity to provide covered services. Provider network managers are responsive to new gaps and adjust network recruitment strategies accordingly.

1.2. Gap Committee

Clear Health has a detailed and proactive process to promptly address network gaps because we know from experience that network gaps are high on the list of reasons for member dissatisfaction and voluntary disenrollment. Our Gap Committee is our frontline team responsible for monitoring gaps in the network and assuring that network deficiencies are resolved. The Gap Committee includes representatives from Member Services, Grievances and Appeals, Medical Management, Quality Management, Health Services, Provider Relations, and Delegation Oversight.

Each of these departments track and trend member or provider barriers obtaining access to covered services, whether it is appointment availability or a lack of a necessary specialty type in the network. We track and trend claims and encounter data for peaks and valleys that could

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indicate a provider is at capacity and identify those that are being under-utilized for special investigation into why Clear Health members are not being seen at expected rates for that provider type. We identify issues and determine root causes through the analysis of Quest Analytics data and review of the PNV files for ratio analysis.

Each department brings the results of their review of network issues, access challenges, and member and provider complaints to the Gap Committee meetings. We review, aggregate, and analyze data from all of these departments. We develop short- and long-term interventions and prioritize the implementation of each strategy based upon the number and type of members impacted, as well as the urgency of the need for the services/provider.

We maintain minutes of each meeting. Minutes document estimated resolution dates for each issue and the individual accountable to support for future follow-up. Each Gap Committee meeting results in a prioritization list that is assigned to the Provider Relations department and a recruitment list is provided to each Provider Network Manager. Recruitment updates are reported back to the Gap Committee or to the workgroups by Provider Relations. We escalate recruitment difficulties in high-impact areas to our Regional Vice President of Provider Solutions for assistance.

The Gap Committee reports network findings, performance metrics, corrective action plans (CAPs), and all other pertinent information to the Quality Management Committee (QMC). Our QMC meeting, led by our Health Services and Quality departments, addresses potential access to care concerns. When members report access issues or complaints about providers, the source department tracks and trends these issues and reports them to the Gap Committee. The Gap Committee reports them to the Quality Management department (and these are included in the Provider's recredentialing review).

1.3. Capacity to Accept New Patients

Clear Health's network includes more than 3,435 Primary Care Providers (PCPs). Our network of PCPs is more than adequate to meet the needs of our projected membership. Using a ratio of members to PCPs of 750:1, our current network can accommodate state-wide membership growth. We evaluate capacity by identifying providers with open panels and mapping them against our current membership. This allows us to measure access against AHCA access standards. We also use other mechanisms to monitor capacity to accept new members including:

- Dedicated staff make outbound calls to providers requesting updated information for the provider directory, which includes whether or not they are accepting new members.
- We send a monthly fax blast to providers requesting them to review their directory information and submit changes via fax, email, mail, or by informing their Provider Network Manager.
- We capture information about provider offices not accepting members during the Appointment Accessibility Audit process and forwarded to Provider Relations for follow-up.

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1.4. Monitoring Access

Our provider agreements require network providers to abide by all AHCA appointment standards, including standards for after-hours availability. We educate providers on these standards through initial and recurring provider training and the provider manual, which we incorporate by reference as part of the provider agreement. Our provider newsletters supplement initial orientation training and serve as recurring reminders for timely scheduling of appointments and after-hours availability.

Clear Health conducts wait time and after-hours surveys to monitor network accessibility in compliance with AHCA requirements. Our Quality Management department contracts with an NCQA certified survey vendor to administer the Appointment Accessibility audit. We conduct initial audits in the spring and re-audits of noncompliance in the fall. We will increase the frequency of our access audits to quarterly in compliance with Attachment B, VIII Provider Services, A.8 Timely Access Standards.

Our Appointment Accessibility Audit program surveys PCPs, OB/GYNs, pediatricians, high volume specialists, high impact specialists, and BH providers (prescribers and non-prescribers). This includes the provider types listed in this MMA SRC 5 – cardiologists, pulmonologists, internists, psychiatrists, obstetricians/gynecologists, and licensed mental health clinicians and other specialty within the network. We provide additional information about monitoring access in Section 3 below.

1.5. Strategies to Increase Capacity if an Accessibility Issue is Identified

Any findings of gaps in access and availability standards result in interventions, focusing on helping improve performance. Our assistance may include working with providers to extend their office hours or expand their practice, or we may recalibrate the member-to-PCP assignments to maximize our network capacity. We assess data at monthly Gap and QMC Committee meetings.

1.5.1. Mitigation Steps if an Issue is Related to a Specific Provider

Clear Health's first priority is to make sure that members have timely access to quality care. For issues related to a specific provider we immediately contact the provider to inquire on the access constraints for the member. If the provider cannot serve the member, we help the member identify other available providers within the area to ensure the member gets timely care/service.

We mail all provider offices a letter advising them of the results of their survey along with access standards when we encounter a problem with timely access either after conducting appointment access audits, reviewing satisfaction surveys, or receiving complaints. Our Grievances and Appeals process includes requesting feedback and providing resolutions back to Provider Relations for investigation and Provider education. The mailing includes a form that the provider must return within 30 days advising what action will be taken to meet the applicable access standard(s). The Provider Network Manager contacts the provider by telephone or through an on-site visit to discuss the plan, re-educate the provider about access standards, formalize a corrective action plan, and obtain agreement for follow-up reassessment. We obtain an acknowledgement of provider engagement immediately following the training.

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The Provider Network Manager monitors and evaluates the action plan to make sure the provider completes the critical tasks according to schedule and that issues do not re-occur. Noncompliant providers are also re-audited to confirm compliance. If provider noncompliance continues, Provider Network Managers re-educate providers on the proper protocol and their contractual obligations and regularly monitor performance.

If provider noncompliance persists, we refer the provider to the Peer Review Committee for guidance. The Peer Review Committee may impose sanctions, such as limiting the provider's referrals. Finally, if the provider does not correct his/her deficiencies after our continued improvement efforts, the sanctions may ultimately lead to termination of active network status.

1.5.2. Incorporating Member Feedback

Clear Health's Quality Management department tracks and trends member complaints regarding access over time to identify ongoing patterns of noncompliance. The Member Advisory Committee (MAC) is also another avenue in which we receive this feedback. When we identify a pattern, The Provider Network Manager sends a written notice to the provider and develops an action plan. The Provider Network Manager meets with the provider to review the action plan and the provider signs an attestation form confirming the meeting took place.

1.5.3. Mitigation Steps for Regional or Systemic Issues

If our analyses indicate that any component of our provider network is insufficient, our Provider Relations team will develop an action plan. The action plan will identify staffing, responsibilities, resources, and a timeline to correct the situation. Actions related to current network providers may include:

- Partnering with existing network providers to recruit and retain clinical staff, expand access through physician extenders, expand services in rural areas, offer additional services to address rural needs, and provide additional after-hours and weekend appointments
- Reviewing the directory and identifying referral pattern needs
- Coordinating transportation for members to see necessary providers outside their access area
- Collaborating with providers to open new practice sites
- Encouraging and supporting PCMH practice models that utilize a patient-centered team-based practice approach. Through our efforts, we identify practices and provide incentives to apply and complete PCMH certification.
- Promoting innovations to expand access to care such as using mid-level practitioners, utilizing health workers, using BH coaches to extend PCP capacity, and bundled FQHC coding to promote integration
- Providing focused training and education in team-based care

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- Encouraging primary care practices to participate in one of our incentive programs. Practices can use these resources to expand office hours or the use of physician extenders
- Educating providers on and encouraging the use of telemedicine

Actions focused on non-participating providers may include:

- Recruiting out-of-network providers to participate in our network through referral trends, PCP referrals, completed out-of-network single case agreements (SCAs), and new providers entering the market, and converting non-traditional managed care providers
- Leveraging relationships with independent practice associations and other provider organizations to recruit additional providers
- Coordinating members' care with out-of-network providers
- Contacting providers (through Network Development outreach efforts) who are not enrolled as Florida Medicaid providers and explaining the process for enrolling, answering any questions they have, and following up with them to check their progress. We also provide them with the appropriate link to the AHCA website and include the paper application.

1.5.4. Incorporating Provider Feedback

We continually seek out provider feedback and improve our processes based on their feedback. For example, we heard from providers via the 2016 provider satisfaction survey that some PCPs were having problems with specialists that are in-network, but say they do not accept the Medicaid plan. Provider Network Managers contacted the specialists that PCPs identified as most problematic with scheduling appointments and re-educated them on their contractual obligations with Clear Health. When onboarding network PCPs, the Provider Network Manager asks which specialists they usually use for referrals to determine if they are participating in our network. If these specialists are not participating, we initiate network development protocols.

1.5.5. Waiver Requests

Clear Health is committed to providing a complete network for each region. Prior to submitting a waiver request, we confirm that there are no providers available to meet member needs. We review provider directories of other MCOs, Department of Health data, perform a Florida license search, and perform additional online searches. In addition, we perform a zip code analysis to determine the closest provider to the member. We check to see if the provider is in our network (and that they are listed appropriately in our provider directory) and outreach with an invitation to join the network if the provider is non-participating.

Next, we evaluate our participating PCPs to determine the pattern of care. Clear Health makes every attempt to accommodate the member with providers in adjacent regions/ counties and provide transportation when needed. We continue to monitor the region for any new providers or facilities that may be available to render services.

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In certain situations, such as rural counties where providers may not be available, Clear Health submits a waiver request to AHCA. We will continue to work with AHCA to address access issues due to limited availability of some specialties. Our proven process for arranging for care from out-of-network providers through SCAs expedites access to medically appropriate care for our members should a service not be available in our network.

2. MEETING MEMBER NEEDS WHEN A SERVICE IS NOT AVAILABLE WITHIN OUR PROVIDER NETWORK

**** SPOTLIGHT ON: Locating a Provider Assures a Successful Return Home**

A member was hospitalized in Atlanta and in need of specialized oxygen in order to be discharged from the hospital. Through our vast provider network of Durable Medical Equipment (DME) providers, we were able to obtain a letter of agreement with an out-of-state vendor in order for the member to be discharged with oxygen. The member was able to travel back to his hometown in Florida successfully. **

We are committed to facilitating access to medically appropriate care for our members. Our comprehensive Florida provider network offers an array of accessible and convenient options for members. In the unlikely event a network provider is unavailable, our procedures foster timely access to out-of-network providers so that our members can access the full range of services quickly, regardless of network capacity. We follow these processes for cardiologists, pulmonologists, endocrinologists, internists, psychiatrists, obstetricians/gynecologists, and licensed mental health clinicians.

We meet the needs of members and provide covered services even if we are unable to provide the service through our provider network. If we are unable to provide medically necessary services to a member with our network providers, we cover the services in an adequate and timely manner by using providers and services that are not in our network. We educate providers on how to interact with the health plan while the member is under their care. In addition, Clear Health also coordinates/facilitates transportation when needed.

We have a clear and consistent process to resolve access issues expeditiously, which includes escalation to senior management if it appears the issue will not be resolved prior to the deadline. Our Regional Vice President of Provider Solutions retains accountability for timely resolution. We review all agreements are reviewed and we attempt to contract with non-participating providers in an effort to further enhance the provider network.

Access issues may be identified within various departments and each department has a method to escalate to the appropriate Provider Relations staff. When we identify an access issue, our Regional Provider Relations Director assigns a representative to negotiate a case contract or LOA, guaranteeing reimbursement of services to out-of-network providers for as long as we are unable to provide the medically necessary covered services within our network.

If it appears that the issue will not be resolved in a timely manner, we escalate it to the Regional Vice President of Provider Solutions for resolution. Issues which are unable to be resolved are escalated to our Plan President and Chief Medical Officer. Clear Health also maintains an open line of communication where any person within the organization who comes across a potential concern can send a detailed request to Provider Relations for research/assistance and resolution.

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MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

2.1. Immediate Interventions

We meet the needs of our members and provide covered services even if we are unable to provide the service through our provider network. When a network provider is not available to meet a member's needs, we refer that member to an out-of-network provider. This process does not apply to emergent situations as no referral is required.

To resolve a gap or barrier using a short-term intervention, Provider Network Managers contact a qualified out-of-network provider/specialist in the county or region who can offer the services needed and negotiate a Letter of Agreement (LOA) or a single-case agreement. We verify provider licensure and confirm that the provider does not appear on any governmental exclusion lists. We provide education on how to interact with the health plan while the member is under the out-of-network provider's care. In addition to the measures taken to coordinate care for the member, Clear Health also coordinates transportation when needed.

2.2. Short-term Interventions

We attempt to contract with out-of-network providers used by our members to enhance access and continuity of care. Our out-of-network coordination nurses encourage out-of-network providers to join our network while they are developing the single case agreement. If the provider is interested in joining, the out of network coordination nurse coordinates with the Provider Network Manager to follow up with the provider for contracting. At this point, the provider relations team negotiates rates in an effort to expedite care and follows up with the provider in an attempt to contract the provider to enhance the participating physician network. As part of our network recruitment strategy, we review all single case agreement patterns in our monthly and quarterly meetings in order to proactively engage providers not currently in network.

2.3. Long-term Interventions

As a long-term intervention, we work to close a gap and/or barrier by negotiating a contract with a qualified provider/specialist in the county or region able to offer the services needed.

If we are unable to provide medically necessary services to a member via our network providers, we will cover the services in an adequate and timely manner by using providers and services that are not in our network. We use a well-established process to resolve these issues expeditiously, which includes escalating to senior management if it appears the issue will not be resolved timely. We hold our Regional Vice President of Network Solutions ultimately accountable for resolution in a timely manner.

2.4. Telemedicine Solutions

Telemedicine services can play an important role in providing members with ready access to both physical health (PH) and behavioral health (BH) services. Telemedicine is used to support health care when the provider and member are physically separated. Telemedicine can also play an important role in expanding access for members in rural areas of Florida where certain specialties might not exist, as well as those in more urban areas of the state for after-hours access to care as an effective alternative to unnecessary use of the emergency department (ED), and for expanding access for members with limited mobility.

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Clear Health will cover telemedicine consistent with Florida state regulations and Medicaid program requirements with respect to the provision of services via telemedicine. We will administer our telemedicine program in accordance with the telemedicine coverage provisions specified in the AHCA Standard Contract, including but not limited to the requirements related to technical safeguards, HIPAA, provider training, member choice, and fraud and abuse. We will comply with the telemedicine requirements specified in Attachment B, and will follow Florida Medicaid billing and reimbursement policies, as well as limitations, and restrictions on the provision of telemedicine.

Clear Health's telemedicine strategy is multi-faceted and designed to increase access to care in the above specialties as well as other services that support achievement of the Agency's goals. Our objective is to provide quicker and easier access to primary care, BH, and specialty services through telemedicine, and to address barriers related to travel, thereby reducing potentially preventable events (PPEs) and improving member health outcomes. Our strategies are designed to provide a comprehensive telemedicine solution and include:

Specialty Teleconsults. Through our strategic partnership with GlobalMed, we will address the lack of adequate access to specialty consultations in rural areas and regions with our innovative pediatric and adult specialty telemedicine consultation solution. We will offer access to telemedicine consultations with locally-based Florida-licensed in-network providers for primary care, and various specialties including cardiology, pulmonology, endocrinology, internal medicine, and licensed mental-health clinicians and psychiatrists. We will use a two-way audio/video communication with a secure Internet connection from a video-enabled device such as a computer, tablet, or smart phone and/or facilitated presentation site with integrated diagnostic equipment. Patients will have telemedicine access to specialist consultations from PCP offices and other provider-facilitated presentation sites. This capability will support multiple participants, allowing the patient, PCP, and specialist to all participate simultaneously in the telemedicine visit. The member could also engage in a provider visit from the comfort of their home making this process convenient for them. We will offer scheduling for specialty consultations at blocks of time during the week for various specialties and engage with our network providers and members to educate and create awareness of appointment availability. We will also establish strategically located and facilitated community-based outreach center (CBOC) presentation sites in rural regions and areas of the state where access to a PCP location is limited.

LiveHealth Online. Through LiveHealth Online (LHO), we will offer our innovative member-direct access solution for urgent care telemedicine. LHO facilitates online access through two-way audio/video technology to Florida-licensed, board-certified physicians covering primary care specialties (such as family practice, general practice, pediatricians, internal Medicine, and emergency medicine) for consultations on clinically appropriate conditions (such as a cough, fever, or flu). Members can access services through a secure Internet connection or an application on their smartphone.

Telemonitoring. Through our strategic partnership with Telemedcare America (TMC) and First Quality Home Care (FQHC) we are developing a pilot to provide telehealth monitoring to members with the goal of reducing utilization and cost. The goals of this pilot program focus on improving outcomes and reducing costs for a selected group of 100 members who suffer from chronic

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conditions of congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and diabetes, for a six month period. Members will be monitored on an integrated model of service facilitated by TMC and FQHC in order to reduce hospitalizations and maintain control of chronic diseases through specific protocols.

3. MEASURING TIMELY ACCESS FOR SPECIFIED PROVIDER TYPES

The primary objectives of our Appointment Availability Audit program include:

- Helping improve the services provided to our members
- Providing quantifiable feedback regarding compliance with access and availability standards
- Assuring compliance with regulations set forth in our Contract with AHCA

We survey providers to determine the accessibility and availability of appointments for members. We currently assess the following appointment types:

- Urgent Care
- Routine Sick Care
- Well Care
- Initial Visit Routine Care
- Follow-up Routine Care
- Non-Life Threatening Emergent Care
- Prenatal First Trimester Care
- Prenatal Second Trimester Care
- Prenatal Third Trimester Care
- Wait Time

Under the new Contract, we will measure timely access against the revised standards set forth in Attachment B, VIII Provider Services, A.8 Timely Access Standards.

3.a. Average Wait Time for an Urgent Appointment

Using a Computer-Assisted Telephone Interviewing (CATI) methodology, we survey providers to determine the accessibility and availability of appointments for our members. Interviewers utilize a prepared script that identifies Clear Health as the health plan. We include scenarios for different appointment types in our scripting and tailor them to be appropriate for the type of provider being surveyed. Interviewers list multiple choice response options to help guide schedulers' answer format. We compare the response to our standards to determine compliance. We document verbatim comments during the call for additional review. We lace telephone calls placed during normal business hours.

We send out corrective action letters to noncompliant provider offices. These letters advise the office of the results of their audit along with access standards. We also include in the mailing a form that the provider must return within 30 days advising what action will be taken to meet the applicable access standard(s). Provider Network Managers reach out to assist providers in developing an action plan. Noncompliant providers are also re-audited to assure compliance. If a provider continues to be noncompliant, Provider Network Managers train providers on the proper protocol.

EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

3.a.1. Additional Monitoring of Behavioral Health Providers

Beacon Health Options (Beacon), our subcontractor for BH, performs additional auditing for their network providers. Beacon provider relations staff contact 100 percent of network prescribers (MDs, DOs, and ARNPs) each quarter and ask questions to determine the provider's ability to accommodate members. If a provider is unable to accommodate a member according to access standards, they assure the provider has an alternate plan in place to help members access care during urgent, emergent, and routine situations. Once the calls have been made to the prescribers, any changes that need to be made in the system are documented via their management information system.

In addition to contacting the provider network quarterly by telephone, Beacon's provider relations and quality improvement departments undertake additional monitoring activities to assure the Florida Medicaid provider network is accessible for members. Their quality improvement team also survey 100 percent of the provider network (including non-prescribers) via an online survey tool. This online tool gives providers the opportunity to self-report their availability to provide timely access to care and their plan if those standards cannot be met. This information is received by Clear Health quarterly. In the event there is a deficiency, the providers within the Beacon network are re-trained and audited for compliance. If a barrier is found after re-training and audit efforts, a Corrective Action Plan (CAP) will be issued. This assures that members have timely access to BH services that will meet their needs; timely opportunities for improvement are identified; and interventions are implemented to continually improve members' access to BH services.

3.b. Average Wait Time for a Routine Appointment

As described in section 3.a above, we survey providers to determine the accessibility and availability of appointments for our members. We notify any noncompliant providers and request an action plan to mitigate the deficiency. Our Provider Network Managers will offer assistance to problems in developing an action plan.

3.1. Other Methods Used to Monitor Compliance with Access Standards

We routinely monitor provider adherence to access standards through trending of member and provider complaint data. We accomplish this through real-time communication from our Member Services and Clinical teams to the Provider Relations team and assessed at monthly staff meetings. We also use annual member satisfaction surveys and provider satisfaction surveys to monitor access standards. We also continually monitor and act on information obtained through our Provider Relations, Case Management, Quality Management, and Marketing departments. We discuss this information at Gap Committee and QMC meetings.

Additional methods we use to monitor access standards include:

- Member Services data, which helps us identify potential compliance issues. For example, for each call we receive regarding a provider's inaccessibility, we contact the provider to investigate.
- Quality of Care and access concerns are investigated as part of our Quality Management program. We review the outcomes of Quality of Care reviews, including Peer Review Committee actions.

EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- HEDIS® scores and our HEDIS® hybrid process enables collaboration with providers to improve access and outcomes. Our staff reviews medical records for documentation, access to care, and quality of services during provider visits.
- Administrative data review and annual comprehensive analysis of access and availability includes analysis of administrative complaints, after-hours availability, survey information, appointment access statistics, Provider Call Center reports, Quest Analytics® reports, and provider satisfaction survey results. We use data from departments, such as Provider Contracting and Database Administration, Operations, Medical Management, and Quality Management in the analysis.
- Grievance and appeals data identify trends at an individual provider level.
- Each year, our Quality Management Department engages a qualified organization to administer the most current version of the Consumer Assessment of Health Care Providers and Systems (CAHPS®) survey that queries members on access to care among other key questions.

4. DEPLOYING RECRUITMENT EFFORTS

The Provider Relations department reviews future membership changes and our capacity to provide covered services by establishing ratios to guide growth. Provider Relations develops ongoing network recruitment strategies based on any identified gaps as well as enrollment modeling for future endeavors.

Adequacy reports are reviewed monthly, or ad hoc when a major network change has occurred. We also consider member services data, quality of care and access concerns, HEDIS® data, administrative data, comprehensive analysis of access and availability, grievance and appeals data, and satisfaction surveys. We review and monitor data in Gap Committee and QMC meetings.

We follow this process for all provider types including cardiologists, pulmonologists, endocrinologists, internists, psychiatrists, obstetricians/gynecologists. We monitor licensed mental health clinicians through our dedicated Florida-based Vendor Delegation Oversight Group (VDOG) which oversees and monitors subcontractor performance.

In addition to our monthly review of adequacy reports, we perform a formal network analysis on an annual basis (Network Development Plan) based on estimated membership for the upcoming year. This annual analysis includes Quest Analytics reports, as well as reports, by market from the Gap Committee, which identify network gap issues based on the tracking and tending that was done during the previous year. Should we identify a gap we immediately start recruiting to located needed providers. Network recruitment activities are ongoing until the gap is filled or until we have determined that there are no providers available to add to the network. Only after we have exhausted all possibilities to fill the gap do we submit a Waiver Request to AHCA.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

The Network Development Plan also takes into account the ease with which care is provided to the member by all providers (including those provided by our subcontractors) by monitoring the number of enrollee and provider complaints, reviewing utilization data to assure enrollees are being seen and assessing the willingness to work with us via interactions and meeting requests and correspondence.

**** SPOTLIGHT ON: Cold Call Brings a New PCP to Our Osceola Members**

Locating a PCP in the southern part of Osceola that meets time and distance standards can be a challenge. In an effort to improve member access and satisfaction, a Provider Relations Manager conducted a cold call field visit to a provider with a new office in Osceola. The provider, an internal medicine specialist, recently opened her practice after serving as a hospitalist. Clear Health was the first Medicaid HMO to contract with this provider who already had a Medicaid number. **

4.1. Recruitment Strategies

**** SPOTLIGHT ON: Opening a New PCP Location**

The need presented itself for an adult PCP in rural east Hillsborough County. We approached Dr. Camejo as he is a high-performing, high-quality network provider who has a Value Based Purchasing (VBP) contract. Clear Health collaborated with Dr. Camejo to fill the need by opening a new practice location in the underserved area, thereby improving member access and satisfaction. **

Our proven recruitment strategies include:

- Recruiting out-of-network providers to participate in our provider network through referral trends, PCP referrals patterns, completed out-of-network SCAs, new providers entering the market, and converting non-traditional managed care providers, and encouraging providers to enroll as Medicaid providers
- Reviewing other MCO provider directories, Facility Finder, Department of Health data, and other internet searches (for example Google) to locate non-participating providers
- Partnering with existing network providers to recruit and retain clinical staff, expand access through physician extenders, expand services in rural areas, offer additional services to address rural needs, and provide after-hours and weekend appointments
- Contracting with providers in adjacent counties to provide services to members
- Increasing the use of telemedicine service providers for members in rural Florida who may not have close access to specialists; in urban areas, where after-hours access to care may be needed to alleviate unnecessary use of emergency departments (EDs); or for members with limited mobility

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

5. THE EXTENT TO WHICH THE RETENTION EFFORTS OUTLINE THE APPROACH TO KEEPING PROVIDERS SATISFIED AND IN GOOD-STANDING WITH THE RESPONDENT

We value providers as allies who help us support members to live independently and thrive in the setting of their choice. Across Florida, we collaborate with providers in our network and support them with timely communications, effective and informative one-on-one training, user-friendly technical assistance, and proactive issue resolution to foster continuous improvement and high-quality care.

We have designed our provider engagement strategy to keep our provider partners satisfied. We value their input and incorporate their feedback into operations. Our experience shows us that providers appreciate frequent outreach and communication, ongoing education opportunities, technical assistance where and when they need it, prompt issues resolution, and provider incentives.

Clear Health is further sharpening our focus on quality by bringing together the best practices and innovative solutions of three Florida health plans that have recently merged to become one entity. Provider satisfaction scores were reported separately for each of the legacy plans comprising the new unified Simply. We are presenting the legacy Simply scores as an example of our Florida provider satisfaction scores.

For legacy Simply, 2016 overall satisfaction with the health plan was 100 percent, with 100 percent of respondents stating they would definitely or probably recommend the health plan to other provider offices. We gather and incorporate provider feedback to maintain our high satisfaction scores. The following areas received the highest satisfaction ratings:

- 99 percent of responding providers expressed satisfaction with the quality of our health education and wellness promotion services for members.
- 99 percent of responding providers are satisfied with our credentialing process.
- 98 percent of responding providers were satisfied with the information provided in the provider manual, as well as communication provided via letters and faxes, received a composite score of 95 percent. The highest scoring item was the provider manual with a 98 percent satisfaction rating.
- 95 percent of responding providers expressed satisfaction with the authorization and appeals processes. The authorization and appeals processes received a composite score of 95 percent. Respondents were satisfied with the various avenues for requesting an authorization, the timeliness of the process, and the clarity of the review decisions.
- 95 percent of responding providers expressed satisfaction with claims. The Claims area received a composite score of 95 percent, which included four components: claims processing accuracy, timeliness, helpfulness of staff when resolving a claims issue, and claims review and/or appeal.
- 94 percent of responding providers were satisfied with Provider Relations. Provider Relations received a score of 94 percent, which included satisfaction with the response time and provider education conducted by this area.

EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

5.1. Provider Outreach and Communications for Programmatic Changes.

We use various methods to outreach and communicate with providers in our network including our provider website, provider manual, newsletters, blast faxes, bulletins, ongoing training, and technical provider assistance delivered online, by telephone, and in-person by our Provider Network Managers. Methods to communicate programmatic changes include provider visits by our Provider Relations staff, workshops, and in-service presentations by Clear Health employees, broadcast faxing, provider mailings, provider web demonstrations and web tutorials, and secure email. In the case of planned programmatic changes, we notify providers at least 30 days prior to the change. Our provider website houses current policies and procedures and includes information specific to SMMC providers when appropriate.

5.2. Ongoing Provider Training

Clear Health providers regularly receive ongoing education through our Clear Health Training Academy, as well as through onsite visits, webinars, network bulletins, fax broadcasts, and resource documents posted to our provider website. We select training topics based on updates to State and federal regulations pertaining to Medicaid and CHIP, NCQA standards, Clear Health's policies and procedures, provider requests, and other relevant sources. The Academy offers a truly comprehensive approach to all provider training. It incorporates multi-modality delivery processes (in-person, online courses, tailored webinars, written materials) for trainings and mechanisms for monitoring, alerting, and reporting on compliance and completion of trainings.

We encourage providers to participate in our intentional training program. This program encompasses four key strategies: 1) integrated care training based on a library of offerings specific to each type of provider, 2) specific training libraries and content related to population-driven health needs, 3) practices of excellence recognition programs that recognize providers for their additional knowledge and management of specific conditions, and 4) trainings related to specific contract requirements, HEDIS® measures, and NCQA requirements.

Training is specific to provider type and tailored to meet the particular needs of regional providers. Sessions give providers program and regulation updates, information on industry and care trends, new ways to improve member outcomes, recommendations for simplifying administration, information that can impact performance, and enhancements to our services and programs.

5.3. Technical Provider Assistance

Our regional Provider Relations staff work with providers to deliver specialized, high-touch training and assistance. They meet with providers in person at convenient locations, explaining processes for authorizations, use of electronic systems, credentialing, needs assessments, policies and procedures, claims issues, and any other technical assistance required. Our provider call center offers specialized assistance to new providers.

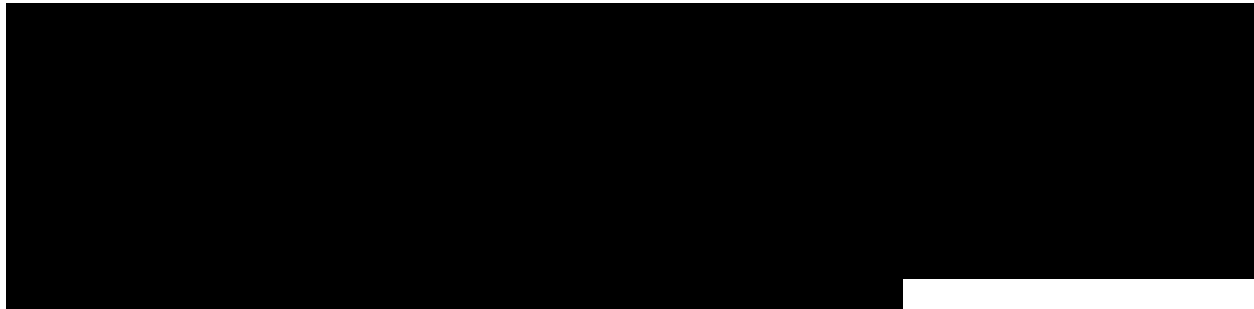
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AND EVALUATION CRITERIA (10-2-17)

5.4. Provider Issue Resolution

We are deeply committed to assuring providers receive timely and accurate issue resolution. Clear Health has frontline Provider Services staff available to assist providers with day-to-day issues. In addition, our regionally-based Provider Relations staff lead the resolution of issues from beginning to end. They are embedded in the local community and meet with providers face-to-face to understand and coordinate the resolution of any issues, share best practices, and continuously refine our provider issue resolution processes. They also coordinate and provide training to providers who are struggling with issues, and provide research and coordination of claims resolution by working with our Florida claims resolution team to reprocess claims for providers who are experiencing special circumstances. We log and track all provider issues in our centralized database.

We also maintain a dedicated, toll-free Provider Services call center for appropriate and timely responses to questions, concerns, and other issues related specifically to the SMMC program. Representatives are available during business hours to assist providers with enrollment, service authorizations, and reimbursement questions. Clear Health provides after-hours services, in which providers can contact so we can assist with any urgent matter that may arise.

5.5. Provider Incentives



6. THE TRANSPARENCY OF QUALITY AND/OR PERFORMANCE METRICS

Collaboration and engagement between providers and our organization is essential to effectively meet the challenges of improving health care for low-income and underserved individuals. Our Provider Network Managers are embedded in the regional communities, meeting face-to-face with providers to build trusting, open communication and develop collaborative relationships. They collaborate with providers to improve the effectiveness and efficiency of their practices and to identify opportunities for improving care and service.

Our Provider Network Managers are in the community meeting face-to-face with providers. We support providers with actionable data (gaps in care reporting, HEDIS® care alerts, prescriptions, lab results, and more to help identify and address barriers to accessing care and services) they can use immediately to make sure members are getting the right care, at the right time, and in the right place.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

6.1. Clear Health Performance Management Reports.

Clear Health provides actionable performance and utilization data to all PCPs and Medicaid Physician Incentive Program (MPIP) participating providers monthly whether or not they are participating in one of our other VBP programs. In addition, each Provider Network Manager is responsible for reviewing monthly reports for their assigned PCPs. They compare current results to the previous month and review the results with the PCP during their monthly visit.

6.1.1. Alternative Access to Performance Metrics

For providers that do not participate in the VBP agreements, we offer access to the Performance Metrics via Financial Recovery Group (FRG), a web-based software program. FRG provides performance targets, measures gains, member dashboard, provider scorecards, inpatient census, ED reporting, HEDIS® care gaps, member opportunities, pharmacy reporting, readmission reporting, institutional outpatient and professional claims detail, last PCP visit by member, specialty referral patterns, and individual member utilization. In addition to FRG, we also provide a secure FTP site for delivery of the PCP roster by location, inpatient concurrent census, Child Health Check-Up (CHCUP) care gap report, and monthly HEDIS® report. We provide CHCUP care gap and HEDIS® reports monthly to the provider by mail.

We also use our data sources to monitor providers across our network for completion rates of key services. For example, we monitor completion rates for EPSDT and HEDIS® services. Through our Case Management System, all providers have quick access to longitudinal data for each member.

6.1.2. Clear Health's Case Management System

Our Case Management System is available on-demand to all providers through our secure provider website, so that providers have electronic access to member data. It enables providers to access a single view that displays member data in an easy-to-navigate dashboard, including HEDIS® care alerts, authorizations, prescriptions, and claims organized by type, such as inpatient, ED, and office visits. The system, updated daily, also serves as our primary method for sharing member case management information, including health needs screenings and individualized plans of care.

6.2. Access to Financial Management and Performance Reports

For providers who participate under our Shared Savings / Risk-based programs, in addition to the data and reports described above, providers have access to our robust suite of financial management and performance reports. Providers can pull a variety of reports to meet their data needs through FRG, our secure FTP site. This site includes the following data is available to providers:

- Monthly capitation report with member detail in excel format
- Daily inpatient census report with member detail in excel format
- Daily roster of membership assigned to PCPs

EXHIBIT A-4-b
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- Cumulative financial summary of group which includes stop loss and IBNR
- Cumulative report detailing all capitation paid to vendors and PCPs
- Cumulative report detailing all claims paid on behalf of members assigned to the PCPs
- Cumulative report detailing all revenue and major expenses of members assigned to the PCPs
- Cumulative financial summary of PCP which includes stop loss and IBNR
- Report listing every part D Medicare member of the contract and provides details about the payments and adjustments made for each member
- Data file version of the risk adjustment model output report - Hierarchical chronic conditions

6.2.1. Provider Care Management Solution

Provider Care Management Solution (PCMS). PCMS is available to Florida providers who participate in our Provider Quality Improvement Program (PQIP) program. PCMS allows providers to see actionable, member-specific information to help identify members who need outreach and engagement, as well as care gaps that may impact a provider's performance. PCMS provides real-time information; including alerts, icons, hover overs, drop downs, and drill-through to support population health management. PCMS has the ability to filter patient populations by key conditions, risk factors, gaps in care, and visit history. PCMS, updated daily, provides real-time availability for providers on demand.

PCMS uses alerts, icons, hover-overs, drop-downs, and drill-through functionality to help providers identify actionable, member-specific information that supports their population health management efforts, including patient outreach and engagement activities that may impact a provider's performance. Providers can use PCMS filters to stratify their patient populations by key conditions, risk factors, gaps in care, visit history, ER utilization, inpatient admissions, and readmissions. Below we provide a description of just some of the data available through PCMS, including the Care Opportunities Dashboard and the ER Visits View.

Care Opportunities Dashboard: PCMS provides information about a provider's attributed members who are found to have care opportunities—active or potential gaps in care associated with recommended evidence-based care and our clinical quality metrics. We alert providers about members due for a particular service or treatment based on a specific condition or measure. The Care Opportunities by Condition dashboard provides a graphic representation of the members attributed to the provider group who have opportunities for the specific condition.

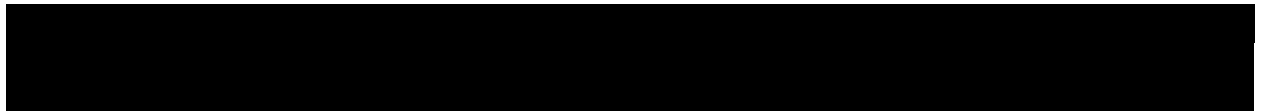
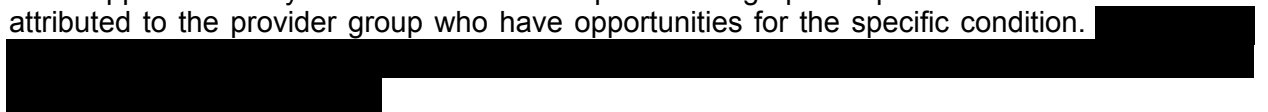


EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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EXHIBIT A-4-b

**MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)**

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The adequacy of the respondent's methodology for identifying and resolving barriers and network gaps; including ongoing activities for network development based on identified gaps and future needs projection.
2. The adequacy of the respondent's plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long-term interventions.
3. The adequacy of the respondent's approach for measuring timely access for the specified provider types and the extent to which the respondent's approach includes clear methodology for determining the following:
 - (a) Average wait time for an urgent appointment; and
 - (b) Average wait time for a routine appointment.
4. The extent to which the recruitment efforts outline the frequency and specific measures to be used to track the need to deploy recruitment activities for the provider types listed.
5. The extent to which the retention efforts outline the approach to keeping providers satisfied and in good-standing with the respondent.
6. The extent to which the quality and/or performance metrics it will use to gauge progress toward the Agency goals are transparent to providers, including the frequency with which providers will be able to access their progress.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

5 additional points will be awarded to respondents who demonstrate that providers shall have real-time access to their progress in achieving quality and/or performance metrics.

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Clear Health Alliance

**DRAFT ANNUAL NETWORK DEVELOPMENT AND
MANAGEMENT PLAN
Statewide**

Prepared by: Provider Relations department

Effective Date:

Revised:

Submitted: 2017

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Annual Network Plan

The mission of Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health) is to expand and simplify access to coordinated health care services for enrollees (members) and beneficiaries in government-sponsored programs. We will enable members to achieve optimal health through an outstanding network of providers and high-touch, local customer service delivered with the highest level of respect and service.

As Florida's largest HIV/AIDS specialty plan, Clear Health has extensive experience and qualifications in contracting and servicing networks designed to meet the special needs of this population. We recognize that to develop and maintain a high quality network to serve the HIV/AIDS Medicaid population our company must have the respect and trust of the community.

We know from experience that an integrated provider engagement model is critical to ongoing success. Everyone at Clear Health shares responsibility for interacting with providers in a way that drives superior results and outcomes. All areas within our organization (such as Member Services, Utilization Management, Case Management, Pharmacy, Claims, Quality Management, HEDIS®, and Medical Economics) work with providers to make sure they have the information, tools, and ongoing support necessary to achieve the best outcomes for our members and reduce providers' administrative burden. Across Florida, we support providers with timely communications, effective and informative one-on-one training, user-friendly technical assistance, actionable data and analytical support, and proactive issue resolution to foster continuous improvement and high-quality care.

We understand that a network of high-quality providers is key to improved member outcomes, positive member experience, and appropriate utilization of services. We have designed our engagement model to move providers along the value-based continuum, providing support to advance them through the array of value-based services.

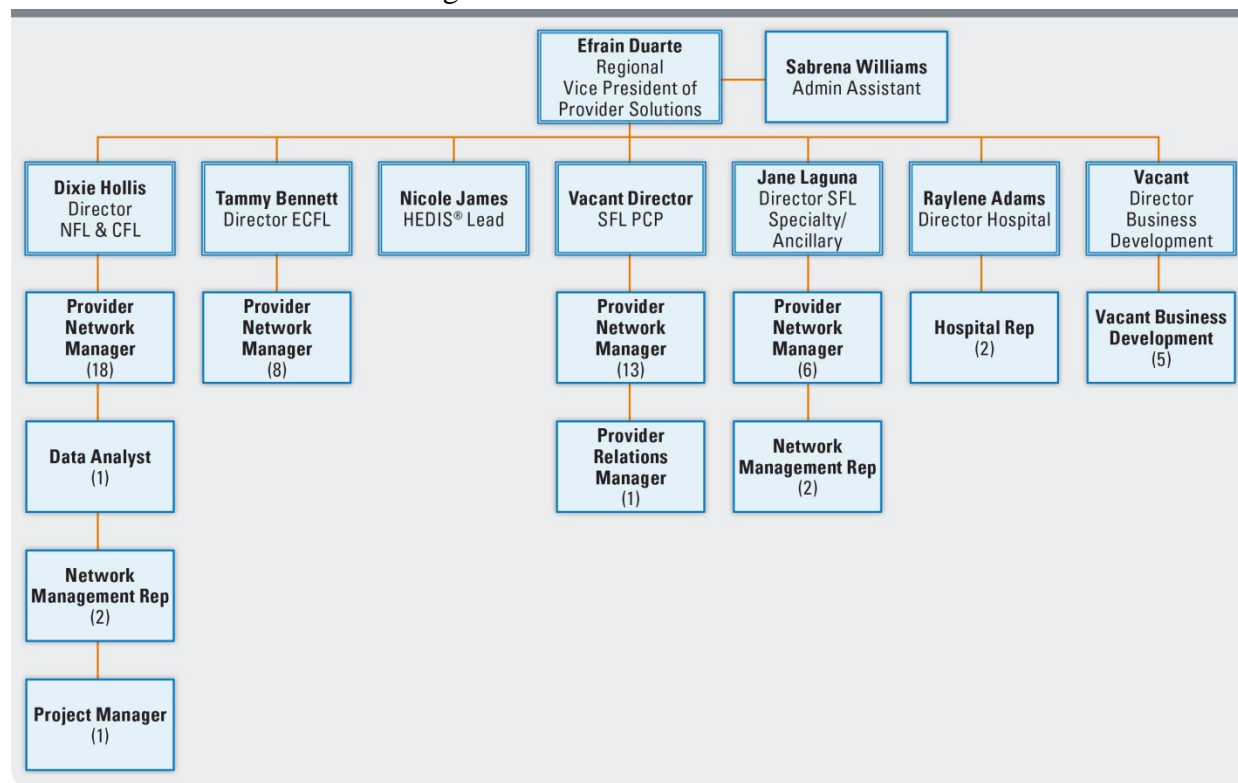
We have developed a provider recruitment strategy and message of inclusivity and collaboration, and have actively provided education and support for the providers who serve our population. Clear Health has built an extensive HIV/AIDS Medicaid network in Florida, establishing close relationships with primary care providers (PCPs), specialists, county health departments, Federally Qualified Health Centers (FQHCs), Regional Health Clinics (RHCs), and teaching institutions. We have been able to recruit PCPs and specialists in infectious disease, cardiology, dermatology, rheumatology, gastroenterology, and endocrinology who have experience in treating patients with HIV disease to become Medicaid providers and contract with us.

We have developed an intimate understanding of the unique needs of members with HIV/AIDS and the providers needed in their treatment and care. We allow family practice, general practice, pediatric, internal medicine, and infectious disease providers to serve as PCPs. An obstetrician may also serve as a PCP for a pregnant member, if that obstetrician meets criteria for HIV expertise and is willing to participate as a PCP. This broader definition has enabled us to lower member-to-provider ratio requirements to facilitate more frequent and more comprehensive interaction with the members.

We provide an enhanced level of support to network providers we designate as red ribbon providers. They have specialized HIV/AIDS training and are designated by a red ribbon beside their names in our provider directory, which informs members of their additional specialized HIV/AIDS care and treatment competency. Our red ribbon program is nationally recognized and a testament to our person-centered model of service and support.

Clear Health has established a Network Development and Management Plan (“Annual Network Plan”). It demonstrates our processes for developing, maintaining, and monitoring the Medicaid provider network. We will continue to submit the plan to the Agency every year by September 1.

Our Florida Provider Relations organization chart is included below



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Provider Relations Approach

Clear Health’s collaborative provider engagement strategy transforms health care delivery, creates an integrated system of care, and drives improved access and health outcomes for our members. Our success is anchored by our local, hands-on approach. We meet providers where they are and have been trusted partners through changes in programs, policy and benefits, demographics, cultural needs, and public health initiatives. Our provider engagement model brings us together with our providers by leveraging data, insights, and technology for a common objective – delivering the right care at the right time in the right place.

We embed Provider Network Managers in the regional communities, meeting face-to-face with providers to build trusting, open communication, and develop collaborative relationships. They

collaborate with providers to improve the effectiveness and efficiency of their practices and identify opportunities to improve care and service. By analyzing quality metrics, utilization trends, and reports for care opportunities, Provider Network Managers help providers coordinate care and create action plans to manage costs and improve quality, performance, and our members' experience while encouraging them to adopt practice management strategies that work for top-performing peers.

Our network management strategy, with its focus on reducing administrative burden and allowing providers more time to take care of our members, includes the following:

- On-demand technical assistance to help providers succeed, such as proactively contacting them if we identify possible submission errors through ongoing claims review
- Proactive education, delivered by a team of professionals focused on Medicaid products, that addresses the specific needs of providers in our network
- Assistance for providers at the point-of-care through actionable information using a variety of delivery methods to help manage members' care, including notifying providers of care gaps through online clinical alerts; providing periodic gaps in care reports for their assigned members; and providing access to our Case Management System that displays HEDIS[®] care alerts, prescriptions, lab results, and more to help identify and address barriers to care and services
- Sound reimbursement practices, including prompt and accurate claims payment and innovative incentive programs that reward providers for improvements in quality measures, leading to improved outcomes
- Practices to simplify and minimize administrative burden, including technology solutions such as online claims and prior authorization submission
- Ongoing collaboration with providers to improve member outcomes
- Educating PCPs on identifying members with behavioral health (BH) needs, including Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Across Florida, we collaborate with network providers and support them with timely communications, effective and informative one-on-one training, user-friendly technical assistance, and proactive issue resolution to foster continuous improvement and high-quality care. Our regionally based Provider Relations staff is located in local communities throughout the state. They know their local communities and the providers in those communities, and they are able to meet face-to-face to build trust, open communication, and collaborative relationships.

A. Processes to Develop, Maintain and Monitor Network

Clear Health maintains an appropriate provider network sufficient to provide adequate access to all services covered under the SMMC MMA Contract. We build our network to reflect the health care needs of our Florida members and our development approach reflects our understanding of the population's unique characteristics as described below.

1. Development

- Clear Health considered the following elements (as required by 42 CFR 438.206) when we established the provider network:

2017 ANNUAL NETWORK DEVELOPMENT AND MANAGEMENT PLAN

1. The anticipated number of members
 2. The expected utilization of services, taking into consideration the characteristics and health care needs of the specific Medicaid population represented
 3. The numbers and types (in terms of training, experience, and specialization) of providers required to deliver the covered services
 4. The numbers of network providers who are not accepting new members
 5. The geographic location of providers and member, including distance
 6. Travel time, the means of transportation ordinarily used by members and whether the location provides physical access for Medicaid members with disabilities
- Clear Health developed our plan for each region by determining network gaps. We use various means to regularly monitor the network and identify any barriers and gaps in care. Our Gap Committee is the primary method for reporting identified gaps in the network and making sure they are resolved. Our Directors are responsible for resolving network gaps and are accountable for any delays. The Gap Committee meets quarterly with department representatives from Member Services, Medical Management, Quality Management, Health Services, Provider Relations, Grievances and Appeals, and Delegation Oversight
 - Each of these departments tracks and trends member or provider disputes with access to covered services, whether it is appointment availability or a lack of a necessary specialty type in the network. We also track and trend claims and encounter data to identify peaks and valleys that could indicate a provider is at capacity and identify those underutilized to investigate why Clear Health members are not seen at expected rates for that provider type. Data from all of these sources is aggregated and prioritized based upon the impact, number of affected members, and urgency of the requested services. Documented minutes of each GAP Committee meeting include accountable individual and estimated dates for issue resolution for follow-up. Gap Committee meetings result in a prioritized list for the Provider Relations department and, when necessary, a recruitment list for each Provider Network Manager. Provider Relations reports recruitment updates to the Gap Committee and difficulties in high-impact areas are escalated to the Regional Vice President of Provider Solutions for resolution assistance.
 - In addition, we consider the wishes of current providers in our network. When new providers join our network, we ask for their preferred referral specialists and providers and proactively add those to the recruitment list. This preserves the new provider's established referral patterns and supports continuity of care for assigned members. Additionally, as the Provider Network Manager meets regularly with providers, we continue to request information on referral specialists to keep current with changes and new providers who may have started practice in the community.

2. Maintaining

To maintain our network, Clear Health reviews data from various sources and takes action based on provider or membership changes, including:

- When members report access issues or complaints about providers, they are tracked and trended by the source department, reported to the Gap Committee and Quality Management (QM) department, and included in the providers' recredentialing review.

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- When Clear Health recognizes a network gap, we identify prospects in the affected area and work to close the gap and address the barrier by negotiating a contract with nearby providers of that specialty as a long-term intervention. During the contracting and negotiation process, we will execute a letter of agreement (LOA) or single-case agreement to meet the needs of members in that region who may require those specialty services. This is a short-term intervention, because our ultimate goal is to fully contract and credential the providers.
- Clear Health monitors any future membership changes and our capacity to provide covered services. We are also responsive to new gaps and adjust network recruitment strategies accordingly.

3. Monitoring

- Adequacy reports and Quest Maps are presented quarterly to the Gap Committee, and more frequently as an ad hoc report when a major network change occurs
- The Gap Committee performs an annual formal network analysis (Annual Network Plan) based on estimated membership for the upcoming year. This analysis includes reports from directors. Reports reflect any new trend identified in the market, gaps, and the closure of any gaps or issues identified in the previous year's Network Development Plan
- Clear Health takes into account the accessibility and availability of our contracted ancillary providers, such as Beacon (BH), DentaQuest (dental), ESI (pharmacy), EyeQuest (vision), contracted hospitals, and specialty providers. This is accomplished through the review of member and provider complaints, Quest Analytics access reports, and quality management and utilization reports
- In addition, Clear Health meets regularly with contracted ancillary providers to review their performance and service standards. Our Director of Statewide Ancillary Contracting and the Subcontractor Oversight Director are included in these meetings.
- The Subcontractor Oversight team is responsible for the contracts and service overviews of all subcontractors. Ancillary providers and subcontractors are held to the same standards that Clear Health is required to uphold. Compliance with standards is determined via pre-delegation audits and annual audits thereafter. Standards must be met to continue participation in our network. We hold monthly meetings with each subcontractor to address deficiencies, concerns, and issues, and discuss intervention strategies, as necessary, to remedy the situation.

Provider Relations employees diligently monitor network adequacy, anticipates future needs, and promptly identify gaps to make sure that members have access to care and we continue to meet AHCA standards. We use our proven techniques to monitor and evaluate our network and seek input from various sources (members, providers, AHCA, and other stakeholders) to make sure our members have access to care when and where they need it.

We identify gaps in our provider network and collaborate with the AHCA to improve access, encouraging providers to enroll as Medicaid providers. We submit regular and ad hoc provider network reports in accordance with AHCA requirements.

Other Data Sources Used to Monitor Access to Care

In addition to Quest Analytics reports, we use a number of other data sources to monitor access to care and quality of services including:

- **Secret shopper phone calls** are used to collect data from providers in our network regarding appointment availability and access to care, including hours of operation and after-hours availability. We document provider responses to confirm compliance, identify potential quality improvement opportunities, and make sure our system contains accurate information for the provider directory
- **Routine appointment waiting times.** We also consider routine appointment waiting times. Every quarter, we survey a statistically sound sample across our network to identify appointment standards and access to services for PCPs, specialists, and BH providers
- **Member services data** identifies potential compliance issues. For example, if we receive repeated calls regarding a provider's inaccessibility, we contact the provider to investigate
- **Quality of Care and access concerns** are investigated as part of our Continuous Quality Improvement (CQI) program. We review the outcomes of Quality of Care reviews, including Peer Review Committee actions
- **HEDIS® scores.** The HEDIS® hybrid process enables collaboration with providers to improve access and outcomes. Our staff reviews medical records for documentation, access to care, and quality of services during provider visits
- **Administrative data review and annual comprehensive analysis of access and availability** includes analysis of administrative complaints, after-hours availability, survey information, appointment access statistics, provider help line reports, Quest Analytics access reports, grievance and appeals data, and provider satisfaction survey results. The analysis includes data from various departments, such as Provider Contracting, Operations, Medical Management, and Quality Management
- **Grievance and appeals data** identify trends at an individual provider level
- **Member satisfaction surveys.** Each year, our Quality Management department engages a qualified organization to administer the most current version of the CAHPS survey that queries members on access to care and other key questions

Any findings of provider non-compliance with access and availability standards will result in interventions, focusing on helping improve performance. We may work with providers to extend their office hours or expand their practices, or we may recalibrate the member-to-PCP assignments to maximize our network capacity.

B. Network Design by Region and County for the General Population

Clear Health is a Medicaid Specialty Plan for people living with HIV/AIDS. Our network includes all Florida regions, except Region 4.

When developing and reviewing the network in each region, Clear Health considers the member population type, its culture, language needs, members' limited resources and education, as well as the availability of providers in the region and access to them. This member population is

composed of Medicaid-eligible children and adults of all ages, which include low-income families, persons with limited resources, Aged, Blind, and Disabled persons, and others.

The population requires specialty provider types with the education and experience serving and treating individuals diagnosed with HIV/AIDS, related disease complications, and co-morbidities. The population also requires BH providers with experience treating individuals with HIV/AIDS and Medicaid.

There are regions in Florida with limited access to certain providers, requiring Clear Health to develop strategies that include access to providers in adjacent regions. This may exceed travel time and distance access standards required in the Contract, and require transportation to these providers.

Clear Health currently serves approximately 9,500 members in our active regions (as of August 2017). The regions vary between very rural and urban areas, with some regions having a mix. The recruitment and contracting was a challenge in regions with rural counties and much easier for the larger urban areas. By having contracts with providers in the larger urban area, we identified patterns of care to enable a member to obtain services when none are available in their area.

Our statewide network for the following identified providers includes:

- Cardiologists (pediatric and adult): 1,102 providers
- Pulmonologists (pediatric and adult): 402 providers
- Endocrinologists (adult): 244 providers
- Internists (adult): 1,043 providers
- Psychiatrists (pediatric and adult): 799 providers
- Obstetricians/Gynecologists (adult): 925 providers
- Licensed mental health clinicians (pediatric and adult): 1,880 providers

Our network also includes the following identified providers by region:

Region 1 includes Escambia, Okaloosa, Santa Rosa, and Walton Counties. Our network for Region 1 also includes:

- Physical therapy (pediatric): 39 providers
- Speech-language pathology services (pediatric): 24 providers
- Occupational therapy (pediatric): 26 providers
- Private duty nursing services (pediatric): 57 providers
- Intermittent skilled nursing (pediatric and adult): 12 providers
- Early intervention services: 64 providers
- Specialized therapeutic foster care: 1 provider
- Compounding pharmacies: 1 provider

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Region 2 includes Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington Counties. Our network for Region 2 also includes:

- Physical therapy (pediatric): 22 providers
- Speech-language pathology services (pediatric): 21 providers
- Occupational therapy (pediatric): 4 providers
- Private duty nursing services (pediatric): 73 providers
- Intermittent skilled nursing (pediatric and adult): 18 providers
- Early intervention services: 28 providers
- Specialized therapeutic foster care: 1 provider
- Compounding pharmacies: 1 provider

Region 3 includes Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwanee, and Union Counties. Our network for Region 3 also includes:

- Physical therapy (pediatric): 59 providers
- Speech-language pathology services (pediatric): 59 providers
- Occupational therapy (pediatric): 21 providers
- Private duty nursing services (pediatric): 71 providers
- Intermittent skilled nursing (pediatric and adult): 30 providers
- Early intervention services: 81 providers
- Specialized therapeutic foster care: 25 providers
- Compounding pharmacies: 1 provider

Region 4 includes Nassau, Baker, Duval, Clay, St. Johns, Flagler, and Volusia Counties. Our network for Region 4 also includes:

- Physical therapy (pediatric): 26 providers
- Speech-language pathology services (pediatric): 14 providers
- Occupational therapy (pediatric): 40 providers
- Private duty nursing services (pediatric): 117 providers
- Intermittent skilled nursing (pediatric and adult): 86 providers
- Early intervention services: 17 providers
- Specialized therapeutic foster care: 4 providers
- Compounding pharmacies: 3 providers

Region 5 includes Pinellas and Pasco Counties. Our network for Region 5 also includes:

- Physical therapy (pediatric): 41 providers
- Speech-language pathology services (pediatric): 48 providers
- Occupational therapy (pediatric): 12 providers
- Private duty nursing services (pediatric): 142 providers
- Intermittent skilled nursing (pediatric and adult): 33 providers
- Early intervention services: 28 providers
- Specialized therapeutic foster care: 1 provider

- Compounding pharmacies: 3 providers

Region 6 includes Hardee, Highland, Hillsborough, Manatee, and Polk Counties. Our network for Region 6 also includes:

- Physical therapy (pediatric): 109 providers
- Speech-language pathology services (pediatric): 218 providers
- Occupational therapy (pediatric): 78 providers
- Private duty nursing services (pediatric): 145 providers
- Intermittent skilled nursing (pediatric and adult): 60 providers
- Early intervention services: 25 providers
- Specialized therapeutic foster care: 5 providers
- Compounding pharmacies: 5 providers

Region 7 includes Seminole, Orange, Osceola, and Brevard Counties. Our network for Region 7 also includes:

- Physical therapy (pediatric): 61 providers
- Speech-language pathology services (pediatric): 37 providers
- Occupational therapy (pediatric): 42 providers
- Private duty nursing services (pediatric): 313 providers
- Intermittent skilled nursing (pediatric and adult): 149 providers
- Early intervention services: 12 providers
- Specialized therapeutic foster care: 3 providers
- Compounding pharmacies: 6 providers

Region 8 includes Charlotte, Collier, Desoto, Glades, Hendry, Lee, and Sarasota Counties. Our network for Region 8 also includes:

- Physical therapy (pediatric): 30 providers
- Speech-language pathology services (pediatric): 44 providers
- Occupational therapy (pediatric): 47 providers
- Private duty nursing services (pediatric): 113 providers
- Intermittent skilled nursing (pediatric and adult): 19 providers
- Early intervention services: 13 providers
- Specialized therapeutic foster care: 11 providers
- Compounding pharmacies: 8 providers

Region 9 includes Indian River, Okeechobee, St. Lucie, Martin, and Palm Beach Counties. Our network for Region 9 also includes:

- Physical therapy (pediatric): 64 providers
- Speech-language pathology services (pediatric): 25 providers
- Occupational therapy (pediatric): 12 providers
- Private duty nursing services (pediatric): 7 providers
- Intermittent skilled nursing (pediatric and adult): 20 providers
- Early intervention services: 9 providers

- Specialized therapeutic foster care: 4 providers
- Compounding pharmacies: 4 providers

Region 10 includes Broward County. Our network for Region 10 also includes:

- Physical therapy (pediatric): 117 providers
- Speech-language pathology services (pediatric): 147 providers
- Occupational therapy (pediatric): 105 providers
- Private duty nursing services (pediatric): 312 providers
- Intermittent skilled nursing (pediatric and adult): 204 providers
- Early intervention services: 189 providers
- Specialized therapeutic foster care: 3 providers
- Compounding pharmacies: 1 provider

Region 11 includes Miami-Dade and Monroe Counties. Our network for Region 11 also includes:

- Physical therapy (pediatric): 166 providers
- Speech-language pathology services (pediatric): 258 providers
- Occupational therapy (pediatric): 169 providers
- Private duty nursing services (pediatric): 522 providers
- Intermittent skilled nursing (pediatric and adult): 183 providers
- Early intervention services: 15 providers
- Specialized therapeutic foster care: 30 providers
- Compounding pharmacies: 3 providers

Provider recruitment efforts are ongoing. We anticipate contracting with all available providers prior to rollout. We will continue to deploy innovative strategies in rural areas, including encouraging providers to open additional locations; extend the hours of established practices; and use mid-level practitioners, BH coaches, and other physician extenders to increase capacity. We will implement telemedicine solutions where appropriate to support the population. Below we describe our process for identifying and mitigating network gaps.

Early Intervention and Specialized Foster Care

Early intervention and specialized foster care are currently accessed through Florida's Early Steps System. Clear Health network providers are experienced in early intervention and specialized foster care services. In fact, our network providers currently render services through Florida's Early Steps System. They understand the needs of medically complex infants and toddlers.

Our network is capable of offering services to the family and child in the community and is designed to maximize participation and development. We are able to meet these specialized needs in the office or home through our provider network and home health services. Beacon offers specialized therapeutic services through Community Mental Health Centers CMHCs. We continue to recruit additional providers to make sure our network has all the necessary capabilities to meet the needs of this population.

Private Duty Nursing and Intermittent Skilled Nursing

Regionally, there are no gaps for home health. The challenge in the more rural areas is for home health nurses to be able to cover the travel distance between members.

We have collaborated with home health providers in our network to increase capacity to mitigate this issue. We have worked hard to establish ongoing, preferential relationships with home health providers. These relationships, which foster a higher level of service and availability, include frequent and open communication. In many cases, it has resulted in enhanced levels of staffing at the home health agency. We offer additional compensation to support home health providers and make sure members get the care they need when they need it.

Clear Health focuses on MMA provider training, network expansions, delivering member access to care, and provider encounter data collection and submission. This last year, we continued the focus on improving processes for measuring our provider network performance. With the availability of prior years' claims data experience and two full MMA years of HEDIS[®] data, Clear Health was better equipped to review collected encounter data and establish network provider performance measures. Using this data and provider-specific performance measures, we identified providers who performed better than their peers in care management, health outcome measures, HEDIS[®] quality measures, CHCUP scores, medical record reviews, and other measures such as re-admission rates, emergency department (ED) visits, and cost saving.

This past year, Clear Health set higher benchmarks and gave providers tools and strategy training aimed at improving health outcomes.

Inpatient Census Report. We learned that giving providers a daily inpatient report increased the rate of timely follow-up visits after admission, expedited and addressed the treatment of high-risk conditions, and prevented readmission. Providers need to know when their members receive inpatient care. One successful initiative is the delivery of an inpatient census report that informed PCPs of a facility admission for members assigned to them. We found that keeping providers informed of inpatient care is critical to overall care of the member and improving health outcomes. Clear Health implemented the automatic delivery of the inpatient census report to high-volume PCPs and we are in the process of rolling this out to the remaining PCP network.

PCP Panel Report. Clear Health continued to deliver the PCP Panel report through our provider portal. This report provides PCPs a list of members in their panel and their contact information. We expect providers to perform outreach to all members and schedule an appointment for a health screening and evaluation.

HEDIS[®] Dashboard Report. Clear Health continued to send the HEDIS[®] Dashboard report, providing PCPs with their performance measure rates. This report helps providers identify the procedures to be rendered to the members on their panel.

PCP Capitation Reports. This year, Clear Health identified a gap between our fee-for-service and capitated providers. The percent of encounters received from capitated providers was very low.

To mitigate the issue, we sent high-volume providers their capitation reports and checks together to make sure PCPs were aware of our members to improve the health of everyone in their panel.

While consistently maintaining our contractual network requirements, Clear Health strives to continue to foster close relationships with providers who demonstrate quality care, good utilization patterns, better quality outcomes, and cost savings.

Overall, the Clear Health network is very tightly knit because of the sensitivity in treating people with HIV/AIDS. Our case management team has developed relationships with community resources and clinics in each county and has thoroughly identified the pattern of care for each member. They communicate closely with organizations to identify new providers moving into the area that can deliver services to our members.

Section J of the Network Development and Management Plan provides additional details on network status.

C. Evaluation of Prior Year

Below is a description of the evaluation of the prior year's plan, including an explanation of the method used to evaluate the network and reference to the success of proposed interventions and/or the need for re-evaluation:

1. Clear Health uses Quest Analytics reports to determine availability and evaluate the network. The Quest Analytics Software includes the MMA Contract-defined access standards to make sure the network is reviewed against AHCA standards. We also conduct a PCP wait time survey for the purpose of accessibility analysis.
2. Clear Health reviews individual provider performance measure data upon recredentialing, as well as member complaints, risk management issues, quality reviews, and other key indicators identified in credentialing policies and procedures.
3. Section J of the document provides details of the prior year and Section K provides supporting reports.

D. Description of the Current Status of the Network

1. How Members Access Services

Members receive covered Medicaid and expanded services through our network of providers, specialists, facilities, and ancillary providers. They are able to locate participating providers using the following methods:

- A printed directory available to each member at no charge by calling the Member Services line or accessing the member website
- A provider directory available on the member website, searchable by name, specialty type, county, and zip code
- A call to the Member Services line to request assistance or a printed copy of the directory

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- A call to a Case Manager or Disease Manager (when enrolled in a case or disease management program) for help locating a provider and arranging care
- The ID card that identifies the name of members' PCPs and phone number to call should the member have any questions about accessing care
- New member welcome calls upon becoming Clear Health members, making sure they have a PCP, as well as explaining how to access care when needed. This process also helps us identify members who would benefit from case or disease management
- An after-hours Nurse help line where members can interact with a nurse who helps them with advice and recommendations for seeking treatment aided by decision support software
- Opportunities for members to communicate with us at all approved community outreach events, as well as through our Mobile Medical Units staffed by licensed providers

In addition, PCPs receive training and education during onboarding that reviews how members access services. PCPs also receive a list of specialty and ancillary providers so they may assist members in the selection, when necessary.

2. Analysis of Timely Access to Services

On an annual basis, Clear Health conducts PCP wait time and after-hours surveys to monitor network accessibility. We conduct initial audits in the spring and re-audits of noncompliance in the fall. For those in a Case or Disease Management program for medically complex cases, the Case Manager (Managed Care Coordinator) will help schedule the member's first visit. We also provide PCPs a monthly roster of new members they can use to initiate contact to schedule their first visit.

The status of the network is monitored quarterly through review of Quest Analytics reports and analysis of their trends and data. Reviews of Internal Ratio network reports and Agency Ratio network reports occur every other week to assure ongoing compliance with MMA contract requirements. (In the annual submission to the State, we will include our Current Network Status report.)

3. Partners

Relationships between the various levels, focusing on provider-to-provider contact and facilitation for PCPs, specialists, hospitals, as well as BH providers, assisted living facilities (ALFs), and home health agencies.

During the recruitment and network maintenance process, determining the relationship between the PCPs, specialists, and facilities within an area is crucial to identifying patterns of care. As mentioned above, when a new physician joins our network, we request a list of preferred referral specialists and facilities and proactively add them to the recruitment list. Not only does this help maintain established referral patterns in the area, it also supports continuity of care for members. The local Provider Relations team meets regularly with network providers to stay current with changes in the area and facilitate relationships between all entities involved with the provision of care to our members.

4. Communication Tools

The assistance and communication tools provided to PCPs when they refer members to specialists and the methods used to communicate availability of this assistance to the providers.

We give all providers a provider handbook when they join the network. Clear Health has a website and provider portal, both used to furnish resources necessary for delivering care to our members. We send fax blasts and policy updates on an ongoing basis to communicate new information or remind providers of a process or change. These communications are typically also available on the website. We advise providers of all available resources during initial training, ongoing education, and through their assigned Provider Network Manager. Each year, we send providers a CD with updated documents for their review and a reminder to visit our websites.

E. Current Barriers and Network Gaps

1. The Methodology Used to Identify Barriers and Network Gaps

Clear Health uses various methods to regularly monitor the network and identify barriers and gaps in care. As mentioned earlier, the Gap Committee is the primary means of reporting identified gaps in the network and confirming that they are resolved. Directors are responsible for resolving the network gaps and held accountable for any delays. Experience has shown that network gaps are one of the primary reasons for member dissatisfaction and voluntary disenrollment. As a result, we have a detailed and proactive process to address network gaps with a heightened sense of urgency.

The quarterly Gap Committee meetings incorporate all departments that interact with network providers and members, such as Member Services, Health Services, Grievances and Appeals, and Provider Relations. The different departments bring results of their reviews of network issues, access challenges, and member and provider complaints to the meetings. We review, aggregate, and analyze data from all of these departments to identify issues and determine the root causes. We develop interventions to resolve issues and gaps and prioritize the implementation of each strategy based upon the number of impacted members, as well as the urgency of need for the services or provider. Meeting minutes track anticipated completion dates, responsible parties, required follow-up, and final resolution of issues.

2. Accommodating Additional Members and Assuring Access Standards Compliance

If our membership exceeds our current network's capacity, we use several methods to deliver access to the services members need, including:

- Communication to current network providers about their ability to service more members
- Coordinating transportation for members to see necessary specialty providers that are not available in their area
- Recruiting out-of-network providers to participate in our network
- Referring members to out-of-network providers for care via a single-case agreement

3. Immediate Short-term Interventions to Address Network Gaps

To resolve a gap or barrier using a short-term intervention, Provider Network Managers outreach to a qualified provider or specialist able to offer the needed services and work to negotiate a

letter of agreement (LOA) or a single case agreement. We provide education on how to interact with Clear Health while the member is under his or her care.

4. Long-term Interventions to Fill Network Gaps and Resolve Barriers

A long-term intervention would consist of closing a gap or barrier by negotiating a contract with a qualified provider or specialist in the county or region able to offer the services needed.

We make sure member needs are met and covered services are provided, even if we are unable to deliver the service within our provider network. We will cover medically necessary services in an adequate and timely manner by using providers and services that are not in our network. We maintain a standard process to resolve these issues in an expedited manner.

Our process includes communication of the issue and resolution time requirements to the team, as well as an escalation to senior management if it appears the issue will not be resolved prior to the deadline. The Regional Vice President of Provider Solutions is ultimately accountable for resolution in a timely manner.

Various departments may identify issues and each department has a method to escalate to the appropriate Provider Relations staff. The issue is communicated verbally and in writing. The Provider Relations Director assigns a representative to negotiate a single-case agreement or LOA, guaranteeing reimbursement of services to out-of-network providers while we are unable to provide the medically necessary covered services within our network. If it appears that the issue will not be resolved in a timely manner, it is escalated to the Vice President of Provider Relations for resolution. Issues that cannot be resolved are escalated to the President and CEO and Chief Medical Officer.

In addition to the measures taken to coordinate care for the member, we also coordinate and facilitate transportation when needed.

5. Outcome Measures/Evaluation of Interventions to Fill Network Gaps and Resolve Barriers

We monitor and evaluate interventions using an interdisciplinary model that includes all necessary departments. All information is reported to the Gap Committee that develops performance measures and monitors progress until resolution. Each measure and outcome is specific to the issue, region/county, and line of business. The Gap Committee considers issue indicators when developing outcome measures, evaluation, and time frames.

6. Projection of Changes in Future Capacity Needs, by Covered Service

The Provider Relations department reviews membership changes, projects growth, and reviews our capacity to provide covered services using internal ratios and MMA contractual requirements to confirm compliance with network adequacy. The team is also charged with developing ongoing network recruitment strategies based on current gaps, as well as enrollment projections. The Gap Committee reviews adequacy reports quarterly or ad hoc when a major network change occurs. In addition, the Gap Committee performs a formal network analysis annually and

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prepares a Network Development and Management Plan based on estimated membership for the coming year. This annual analysis includes Quest Analytics reports that identify network gap issues from tracking and trending done during the previous year. The Network Development and Management Plan also takes into account the ease in which care is provided to members by network ancillary providers (such as BH, dental, and specialty providers) by monitoring the number of member and provider complaints, reviewing utilization data to confirm that members are being seen, and assessing willingness to work with the plan through interactions and meeting requests correspondence.

7. Ongoing Activities for Network Development Based on Identified Gaps and Future Needs Projection

Each Gap Committee meeting results in a prioritization list that is assigned to the Provider Relations department and a recruitment list for each Provider Network Manager. Provider Relations reports recruitment updates to the Gap Committee each month and escalates recruitment difficulties in high-impact areas to the Vice President for resolution.

F. Committees

The Gap Committee promotes communication and coordination among internal departments pertaining to network development and adequacy. The committee consists of representatives from Member Services, Quality Management, Health Services (including utilization, case, and disease management), Grievances and Appeals, and Provider Relations, with each presenting on behalf of his or her department. Issues are tracked and trended, and short- and long-term interventions are developed and monitored to completion. The Gap Committee reports network findings, performance metrics, corrective action plans (CAPs), and all other pertinent information to the Quality Improvement Committee and Compliance Committee.

G. Description of Coordination with Outside Organizations

Clear Health maintains a community presence by working closely with local organizations. We support our relationships with these partners through frequent outreach and visits to offer pertinent health care information and resources. During these visits, we focus on methods to inform members of their health care options, provide educational materials, and offer updates of various community events. Our objective for outreach is creating an open forum to obtain feedback from the community in the form of questions, concerns, and suggestions pertaining to situations they may be encountering. This enables us to better address members' concerns and offer further support to our community.

Clear Health works closely with community organizations that also service our members. We contract with Rural Health Clinics (RHCs), FQHCs, and County Health Departments (CHDs). We also have an agreement with the Statewide Healthy Start Coalition to provide outreach and educational services to our pregnant members. In addition, we work closely with the Florida Assertive Care Teams (FACT) and the PAC AIDS Waiver programs to provide care for our most vulnerable members. We refer them to these and other identified community organizations to assist with the coordination of additional non-Medicaid covered and wrap-around services available to them.

While working with community organizations, we are also able to obtain leads on providers who serve the population for recruiting opportunities.

H. Continuity of Care Waiver

A. Per the MMA Contract, if Clear Health is able to demonstrate to the Agency's satisfaction that a region as a whole is unable to meet network requirements, the Agency may waive the requirement at its discretion in writing. However, as soon as additional service providers become available, we shall augment its network to include such providers in order to meet the network adequacy requirements.

Clear Health is committed to providing a complete network for each of its MMA regions. In certain situations, such as rural counties where providers may not be available, we will approach AHCA to request a waiver. We will also make all attempts to accommodate the member with providers in adjacent regions and provide transportation when needed.

In addition, following the implementation of the MMA Program, the Agency began issuing quarterly Facility/Group/Organization Waivers applicable to specific regions and counties. We monitor the providers, facilities, groups, and organizations in each region and county to make sure that we contact any new qualified entities that come into the market and add them to our network when possible.

B. If Clear Health is unable to provide medically necessary services to a member through its network, we will cover these services in an adequate and timely manner by using providers and services that are not in the Clear Health network for as long as needed to provide the medically necessary services.

As mentioned previously in this document, we make sure the needs of members are met and covered services are provided, even if we are unable to provide the service within our provider network. In those cases, we will cover the services in a timely manner using providers and services outside of the network. We have a standard process to resolve these issues in an expedited manner.

Our process includes communication of issue and resolution time requirements to the team, as well as an escalation process to senior management if it appears the issue will not be resolved prior to the deadline. The Regional Vice President of Provider Solutions is ultimately accountable for resolution in a timely manner.

Issues may be identified within various departments and each has a method to escalate to the appropriate Provider Relations employee. The issue is communicated verbally and in writing. The Provider Relations Director assigns a representative to negotiate a single-case agreement or LOA, guaranteeing reimbursement of services to out-of-network providers while we are unable to provide the medically necessary covered services within our network. If it appears that the issue will not be resolved in a timely manner, the issue is escalated to the Regional Vice

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President of Provider Solutions. Issues that cannot be resolved are escalated to the President and CEO and Chief Medical Officer.

In addition to the measures taken to coordinate care for the member, Clear Health will also coordinate and facilitate transportation when needed.

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I. Regional Network Change Requirements

A. Clear Health has procedures to address changes in the network that negatively affect members' ability to access services, including access to a culturally diverse provider network.

In the annual submission to the State, we will include our most recent policy for handling and reporting regional network changes.

B. Clear Health will provide the Agency documentation of compliance with access requirements at any time there has been a significant change in regional operations that would affect adequate capacity and services, including the following:

1. Changes in Managed Care Plan services
2. Enrollment of a new population

In the annual submission to the State, we will include our most recent policy for handling and reporting regional network changes.

C. Clear Health will notify the Agency within seven business days of any adverse changes to its regional provider network. An adverse change is defined as follows: For MMA, adverse changes to the composition of the network that impair access standards as specified in the MMA Exhibit.

In the annual submission to the State, we will include our most recent policy for handling and reporting regional network changes.

D. Significant changes in regional network composition that the Agency determines negatively impact member access to services may be grounds for Contract termination or sanctions as determined by the Agency and in accordance with Section XI, Sanctions.

In the annual submission to the State, we will include our most recent policy for handling and reporting regional network changes.

If at any point during our regular network analysis we identify a change that affects the ability of members to access services, we will immediately notify the Agency. The notification will include information on how we will accommodate the members impacted by the change and make sure covered services will continue to be rendered, including access to a culturally diverse provider network and translation services. We report adverse changes to the Agency within seven days when the change causes more than five percent of members in the region to change their PCP or when there is a decrease in the total number of PCPs by more than five percent. We also provide an impact analysis to the Agency whenever changes in services are made, when there are adverse changes, and upon request.

J. Regional Network Analysis

1. Challenges and Barriers

Region 1

Region 1- Hospital or Facility with Birth/Delivery Services and Hospice.

Some of the major challenges/barriers revolve around the sensitivity of the patient population that we serve and how this population impacts other patients and/or clients. Providers in some of these areas feel they do not have adequate resources and time to manage the patients. This issue is more evident in many of these rural counties because there are limited or no providers. There are many providers who have refused to contract with the Plan as a result of the potential risk factors. We continue our efforts to contract with providers to develop and maintain a complete and comprehensive network.

Our network is currently lacking in respiratory therapy (RT) therapy in each county. The cause of this gap, the same as has been described to the Agency in the past, is that therapists work for facilities and will not contract independently with health plans. As they are considered part of medical staff, Medicaid ID and NPIs are not always available for this provider type. We continue efforts to contract respiratory therapists.

Region 2

Region 2 – Hospital or Facility with Birth/Delivery Services, 24/7 Emergency Facilities, Licensed Community Substance Abuse Treatment Centers, Home Health Agency, Assisted Living Facility, Hospice, Nursing Home.

Our network meets or exceeds the provider capacity ratios in all specialties except respiratory therapy (RT). Our network is currently lacking in RT therapy in each county. The cause of this gap, the same as has been described to the Agency in the past, is that therapists work for facilities and will not contract independently with health plans. As they are considered part of medical staff, Medicaid ID and NPIs are not always available for this provider type. We continue efforts to contract respiratory therapists.

Some of the major challenges/barriers revolve around the sensitivity of the patient population that we serve and how this population impacts other patients and/or clients. Providers in some of these areas feel they do not have adequate resources and time to manage the patients. This issue is more evident in many of these rural counties due to the fact that there are limited or no providers. There are many providers who have refused to contract with the plan as a result of the potential risk factors. We continue our efforts to contract with providers to develop and maintain a complete and comprehensive network.

Allergy – the number of allergists is limited in the region. We continue to search for new providers in the area. Based on the placement of these clinics, time and distance cannot cure all counties within the region.

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Dermatology – the plan was able to locate 13 within the region of which the health plan has nine and continues efforts to contract the remaining. Based on the placement of these clinics time and distance cannot cure all counties within the region.

Endocrinology – the Plan was able to locate 12 within the region of which the health plan has five and continues efforts to contract the remaining. Based on the placement of these clinics time and distance cannot cure all counties within the region.

Podiatry – the Plan has built out the podiatry network based on clinics within the region. The required ratio is higher than what exists in the County.

Pulmonology – the Plan has built out the pulmonology network based on clinics within the region. Based on the placement of these clinics time and distance cannot cure all counties within the region.

Rheumatology – the Plan has built out the rheumatology network based on clinics within the region. Based on the placement of these clinics time and distance cannot cure all counties within the region.

Urology – the Plan has built out the urology network based on clinics within the region. The required ratio is higher than what exists in the County.

Region 3

Region 3 – Hospital or Facility with Birth/Delivery Services, 24/7 Emergency Facilities, Assisted Living Facilities, Hospice, and Licensed Community Substance Abuse Treatment Centers, Nursing Home, Home Health Agency.

Some of the major challenges/barriers revolve around the sensitivity of the patient population that we serve and how this population impacts other patients and/or clients. Providers in some of these areas feel they do not have adequate resources and time to manage the patients. This issue is more evident in many of these rural counties due to the fact that there are limited or no providers. There are many providers who have refused to contract with the Plan as a result of the potential risk factors. We continue our efforts to contract with providers to develop and maintain a complete and comprehensive network.

Our network meets or exceeds the provider capacity ratios in all specialties except respiratory therapy (RT). Our network is currently lacking in RT therapy in each county. The cause of this gap, the same as has been described to the Agency in the past, is that therapists work for facilities and will not contract independently with health plans. As they are considered part of medical staff, Medicaid ID and NPIs are not always available for this provider type. We continue efforts to contract respiratory therapists.

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Region 4

The counties in region 4 are considered Metro with an abundance of providers in the area, including various Medical schools and centers. However, due to the competitive nature of the region, maintaining reasonable negotiated rates is a challenge.

Our network meets or exceeds the provider capacity ratios in all specialties except respiratory therapy (RT). Our network is currently lacking in RT therapy in each county. The cause of this gap, the same as has been described to the Agency in the past, is that therapists work for facilities and will not contract independently with health plans. As they are considered part of medical staff, Medicaid ID and NPIs are not always available for this provider type. We continue efforts to contract respiratory therapists.

Region 5

The network for Region 5 is robust, with the exception of Hospice facilities and Home Health Agency in the region (currently only one). The area is urban and the Plan experienced less challenges in identifying providers willing to treat members diagnosed with HIV/AIDS.

The Agency has issued Facility/Group/Organization Waivers for Hospice facilities applicable to certain counties in the region.

Our network meets or exceeds the provider capacity ratios in all specialties except respiratory therapy (RT). Our network is currently lacking in RT therapy in each county. The cause of this gap, the same as has been described to the Agency in the past, is that therapists work for facilities and will not contract independently with health plans. As they are considered part of medical staff, Medicaid ID and NPIs are not always available for this provider type. We continue efforts to contract respiratory therapists.

Region 6

The Plan has encountered some geographical barriers in certain counties in this region, and a lack of specialties serving this area.

The Agency has issued Facility/Group/Organization Waivers for Hospital or Facility with Birth/Delivery Services, 24/7 Emergency Facilities, Hospice, Licensed Community Substance Abuse Treatment Center, Adult Family Care Home, and Home Health Agency, applicable to certain counties in the region.

Provider Type	Required Provider Description	Required Amount	Contracted	Comments:
200	Hospital or Facility with Birth/Delivery Services	10	15	Hardee County has zero licensed facilities in the County.
201	24/7 Emergency Service Facility	10	14	Hardee County has zero licensed facilities in the County.
915	Hospice	10	8	Hillsborough and Manatee Counties only have one facility licensed in the County.

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905	Licensed Community Substance Abuse Treatment Centers	10	12	Hardee County only has one licensed facility in the County.
965	Home Health Agency	10	8	Hardee County has zero licensed facilities in the County.

Our network meets or exceeds the provider capacity ratios in all specialties except respiratory therapy (RT). Our network is currently lacking in RT therapy in each county. The cause of this gap, the same as has been described to the Agency in the past, is that therapists work for facilities and will not contract independently with health plans. As they are considered part of medical staff, Medicaid ID and NPIs are not always available for this provider type. We continue efforts to contract respiratory therapists.

Region 7

The network for Region 7 is robust. The Agency has issued waivers for Hospice, Adult Day Care Center, and Home Health Agency. The makeup of the community is urban with the exception of Brevard County that has certain rural areas to the north; however members do have access to providers within Network Adequacy Standards.

Our network meets or exceeds the provider capacity ratios in all specialties except respiratory therapy (RT). Our network is currently lacking in RT therapy in each county. The cause of this gap, the same as has been described to the Agency in the past, is that therapists work for facilities and will not contract independently with health plans. As they are considered part of medical staff, Medicaid ID and NPIs are not always available for this provider type. We continue efforts to contract respiratory therapists.

Region 8

Region 8 is challenging due to the rural counties located in this region and the lack of providers in the vicinity.

The Agency has issued Facility/Group/Organization Waivers for Hospital or Facility with Birth/Delivery Services, 24/7 Emergency Facilities, Adult Day Care Center, Assisted Living Facilities, Hospice, Licensed Community Substance Abuse Treatment Centers, and Home Health Agency applicable to certain counties in the region.

Our network meets or exceeds the provider capacity ratios in all specialties except respiratory therapy (RT). Our network is currently lacking in RT therapy in each county. The cause of this gap, the same as has been described to the Agency in the past, is that therapists work for facilities and will not contract independently with health plans. As they are considered part of medical staff, Medicaid ID and NPIs are not always available for this provider type. We continue efforts to contract respiratory therapists.

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Region 9

We have been successful in identifying and contracting providers willing to see our members in this region; however, the region is a difficult one for finding providers willing to treat patients diagnosed with HIV/AIDS. We encountered hesitation from facilities in which we are currently deficient in due to the complexity HIV members would require. The population is composed of an elderly population and the network has developed in a way support those demographics. There is one provider that specializes and treats the bulk of our membership in this area to which we have established very good case management communication to facilitate access to care.

The Agency has issued Facility/Group/Organization Waivers for Hospital or Facility with Birth/Delivery Services, 24/7 Emergency Facilities, Adult Day Care Center, Adult Family Care Home, Assisted Living Facilities, Hospice, and Nursing Home applicable to certain counties in the region.

Our network meets or exceeds the provider capacity ratios in all specialties except respiratory therapy (RT). Our network is currently lacking in RT therapy in each county. The cause of this gap, the same as has been described to the Agency in the past, is that therapists work for facilities and will not contract independently with health plans. As they are considered part of medical staff, Medicaid ID and NPIs are not always available for this provider type. We continue efforts to contract respiratory therapists.

Region 10

It is an urban area with a vast amount of providers in the required specialties. However, due to the competitive nature of the region, maintaining reasonable negotiated rates was and continues to be a challenge. The Plan currently is experiencing challenges with the development of an ST/PT/OT network as the majority of therapy providers in the region are employed by facilities that do not require that they obtain a Medicaid provider number. The challenge has been in the Plan's receipt of the completed and signed Medicaid Provider Registration Forms from the therapist. Our subcontractor, HN1 assists us by ensuring their providers are appropriately registered when submitted to the Plan.

Our network meets or exceeds the provider capacity ratios in all specialties except respiratory therapy (RT). Our network is currently lacking in RT therapy in each county. The cause of this gap, the same as has been described to the Agency in the past, is that therapists work for facilities and will not contract independently with health plans. As they are considered part of medical staff, Medicaid ID and NPIs are not always available for this provider type. We continue efforts to contract respiratory therapists.

Region 11

Our network development efforts consider the cultural needs of our membership in all regions; however due to the vast cultural diversity within Miami-Dade County, we worked to ensure that the provider network is reflective of the demographics of the community. The network consists

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of providers who are fluent in Spanish and Creole. The South Florida market also demonstrates strong relationships between the PCP and members due to the amount of PCPs available in this county. We have contracted a large network of PCP's to accommodate our enrollees and ensure continuity of care. In such a large metropolitan area, case management is critical to treat enrollees with specialized care; the Plan prepared internally for this volume as well as developing relationships with groups of providers that treat many of our enrollees and develop the open communication needed for this population.

Specialists are limited in Monroe County and the Plan experienced challenges in contracting in this county. We have made transportation available to members as needed to assist with access to covered services. We contracted with the largest provider network in the area as well as many of the individual providers. The network of providers in this area is close knit and do not always welcome managed care plans. Repetition and persistence allowed us to secure the vast majority of PCP's in the area.

The Plan encountered many plan members in the county who are very transient with no stable place for housing, making health care less of a priority. Our Managed Care Coordinators have gone above and beyond trying to outreach to the members and "find" them. The strategy remains the same to outreach to these members as traditional mail and systems is not effective.

The Agency has issued Facility/Group/Organization Waivers for Hospital or Facility with Birth/Delivery Services, Adult Family Care Home, Home Health Agency, and Hospice.

We have low membership in comparison to our other health plans; therefore, we exceed the maximum enrollments levels for the Plan as we offer all providers all our products when contracting. The Plan does have some of the same waivers for facilities and issues for lack of providers in certain remote counties. The Plan checks facility finder quarterly to review waivers in the case a new facility may have opened in those counties.

The Plan does not have provider ratio issues but does have time and distance issues. Based on how the analysis is run, which is to be within range of our membership, some of our members live in very remote areas where we are not able to find a provider near them within guidelines. In these instances, we have identified patterns of care for the member and where they can obtain services, have made transportation available, and continue our recruitment efforts in case providers move into surrounding area.

We include in the following table the provider type and area where we have a waiver, as the specialty type is not found in the county.

Provider Type	Required Provider Description	Providers per Recipient	Recipients Serviced by Single Provider/Bed	Required Amount	Contracted	Comments
965	Home Health Agency	2 per county	n/a	2	1	Only 1 in Monroe County

The Plan is currently lacking in RT therapy in each county. The cause of this gap is the same as that described to the Agency in the past where therapist work in facility basis and not contract independently with health plans. As they are considered part of medical staff, Medicaid ID and NPI's are not always available for this provider type.

Monroe has quite a few gaps due to the lack of specialist in the region and/or providers not accepting Medicaid. These patterns of care for members in Monroe is to use the providers in the southern region of Miami Dade. The Plan has also submitted most of the failing specialties in Monroe as a waiver request; we are pending response from the agency.

(In the annual submission to the State, we will include our SMMC Network Waiver Request Report).

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2. Out of Network Usage

Clear Health manages and reviews out-of-network usage on a monthly basis and reports trending analysis to the Gap Committee every quarter. A review of the first three quarters of 2017 demonstrates low utilization of out-of-network providers. With membership less than 5,000, we averaged 29.1 LOAs for the year. There was no identified trend of LOA providers because services were approved as needed for all members. Integrated Home Care Services, Inc., (IHCS) a durable medical equipment, infusion therapy and home health provider, accounting for over 50 percent of our LOA volume. This was a result of contractual changes between providers in our network and IHCS.

Clear Health adds data to previous months' data to identify any high or low indicators. (In the annual submission to the State, we will include our LOA Statistics Report as reported to the Gap Committee).

3. Network Adequacy

Clear Health uses Quest Analytics to determine time and distance network adequacy based on the ratio and time and distance requirements per specialty required under the Contract. Traditionally, ratio and time and distance analysis were generated from software called Geo Networks. Although Geo Networks and Quest perform the same functions, we could not replicate the Agency's result using Geo Networks. To adequately monitor contract requirements, we purchased Quest Analytics, the same software currently used by the Agency and CMS, allowing consistent monitoring and reporting of our networks. We run analysis bi-weekly and reported every quarter to the Gap Committee and before a significant provider termination to confirm adequate coverage.

Requests for waiver are submitted to the Agency using the approved template, including detail around ratio and time and distance waiver requests and details on geographic and provider make-up of the area. (In the annual submission to the State, we will include our SMMC Network Waiver Request, Gap Committee Minutes, and Quest analysis).

4. Member Experience

The Grievance and Appeals department also provides analysis to the Gap Committee. A review of 2017 complaints and grievances did not identify trends specific to any provider type. The highest percentage of Medicaid grievances is for access to care at 36.9 percent, due partially because of dissatisfaction with Medicaid limits. This is consistent with the highest percentage of appeals, which are for Medicaid deny, and limit authorization. Unfortunately, although we educate members on the reasons for denial, it leads to grievances and perceived issues with quality of customer service.

Our Member Advisory committee (MAC) assures a mechanism is in place for obtaining member input into our QI Program and its priorities. This includes receiving member feedback on the provider network and their satisfaction with the network. In the past year, the MAC did not present any network concerns to the Gap Committee. The MAC meets at least annually for each line of business. (In the annual submission to the State, we will include our Medicaid Grievance and Appeals Log).

In addition, Clear Health makes sure that National **Standards** for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) measures are met for the member population with emphasis on languages. Clear Health currently meets the language requirements for our population. Our monitoring and results report provides information over the past year. (In the annual submission to the State, we will include our Cultural Competency report.)

The MAC assures provider offices are maintained in line with facility requirements. Providers must receive a passing site visit prior to initial credentialing and maintain compliance, which is verified no less than every three years.

5. Provider Complaints

Provider complaints are presented and analyzed each quarter at our Gap Committee. Depending on the issue, short- or long-term interventions are discussed.

A review of the provider complaints received in the second quarter of 2017 demonstrated an increase in the number of complaints related to claims payment and service authorizations. A review of the complaints did not reflect any significant trends as to the cause of this increase, because there were multiple complaint types. We continue to monitor provider complaints related to claims and authorizations. (In the annual submission to the State, we will include our monthly Provider Complaint report.)

6. Provider Survey

Clear Health greatly improved our provider satisfaction survey method in 2016. We increased distribution of surveys by 70 percent with the help of a new subcontractor, Morpace. This

allowed us to obtain valuable and actionable data to create effective action plans. We list a few of the initiatives below, and we include action plans as part of our supporting documents.

The survey was distributed to 1,000 providers. We conducted the annual survey using a mixed mode methodology (mail, telephone, and Internet). The initial mailing in March 2017 consisted of a cover letter, self-addressed envelope, and survey. The letter informed providers of the option to complete the survey online. A second survey was mailed in April 2017 to all providers who had not returned the original survey. In May 2017, provider offices that had not responded to the survey were called and the survey conducted telephonically. Two hundred and fifty-seven surveys were completed for a response rate of 25.7 percent. Morpace conducted a key driver analysis that identified items with the most significant impact on provider satisfaction and dissatisfaction. The results were presented to the Gap Committee who used the key driver analysis identify items needing an action plan.

The provider satisfaction survey tool measures the following:

- Claims processing and provider reimbursement
- Utilization Management
- Quality Management
- Disease Management
- Provider services
- Communication and technology
- Continuity and coordination
- Provider help line
- Complaint resolution
- Provider enrollment process

The results and analysis of the surveys were shared with the Provider Relations, Health Services, Claims, and Credentialing departments. Results were also presented to the Gap Committee, Quality Improvement Committee, and Board of Directors.

Strengths

Strengths are those items that have a high impact on providers' satisfaction and small room for improvement. The following five measures received the highest satisfaction ratings in the 2017 Provider Satisfaction Survey:

- Satisfaction with provider orientation and training process
- Satisfaction with the timeliness of information to coordinate care
- Satisfaction with the knowledge of the Provider help line staff
- Satisfaction with the helpfulness of the complaint resolution staff
- Satisfaction with the accuracy of information to coordinate care

Opportunities

Opportunities are areas that have the highest impact on the provider's overall satisfaction with and have the highest room for improvement. These items include:

- Rate the quality and effectiveness of general provider communications

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- Rate the quality and effectiveness of the provider handbook
- Rate the quality and effectiveness of the provider newsletters
- Rating of the quality of case management services regarding continuity and coordination of care

We created a detailed action plan to address opportunities for improvement. (In the annual submission to the State, we will include our Provider Satisfaction Action Plan.)

7. HEDIS®

Clear Health prepares a full set of HEDIS® measures annually using the analysis and reporting of data collected through medical record review, claims, and encounter data (such as laboratory, pharmacy, and health care utilization). Network providers share health care data with us so that we can generate accurate and complete reports. As part of this annual data collection, the Quality Improvement department requests access to medical records and charts to abstract specific HEDIS® information.

Following NCQA technical specification, the HEDIS® Roadmap is the tool used to describe how information collection practices affect HEDIS® data reporting. The Roadmap provides preliminary information for the contracted auditor to conduct the audit.

We contract with a CMS and AHCA approved NCQA-certified HEDIS® audit firm or auditor.

HEDIS® reports are certified by the HEDIS® auditor, and the auditor must certify the actual file submitted to AHCA and CMS. The HEDIS® auditor is responsible for ensuring the HEDIS® production process adheres to the regulatory agencies requirements and specifications. The auditor is available to assist with the HEDIS® Roadmap development and completion. Onsite visits by the auditor to Clear Health occur at least annually.

Clear Health annually evaluates the HEDIS® and CAHPS results to determine the effectiveness of the Quality Improvement Plan, the quality of our network providers, and to identify opportunities for improvement, implement corrective actions and interventions such as provider and member education and outreach, and development of Performance Improvement and Quality Improvement projects.

We report the results of the evaluation and any interventions to the Quality Management Committee and Board of Directors.

Clear Health collects, analyzes, and reports quality performance measures as defined by the Agency. We also collect internal service performance data that measures the quality of service delivered to all members and providers. This includes data related to Member Services line phone metrics and problem resolution timeframes, member and provider complaints, grievances and appeals, utilization rates, authorizations, referrals, and claims processing time standards. These measures are reported, tracked, and trended through our quarterly Quality Improvement Committee meetings.

Clear Health also collects the following information:

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- Access to care (such as Quest Analytics reports, appointment availability surveys, service and benefit utilization rates, and timeliness of referrals or treatment)
- Improvement in the member's health status such as quality of life indicators, depression scales, or chronic disease outcomes
- Comprehensive health assessment that includes accuracy of acuity stratification, safety indicators, or timeliness of initial assessments or annual reassessments
- Implementation of an individual plan of care (rate of participation by multi-disciplinary team members and beneficiaries in care planning)
- Use and adequacy of a provider network having targeted clinical experience via claims review, pharmacy claims, and diagnostic reports
- Delivery of add-on services and benefits that meet the specialized needs of the most vulnerable members (such as frail, disabled, or near the end-of-life)
- Provider use of evidence-based practices and or nationally recognized clinical protocols
- Effectiveness of communication, such as call center utilization rates, rates of beneficiary involvement in plan of care development, analysis of member or provider complaints

In the event of an ongoing failure by a provider to meet our health information standard, the provider-specific data is incorporated into the provider re-credentialing and re-contracting processes (or earlier, if necessary). During the HEDIS® session, 90 percent of providers were able to provide records to support the required measures. Please refer to the Provider Interventions section below that illustrates the steps taken by our Provider Relations team to outreach to the providers about required metrics and importance of capturing data.

We evaluate the results of the HEDIS® and CAHPS annually to determine the effectiveness of our disease management programs and case management activities. This evaluation process is part of a comprehensive system to track all quality improvement data and results to track member outcomes and experience of care.

We will develop and apply strategies to address the results. We may implement quality improvement strategies that include feedback to providers, regular prioritization of measures, and goals to ensure that the quality measures are appropriate for the member population.

The results of the evaluation and any interventions implemented are reported to the QMC and Board of Directors.

To allow members to be able to perform a reliable comparison of performance among different managed care plans, we publish HEDIS® measures results on our website.

(In the annual submission to the State, we will include our Quality Evaluation.)

An intervention process was identified to send providers their scores; it is currently being rolled out to the network.

8. Provider Specific Performance Monitoring

Clear Health monitors the quality and performance of each network provider. At the beginning of the Contract period, we will notify all network providers of the metrics we use to evaluate performance and determine continued participation in the network.

We monitor the quality and performance of participating providers, including the use of nationally accepted performance measures (HEDIS®) and use certified software to extract data and develop provider profiles by provider and measure.

In addition to HEDIS®, we use other measures of access to care and services, disease management and monitoring measures, as well as preventive services. We also address provider performance issues, including contract termination, when necessary.

Clear Health performs ongoing activities to monitor and improve provider performance, promote education, as well as promote improvements in the quality of care and services delivered by providers in our network.

We maintain two essential provider monitoring processes: Peer Review and Medical/Case Record Review.

In addition to the Peer Review and the Medical/Case Record Review, we perform the following provider monitoring activities:

- Provider profiling using HEDIS® accredited performance measures
- “Secret shopper” calls to providers
- Investigation and tracking potential Quality of Care concerns through complaint and occurrence reporting
- Monitoring access, availability, and cultural competence
- Monitoring continuity and coordination of care
- Monitoring appropriate utilization of services
- Promoting member safety
- Monitoring of subcontractors
- Member satisfaction survey and complaint analysis

9. Provider Interventions

Each month QM provides the Provider Relations department with a list of members who have not had a child health check-up in compliance with the periodicity schedule, sorted by enrollment date. Provider Network Managers discuss results from this report with providers, focusing on providers who have large lists of non-compliant members. We encourage providers to contact non-compliant members and attempt to schedule well-child visits.

We include provider education on CHCUP and dental screenings in the provider handbook and newsletters, as well as performed during onsite visits by Provider Network Managers and medical record reviewers. We send fax blasts to providers to remind them about non-compliant members and correct CHCUP coding requirements.

10. Appointment Access Times and After Hours

We conduct an Appointment Availability Survey quarterly and submit results to the Agency by February 1. The QI department audits using calls to PCP offices to verify compliance and provides the Provider Relations department with providers who need intervention or education because they are not meeting one or more standards. Failure to comply when re-audited may result in termination.

Providers were audited to determine the accessibility and availability of appointments for members. The Appointment Availability Survey was administered in two waves: PCPs and BH providers (8/17/16 through 8/30/16) and pediatricians (9/8/16 through 9/19/16). The following appointments types were assessed:

- (1) Urgent care
- (2) Routine sick care
- (3) Well care
- (4) Initial visit routine care
- (5) Follow-up routine care
- (6) Non-life threatening emergent care
- (7) Wait time

Interviewers utilized a prepared script that identified Clear Health during the call. The script included scenarios for each type of appointment and was tailored for the type of provider.

Interviewers listed multiple choice response options to help guide schedulers' answer format. Morpace compared the response to Clear Health's standards to determine compliance for each appointment type.

Telephone calls were placed during normal business hours: 8:30 a.m. to 5:30 p.m. EDT.

After-hours Surveys were conducted 8/17/16 through 8/26/16 weekdays between 5:30 p.m. and 9:00 p.m. Morpace surveyed a random sample of providers in the Florida providers in our network. Noncompliant providers from 2015 may be included in the random sample. Noncompliant providers from 2015 were re-surveyed in 2016, either as a part of the random sample or through census dialing all remaining noncompliant providers after the random sample quotas was achieved. Prior to dialing, Morpace "cleaned" the database so that there would be only one record for each phone number even though other providers shared the same number. After the survey was conducted, Morpace extrapolated the After-hours Survey data collected to all remaining providers at the same number. Because of this extrapolation, the total number of providers after extrapolation is greater than the actual number of surveys conducted.

In 2016, the Provider Appointment Access and After Hours Survey results performance standard of greater than 90 percent was met. (In the annual submission to the State, we will include analytics from a Gap presentation.)

11. Delegated Vendors

Clear Health retains sole responsibility for fulfilling SMMC Contract requirements. We are fully accountable for our subcontractors' performance, and will continue our successful Subcontractor Oversight Program. Clear Health will continue to oversee, monitor, supervise, and enforce Contract compliance, as well as promote frequent, open, and effective communication that emphasizes delivery of quality services to members.

Our dedicated Florida-based Vendor Delegated Oversight Group (VDOG) oversees and monitors subcontractor performance. Led by our Staff Vice President of Operations and System Solutions, VDOG includes four full-time dedicated staff. VDOG has support from executive leadership and departments across Clear Health, including Provider Relations, Compliance, Regulatory, Operations, Utilization Management, and Medical Management.

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VDOG assigns an Account Manager to each subcontractor to conduct day-to-day management, as well as oversight and review of subcontractor performance using tools such as the monthly Key Performance Indicator (KPI) report.

The Account Manager works in conjunction with Provider Relations to monitor the subcontractor's network development and ongoing network management efforts to confirm continued compliance with AHCA access and availability requirements.

For example, we receive a weekly add/termed provider report from each subcontractor in addition to their monthly full roster submissions. The weekly add/terms provider reports allow us to update our systems to have the most updated provider directory for our members.

In the event we have any concerns of gaps within the subcontractor networks, VDOG will immediately bring those gaps to the attention of the subcontractor and request for an updated roster to fill the gap or an action plan outlining efforts being taken to fill the gap. If the subcontractor is unable to fill the gap, we ask them to submit a waiver with all details of attempt to fill their gap.

Due to the unique nature of administering pharmacy benefits, the Pharmacy Performance Oversight Council will continue to monitor the performance of Clear Health's pharmacy subcontractor. This assures performance meets all regulatory and accreditation standards (such as NCQA, CMS, URAC, State, and federal regulations).

Subcontractor standards are established and must be met to continue participation in our network. Monthly meetings are held with each subcontractor to address any issues at the time or develop an intervention strategy to remedy the situation. Participation and support are items reviewed as part of our Annual Network Plan.

Clear Health engages our subcontractors with any changes that are or will be implemented. Our subcontractors are required to meet the same standards as network providers including network adequacy and education. Our subcontractors have established a series of provider trainings as well as other initiatives to improve the communication and knowledge of their providers.

Clearly defined expectations and consistent monitoring of performance against them is a key component of our Subcontractor Oversight Program. Clear Health executes written agreements with each subcontractor that detail the specific scope of services required, performance standards, service level agreements (SLAs), and reporting responsibilities. The agreements also specify the actions Clear Health will take to address inadequate or substandard performance, such as development of a CAP, use of sanctions, and termination. If at any time performance does not meet requirements, we take action and work closely with the subcontractor toward a resolution and a return to complete and ongoing compliance.

We outline specific SLAs for each function we delegate to the subcontractor. SLAs are never less stringent than those required by AHCA in the SMMC Program Scope of Services. If AHCA modifies a standard, we will amend the delegation agreement to reflect the change.

Clear Health also at times requires subcontractors to meet SLAs for areas that do not have a corresponding AHCA requirement. For example, Clear Health requires our transportation

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subcontractors to meet an on-time performance metric, a standard that is not a current AHCA requirement. In addition, Clear Health sent subcontractors a survey to make sure they were addressing and reporting Access and Availability according to Contract requirements. All subcontractors explained their process and addressed compliance requirements. We will use the document in upcoming audits as part of the subcontractors' annual review.

We requested the following information:

1. Explain how you identify network gaps time/distance standards and availability when panels are closed
2. What strategies will you deploy to increase provider capacity to meet member needs where network gaps have been identified?
3. Describe how you ensure members receive timely access to services by measuring the time from when services are authorized to when they are received
4. What recruitment strategies and retention efforts are planned for each provider type and include quality and performance metrics used to determine provider's success?
5. What methodology is used to identify and resolve barriers for network gaps? Please also include strategies used to support ongoing monitoring activities for your provider network
6. How do you meet the needs of the member if you are unable to provide the service within your provider network? Please include your approach for long-term and short-term solution
7. What is the average wait time for an urgent appointment?
8. What is the average wait time for a routine appointment?

(In the annual submission to the State, we will include information on our vendors/subcontractors).

12. Telemedicine

Telemedicine services can play an important role in providing members with ready access to both physical health (PH) and behavioral health (BH) services. Telemedicine is used to support health care when the provider and member are physically separated. Telemedicine can also play an important role in expanding access for members in rural areas of Florida where certain specialties might not exist, as well as those in more urban areas of the state for after-hours access to care as an effective alternative to unnecessary use of the emergency department (ED), and for expanding access for members with limited mobility.

Clear Health will cover telemedicine consistent with Florida state regulations and Medicaid program requirements with respect to the provision of services via telemedicine. We will administer our telemedicine program in accordance with the telemedicine coverage provisions specified in the AHCA Standard Contract, including but not limited to the requirements related to technical safeguards, HIPAA, provider training, member choice, and fraud and abuse. We will comply with the telemedicine requirements specified in Attachment B, and will follow Florida Medicaid billing and reimbursement policies, as well as limitations, and restrictions on the provision of telemedicine.

Clear Health's telemedicine strategy is multi-faceted and designed to increase access to care in the above specialties as well as other services that support achievement of the Agency's goals. Our objective is to provide quicker and easier access to primary care, BH, and specialty services through telemedicine, and to address barriers related to travel, thereby reducing potentially preventable events (PPEs) and improving member health outcomes. Our strategies are designed to provide a comprehensive telemedicine solution and include:

Specialty Teleconsults. Through our strategic partnership with GlobalMed, we will address the lack of adequate access to specialty consultations in rural areas and regions with our innovative pediatric and adult specialty telemedicine consultation solution. We will offer access to telemedicine consultations with locally-based Florida-licensed in-network providers for primary care, and various specialties including cardiology, pulmonology, endocrinology, internal medicine, and licensed mental health clinicians and psychiatrists. We will use a two-way audio/video communication with a secure internet connection from a video-enabled device such as a computer, tablet, or smart phone and/or facilitated presentation site with integrated diagnostic equipment. Patients will have telemedicine access to specialist consultations from PCP offices and other provider-facilitated presentation sites. This capability will support multiple participants, allowing the patient, PCP, and specialist to all participate simultaneously in the telemedicine visit. The member could also engage in a provider visit from the comfort of their home making this process convenient for them. We will offer scheduling for specialty consultations at blocks of time during the week for various specialties and engage with our network providers and members to educate and create awareness of appointment availability. We will also establish strategically located and facilitated community-based outreach center (CBOC) presentation sites in rural regions and areas of the state where access to a PCP location is limited.

LiveHealth Online. Through LiveHealth Online (LHO), we will offer our innovative member-direct access solution for urgent care telemedicine. LHO facilitates online access through two-way audio/video technology to Florida-licensed, board-certified physicians covering primary care specialties (such as family practice, general practice, pediatricians, internal medicine, and emergency medicine) for consultations on clinically appropriate conditions (such as a cough, fever, or flu). Members can access services through a secure internet connection or an application on their smart phone.

Telemonitoring. Through our strategic partnership with Telemedcare America (TMC) and First Quality Home Care (FQHC) we are developing a pilot to provide telehealth monitoring to members with the goal of reducing utilization and cost. The goals of this pilot program focus on improving outcomes and reducing costs for a selected group of 100 members who suffer from chronic conditions of congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and diabetes, for a six month period. Members will be monitored on an integrated model of service facilitated by TMC and FQHC in order to reduce hospitalizations and maintain control of chronic diseases through specific protocols.

K. Reports

In our submission of our Annual Network Plan to the State, we will include the most recent versions of reports and policies.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 6 – Provider Network Agreements/Contracts (Regional):

The Agency has identified some of the key network service provider types that will be critical in order for the respondent to promote the Agency's goals.

The respondent shall demonstrate its progress with executing agreements or contracts it has with providers in the region by submitting **Exhibit A-4-b-1**, Provider Network Agreements/Contracts (Regional):

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health) is building upon its existing Specialty Plan network in Region 1. Clear Health has successfully executed agreements/contracts with the key network service provider types (identified by the Agency in Exhibit A-4-b-1) that will be critical in order for the respondent to promote the Agency's goals in Region 1 including:

- Board Certified or Board Eligible Adult Psychiatrist: 31 agreements/contracts executed
- Board Certified or Board Eligible Child Psychiatrist: 6 agreements/contracts executed
- Cardiology: 49 agreements/contracts executed
- Cardiology (PEDS): 11 agreements/contracts executed
- Cardiovascular Surgery: 12 agreements/contracts executed
- Endocrinology: 10 agreements/contracts executed
- Endocrinology (PEDS): 3 agreements/contracts executed
- Internal Medicine: 55 agreements/contracts executed
- Obstetrics/Gynecology: 64 agreements/contracts executed
- Pulmonology: 20 agreements/contracts executed

The ratio percentage of agreements/contracts for each service provider type is 100%.

As required, Clear Health has submitted Attachment MMA SRC# 6-1: Exhibit A-4-b-1, Provider Network Agreements/Contracts, which demonstrates our progress with executing agreements or contracts with providers in Region 1.

**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)**

Evaluation Criteria:

For each service provider type the respondent may receive up to 20 points as described below. Points for each service provider type will be awarded as outlined in the table below:

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0% - 25%	5
25.1%- 50%	10
50.1%- 75%	15
75.1% or greater	20

Score: This section is worth a maximum of 240 raw points based on the above point scale.

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EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS
(REGIONAL) (10-2-2017)

Enter Respondent Name Below

Simply Healthcare Plans, Inc., D/B/A Clear Health Alliance

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS
(REGIONAL) (10-2-2017)

SRC SCORE
240

Service Provider Type	Agreements/Contracts	Total Population	% of Population	Recipient Count	Ratio	Ratio Results	%	Score
Board Certified or Board Eligible Adult Psychiatrist	31	117,974	0.3	35392	1500	23.00	100.0%	24
Board Certified or Board Eligible Child Psychiatrist	6	117,974	0.3	35392	7100	4.00	100.0%	24
Cardiology	49	117,974	0.3	35392	3700	9.00	100.0%	24
Cardiology (PEDS)	11	117,974	0.3	35392	16667	2.00	100.0%	24
Cardiovascular Surgery	12	117,974	0.3	35392	10000	4.00	100.0%	24
Endocrinology	10	117,974	0.3	35392	25000	1.00	100.0%	24
Endocrinology (PEDS)	3	117,974	0.3	35392	20000	2.00	100.0%	24
Internal Medicine	55	117,974	0.3	35392	3000	12.00	100.0%	24
Obstetrics/Gynecology	64	117,974	0.3	35392	1500	23.00	100.0%	24
Pulmonology	20	117,974	0.3	35392	7600	5.00	100.0%	24

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0%	9
25.1%	14
50.1%	19
75.1%	24

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 7 – MMA Physician Incentive Program (MPIP) (Statewide):

The Agency has designed the MMA Physician Incentive Program with the expectation that Managed Care Plans should be able to increase compensation for physicians, using funds achieved through savings from effective care management, as specified by Section 409.967(2)(a), Florida Statutes. The respondent shall describe its plan for ensuring physician compensation rates are equal to or exceed Medicare rates for MMA covered services. Specifically, the response shall include detailed descriptions of quality initiatives the respondent intends to implement or maintain that produce savings by promoting the Agency's goals, as well as other areas where the respondent has evidence that a potential for savings and increased quality exists.

Response:

Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance (Clear Health) has participated in AHCA's MMA Physician Incentive Program (MPIP) program since 2016. The purpose of this program is to allow our organization to monitor the performance and quality of care and service of our network on an annual basis with the intent to increase quality and enrollee (member) satisfaction, reduce readmissions, lower avoidable emergency department (ED) use, and increase Clear Health's overall performance. Our MPIP provides enhanced payment for select pediatric primary care providers (PCPs), pediatric subspecialties, and OB/GYNs by supplementing their current contracted rate under the Medicaid line of business and increasing it to the Medicare reimbursement rate.

Our initial AHCA-approved MPIP (10/1/16-9/30/17) was focused on being designated as a health plan PCP as well as board-certified OB/GYNs who met or exceeded specified quality measures and target benchmarks. For the first three quarters of the program (10-1-16 through 6/30/17), Clear Health paid out over \$22,000 in MPIP incentive payments to MPIP program providers

For the 10/1/17-9/30/18 period, in line with AHCA goals to increase provider compensation to Medicare rates for a larger segment of provider services, Clear Health expanded the program. The expansion will include additional pediatric PCPs (pediatricians, family practitioners, general practitioners) and board certified OB/GYNs who meet or exceeded quality measure benchmarks, or who meet or exceed ER utilization quality measures benchmarks. Clear Health also expanded the program to board certified pediatric cardiologists, pediatric endocrinologists, pediatric nephrologists, pediatric neurologists, and to pediatric psychiatrists who meet or exceed the follow-up after a hospitalization for mental illness quality measures and target benchmarks.

Beginning 10/1/18 and forward, we will enhance our existing MPIP to further align with AHCA's goals of redirecting costs to incentivize improvements in quality and efficiency. We will do this by expanding MPIP participation to additional subspecialists and by implementing additional quality and utilization performance measures and targets that drive improvements in quality outcomes. We will expand the program to incorporate both pediatric and adult subspecialists and member populations. We will also expand our array of quality measures for OB/GYNs to further drive achievement of the Agency's goals for improvements in birth outcomes and prenatal care.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

For PCP and OB providers, we will continue to value and incentivize PCMH recognition as a component for enhanced reimbursement, but going forward PCMH certification alone will no longer be the sole criteria for enhanced reimbursement. In order to further drive utilization and quality performance, PCPs and OB/GYNs who meet the PCMH incentive criteria will now also be required to meet additional utilization and quality performance targets in order to fully qualify for enhanced reimbursement. This approach will drive improvements in efficient utilization of services and increase quality outcomes, thereby resulting in reduced costs, while simultaneously making incentive dollars available to a larger pool of providers.

1. REDIRECTING COSTS TO PAY HIGHER RATES

Our MPIP proposal is a key component of our value-based purchasing (VBP) strategy in Florida. We describe our array of value-based programs and strategies in detail in our response to MMA SCR 13, Value Based Purchasing. In addition to MPIP, our VBP models incentivize the shift from payment based on volume of services to payment based on quality, thereby driving improved outcomes and cost reductions.

1.1. MPIP Pediatric Primary Care Providers

1.1.1. Provider Eligibility; Qualified providers include Primary Care Providers (PCPs) (including pediatricians, family practitioners, and general practitioners) that provide medical services to members under the age of 21 years.

1.1.2. PCMH Recognition (Weight = 25 percent): Recognition by one of the following organizations as a Patient-Centered Medical Home (PCMH):

- National Committee for Quality Assurance (NCQA)
- Accreditation Association for Ambulatory Health Care (AAAHC)
- The Joint Commission (JC)
- Utilization Review Accreditation Commission (URAC)

1.1.3. Performance Measures

We utilize a set of internally developed performance measures to track readmissions and emergency department (ED) utilization. We compare the measure results for Readmission Avoidance and ED Utilization to the national HEDIS® percentiles for the Plan-All Cause Readmissions (PCR) and Emergency Department Utilization (EDU) measures as published by the National Committee for Quality Assurance (NCQA).

The next set of measurements used when evaluating the provider's performance are a combination of HEDIS®, HEDIS-like measures, or National Quality Forum (NQF) measures. The same methodology used for the utilization-based measures will be used for the HEDIS® measures or the provider's peers within our organization if NQF measures are being used. We believe that this case mix of measures provides the optimal representation of the circle of care the member receives.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1.1.3.1. Utilization Measures (Weight = 35 percent if Provider is PCMH; 50 percent if Provider is Non-PCMH)

We use the following utilization based measures for all providers:

- Avoidance of Readmissions (RA): the percentage of members in the provider's panel/roster of care that stay in our coverage for at least 6 months of enrollment prior to the discharge date for a diagnosis for which the provider is responsible for and continuously enrolled for, at least, 30 days after the date of the discharge who are readmitted to an inpatient facility within 30 days for diagnoses related to the specific specialty This is an inverse measure (lower score is better).
- Emergency Department Utilization (EDU): the percentage of members in the provider's panel/roster of care that stay in our coverage for at least 6 months of enrollment prior to the end of the measurement period and for who Clear Health receives a claim for ED for diagnoses related to the specific specialty within the measurement year. This is an inverse measure (lower score is better).
- Percentage of Outpatient procedures Performed in the Hospital setting: The percentage of procedures that are not on the plan's inpatient-only list performed at a hospital where the referring provider matches the provider in the measurement. This is an inverse measure (Lower rate indicates better performance).

1.1.3.2. Quality Measures - HEDIS, HEDIS-Like and NQF Measures (Weight =40 percent if Provider is PCMH; 50 percent if Provider is Non-PCMH)

The Plan will use a combination of measures to evaluate providers. A site with at least 30 panel members must achieve or exceed the benchmark for the following metrics:

- Adolescent Well-Care Visits: percentage of members 12-21 years who had one or more well-care visits
- Children and Adolescent Access to Primary Care Practitioners (12-24 months): percentage of members 12-24 months old who had a visit with a PCP during the measurement period
- Children and Adolescent Access to Primary Care Practitioners (25 months-6 years): Percentage of members 25 months-6 years of age who had a visit with a PCP during the measurement period
- Children and Adolescent Access to Primary Care Practitioners (7-11 years): percentage of members 7-11 years old who had a visit with a PCP during the measurement period
- Children and Adolescent Access to Primary Care Practitioners (12-19 years): percentage of members 12-19 years old who had a visit with a PCP during the measurement period
- Well-Child Visits in the 3rd, 4th, 5th and 6th years: percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year
- Lead Screening: percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- Newly assigned Member PCP visit: Percentage of Members newly assigned to the PCP during the first 9 months of the measurement period (MP) and who were attributed for at least 60 days of the MP and who have a PCP visit within 60 days of assignment

1.2. MPIP Obstetricians and Gynecologists (OB/GYNs)

1.2.1. Provider Eligibility: Providers who are board certified in Obstetrics and Gynecology by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology. Board certified OB/GYNs must also meet the following qualification levels:

1.2.2. PCMH Recognition (Weight = 25 percent): Recognition by one of the following organizations as a Patient-Centered Medical Home (PCMH):

- National Committee for Quality Assurance (NCQA)
- Accreditation Association for Ambulatory Health Care (AAAHC)
- The Joint Commission (JC)
- Utilization Review Accreditation Commission (URAC)

1.2.3. Quality Measures - HEDIS, HEDIS-Like and NQF Measures (Weight =75 percent if Provider is PCMH; 100 percent if Provider is Non-PCMH)

- Frequency of Ongoing Prenatal Care: Percentage of women with Medicaid deliveries who had 81 percent or more of expected prenatal visits (using HEDIS® 2017 specifications)
- Postpartum Care: Percentage of women who had a postpartum visit on or between 21 and 56 days after delivery (using HEDIS® 2017 specifications). Benchmark is 62 percent
- Overall Cesarean Section Rate: Percentage of single live born Medicaid births in a practice that were delivered via cesarean section (using 2017 Agency Specifications)
- First Prenatal care visit timeliness: Percentage of attributed members who received a prenatal visit within the first trimester or within 42 days of enrollment
- Preterm Birth Rate: Percentage of all attributed member deliveries where the delivery occurred less than 37 weeks gestation.
- Low Birth Weight Rate: Percentage of all attributed member deliveries where the birth weight of the newborn was less than 2,500 grams.
- Postpartum visit rate: Percentage of attributed members who received postpartum visits 21 to 56 days after delivery.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1.3. MPIP Pediatric Subspecialists

Clear Health will reward certain pediatric specialties with the focus on lowering readmissions and ED utilization and will improve quality of care and services by choosing several measures endorsed by NCQA, NQF, and some developed internally by the plan. There will be two components of the program with the intent of ensuring the overall performance of the provider is accurately measured. We compare the final score for each provider to the national benchmarks for every provider specialty chosen for this incentive program.

1.3.1. Provider Eligibility: The eligible pediatric subspecialists include:

- Pediatric endocrinologists who are board certified by the American Board of Pediatrics or American Osteopathic Board of Pediatrics
- Pediatric neurologists who are board certified by the American Board of Pediatrics and American Board of Psychiatry and Neurology
- Pediatric cardiologists who are board certified by the American Board of Pediatrics
- Pediatric nephrologists who are board certified by the American Board of Pediatrics

1.3.2. Assignment Methodology

Clear Health will use the following methodology to identify the specialist as the treating and caring provider for a member.

We will look at the calendar year data, and based on the claims utilization for past 12 months, will assign members based on the following criteria:

- First choice will be the provider seen the most by the member for specific specialty
- Second choice will be if the provider seen the most has a gap greater than 90 days and a new provider is identified to have seen the member on a more recent basis

1.3.3. Performance Measures

Our MPIP will use a set of utilization measures developed internally to measure the use and avoidance of readmission (RA) and ED utilization. We will then compare the measure results to the national HEDIS® percentiles for the Plan-All Cause Readmissions (PCR) and ED measures as published by the National Committee for Quality Assurance (NCQA).

The next set of measurements used when evaluating the provider's performance will be a combination of HEDIS® or HEDIS-like measures or National Quality Forum (NQF) measures as described below. We will use the same methodology used for utilization-based measures for HEDIS® measures or the physician's peers within our organization if NQF measures are being used. Clear Health strongly feels that this mix of measures will provide for a full representation of the circle of care the member. We outline measures by domain in the following section.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1.3.3.1. Utilization Measures (Weight = 50 percent)

Utilization measures for pediatric cardiologists, pediatric endocrinologists, pediatric neurologists, and pediatric nephrologists are:

- **Avoidance of Readmissions:** The percentage of members in the provider's panel/roster of care that stay in the coverage of the Plan for at least 6 months of enrollment prior to the Discharge date for a diagnosis for which the provider is responsible for and continuously enrolled for, at least, 30 days after the date of the discharge who are readmitted to an inpatient facility within 30 days for diagnoses related to the specific specialty .This is an inverse measure (lower score is better).
- **ED utilization:** The percentage of members in the provider's panel/roster of care that stay in the coverage of the Plan for at least 6 months of enrollment prior to the end of the measurement period and for who the Plan receives a claim for ED for diagnosis specific to the specialty within the measurement year. This is an inverse measure (lower score is better).
- **Percentage of Outpatient procedures Performed in the Hospital setting:** The percentage of procedures that are not on the plan's inpatient –only list performed at a hospital where the referring provider matches the provider in the measurement. This is an inverse measure (Lower rate indicates better performance).

1.3.3.2. Quality Measures - HEDIS®, HEDIS-Like, and NQF Measures (Weight = 50 percent)

1.3.4. Pediatric Endocrinologists

- **Comprehensive Diabetes Care (CDC):** the percentage of members 1-17 years of age with diabetes (type 1 and type 2) who had each of the following during the measurement year: Eye Exam (Retinal) performed, Lipid Profile, HbA1c Control (<8 percent), and Urine Micro albumin

1.3.5. Pediatric Neurologists

- **Adherence to Anti-epilepsy/Anti-Convulsion Drugs:** the percentage of members 1-17 years of age with a diagnosis of epilepsy/convulsions who remained on the medication for, at least, 80 percent of the percentage of days covered after the first fill.
- **Follow-up Care for Children Prescribed ADHD Medication (ADD):** the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication that had at least three follow-up care visits within a 10-month period. (*Prescribing provider data will be included in this measure to decide who is treating the member and eliminate false positives for the provider).

1.3.6. Pediatric nephrologists

- **Monthly Hemoglobin Measurement for Pediatric Members:** the percentage of members 1-17 years of age with a diagnosis of chronic kidney disease, in-center hemodialysis, home hemodialysis, and peritoneal dialysis who have monthly measures for hemoglobin during the reporting period.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1.3.7. Pediatric cardiologists

- No applicable HEDIS®, HEDIS-Like, and NQF Measures have been identified for pediatric cardiologists.
- Until such time as a reliable Quality Measure has been identified, pediatric cardiologist performance for incentive purposes will be 100 percent based on the Utilization Measures specified above

1.4. MPIP Adult Subspecialists

Clear Health will reward certain adult subspecialties with the focus on lowering readmissions and ED utilization and will improve quality of care and services by choosing several measures endorsed by NCQA, NQF, and some developed internally by the plan. There will be two components of the program with the intent of ensuring the overall performance of the provider is accurately measured. We compare the final score for each provider to the national benchmarks for every provider specialty chosen for this incentive program.

The eligible adult subspecialists include:

- Adult Endocrinologists who are board certified by the American Board of Medical Specialties
- Adult Neurologists who are board certified by the American Board of Medical Specialties
- Adult Cardiologists who are board certified by the American Board of Medical Specialties
- Adult Nephrologists who are board certified by the American Board of Medical Specialties
- Adult Pulmonologists who are board certified by the American Board of Medical Specialties
- Adult Gastroenterologists who are board certified by the American Board of Medical Specialties

1.4.1. Assignment Methodology

Clear Health will use the following methodology to identify the specialist as the treating and caring provider for a member.

We will look at the calendar year data, and based on the claims utilization for past 12 months, will assign members based on the following criteria:

- First choice will be the provider seen the most by the member for specific specialty
- Second choice will be if the provider seen the most has a gap greater than 90 days and a new provider is identified to have seen the member on a more recent basis

1.4.2. Performance Measures

Our MPIP will use a set of utilization measures developed internally to measure the use and avoidance of readmission (RA) and emergency department (ED) utilization. We will then compare the measure results for RA and ED to the national HEDIS® percentiles for the Plan-All Cause Readmissions (PCR) and ED measures as published by the National Committee for Quality Assurance (NCQA).

EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

The next set of measurements used when evaluating the provider's performance will be a combination of HEDIS® or HEDIS-like measures or National Quality Forum (NQF) measures as described below. The same methodology used for utilization-based measures will be used for HEDIS® measures or the physician's peers within our organization if NQF measures are being used. Clear Health strongly feels that this mix of measures will provide for a full representation of the circle of care the member. We outline measure by domain in the following section.

1.4.2.1. Utilization Measures (Weight = 50 percent)

Utilization measures for pediatric cardiologists, pediatric endocrinologists, pediatric neurologists, and pediatric nephrologists are:

- **Avoidance of Readmissions (RA):** The percentage of members in the provider's panel/roster of care that stay in the coverage of the Plan for at least 6 months of enrollment prior to the Discharge date for a diagnosis for which the provider is responsible for and continuously enrolled for, at least, 30 days after the date of the discharge who are readmitted to an inpatient facility within 30 days for diagnoses related to the specific specialty This is an inverse measure (lower score is better).
- **Emergency Department utilization (ED):** The percentage of members in the provider's panel/roster of care that stay in the coverage of the Plan for at least 6 months of enrollment prior to the end of the measurement period and for who the Plan receives a claim for ED for diagnoses related to the specific specialty within the measurement year. This is an inverse measure (lower score is better).
- **Percentage of Outpatient procedures Performed in the Hospital setting:** The percentage of procedures that are not on the plan's inpatient-only list performed at a hospital where the referring provider matches the provider in the measurement. This is an inverse measure (Lower rate indicates better performance).

1.4.2.2. Quality Measures - HEDIS®, HEDIS-Like, and NQF Measures (Weight = 50 percent)

1.4.3. Adult Endocrinologists

- **Comprehensive Diabetes Care (CDC):** The percentage of adult members with diabetes (type 1 and type 2) who had each of the following during the measurement year:
 - Eye Exam (Retinal) performed
 - Lipid Profile
 - HbA1c Control (<8 percent)
 - Urine Micro albumin

1.4.4. Adult Neurologists

- **Adherence to Anti-epilepsy/Anti-Convulsion Drugs:** The percentage of adult members with a diagnosis of epilepsy/convulsions who remained on the medication for at least 80 percent of the percentage of days covered after the first fill.

EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1.4.5. Adult Cardiologists

- Heart Failure - Use of ACE Inhibitor (ACEI) or Angiotensin Receptor Blocker (ARB) Therapy: the percentage of patients aged 18 and older with Heart Failure who are on an ACEI or ARB
- Heart Failure - Use of Beta Blocker Therapy: Patients with a current fill for beta blocker therapy who are diagnosed with congestive heart failure

1.4.6. Adult Gastroenterologists

- Screening Colonoscopy: For patients aged 50 – 75, colorectal cancer screening (FOBT yearly or colonoscopy every 10 years)

1.4.7. Adult Pulmonologists

- Chronic Obstructive Pulmonary Disease COPD: Inhaled Bronchodilator Therapy: Percentage of patients aged 18 years or older, with a diagnosis of COPD ($FEV_1/FVC < 70$ percent) who have an $FEV_1 < 60$ percent predicted and have symptoms who were prescribed an inhaled bronchodilator
- Pharmacotherapy Management of COPD Exacerbation: This measure assesses the percentage of COPD exacerbations for patients 40 years of age and older who had an acute inpatient discharge or ED encounter on or between January 1–November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:

1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event

2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event

Note: We base the eligible population for this measure on acute inpatient discharges and ED visits, not on patients. It is possible for the denominator to include multiple events for the same individual.

1.4.8. Adult Nephrologists

- Chronic Kidney Disease (CKD): Monitoring Calcium. To assure that members with chronic kidney disease (CKD), but who are not on dialysis, are monitored for blood calcium levels at least annually.
- Chronic Kidney Disease (CKD): Monitoring Parathyroid Hormone (PTH). To assure that members with chronic kidney disease are monitored for PTH levels at least once annually.
- Chronic Kidney Disease (CKD): Monitoring Phosphorus. To assure that members with chronic kidney disease (CKD) who are not on dialysis are monitored for blood phosphorus levels at least once annually.

EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- Adult Kidney Disease: Laboratory Testing (Lipid Profile). Percentage of patients aged 18 years and older with a diagnosis of chronic kidney disease (CKD) (stage 3, 4, or 5, not receiving Renal Replacement Therapy [RRT]) who had a fasting lipid profile performed at least once within a 12-month period

2. QUALITY INITIATIVES THAT WILL RESULT IN REDUCING COSTS BY AVOIDING POTENTIALLY PREVENTABLE EVENTS

MMA SCR 1 defines potentially preventable events (PPEs) as potentially preventable hospital admissions (PPA) and readmissions (PPR), reduction in the use of the emergency department for non-emergent/urgent visits (PPV), and reduction in the use of unnecessary ancillary services during hospitalization and outpatient visits (UAS).

Through the combination of our MPIP and VBP programs and provider collaboration strategies, we encourage and engage our providers to promote continuous quality improvement. We will also promote enhanced access to care — seeing members when they need to be seen — because it is essential for improving clinical outcomes, providing a satisfying member experience, reducing potentially preventable events and reducing health care costs. In combination, our MPIP and VBP programs include the following quality measures that directly and indirectly target reductions in potentially preventable events:

- ED utilization rate
- Readmissions within 30 days of inpatient discharge
- New member PCP visit within 60 days of assignment
- Outpatient procedures performed in the hospital setting
- Frequency of PCP visits within the measurement period
- Seven-day follow-up visit after mental health inpatient discharge
- Thirty-day follow-up visit after mental health inpatient discharge
- Thirty-day BH-related readmission rate
- Sixty-day BH-related readmission rate
- Ninety-day behavioral health-related readmission rate
- Total Medical Expenses

We will provide an enhanced access toolkit that offers resources on streamlining the appointment process. This will help to offer more open scheduling and same-day appointments, as well as managing supply and demand through suggestions such as extending office hours, maximizing visits, and optimizing member involvement in their care as referenced in our Timely Access Standard Strategy in SRC 9.

**** RESULTS & SUCCESSES:** Clear Health Outperforms All Plans in Reducing Potentially Preventable Admissions (PPAs). We have the lowest rate of potentially PPAs and PPVs all the MMA plans. Our risk adjusted PPA rate per 1,000 enrollee is 1.30, compared to the statewide average of 2.14. ******

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MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

In addition to our MPIP and VBP programs, we have developed the following quality initiatives to support further reductions Potentially Preventable Events:

ED Diversion Program. To address the root causes of unnecessary, frequent ED use, our Case Management program helps members and their families or caregivers manage the member's symptoms in alternative settings. Managed Care Coordinators exchange information about ED "frequent flyers" with key hospitals, educate members on proper utilization of services, discuss the importance of primary and preventive care, provide information on nearby resources such as urgent care, and determine whether the member should be referred to additional Case Management programs.

Rising Star Program. This program focuses on continuity of care for members with complex physical or behavioral health conditions with frequent ED visits and multiple hospital admissions. We will facilitate improved collaboration and communication with providers by guiding the member to a single Home Hospital, Health Home, Home Psychiatrist, and Care Manager. Caring for our members at the same facility, with the same providers, promotes improved health, recovery, and more appropriate use of evidence-based practices, services, and social supports. It also reduces inpatient admissions, length of stay, readmissions, and ED visits, and improves provider satisfaction.

Transition of Care Program (TOC). The TOC is a cost of care and quality initiative to reduce controllable expenses associated with readmissions and to improve member health outcomes. Our Managed Care Coordinators work closely with hospital and skilled nursing facility staff and our members to assure readiness to re-enter the community and a seamless transition plan is in place before discharge, and follows the member into the community to assure adequate conditions and support for recovery.

3. QUALITY INITIATIVES THAT WILL RESULT IN IMPROVING PRENATAL CARE AND BIRTH OUTCOMES.

MMA SCR 2 defines Birth Outcomes as prematurity prevention, improve perinatal outcomes, and reduce unintended pregnancies.

Clear Health also incorporates quality measures designed to improve prenatal care and birth outcomes into our MPIP and other VBP programs our MPIP and VBP programs include the following quality measures that directly and indirectly target improvements in birth outcomes:

- First prenatal visit
- Frequency of ongoing prenatal care
- Overall C-section rate
- Preterm birth rate
- Low birth weight rate
- Postpartum visit rate
- Postpartum care

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MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

In addition to our MPIP and VBP programs, we have developed the following quality initiatives to further improve Prenatal Care and Birth Outcomes:

Taking Care of Baby and Me. Clear Health's comprehensive, Taking Care of Baby and Me program and focus on improving birth outcomes is working. In 2016, our rates for pre-term births, caesarian sections, and early elective deliveries were lower than the national average. We make every effort to provide accurate, actionable, and culturally appropriate information regarding these risks to help women make informed decisions about when and how they deliver their babies.

Maternal Postpartum Outreach Program (MPOP). Our Maternal Postpartum Outreach Program (MPOP) is an all-inclusive (member, provider, and data collection) outbound call outreach program focused on improving access to care and ensuring the timeliness of a mother's visits with a practitioner after delivery of her baby. Through MPOP, outreach is completed by providing experienced compassionate outreach care specialists and a state-of-the-art web based system to assist members with postpartum visits. MPOP employs a state-of-the-art web based system that identifies moms who have just delivered a baby and may need assistance with scheduling their postpartum visit and captures all components of the outreach process (appointments, mailings, outreach attempts, etc.). Experienced Outreach Care Specialists then attempt to contact new mothers assigned in the MPOP system to assist with appointment scheduling, appointment reminder (5 days prior to the mom's postpartum appointment), and appointment coordination and verification (contact OB provider to schedule an appointment for moms and verify mom kept her postpartum appointment).

Screening, Brief Intervention, and Referral to Treatment (SBIRT). We include SBIRT for screening of pregnant members to identify as early as possible if potential BH referral / consult is needed. We designed our maternal programs to identify existing health risks for pregnant members and similarly to prevent future health problems. For example, we have developed specific programs to integrated comorbid conditions such as diabetes, depression, hypertension and heart disease and SUD, including tobacco. We include a registered dietician/certified diabetes education in the members' multi-disciplinary care team who will assist (co-manage) these members.

Long-acting reversible contraceptives (LARCs). The CDC identifies long-acting reversible contraceptives (LARCs) as the most effective in preventing pregnancy. Clear Health includes LARCs as a benefit to members. In addition, we educate our members on LARCs through materials like brochures, as well as through our OB case managers who have training on LARC. Our LARC program reimburses providers for the actual cost of LARC and the full range of contraceptive services, as well as for immediate postpartum insertion of long-acting reversible contraceptives. We also remove administrative and logistical barriers to LARC contraception by removing pre-approval requirements and step therapy restrictions.

4. OTHER QUALITY INITIATIVES OR EFFICIENCIES RESULTING IN POTENTIAL COST SAVINGS.

Since its inception, Clear Health has actively promoted Patient-Centered Medical Home (PCMH) recognition and sought to contract with primary care providers that have been recognized PCMHs. Our PCMH incentive program supports the PCMH model of patient-centered primary care delivery. PCMHs get to know patients in long-term partnerships. They make treatment decisions together with patients based on individual needs and preferences. PCMHs help patients become

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better engaged in their own healthy behaviors and healthcare. Everyone in the practice works as a team to coordinate care from other providers and community resources. This maximizes efficiency by ensuring that highly trained clinicians are not doing tasks lower level staff can do. They also avoid costly and preventable complications and emergencies by focusing on prevention and managing chronic conditions.

Clear Health Alliance has 65 PCMH practices with over 500 providers and over 900 members.

As an incentive for those practices pursuing NCQA, AAAHC, JC, or URAC PCMH recognition, we reimburse practices up to \$3,000 to pursue PCMH recognition, \$1,500 at the time of initial application and \$1,500 when they receive recognition. Together with our affiliates, we have more than 26 years of experience building provider networks that include PCMHs, health homes, and similar models that promote the delivery of services and follow-up care.

We designed our strategic approach to provider collaboration and network management to drive efficiencies and quality performance that results in potential costs savings. Our locally based Provider Network Managers are in the field offering ongoing support to providers, helping them improve the effectiveness and efficiency of their practices. For example, they will analyze quality metrics and reports for improvement opportunities; help providers create and implement action plans to improve cost and quality performance under our VBP programs, and provide ongoing training and education to assist in meeting their goals.

Our Quality-based Member Assignment Algorithm (QMAA), one of the components of our strategic network management and performance optimization strategy, drives performance resulting in cost savings related to Agency goals and improving member health outcomes. Our QMAA methodology incorporates quality and performance measures to drive member assignments to our highest performing PCPs. QMAA is designed to assure that the majority of our members are cared for by high-performing, engaged providers that collaborate with us. Our high-touch approach to provider collaboration focuses on quality and our competitive value proposition.

Our Pharmacy Provider Engagement Program provides an effective means of delivering important clinical information to our network prescribers, facilitating sound clinical decision-making that will translate into delivery of the highest quality medical care. The program provides an interactive clinical detailing platform, which employs the use of four clinical pharmacists that meet regularly with network physicians, on a “one-on-one” basis, to educate, inform, and review medication prescribing patterns, and to communicate best clinical practice guidelines. This “clinician-based” delivery model provides network providers with real time utilization metrics, comparative performance measures, educational materials, and additional critical information in a format that promotes quality-based and medically appropriate clinical decision-making.

** RESULTS & SUCCESSES: The Pharmacy Provider Engagement Program has been responsible for a combined 75 percent reduction in the incidence of polypharmacy over the past two years in two cohorts which have been consistently monitored for incidence of polypharmacy.
**

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Evaluation Criteria:

1. The extent to which the respondent's proposal to improve quality can be tied to redirecting costs to pay higher physician rates.
2. The extent to which the respondent incorporates quality initiatives that will result in redirecting costs by reducing potentially preventable events.
3. The extent to which the respondent incorporates quality initiatives that will result in redirecting costs by improving prenatal care and birth outcomes.
4. The extent to which the respondent identifies other areas for quality initiatives or efficiencies that will result in potential cost savings.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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C. RECIPIENT EXPERIENCE

MMA SRC# 8 – Primary Care Providers (PCP) Assignment (Statewide):

The respondent shall describe its overall process of assigning enrollees to primary care providers (PCPs), including its assignment algorithm. The response shall include the quality and/or performance metrics used to determine high quality PCPs, and the timeframes associated with processing an enrollee's request to change PCPs.

Response:

Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance (Clear Health's) Florida-specific Quality-based Member Assignment Algorithm (QMAA) is one of the components of our strategic network management and performance optimization strategy. QMAA maximizes the extent to which high quality providers receive enrollee (member) assignments. This assures high-performing, engaged providers that collaborate with us because of our high-touch approach to provider collaboration and support, our focus on quality, and our competitive value proposition regarding care for members. Our QMAA methodology incorporates quality and performance measures to drive member assignments to high performing providers. Our goal for the QMAA strategy is to improve performance related to Agency goals, member health outcomes, and overall network performance improvement.

1. DEFINING AND UTILIZING QUALITY AND/OR PERFORMANCE METRICS IN THE ASSIGNMENT PROCESS.

We assign members to identified high quality, high performance providers in our network within time and distance standards. QMAA places providers in a two tier scale based on performance and quality thresholds. It assigns a PCP with the highest performance rating within time and distance standards. Our assignment process assigns members to our red ribbon providers whenever possible. These are providers with specialized HIV/AIDS training designated by including a red ribbon beside their name in our provider directory, informing members of the provider's additional specialized HIV/AIDS care and treatment competency. Our red ribbon program is nationally recognized and is a testament to our patient-centered model of service and support.

The goal of our QMAA methodology is to steer the majority of membership to our highest performing PCPs as measured by a set of quality and performance metrics. By supporting high performing PCPs with targeted member assignment, we share a commitment to our members getting the best care possible by ensuring high quality care is being provided.

QMAA contains quality and performance ranking components. We base quality scoring for preferred providers on select HEDIS metrics compiled by Clear Health's Quality Performance Rating team. Each quarter, we calculate HEDIS rates for practices with at least 30 members in the Denominator of the measure. We target our measures to current State Performance Measures. We compare providers to their peers within the quarterly measurement period using percentiles as the comparison value. We then assign points based on percentile and standard

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

deviation placement. We combine quality and performance scores for each provider creating their profile and assigning a provider score that is utilized in the QMAA process.

The QMAA methodology establishes and applies internal and proprietary algorithms and criteria to evaluate providers based on various quality and efficiency measures. We apply our proprietary algorithms to all members that do not have a PCP assigned through Choice Counseling after the preferred provider assignment. We notify both the member and the provider once a member has received a PCP assignment.

2. ASSIGNMENT OF MEMBERS TO HIGH QUALITY PCPS

The first step in our assignment process is to assign a member to an identified quality provider. As described above, we select the preferred provider using both quality and performance ranking components, taking into account time and distance contract requirements.

Once we receive the 834 Enrollment File from the State, we will assign all members that have selected their PCPs. We then assign members who have not selected a PCP to a preferred provider using the QMAA algorithm. We assign members to high performing primary care providers within time and distance ratios.

Our proprietary assignment process helps identify PCPs that best meet the needs of members by examining continuity and quality of metrics, as well as convenience of location. Our methodology establishes and applies internal and proprietary algorithms and criteria to evaluate providers based on various quality and efficiency measures.

We calculate quality rankings based on performance against plan objectives and HEDIS® measures, including those related to access to care, behavioral health, diabetes, immunizations, respiratory issues, screenings, and other requirements such as BMI assessment, controlling high blood pressure, and annual monitoring for patients on persistent medications.

We assess providers on their percentile ranking within their specialty based on the members assigned to them. We also assign a performance ranking based on the provider's performance relative to other measured providers related to achieving performance targets. We incorporate those results into the assignment process to preferentially assign members to higher-scoring providers.

In addition, we assign our Clear Health members to a HIV/AIDS certified provider or Infectious Disease provider, referred to as our Red Ribbon providers. These providers have obtained plan credentialing in the treatment of members with HIV/AIDS.

Our member assignment process factors member preference/familiarity with providers into each auto-assignment, based on the following methodology:

- Members are assigned to a PCP from whom they receive or previously received services if that information is available, the PCP is in our provider network, and geographically accessible to the member.

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- Members are assigned a PCP who are within time and distance standards by AHCA for the specific region.
- Members are assigned to a PCP that best meets the cultural needs of the member using measures such as ethnicity and linguistics when available.
- When assigning a provider to multiple children in a household, we assign a PCP that can treat all children in the household regardless of the children's ages
- Our Case Managers (Managed Care Coordinators) assist our medically complex children with assignment of a PCP familiar with their condition.

3. PROCESSING REQUESTS FOR PCP CHANGES

We receive PCP change requests through our Member Services line from members. PCP changes are made effective the day of the request, unless the member has seen their existing PCP that day. The Customer Care Representative will ask the member if they saw their existing PCP that day; if the member has not seen their PCP on the date of the request, the change is effective the same day. If the member has seen their PCP on the date of the request, the change is effective the following day. In either case we meet or exceed the State's PCP change timeline of three business days and will continue to meet this requirement under the new Contract.

A provider's office may also call to request a PCP change while the member is at the office. The Customer Care Representative follows the HIPAA Verification and Authentication Chart for this type of call and completes validation. The Representative obtains the name and National Provider Identifier (NPI) of the PCP the member is requesting the change to and asks to speak with the member. The Representative makes the change with the member or member's representative using the standard PCP change process. After the change is completed, the Representative offers to send a confirmation fax to the provider's office. If we cannot complete the PCP change, the Representative advises the member and provider of the reason and offers to help find the member another PCP. If appropriate, the Representative follows the process for one-time-sick visit notification.

Members can also request to change their PCP through our Internal Voice Response (IVR) system. The change will be effective no later than the following day. Members can also change their PCP through the secure Member Portal, as well as request a copy of their Member ID card.

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MMA SUBMISSION REQUIREMENTS
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Evaluation Criteria:

1. The extent to which the respondent's description includes how quality and/or performance metrics are defined and utilized in the assignment process.
2. The extent to which the respondent's algorithm includes assignment of enrollees to high quality PCPs.
3. The extent to which the respondent can process requests for PCP changes within three (3) business days.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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MMA SRC# 9 – PCP Timely Access Standards (Statewide):

The respondent shall describe the process and monitoring plan it uses to ensure compliance with the timely access standards as defined in **Exhibit B-1**, Managed Medical Assistance (MMA) Program, **Section VIII.**, Provider Services **Item A.**, Network Adequacy Standards, **Sub-Item 8.**, Timely Access Standards. The respondent shall also describe the process and methodology it uses for determining whether a PCP has the capacity to accept new patients.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health) monitors provider appointment accessibility to make sure members have timely access to services. We know that Clear Health members very often develop a very different type of relationship with their Primary Care Provider (PCP) compared to members enrolled in the MMA program. We monitor, track, and trend results of appointment access surveys in order to assure compliance with access standards, identify emerging patterns related to timely access to appointments, and support the deeper relationship members develop with their providers. We have also broadened our definition of PCPs to include infectious disease specialists to meet the needs of our members.

Clear Health's PCP network is integral to coordination of member care and providing access to preventive care. Members with HIV/AIDS may be reluctant to accept their diagnosis and may be wary of potential stigma related to their diagnosis. Trust is critical to our members with HIV/AIDS and this drives a deeper relationship between the member and the PCP. Our red ribbon providers have the training and experience necessary to support members living with HIV/AIDS. We provide ongoing support to make sure that our PCPs are successful in managing the unique health care needs of members.

We have developed an intimate understanding of the unique needs of members with HIV/AIDS and the providers needed in their treatment and care. We allow Family Practice, General Practice, Pediatrics, Internal Medicine, and/or Infectious Disease providers to serve as PCPs. An Obstetrician may also serve as a PCP for a pregnant member. This broader definition has allowed us to lower enrollee-to-provider ratio requirements to facilitate more frequent and more comprehensive interaction with the members as well as provide greater access and availability to specialized care.

In accordance with 42 CFR 438.206(c)(1), Clear Health takes action to assure network providers comply with timely access requirements, monitors regularly to determine compliance, and takes corrective action for noncompliance for both urgent and non-urgent services. Clear Health complies with all current contractual requirements related to monitoring timely access. We are in the process of aligning our operations to comply with new Contract provisions as identified in Attachment B, VIII Provider Services, A.8 Timely Access Standards related to appointment availability. This will include a quarterly review of a statistically valid sampling of providers and measuring timely access against revised standards.

Our provider agreements require network providers to abide by all AHCA appointment standards as indicated in Clear Health's contract, including standards for after-hours availability. We educate providers on these standards through initial and recurring provider training as well as the provider handbook, which we incorporate adherence by reference as part of the provider agreement. Our

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provider newsletters supplement initial orientation training and serve as recurring reminders for timely scheduling of appointments and after-hours availability standards.

We are proud of our Primary Care Provider (PCP) performance related to meeting timely access standards. Appointment Accessibility Audit scores for PCPs were analyzed and reported individually for each of the legacy plans. As an example, 2016 PCP access results for legacy Simply include:

- 99 percent urgent care appointment (goal is 90 percent within one day)
- 100 percent routine sick care appointment (goal is 90 percent within one week)
- 100 percent well-care appointment (goal is 90 percent within one month)
- 94 percent after-hours care (performance standard is 24/7 coverage)

1.1. Appointment Accessibility Audit

Clear Health conducts wait time and after-hours surveys to monitor network accessibility in compliance with AHCA requirements. We conduct surveys of a statistically valid sample across our network to monitor network accessibility in compliance with AHCA requirements. Our Quality Management department contracts with an NCQA certified survey vendor to administer the Appointment Accessibility Audit. We conduct initial audits in the spring and re-audits of noncompliance in the fall.

We are in the process of increasing the frequency of our access audits to quarterly in preparation to meet the new compliance requirements with Attachment B, VIII Provider Services, A.8 Timely Access Standards. This will allow us the ability to broaden the scope of the survey and allocate additional resources to ensure appointment availability. Clear Health recognizes the primary objective of the study is to ensure our members can obtain care when needed.

The objectives of our Appointment Accessibility Audit program include:

- Helping improve the services provided to our members
- Providing quantifiable feedback regarding compliance with access and availability standards
- Assuring compliance with regulations set forth in our Contract with AHCA

We survey PCPs to determine the accessibility and availability of appointments for members for urgent care appointments, routine sick care appointments, well-care appointments, and after-hours care.

Using a Computer-Assisted Telephone Interviewing (CATI) methodology, we survey providers to determine the accessibility and availability of appointments for our members. We review results in our Gap Committee and Quality Management Committee (QMC) meetings. We review the results of the audit to make sure services comply with AHCA standards, and report PCP results to the AHCA as required in the format specified, in accordance with Section XIV, Reporting Requirements, and the Managed Care Plan Report Guide.

1.2. Other Methods Used to Monitor Compliance with Access Standards

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We routinely monitor provider adherence to access standards through trending of member and provider complaint data. We accomplish this through communication and collaboration from Managed Care Coordinator/Case Manager to the Provider Relations team and review at workgroup meetings. We also use annual member satisfaction surveys and provider satisfaction survey data to monitor access standards. We also continually monitor and act on information obtained through our Provider Relations, Case Management, Quality Management, and Marketing departments. The forum to review the information from various departments is the Gap Committee, GAP Committee workgroups and QMC meetings.

The below reports/data are provided and analyzed by the GAP Committee which is used by its members to develop short and long term interventions.

- Member services data
- Quality of care and access concerns
- Administrative data
- Comprehensive analysis of access and availability
- Grievance and appeals data
- Member feedback
- Provider feedback

1.3. Gap Committee

Clear Health has a detailed and proactive process to promptly address network gaps because we know from experience that network gaps are high on the list of reasons for member dissatisfaction and voluntary disenrollment. Our Gap Committee is our frontline team responsible for monitoring gaps in the network and assuring that network deficiencies are resolved. The Gap Committee includes representatives from Member Services, Grievance and Appeals, Medical Management, Quality Management, Health Services, Provider Relations, and Delegation Oversight.

Each of these departments track and trend member or provider barriers obtaining access to covered services, whether it is appointment availability or a lack of a necessary specialty type in the network. We track and trend claims and encounter data for peaks and valleys that could indicate a provider is at capacity and identify those that are being under-utilized for special investigation into why Clear Health members are not being seen at expected rates for that provider type. We identify issues and determine root causes through the analysis of Quest Analytics data and review of the PNV files for ratio analysis.

Each department brings the results of their review of network issues, access challenges, and member and provider complaints to the Gap Committee meetings. We review, aggregate, and analyze data from all of these departments. We develop short- and long-term interventions and prioritize the implementation of each strategy based upon the number and type of members impacted, as well as the urgency of the need for the services/provider.

We maintain minutes of each meeting. Minutes document estimated resolution dates for the issue and the individual accountable to support for future follow-up. Each Gap Committee meeting results in a prioritization list that we assign to the Provider Relations department and a recruitment list is provided to each Provider Network Manager. Recruitment updates are reported back to the

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Gap Committee or to the workgroups by Provider Relations. We escalate recruitment difficulties in high-impact areas to our Regional Vice President of Provider Solutions for assistance.

The Gap Committee reports network findings, performance metrics, corrective action plans (CAPs), and all other pertinent information to the Quality Management Committee (QMC). Our QMC meeting, led by our Health Services and Quality departments, addresses potential access to care concerns. When members report access issues or complaints about providers, the source department tracks and trends these issues and reports them to the Gap Committee. The Gap Committee reports them to the Quality Management department (and these are included in the Provider's recredentialing review).

2. MITIGATION STEPS IF THERE IS A POTENTIAL ACCESSIBILITY ISSUE IDENTIFIED

2.1. Mitigation Steps if an Issue is Related to a Specific Provider

Clear Health's first priority is to make sure that members have timely access to quality care. For issues related to a specific provider we immediately contact the provider to inquire on the access constraints for the member. If the provider cannot serve the member, we help the member identify other available providers within the area to ensure the member gets timely care/service. Clear Health assures the member receives care as soon as we are made aware of the situation.

Any deficiencies in network access or findings of provider non-compliance with access and availability standards result in interventions focused on resolving any deficiencies. The Provider Network Manager informs individual providers of any deficiencies in writing and request an action plan to address issues within 10 days. Failure to address the issue will result in a corrective action plan and subject to termination if not remediated within established timeline. Provider Network Managers monitor and evaluates all action plans to make sure the provider completes the critical tasks according to schedule and re-audit as necessary to monitor continuous compliance. We give the provider training as well as practice management tips to assist in efficiently scheduling members

2.2. Mitigation Steps for Regional or Systemic Issues

If our analyses indicate that any component of our provider network is insufficient, our Provider Relations team will develop an action plan. The action plan will identify staffing, responsibilities, resources, and a timeline to correct the situation. Actions related to current network providers may include:

- Partnering with existing network providers to recruit and retain clinical staff, expand access through physician extenders, expand services in rural areas, offer additional services to address rural needs, and provide additional after-hours and weekend appointments
- Reviewing the directory and identifying referral pattern needs
- Coordinating transportation for members to see necessary providers outside their access area
- Collaborating with providers to open new practice sites

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- Encouraging and supporting patient centered medical home (PCMH) practice models which utilize a patient-centered team-based practice approach. Through our efforts, we identify practices and provide incentives to apply and complete PCMH certification.
- Promoting innovations to expand access to care such as using mid-level practitioners, utilizing health workers, using behavioral health (BH) coaches to extend PCP capacity, and bundled Federally Qualified Health Center (FQHC) coding to promote integration
- Providing focused training and education in team-based care
- Encouraging primary care practices to participate in one of our incentive programs. Practices can use these resources to expand office hours or the use of physician extenders
- Educating providers on and encouraging the use of telemedicine

Actions focused on non-participating providers may include:

- Recruiting out-of-network providers to participate in our network through referral trends, PCP referrals, completed out-of-network single case agreements (SCAs), and new providers entering the market, and converting non-traditional managed care providers
- Leveraging relationships with independent practice associations and other provider organizations to recruit additional providers
- Coordinating members' care with out-of-network providers
- Contacting providers (through Network Development outreach efforts) who are not enrolled as Florida Medicaid providers and explaining the process for enrolling, answering any questions they have, and following up with them to check their progress. We also provide them with the appropriate link to the AHCA website and include the paper application.

3. DETERMINING IF A PCP HAS THE CAPACITY TO ACCEPT NEW PATIENTS

We measure PCP capacity against system entered limitation parameters to restrict providers based on panel size of 500 members. While this is lower than the ratio standard required by AHCA, given the increased needs of members with HIV/AIDS we feel this is an appropriate panel size. Our system has a preset panel limit which closes the panel if the threshold is met.

If the provider brings on additional allied providers, we extend the panel to accommodate a higher threshold as set forth by AHCA. We review panels for adjustment at the time the provider submits a new allied provider for credentialing. PCPs can also set their own limits and close or restrict their panels (for example to existing patients) per their practice needs and capabilities.

We evaluate PCP capacity by identifying PCPs with open panels and mapping them against our current membership. This allows us to measure access against AHCA standards. Our network includes more than 2,500 PCP's. More than 500 Clear Health PCPs are designated as red ribbon providers. These providers meet our stringent credentialing requirements to service members living in HIV/AIDS. Clear Health's network of PCPs is more than adequate to meet the needs of

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our projected membership. Clear Health historically has a high rate of PCPs with open panels; our current rate stands at 95 percent.

We also use other mechanisms to monitor PCP capacity to accept new members including:

- Dedicated staff make outbound calls to PCPs requesting updated information for the provider directory which includes whether or not they are accepting new members.
- We send monthly fax blasts to PCPs requesting them to review their directory information and submit changes via fax, email, mail, or by informing their Provider Network Manager. This includes panel status.
- During the appointment access audits, we capture information about provider offices not accepting members and forward to Provider Network Managers for follow-up and updates to our system including directories.

In addition to evaluating PCP capacity, we evaluate the adequacy of our other provider types, including specialists, dental providers, BH providers, vision providers, pharmacies, and ancillary providers to accommodate the new membership.

Evaluation Criteria:

1. The extent to which the respondent's process and monitoring plan ensure that enrollees have access to urgent or non-urgent services within the timely access standards defined in **Exhibit B-1**, Managed Medical Assistance (MMA) Program, **Section VIII.**, Provider Services, **Item A.**, Network Adequacy Standards, **Sub-Item 8.**, Timely Access Standards.
2. The extent to which the respondent's monitoring plan includes specific mitigation steps it will take if there is a potential accessibility issue identified.
3. The extent to which the respondent's process and methodology for determining PCP capacity clearly outline the steps and data used for determining whether a PCP has the capacity to accept new patients.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 10 – Transitions of Care (Statewide):

The respondent shall describe how it will address the transition of care between service settings, including transitions from hospital to nursing facility rehabilitation and from hospital or nursing facility rehabilitation to home. Identify specific methodologies for ensuring that transition planning ensures appropriate primary care and behavioral health follow up, where appropriate. Provide an example of an effective transition plan.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Given the complexities of managing the HIV/AIDS disease processes and the unique co-morbidities of our members, Clear Health Case Managers (Managed Care Coordinators) closely monitor all inpatient admissions or rehabilitation stays and take a proactive role through transitions. Supporting our members through care transitions between service settings is essential in reducing potentially preventable events due to fragmented care and is fundamental to our case management model. Our Clear Health team works closely with all members of the treatment team, including Primary Care Providers (PCPs), specialists, ancillary providers, hospital and skilled nursing facility staff and our members to ensure readiness to re-enter the community and a seamless transition plan is in place before discharge. The Managed Care Coordinators follow the member into the new setting to ensure adequate conditions and support for recovery are provided. We use the strength of our combined plans to invest in on-the-ground infrastructure to promote engagement, coordination and continuity of care, and innovations that improve outcomes for our members.

1. TRANSITION OF CARE REQUIREMENTS

Clear Health has a robust and person-centered process for managing inpatient admissions, discharge planning and post-discharge periods to assure our members' needs are met and their conditions stabilized. We meet all Agency for Health Care Administration (AHCA) standards for transitions of care. Clear Health:

- Provides inpatient case management, including participation in rounds with our medical director to concurrently review and assess member' discharge needs and appropriateness of level of care settings
- Conducts face-to-face or telephonic visit with member or family when they are in the hospital or a facility
- Assesses member readiness for transition between settings
- Determines appropriate services are in place before discharge

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- Provides follow-up contact by member services discharge team to conduct discharge assessment, order home delivered meals in accordance with physician orders, and coordinate any other immediate needs within 24 hours of discharge
- Provides follow-up by inpatient coordinators to ensure assignment of appropriate providers and delivery of any needed equipment, supplies, and/or home health services that were not previously ordered, within 24 hours of discharge
- Provides follow-up call or visit by Managed Care Coordinator within seven days of discharge
- Subsequent follow-up call or visit by Managed Care Coordinator 14, 21 and 30 days after discharge, at a minimum.

Clear Health Managed Care Coordinators follow members into the hospital and rehab facility and through transitions, working in collaboration with our Medical Director, Concurrent Review Nurses and other teams. They communicate with PCPs and specialists as well as Ryan White or Project AIDS Care (PAC) waiver case managers to engage their assistance when needed for follow up care. This continuity of care is especially important for our members with HIV/AIDS, using the trusting relationship, to assure member engagement through challenging times.

1.a. ASSESSMENT CRITERIA FOR MAKING SURE MEMBERS CAN BE SERVED SAFELY IN THE COMMUNITY

Discharge planning begins on the date of admission. Our case management staff are involved in all aspects of our member's hospital or nursing facility rehabilitation admission to assure continuity of care and the timely and comprehensive flow of information.

We receive notifications of admission through our daily census of members at network facilities, through our on-site review by Concurrent Review Nurses, routine review of claims and authorization data and forthcoming use of Event Notification Service (ENS), Florida's system for notification of inpatient and ER admissions and discharges. Once informed of the admission, our Concurrent Review Nurses and our Managed Care Coordinators engage with the member regarding barriers and goals and perform frequent reviews of the discharge plan with facility staff. For members who are difficult to reach or engage, their Managed Care Coordinators will perform a face-to-face visit when possible while members are inpatient to coordinate care and attempt to engage the member in broader case management services. Our clinical staff participate in Rounds and case reviews with Medical Directors to review previous and current clinical acuity including CD4 count and immune system functioning, medication regimen and history, functional status, relevant information about the home environment, services required and support structure, and member goals that may contribute to developing a robust and responsive discharge plan.

We work proactively with our hospital partners to ensure that discharges are appropriate and that the timing facilitates success in the step-down facility or community setting to reduce the risk of re-admissions. Members discharging from inpatient and subacute care facilities are assessed to ensure that they meet clinical criteria using a formalized discharge assessment tool and have a safe discharge plan that is based on evidence-based guidelines. We also assess caregiver support, member functional status and need and frequency of services in the community to promote safety. Since all our members have complex medical and often behavioral health co-

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morbidities, all discharges are reviewed by our Medical Director to confirm transition to the safest level of care for the member. Members requiring services to be in place prior to discharge such as ventilators, oxygen, and feeding pumps remain in the hospital until services and/or equipment are confirmed to be immediately available in the new setting. Likewise, we hold discharges for members requiring a caregiver or Private Duty Nursing (PDN) services until those services are confirmed and the Nurse can meet the member at home. Our Inpatient team is trained to submit service authorizations so that post-discharge care and equipment requests are reviewed timely and services put into place as needed and discharge is not delayed. For members transitioning from a hospital to nursing facility, our Concurrent Review Nurses obtain the Pre-Admission Screening and Resident Review (PASRR) form and the Department of Children and Families (DCF) assessment as required to measure mental capacity and/or intellectual disability and to ensure placement in the most appropriate and least restrictive setting possible.

For children and youth who are being discharged from a State Inpatient Psychiatric Program (SIPP) facility, we actively participate with the member's treatment team to develop a comprehensive discharge plan that assures that progress made while in the facility continues after discharge. A dedicated SIPP BH Case Manager is assigned to the member at least 30 days prior to discharge. The BH Case Manager works closely with the SIPP provider's discharge planner and the member's family members, providers, and other identified supports when approved by the member. This assures all required services and supports are in place well before the actual discharge date.

1.b. COLLABORATION WITH FACILITIES, INCLUDING DISCHARGE STAFF

Our transitions of care process begins when the member is first admitted to the hospital or rehabilitation facility with acute medical or behavioral health needs. Upon notification of admission, our Concurrent Review Nurses and Clear Health Managed Care Coordinators access information about our members through our integrated Case Management System and initiate coordination with the facility. For example, our Concurrent Review Nurses convey to facility staff which HIV medication regimen the member is on, so they do not experience any interruptions in HIV treatment during in-patient care. We also provide information on HIV viral load and CD4 counts, vital information to ensure continuity of care through an admission. Our Concurrent Review Nurses support members in all Simply plans, including the MMA plan, the LTC plan and our specialty plan for an efficient use of combined best practices. Concurrent Review Nurses are local and assigned to work with a limited number of facilities in a region. This improves communication and familiarity between our staff and the facilities. We communicate about underlying health status of members, baseline functioning, caregiver support and current services in place. Clear Health Managed Care Coordinators also connect with behavioral health staff, including co-located staff at some facilities, to assure comprehensive responses to member needs during their inpatient stay and discharge planning process.

Throughout our members' inpatient stay, we remain in close communication with the care team to ensure collaboration and focus on achieving goals. Our Managed Care Coordinators and clinical staff participate in Rounds with the facility staff to remain current on members' changing status and develop an effective discharge plan. Our Managed Care Coordinators conduct face to face or telephonic visits with the member, caregivers, and facility staff to discuss the discharge plan. For members with frequent admissions, Managed Care Coordinators, Concurrent Review Nurses or Clear Health Physicians may visit the member while inpatient to discuss barriers, coping

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mechanisms, and engage members in self-management. We focus on helping members understand their role in their own care. Prior to discharge, the Concurrent Review Nurse staff initiate authorization for necessary supports in the home and confirm that home health services are available immediately upon discharge.

For members transitioning from hospital settings to skilled nursing rehabilitation facilities, we work with facility staff, members, and their caregivers to secure appropriate placements and sufficient flow of information to ensure continuity of care. When appropriate, our Concurrent Review Nurses offer members' admission to preferred Skilled Nursing Facilities, identified for quality and alignment with our model of care. Our Managed Care Coordinators work closely with these rehabilitation facilities to coordinate care, proactively establish goals for the members' rehabilitation and follow-up on progress towards these goals. For members admitted for acute behavioral health crises or medical detoxification, we facilitate transitions to appropriate step-down facilities for continued rehabilitation, residential treatment, or intensive community detoxification services until transition to appropriate community settings are available.

For members under the age of 21, we work actively with AHCA and the Department of Children and Families to define the needs for long-term services following admissions. We participate in the Children's Multidisciplinary Assessment Team (CMAT) process as required to support our members.

1.c. REFERRAL AND SCHEDULING ASSISTANCE

Our Managed Care Coordinators are actively involved in making appointments for members' outpatient care during the transition from facility-based care to home, including visits with primary care, infectious disease specialists, behavioral health providers, specialty providers or physical therapy. We also make arrangements for home health or skilled nursing services, home care to assist members with daily living activities and meal support, as needed, to promote recovery. Managed Care Coordinators help to facilitate the processing of prior authorizations and utilization management reviews for necessary care during the transition period so that our members and providers experience a seamless transition.

Our Managed Care Coordinators routinely facilitate post-transition provider visits including scheduling appointments, arranging transportation, conducting reminder calls to the member or caregiver, and following up after the visit to review the treatment plan. The Managed Care Coordinators, working with Clear Health Clinical Pharmacists, review new orders and medications to ensure safety and that members and their families are confident in their treatment plan. Our Managed Care Coordinators arrange for at-home prescription delivery for members who cannot access pharmacies.

A primary goal of Clear Health Managed Care Coordinators is to reconnect our members to regular sources of care through all programs. And we incorporate post-discharge interventions as a key opportunity to make these links.

Clear Health Managed Care Coordinators work with our members and caregivers to implement an effective treatment plan. And our person-centered plan of care, defined as a part of the discharge plan, includes referral and scheduling assistance for primary and specialty health care visits, transportation to all necessary appointments and other service supports. We use the local

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knowledge of our Managed Care Coordinators and our comprehensive provider directory to assist members and caregivers in selecting new service providers, considering language and cultural preferences, and scheduling timely post-discharge or initial visits. We determine the need for non-covered services and refer the member to the appropriate social service or other setting as required. We facilitate transfer of medical records as requested and authorized by our members. We document referrals and follow-ups in our integrated Case Management System.

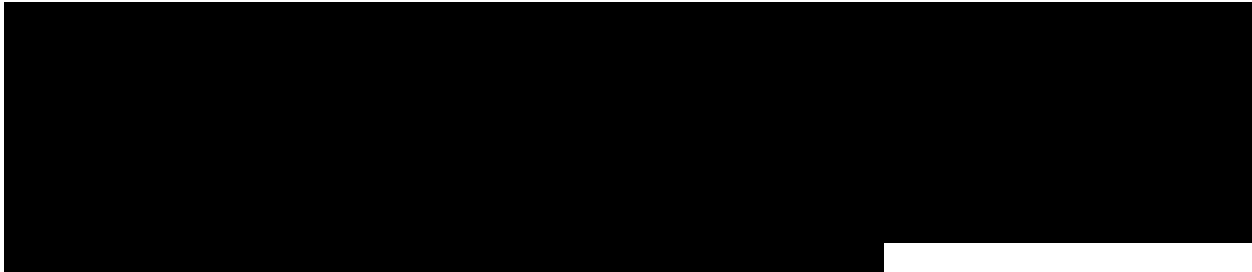
1.d. COORDINATION WITH PCP AND BEHAVIORAL HEALTH PROVIDERS FOR APPROPRIATE FOLLOW-UP

Reconnecting members to their regular, outpatient providers is one of Managed Care Coordinators' four priorities in the time immediately following discharge. Closing information and care gaps is an effective strategy to promote stabilization, recovery, resiliency and prevent re-admissions. We work closely with our providers to share information when members are hospitalized and discharged. This includes our customized daily inpatient census and follow-up communication by Managed Care Coordinators regarding the discharge plan and medication changes. We facilitate communication between providers, engaging multiple specialties as needed, to generate a cohesive and comprehensive discharge or treatment plan that supports member goals.

Clear Health's Care Coordination templates and guideline documents provide staff with processes to achieve expectations of a follow-up appointment for the member, within seven (7) days of the discharge. Clear Health:

- Identifies each provider that the member must see, including specialists, from the inpatient facility
- Contacts each provider to ensure that timely follow-up appointments are scheduled, advocating for the member as needed to secure timely appointments
- Plans each provider visit with the member, including questions on treatment plan and medications
- Supports the follow-up visit by providing reminders before the visit, ensures transportation is scheduled and arrives, and reminds the member to take the member-centered health record and medication list to the visit
- Reviews the results of each follow-up provider visit with the member
- Works on empowering the member to schedule and keep subsequent follow-up appointments
- Assures that members receive ancillary care and durable medical equipment to support treatment plans
- Shares BH plans of care with Primary Care Physicians for cases with complex medical/behavioral conditions, as appropriate.

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1.e. PROCESS TO PREVENT UNNECESSARY RE-ADMISSIONS

All Clear Health members transitioning out of hospital or rehabilitation stays are contacted by their existing Managed Care Coordinators to facilitate continuity of care. These Managed Care Coordinators are knowledgeable about locally-based resources and bring extensive experience managing the HIV/AIDS disease processes, evidence-based case management protocols and knowledge of providers and community resources. Our Managed Care Coordinators use the evidence-based Coleman model for post-discharge case management that emphasizes building skills and empowering our members to improve self-management of their conditions. We support members by engaging them in care through aggressive coordination and partnerships with inpatient and outpatient providers which results in reduced readmission rates and improved quality of care. Our Managed Care Coordinators emphasize four points with members to promote stabilization and reduce the risk of re-admission:

- Medication Reconciliation: ensuring that members are only taking medications prescribed at discharge. Managed Care Coordinators may engage our Clinical Pharmacists as needed for review of medications for patient safety or side effects concerns and to provide member education about medication regimens
- Red-flag Recognition: identifying the root cause of the admission with members and developing an action plan to deal with early warning signs
- Follow-up Care: ensuring members are reconnected to their outpatient providers for follow-up visits and to close gaps in care
- Member-centered Health Record: providing members with a comprehensive account of their medical history and discharge plan to support continuity of care

Members discharged home from facilities with home health care orders receive a phone call from the plan within 24 hours to ensure that needed services have commenced. Our Managed Care Coordinators contact the member once initial discharge plan of care is in place, with subsequent

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contacts within 7, 14, 21 and 30 days after discharge to assure successful continued stabilization to prevent readmission. The goal of these visits is to assure that follow-up appointments are scheduled and that any services put in place as a part of the discharge plan have arrived. Prior to these communications, our Managed Care Coordinators often connect with the PCP or infectious disease specialist to update them on discharge instructions and to reconcile any medication changes. The Managed Care Coordinator conveys any important instructions or changes to the medication plan to the member and caregivers, as well as confirms follow-up medical appointments.

As a part of the post-discharge case management, the Managed Care Coordinator again confirms follow-up appointments and checks in with the member and caregiver about “red flags” indicating worsening conditions that may result in a readmission if not managed appropriately. Using motivational interviewing techniques, the Managed Care Coordinator engages the member and the caregivers in defining follow-up self-management strategies. The Managed Care Coordinator checks on self-reporting of clinical metrics, including daily weight checks or blood pressure readings, and schedules follow-up testing as defined by the discharge plan. They confirm receipt of supports in the home as needed to promote recovery. For members who are not adherent to the treatment plan or medication regimens, or who have a high likelihood of re-admission, the Managed Care Coordinator may discuss the case with the PCP, Clear Health Medical Directors and BH Case Management staff to define alternative strategies.

As a result of the proactive engagement from our Managed Care Coordinators, we have seen significant increases in member follow-up after discharge (HEDIS measures) and reductions in the re-admission rates.

- Follow-up for hospitalization for mental illness: 29 percent (up from 16 percent in 2015)
- All cause 30-day readmission rate: 28 percent (down from 31 percent in 2015)

While these rates may be higher than non-specialty plans the population has a concentrated mix of high co-morbidities, co-occurring disorders, and increased risk factors within social determinants of health. This is best understood when reviewed in conjunction with the rate of potentially preventable hospital admissions, which as per the AHCA Quarterly SMMC Report Spring 2017, show that CHA has the second lowest risk-adjusted PPA rates per 1000 for all Florida plans, including those that are non-specialty with healthier non-specialty populations.

1.f. EXAMPLE OF EFFECTIVE TRANSITION PLAN

Bill (name changed for privacy) is a 16 year-old Clear Health member with a complex medical history in addition to his HIV, acquired at birth. Following a string of incidents in 2015, psychiatrists evaluated the member and recommended residential-based placement due to the extent of mental state and potential harm to himself and others in the home at the time. Member was admitted to State Inpatient Psychiatry program (SIPP) for five month stay to address ongoing issues and acute psychiatric crisis.

Bill's Managed Care Coordinator, Marlen, visited Bill's parents routinely during his inpatient stay. Additionally, Marlen and Bill's parents participated in treatment team calls with Brian and the SIPP staff to assess his progress toward meeting goals that would facilitate a safe transition to the community or the preferred location. Our Managed Care Coordinator also spoke with facility staff

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to assess progress and address any barriers in the treatment plan. For example, Marlen assured that Bill continued his treatment for HIV while in the SIPP, including daily anti-retroviral medications, and that routine testing did not show negative impacts on his CD4 count or other measures of control. Likewise, we confirmed his diet in the facility aligned with GI requirements to prevent flare-ups of his Crohn's Disease. With the parents' permission, the Managed Care Coordinator also connected with Bill's PCP, psychiatrist, pediatric HIV specialist and GI specialist throughout the admission to keep them informed of progress and concerns.

As Bill continued to make progress in meeting goals, he began expressing a desire to return to the community. His Managed Care Coordinator worked with a BH Specialist and in conjunction with Bill and his parents, began a transition plan including assessment of needs to live in the community safely and with support. Development of this plan began during the transition planning to the facility from the home (See Attachment MMA SRC# 10-1: Plan of Care for details on the transition plan from facility to home). In this case, Bill has strong natural supports in his family. The BH Specialist and the Managed Care Coordinator visited the home setting to determine safety and any barriers to transition and worked with the member and family to develop a plan of care to maintain healthy behaviors after discharge. This plan of care is attached, see Attachment MMA SRC# 10-2: Workflow for Transitions. Bill conducted two short-term home stays to test the plan of care before discharge.

Immediately following discharge, the Managed Care Coordinator contacted the family within 24 hours to determine how the transition was going. Marlen also made sure the member had a follow-up visit established with the psychiatrist. She visited 7 days after discharge to review the plan with the member and family and to discuss re-connecting with outpatient providers and other strategies to maintain the plan of care.

Bill's Managed Care Coordinator continued to visit Bill and his family weekly for the month following discharge and as needed afterwards to promote stabilization and re-connection to outpatient sources of care.

2. PROTECTING MEMBERS' PRIVACY

Protecting our members' privacy is among our highest priorities and is built into all policies and procedures for our staff. We comply with all legal responsibilities and the expectations of our members. All interactions begin with the three-point review of identity including confirming the name, date of birth, last four digits of the social security number and address of our members. We gain member consent before engaging them in case management and fully explain the coordination and information sharing aspects of our program at multiple points, including at enrollment and initiation of services. All staff, including Managed Care Coordinators and Customer Care Representatives, confirm members' contact preferences per our Telecommunications Policy and confirm whether member has agreed to be contacted by that phone number before making all outbound calls and leaving messages.

Managed Care Coordinators engaging in post-discharge follow-up comply with Clear Health's Telecommunications Policy to protect member privacy and communications preferences. Standard Operating Procedure requires Managed Care Coordinators to check our internal "Do Not Call" list – members who have indicated they do not wish to be contacted by the health plan staff -- before making outreach attempts and to honor those requests. Managed Care

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Coordinators and other health plan staff ensure that all disclosures of protected health information (PHI) for the purposes of case coordination across settings, discharge planning and utilization management is the minimum necessary information to effectively manage members' care. We also take great care to protect member privacy and reduce the chances of accidental disclosure of health information when sending information by mail or fax by ensuring no PHI is visible on the cover page. Our staff only communicate with members by email when consent to do so is obtained, and all emails with PHI are encrypted to protect from disclosure. All health plan staff are trained on these and other HIPAA-related policies and procedures at least annually during compliance trainings.

Given the special sensitivity to confidentiality for members with HIV/AIDS, Clear Health takes extra precautions to assure all communications from the plan do not reveal members status. In response to feedback from our members and concerns about confidentiality, we removed the HIV/AIDS red ribbon from all letterhead and envelope logos for member-facing communications, as well as all marketing materials. We take extra precautions in communicating with our members to protect their trust and confidentiality.

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Evaluation Criteria:

1. The extent to which the respondent's process and example address the following transition of care requirements:
 - (a) Assessment criteria for making sure the enrollee can be served safely in the community;
 - (b) Collaboration with providers' (e.g., hospitals, institutional settings, assisted living facilities, crisis stabilization unit, statewide inpatient psychiatric program) discharge planning staff;
 - (c) Referral and scheduling assistance;
 - (d) Coordination with PCP and behavioral health providers to ensure appropriate follow up has occurred; and
 - (e) Processes to prevent unnecessary hospital or nursing facility readmissions.
2. The extent to which the respondent's process and example ensures the protection of the enrollee's privacy consistent with confidentiality requirements.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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Nursing Facility Transition Planning	
Member Name: Bill	Member ID: XXXXXXXXXX
Primary Unpaid Support: parents	Phone Number:
*Transition FROM: Hospital Behavioral Health SIPP treatment facility: Daniel Kids Treatment	Transition TO: Home/Community Living
Facility Name, Address & Phone : SIPP Placement – Location Jacksonville, Florida	

1. TRANSITION ASSESSMENT SUMMARY

The Case Manager must complete their assessment of the member's needs prior to the completion of this section.

1. Member's physical needs can be met in the community

☒ Yes ☐ No

If no, please describe: Member diagnosed with HIV from birth, Crohn's Disease, anxiety and panic disorder post G-tube removal back in 12/2014. Member has HIV provider and GI specialist within the community setting.

2. Member's behavioral health needs can be met in the community

☐ Yes ☒ No ☐ N/A

If no, please describe: Member was (and still is) under psych care due to manipulative behavior, self-harmful thoughts and actions, and sexual aggression towards others including his sibling. In 2015, member was evaluated by psychiatry and recommendations were made for residential-based placement due to the extent of mental state and potential harm to self and others in the home at the time.

3. Member's has adequate natural supports available in the community

☒ Yes ☐ No

If no, please describe: Member's adoptive parents chose to adopt Bill and another male child born with HIV as young children. In addition to HIV, member was born premature, diagnosed with failure to thrive, and developed Crohn's Disease. The parents also adopted another child (female) with complex medical needs that requires PDN (child enrolled with another plan). Member has been in behavioral care services for a number of years due to G-Tube placement due to Crohn's Disease, his HIV and inappropriate sexual behavior towards siblings and parents. Adoptive father works in the mental health field and is aware of behavioral health resources for member. Parents have paid out of pocket for therapists who were not Medicaid providers in

search of help for their son. Parents have worked closely with the plan and the BH provider to help meet their son's needs but the child continued to engage in inappropriate sexual activity including internet searches for sex.

4. Member will have a safe home environment in the community

☐ Yes ☒ No ☐ N/A

If no, please describe: Please see above.

5. Is member homeless?

☐ Yes ☒ No

6. Member's social needs can be met?

☒ Yes ☐ No

If no, please describe: Member's parents are very involved. Member is seen by HIV pediatric specialist and her practice is devoted to the needs of children born with and living with HIV. In addition, Managed Care Coordinator has developed a wonderful rapport with family and member and suggested additional community resources to address HIV and sexual identity as well as provide peer-to-peer education re: consequences of unprotected sex (both legal and medical)

7. Member has adequate finances to maintain a safe home in the community

☐ Yes ☒ No

Member does not work and is dependent on parents for home.

8. Member will require assistance with (Check all that apply):



- | | |
|--|---|
| <input type="checkbox"/> Assistance with Utilities | <input type="checkbox"/> Food Stamps |
| <input type="checkbox"/> Monthly Rent Assistance | <input type="checkbox"/> Recreation Needs |
| <input type="checkbox"/> Transportation Needs | <input checked="" type="checkbox"/> Other |

If OTHER, please describe: Member required assistance with HIV and other meds as the SIPP facility was located in an area that the plan is not operating in (Region 4). The Care Coordination team worked with a pharmacy that agreed to mail the member's medications to the facility. The member's mother had been unable to provide the bottles for the medications because they use a lockbox system in their house due to the presence of two other children with special needs. As the medications were in zip lock bags, there was confusion from the nursing staff. All was coordinated between mother, plan, and pharmacy to ensure that the member did not experience any lapse in treatment due to the special circumstances described above. Communication between member's GI specialist, HIV specialist, Care Coordinator, Pharmacy, BH Provider, and parents was maintained throughout the 5-month stay in the SIPP. Member was successfully discharged 11.19.15 having voiced that he had benefitted from the program and would use the tools/information he learned from his stay in order to remain sexually safe. Appointments to specialists and to aftercare program in addition to continued mental health care thru his private provider prior to SIPP placement was arranged. Member to see GI specialist due to 2 lbs weight loss. One week after discharge, MCC was informed that member had adapted well to his family environment (no maladaptive behaviors). Member's mother was in the process of getting member set up as a volunteer in animal shelter or vet office. Member and family were going on a 3-week Holiday vacation to visit relatives in Colorado.

9. Other Potential Barriers to Transition to the Community

☒ Yes ☐ No

If yes, please describe barriers: Concerns that member will remain focused on his school and not re-engage in sexual maladaptive behaviors including soliciting sex via the internet, which had occurred in the past and had led to the arrest of an adult man who picked the member up and engaged in oral sex with him. In addition to the Managed Care Coordinator assisting the family and the member, the Plan assigned a Behavioral Health Specialist to help address the behavioral health needs of the member and to coordinate care between BH providers.

10. Member's needs can be safely and effectively met in the community ☒ Yes ☐ No
11. DME/Medical Supplies required? ☐ Yes ☒ No
If yes, DME/Medical Supplies details: _____
12. DME scheduled for delivery prior to discharge/transition? ☐ Yes ☐ No ☒ N/A
13. DME delivery date? 
14. Transportation for discharge required? ☒ Yes ☐ No
Member's father picked him up. Drove from Ft Lauderdale to Jacksonville, FL.
15. Transportation scheduled? ☐ Yes ☒ No
16. Member is a candidate for transition to community? ☒ Yes ☐ No
17. If NO, date member was notified: 
18. Case Reviewed with Manager/Medical Director, etc.: ☒ Yes ☐ No
19. Topics covered during discharge/transition planning visit (check all that apply):
- | | |
|---|--|
| <input checked="" type="checkbox"/> Caregiver/Natural Supports information | <input checked="" type="checkbox"/> Community Supports |
| <input checked="" type="checkbox"/> Community Living Placement Setting | <input checked="" type="checkbox"/> Comprehensive Service Needs Assessment |
| <input checked="" type="checkbox"/> Discharge Planning completed | <input checked="" type="checkbox"/> Member desire to return to community |
| <input checked="" type="checkbox"/> Onsite eval of member community placement | <input type="checkbox"/> Permanent Placement |
| <input type="checkbox"/> Transition Allowance Determination <input checked="" type="checkbox"/> N/A | <input checked="" type="checkbox"/> Transition Plan of Care |
| <input type="checkbox"/> Other (provide detail via summary) | |
20. Detailed Summary: Member was a good candidate for transition back to home after successful 5-month stay at the SIPP location that was specialized in dealing with this member's unique mental health issues. Supports were coordinated and in place at the time of the transitions to and from the SIPP facility. Managed Care Coordinator worked with BH provider and plan assigned behavioral health Case Manger to ensure smooth transitions and that member would have all resources in place. Member continued to receive support from plan to ensure that medication, specialty visits, and coordination of behavioral health services were continuous and uninterrupted. Member's social well-being was addressed as well with support of school and volunteer activities post SIPP stay. Family was very grateful for the support received and participated in a short film about the plan.
21. Just prior to release, the SIPP facility reported that member had shown tremendous progress with unsafe behaviors, conduct, aggression, OCD, and health issues. Member participated in Reactive Therapy. Member had two home passes. Member had not had any unsafe behaviors since July 2015 (entered SIPP in June of 2015). Member was working on understanding how he should act at home. Member was not aggressive with peers or staff. Member worked on coping mechanisms and followed facility rules. Member made good choices for 30 consecutive days per facility. Member had not demonstrated any inappropriate sexual behaviors towards self, peers, or staff. Member's therapist at the facility was concerned about what member might do when he went home but member met over 97% of his expectations. Member had had minimal behavior problems. Member expressed the ability to maintain behaviors of a healthy lifestyle.

Member compliant with medication. Plan Behavioral Health Case Manager agreed to follow up with Plan pharmacy to ensure medications were in place upon his return. Member in compliance with medical follow up. Member's father indicated that member had no instances of inappropriate behavior during his home passes. Member had alone time to watch television without incident. Per SIPP facility, member was a good candidate for transition home given individualized services and supports are in place upon transition to meet her identified needs, desires, and goals.

2. COMMUNITY LIVING PLACEMENT SETTING

Select the setting which the member will be/is transitioning to in the community (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Adult Critical Care Home | <input type="checkbox"/> Assisted Living Facility |
| <input type="checkbox"/> Group Home | <input checked="" type="checkbox"/> Living with Family/Caregiver |
| <input type="checkbox"/> Member owned housing | <input type="checkbox"/> Rental (apartment) |
| <input type="checkbox"/> Other (provide detail via summary) | |

1. **Detailed Summary:** Member's living situation at home has presented challenges in the past due to member siblings are also medically complex and require specialized care. Member has had history of inappropriate sexual conduct and has not been allowed to use family computer or cellphones due to fear of solicitation of sex over the internet. Upon discharge, member was enrolled in a charter school, pursued volunteer opportunities with an animal shelter (member is interested in veterinary work) and had PCP appointment scheduled for 12/8/2015. Therapeutic appointments with private provider as well as Plan BH provider suggested community programs in place. Behavioral Health Specialist assigned to member by Plan to assist in all follow up services post discharge. Both member and parents expressed that he had a good visit with his family during his last pass for home weekend visit. Member stated that he never wanted to be "locked up" again and would use coping skills to not engage in unsafe behaviors. Member stated that he was thankful for his family and that he wanted an opportunity to go back to school and do better.

2.

3. CAREGIVER/NATURAL SUPPORTS INFORMATION

Please provide information regarding the member's caregivers/natural supports, their phone number, and their availability. This information should be used, as appropriate, in the development of the member's Plan of Care.

☐ **Not Applicable** - Member will not/does not have any available caregivers/natural supports.

<u>Name:</u>	<u>Phone #:</u>	<u>Availability</u>
1. Father	_____	Available most of the time and working in the mental healthcare field.
2. Mother	_____	Available all of the time as stay at home mom. Assists with all health care needs.
3.	_____	_____

4.		
5.		
6.		

4. ONSITE EVALUATION OF MEMBER RESIDENCE/COMMUNITY LIVING PLACEMENT SETTING

Indicate specific areas where there are potential safety or accessibility problems for the member (check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Bathtub/shower unsafe | <input type="checkbox"/> Building repairs needed | <input type="checkbox"/> Commode unsafe |
| <input type="checkbox"/> Electrical hazards | <input type="checkbox"/> Furniture repairs needed | <input type="checkbox"/> Grab bars/handrails needed |
| <input type="checkbox"/> Insects/pests present | <input type="checkbox"/> Lighting inadequate | <input type="checkbox"/> No air conditioning |
| <input type="checkbox"/> No/insufficient hot water | <input type="checkbox"/> No telephone/not working | <input type="checkbox"/> Ramp needed/unavailable |
| <input type="checkbox"/> Stairs/railings unsafe | <input type="checkbox"/> Stove not working | <input type="checkbox"/> Unsanitary conditions/odors |
| <input type="checkbox"/> Flooring/rugs loose | <input type="checkbox"/> Inadequate plumbing | <input type="checkbox"/> No/insufficient heat |
| <input type="checkbox"/> Refrigerator not working | <input type="checkbox"/> Other (provide detail via summary) | |

1. Home Modification Needed?

☐ Yes ☒ No

Detailed Summary: _____

7. TRANSITION PLAN OF CARE

☒ Transition Plan of Care Completed

- | | |
|---|---|
| <input type="checkbox"/> Includes any Identified Minor Home Modifications | <input checked="" type="checkbox"/> N/A |
| <input type="checkbox"/> Includes any Identified Transition Allowance Expenses (as appropriate) | |
| <input checked="" type="checkbox"/> Addresses Services Needed to Safely Transition to the Community | |

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 11 – Provider Network – Network Development Plan (Regional):

The respondent shall submit a draft network development and management plan demonstrating how it will ensure timely access to the following services:

- Physical therapy (pediatric);
- Speech-language pathology services (pediatric);
- Occupational therapy (pediatric);
- Private duty nursing services (pediatric);
- Intermittent skilled nursing (pediatric and adult);
- Early intervention services;
- Compounding pharmacies; and
- Specialized therapeutic foster care.

The respondent's approach shall include at a minimum:

- a. Identification of network gaps (time/distance output reporting, after-hour clinic availability, open/closed panels, etc.);
- b. Strategies that will be deployed to increase provider capacity where network gaps have been identified;
- c. Strategies for ensuring timely access to services by measuring the time in-between when services are authorized and when they are received; and
- d. Strategies for updating the network development and management plan, including the data that will be used to inform improvements to increase access to services.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health's) comprehensive, contracted network of more than 26,852 providers was developed to meet the specific needs of our Florida enrollees (members). In Region 1, Clear Health Alliance has developed a network that consists of 1,293 Primary Care Providers (PCPs) and specialists. Clear Health maintains an annual network development and management plan (annual network plan), including policies and procedures for assuring covered services are available, accessible, and provided promptly. In our response we describe the various tools and methods we use to monitor our network and identify gaps, including time/distance standards, after-hours clinic availability, and closed panels.

1. IDENTIFYING AND RESOLVING BARRIERS AND NETWORK GAPS

Our network plan and corresponding policies and procedures are submitted to the Agency for Health Care Administration on an annual basis for approval. We make sure covered services are available and accessible for all members and develop and monitor network development plans

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

that assure the provision of covered services for the maximum number of members for each region.

Clear Health acknowledges that we have read and will comply with all contract provisions as identified in Attachment B, VIII Provider Services, B.2 Annual Network Development Plan. A draft network development and management plan is included as Attachment MMA SRC# 11-1: Network Development and Management Plan (Regional).

Private duty nursing (pediatric), intermittent skilled nursing (pediatric and adult), and early intervention services are all included in Clear Health's network. Physical therapy (pediatric), speech-language pathology services (pediatric), and occupational therapy (pediatric) are provided by our subcontractor Health Network One. Specialized therapeutic foster care is provided by our subcontractor Beacon Health Options. Compounding pharmacy services are provided by our subcontractor Express Scripts, Inc. (ESI).

We view subcontractors as valued partners in delivering the highest quality services to members, providers, and the Agency. We work hard to select top-level qualified subcontractors who can best serve our members through a comprehensive vetting process. Additional information on subcontractor oversight can be found below in our response to section 5, Delegation and Oversight of Provider Network Functions.

1.1. Regional Analysis

Region 1 includes Escambia, Okaloosa, Santa Rosa, and Walton Counties. Clear Health has 233 members living with HIV/AIDS in this region.

Clear Health reviews the market consistently and deploys network development to ensure the network meets requirements where the specialty exists. We contract with therapy providers who provide care to both adults and pediatrics and continue our efforts with active network development deployment in identifying and contracting pediatric specific therapy providers in anticipation of new membership assignment including contracting across state/county/regional lines when applicable. We have identified in Region 1 that the below specialties are available for membership within the region for the provider types identified above:

- Pediatric physical therapy: 39 providers
- Pediatric speech-language pathology services: 24 providers
- Pediatric occupational therapy: 26 providers
- Pediatric private duty nursing services: 57 providers
- Intermittent skilled nursing: 12 providers
- Early intervention services: 64 providers
- Specialized therapeutic foster care: 1 provider
- Compounding pharmacies: 1 provider

The plan continues its network development activities to enhance the region's therapy availability. Our network includes the following groups that provide therapy services: Baptist Hospital, Andrews Institute, and Arc Gateway. The plan continues to review the specialized therapeutic foster care option in region 1 and have found membership has access to care in the neighboring region (Region 2). The plan has also engaged with therapy providers and home health agencies

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who are available (contracted) and willing to treat members requiring therapeutic care while living in foster care either at the member's home (via home health) or within the therapy provider's clinics.

Provider recruitment efforts are ongoing. We anticipate all available providers will contract with us prior to roll-out. We will continue to deploy innovative strategies in rural areas including encouraging providers to open additional locations, extend the hours of established practices, and encourage the use of mid-level practitioners, BH coaches, and other physician extenders to increase capacity. We will implement telemedicine solutions where appropriate to support the population. Below we describe our process for identifying and mitigating network gaps.

1.2. Early Intervention and Specialized Foster Care

Early intervention and specialized foster care can be accessed through Florida's Early Steps coordination. Clear Health network providers are experienced in providing early intervention and specialized foster care services. In fact, Clear Health network providers currently provide services through Florida's Early Steps System. They understand the needs of medically complex infants and toddlers.

Our network is capable of offering services to the family and child in the community and is designed to maximize participation and development. We are able to meet these specialized needs in the office or home through our provider network and home health services. Beacon offers specialized therapeutic services through Community Mental Health Centers. We continue to recruit additional providers to assure our network has all the necessary capabilities to meet the needs of this population.

1.3. Private Duty Nursing and Intermittent Skilled Nursing

Regionally there are no gaps for home health. The challenge faced in the more rural as well as in the rural territories of other regions is for home health nurses to be able to cover the travel distance between members.

We have collaborated with our home health partners to increase capacity to mitigate this issue. We have worked hard to establish ongoing, preferential relationships with home health providers. These relationships, which foster a higher level of service and availability, include frequent and open communication. In many cases it has resulted in enhanced levels of staffing at the home health agency. We offer home health providers additional compensation to support home health providers and to make sure members get the care they need when they need it.

1.4. Ongoing Network Monitoring

Clear Health knows that a network composed of high quality providers is key to improved member outcomes, positive member experience, and appropriate utilization of services. We review data from various sources and take action based on analysis of data as well as provider or membership changes. And while comprehensive network data plays an important role in the ongoing management of our network, our hands-on collaborative approach to provider engagement is also a critical source of information allowing us to best meet the needs of our members and providers.

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The Provider Relations department reviews future membership changes and our capacity to provide covered services by establishing ratios to guide growth. Provider Relations develops ongoing network recruitment strategies based on any identified gaps as well as enrollment modeling for future endeavors.

Adequacy reports are reviewed monthly, or ad hoc when a major network change has occurred. We also consider member services data, quality of care and access concerns, HEDIS® data, administrative data, comprehensive analysis of access and availability, grievance and appeals data, and satisfaction surveys.

In addition to our monthly review of adequacy reports, we perform a formal network analysis on an annual basis (Network Development Plan) based on estimated membership for the upcoming year. This annual analysis includes Quest Analytics reports, as well as reports by market from the Gap Committee, which identify network gap issues based on the tracking and trending that was done during the previous year. We immediately start recruiting to locate needed providers should we identify a gap. Network recruitment activities are ongoing until the gap is filled to we have determined that there are no providers available to add to the network. Only after we have exhausted all possibilities to fill the gap do we submit a Waiver Request to AHCA.

The Network Development Plan also takes into account the ease with which care is provided to the member by all providers (including those provided by our subcontractors) by monitoring the number of member and provider complaints, reviewing utilization data to assure members are being seen and assessing the willingness to work with the plan via interactions and meeting requests and correspondence.

1.4.1. Additional Data Sources

We routinely monitor provider adherence to access standards through trending of member and provider complaint data. We accomplish this through communication from managed care coordinator/case manager to the Provider Relations team and review at monthly staff meetings. We also use annual member satisfaction surveys and provider satisfaction surveys to monitor access standards. We also continually monitor and act on information obtained through our Provider Relations, Case Management, Quality Management, and Marketing departments. We discuss this information at Gap Committee and QMC meetings.

Additional methods we use to monitor access standards include:

- Member services data
- Quality of care and access concerns
- Administrative data
- Comprehensive analysis of access and availability
- Grievance and appeals data
- Member feedback
- Provider feedback

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1.5. Gap Committee

Our Gap Committee is our frontline team responsible for monitoring gaps in the network and assuring that network deficiencies are resolved. The Gap Committee includes representatives from Member Services, Grievances and Appeals, Medical Management, Quality Management, Health Services, Provider Relations, and Delegation Oversight. Data from all of these departments is reviewed, aggregated, and analyzed. Short- and long-term interventions are developed and the implementation of each strategy is prioritized based upon the number and type of members impacted, as well as the urgency of the need for the services/provider.

1.6. Capacity to Accept New Patients

We evaluate capacity by identifying providers with open panels and mapping them against our current membership. This allows us to measure access against AHCA access standards. We also use other mechanisms to monitor capacity to accept new members including:

- Dedicated staff make outbound calls to providers requesting updated information for the provider directory which includes whether or not they are accepting new members.
- A monthly fax blast is sent to providers requesting them to review their directory information and submit changes via fax, email, mail, or by informing their Provider Network Manager.
- During the Appointment Accessibility Audit process, information about provider offices not accepting members is captured and forwarded to Provider Relations for follow-up.

Clear Health's network includes more than 3,435 PCPs, of which 393 are in Region 1. Our network of PCPs is more than adequate to meet the needs of our projected membership. Using a ratio of members to PCPs of 750:1, our current network can accommodate statewide membership growth.

1.7. Monitoring Access

Our provider agreements require network providers to abide by all AHCA appointment standards, including standards for after-hours availability. We educate providers on these standards through initial and recurring provider training and the provider manual, which we incorporate by referencing as part of the provider agreement. Our provider newsletters supplement initial orientation training and serve as recurring reminders for timely scheduling of appointments and after-hours availability.

Clear Health conducts wait time and after-hours surveys to monitor network accessibility in compliance with AHCA requirements. Our Quality Management department contracts with an NCQA certified survey vendor to administer the Appointment Accessibility audit. We conduct initial audits in the spring and re-audits of noncompliance in the fall. We will increase the frequency of our access audits to quarterly in compliance with Attachment B, VIII Provider Services, A.8 Timely Access Standards.

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Results are reviewed in Gap and Quality Management Committee (QMC) meetings. We review the results of the audit to make sure services are in compliance with the referenced subsection, and report Primary Care Physician results to the Agency as required in the format specified, in accordance with Section XIV, Reporting Requirements and the Managed Care Plan Report Guide.

1.8. Strategies to Increase Capacity if an Accessibility Issue is Identified

Clear Health's first priority is to make sure that members have timely access to quality care. For issues related to a specific provider we immediately contact the provider to inquire on the access constraints for the member. If the provider cannot serve the member, we help the member identify other available providers within the area to be sure the member gets timely care/service.

Any deficiencies in network access or findings of provider non-compliance with access and availability standards result in interventions focused on resolving any deficiencies. We inform individual providers of any deficiencies and request an action plan. Provider Network Managers monitor and evaluate the action plan to make sure the provider completes the critical tasks according to schedule and that issues do not re-occur.

If our analysis indicates a systemic or regional issue such as a component of our provider network being insufficient, our Provider Relations team develops and implements an action plan. The action plan will identify staffing, responsibilities, resources, and a timeline to correct the situation. We will explore deploying telemedicine to mitigate gaps as a potential solution.

1.8.1. Waiver Requests

Clear Health is committed to providing a complete network for each region. Prior to submitting a waiver request, we confirm that there are no providers available to meet member needs. We review provider directories of other MCOs, Department of Health data, perform a Florida license search, and perform additional online searches. In addition, we perform a zip code analysis to determine the closest provider to the member. We check to see if the provider is in our network (and that they are listed appropriately in our provider directory) and outreach with an invitation to join the network if the provider is non-participating.

Next, we evaluate our participating PCPs to determine the pattern of care. Clear Health makes every attempt to accommodate the member with providers in adjacent regions/ counties and provide transportation when needed. We continue to monitor the region for any new providers or facilities that may be available to render services.

In certain situations, such as rural counties where providers may not be available, Clear Health imply submits a waiver request to AHCA. We will continue to work with AHCA to address access issues due to limited availability of some specialties. Our proven process for arranging for care from out-of-network providers through single-case agreements expedites access to medically appropriate care for our members should a service not be available in our network.

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2. MEETING MEMBER NEEDS WHEN A SERVICE IS NOT AVAILABLE WITHIN OUR PROVIDER NETWORK

We are committed to facilitating access to medically appropriate care for our members. While our comprehensive provider network offers an array of accessible and convenient options for members and in almost all cases exceeds required access standards, due to limited availability of some specialties within Florida we occasionally need to refer a member out-of-network for services. Our procedures foster timely access to out-of-network providers so that our members can access the full range of services quickly, regardless of network capacity.

We assure the needs of members are met and covered services are provided, even if we are unable to provide the service through our provider network. If we are unable to provide medically necessary services to a member with our network providers, we cover the services in a timely manner by using providers and services that are not in our network. Education is given to providers on how to interact with the health plan while the member is under their care. In addition, the plan also coordinates/facilitates transportation when needed.

We have a clear and consistent process to resolve these issues in an expedited manner. The process includes communication of issue and time requirements to resolve issue as well as an escalation process to senior management if it appears the issue will not be resolved prior to the deadline. Our Regional Vice President of Provider Solutions is held ultimately accountable for resolution in a timely manner.

2.1. Immediate Interventions

Our first priority is to make sure the needs of our members are met and covered services are provided, even if we are unable to provide the service through our provider network. When a network provider is not available to meet a member's needs, we refer that member to an out-of-network provider and execute a single case agreement. This process does not apply to emergent situations as no referral is required.

To resolve a gap or barrier using a short-term intervention, Provider Network Managers contact a qualified out-of-network provider/specialist in the county or region who can offer the services needed and negotiate a Letter of Agreement (LOA) or a single-case agreement. We verify provider licensure and confirm that the provider does not appear on any governmental exclusion lists. We provide education on how to interact with the health plan while the member is under the out-of-network provider's care. In addition to the measures taken to coordinate care for the member, Clear Health also coordinates transportation when needed.

2.2. Short-term Interventions

We attempt to contract with out-of-network providers used by our members to enhance access and continuity of care. Our Out-of-network Coordination Nurses encourage out-of-network providers to join our network while they are developing the single case agreement. If the provider is interested in joining, the Out-of-network Coordination Nurse coordinates with the Provider Network Manager to follow up with the provider for contracting. At this point, the Provider Relations team negotiates rates in an effort to expedite care and follows up with the provider in an attempt to contract the provider to enhance the participating physician network. As part of our

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network recruitment strategy, we review all single case agreement patterns in our monthly and quarterly meetings in order to proactively engage providers not currently in network.

2.3. Long-term Interventions

A long-term intervention would consist of closing a gap and/or barrier by negotiating a contract with a qualified provider/specialist in the county or region able to offer the services needed.

We assure the needs of enrollees are met and covered services are provided, even if we are unable to provide the service within our provider network. If we are unable to provide medically necessary services to a member via our network providers, we will cover the services in an adequate and timely manner by using providers and services that are not in our network. Our standard process is used to resolve these issues in an expedited manner.

The process includes communication of the issue and time requirements to resolve issue to the team, as well as an escalation process to senior management if it appears the issue will not be resolved prior to the deadline. Our Regional Vice President of Provider Solutions is held ultimately accountable for resolution in a timely manner.

2.4. Telemedicine Solutions

Telemedicine services can play an important role in providing members with ready access to both physical health (PH) and behavioral health (BH) services. Telemedicine is used to support health care when the provider and member are physically separated. Telemedicine can also play an important role in expanding access for members in rural areas where certain specialties might not exist, as well as those in more urban areas of the State for after-hours access to care as an effective alternative to unnecessary use of the emergency department (ED), and for expanding access for members with limited mobility.

Clear Health will cover telemedicine consistent with State regulations and Medicaid program requirements with respect to the provision of services via telemedicine. We will administer our telemedicine program in accordance with the telemedicine coverage provisions specified in the AHCA Standard Contract, including but not limited to the requirements related to technical safeguards, HIPAA, provider training, member choice, and fraud and abuse. We will comply with the telemedicine requirements specified in Attachment B, and will follow Florida Medicaid billing and reimbursement policies, as well as limitations, and restrictions on the provision of telemedicine.

Clear Health's telemedicine strategy is multi-faceted and designed to increase access to care in the above specialties as well as other services that support achievement of the Agency's goals. Our objective is to provide quicker and easier access to primary care, BH, and specialty services through telemedicine, and to address barriers related to travel, thereby reducing potentially preventable events (PPEs) and improving member health outcomes. Our strategies are designed to provide a comprehensive telemedicine solution and include:

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Specialty Teleconsults. Through our strategic partnership with GlobalMed, we will address the lack of adequate access to specialty consultations in rural areas and regions with our innovative pediatric and adult specialty telemedicine consultation solution. We will offer access to telemedicine consultations with locally-based Florida-licensed in-network providers for primary care, and various specialties including cardiology, pulmonology, endocrinology, internal medicine, and licensed mental health clinicians and psychiatrists. We will use a two-way audio/video communication with a secure internet connection from a video-enabled device such as a computer, tablet, or smart phone and/or facilitated presentation site with integrated diagnostic equipment. Patients will have telemedicine access to specialist consultations from PCP offices and other provider-facilitated presentation sites. This capability will support multiple participants, allowing the patient, PCP, and specialist to all participate simultaneously in the telemedicine visit. The member could also engage in a provider visit from the comfort of their home making this process convenient for them. We will offer scheduling for specialty consultations at blocks of time during the week for various specialties and engage with our network providers and members to educate and create awareness of appointment availability. We will also establish strategically located and facilitated community-based outreach center (CBOC) presentation sites in rural regions and areas of the State where access to a PCP location is limited.

LiveHealth Online. Through LiveHealth Online, we will offer our innovative member-direct access solution for urgent care telemedicine. LiveHealth Online facilitates online access through two-way audio/video technology to Florida-licensed, board-certified physicians covering primary care specialties (such as family practice, general practice, pediatricians, internal medicine, and emergency medicine) for consultations on clinically appropriate conditions (such as a cough, fever, or flu). Members can access services through a secure internet connection or an application on their smart phone.

Telemonitoring. Through our strategic partnership with Telemedcare America (TMC) and First Quality Home Care (FQHC) we are developing a pilot to provide telehealth monitoring to members with the goal of reducing utilization and cost. The goals of this pilot program focus on improving outcomes and reducing costs for a selected group of 100 members who suffer from chronic conditions of congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and diabetes, for a six month period. Members will be monitored on an integrated model of service facilitated by TMC and FQHC in order to reduce hospitalizations and maintain control of chronic diseases through specific protocols.

3. MEASURING THE TIME BETWEEN WHEN SERVICES ARE AUTHORIZED AND RECEIVED

Clear Health's Health Services department currently monitors reauthorizations. Health Services monitors when services are approved and authorizations are issued to assure members are seen in a timely fashion. If there is a concern with the length of time between when a service is authorized and when a member is seen, Health Services contacts Provider Relations. Provider Relations speaks with the provider and attempts to secure an earlier visit for the member. Each preauthorization remains open for 60 days. If services have not been received within 60 days a new preauthorization is required.

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We are adapting our process to monitor when services are approved and authorizations are issued to assure members receive services in a timely fashion. On a weekly basis, we will review a report which provides an aging of preauthorizations without a matching service provided. If there is a concern with the length of time between when a service is authorized and when a member is seen (we require that all members are seen within AHCA standards), Health Services will contact Provider Relations. Provider Relations speaks with the provider and attempts to secure an earlier visit for the member. We also confirm delivery of durable medical equipment (DME) items within three business days to make sure member needs are being met.

If the provider is unable to meet the member's need for any reason, and the member is in agreement, Clear Health assists the member in finding another provider with earlier appointment availability. The Provider Network Manager also reaches out to the member's preferred provider to remind them of their contractual obligations.

4. SOURCES INFORMING THE NETWORK DEVELOPMENT AND MANAGEMENT PLAN

4.1. Data Sources

Provider Relations staff diligently monitor network adequacy, anticipate future needs, and promptly identify gaps to make sure that members have access to care and verify we meet AHCA standards. We use our proven techniques to monitor and evaluate our network (including cardiologists, pulmonologists, endocrinologists, internists, psychiatrists, obstetricians/gynecologists, and licensed mental health clinicians) and seek input from various sources (members, providers, AHCA, and other stakeholders) to make sure our members have access to care when and where they need it. Data is reviewed and monitored in Gap Committee and QMC meetings.

We identify gaps in our provider network and collaborate with AHCA to improve access, including encouraging providers to enroll as Medicaid providers. We submit regular and ad hoc provider network reports in accordance with AHCA requirements.

4.1.1. Quest Analytics®

As described earlier in this response, adequacy reports and Quest maps are reviewed biweekly, and reported quarterly at Gap Committee and QMC meetings, and more frequently as an ad hoc report when a major network change occurs. Quest Analytics® is an industry-standard tool specifically designed to measure a member's access to care through a variety of analytical approaches.

A standard Quest report includes the following features:

- **Geographical Overview Maps:** Overview maps display the provider locations in the geographical area requested. We can shade the service area by ZIP code, county, or state for easier interpretation by the end-user.

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- **Provider and Member Location Maps:** Provider/member maps plot members and providers of any or all specialty/specialties – or combinations of both. These maps overlay the provider network against the membership base, with the appropriate radius encompassing each provider to identify geographical coverage in the service area.
- **Member Accessibility Summary:** The Member Accessibility Summary is a data sheet that provides an overview of the entire analysis displayed in the report. It shows the number and percentage of members with or without access. In addition, the Summary displays the top 10 key geographic areas and summary information. The top 10 key geographic areas are determined by the greatest number of members in that area.
- **Access Standard Comparison:** The Access Standard Comparison graph demonstrates the point at which the percentage of members attains compliant status with the specified provider type and defined access standard. The information from this graph can provide a quick evaluation of the strength-of-network in conjunction with the membership.
- **Accessibility Detail:** The Accessibility Detail data sheet provides an in-depth look at the summary information contained on the Accessibility Summary Page. We assess this data on a ZIP code level and display counts of members with and without access to care under the defined access standards. The detail provides the total number of members and providers along with a member-to-provider ratio for the demographic/geographic area analyzed. Additionally, the report continues this detailed analysis of a member's choice of up to five providers and the average distance to achieve that access.

4.1.2. Other Data Sources Used to Monitor Access to Care

In addition to Quest Analytics reports, we use other data sources to monitor access to care and quality of services including:

- **Routine Appointment Waiting Times.** We survey a statistically sound sample across our network quarterly to identify appointment standards and access to services for PCPs, specialists, and behavioral health providers.
- **Member Services data** identifies potential compliance issues. For example, if we receive repeated calls regarding a provider's inaccessibility, we contact the provider to investigate.
- **Quality of Care and access concerns** are investigated as part of our Continuous Quality Improvement (CQI) Program. We review the outcomes of Quality of Care reviews, including Peer Review Committee actions.
- **HEDIS® scores.** The HEDIS hybrid process enables collaboration with providers to improve access and outcomes. Our staff reviews medical records for documentation, access to care, and quality of services during provider visits.

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- Administrative data review and annual comprehensive analysis of access and availability includes analysis of administrative complaints, after-hours availability, survey information, appointment access statistics, Provider Call Center reports, Quest Analytics reports, grievance and appeals data, and provider satisfaction survey results. Data from departments, such as Provider Contracting and Database Administration, Operations, Medical Management, and Quality Management are used in the analysis.
- Grievance and appeals data identify trends at an individual provider level.
- Member satisfaction surveys. Each year, our Quality Management Department engages a qualified organization to administer the most current version of the Consumer Assessment of Health Care Providers and Systems (CAHPS®) survey that queries members on access to care among other key questions.

Any findings of provider non-compliance with access and availability standards result in interventions, focusing on helping improve performance. Our assistance may include working with providers to extend their office hours or expand their practice, or we may recalibrate the member-to-PCP assignments to maximize our network capacity.

4.2. Gap Committee

The Gap Committee, described above, performs a formal network analysis annually and prepares a Network Development Plan based on estimated membership for the upcoming year. This annual analysis includes reports from the market directors. These reports reflect any new trend identified in the market, gaps, and the closure of any gaps or issues identified in the previous year's Network Development Plan.

Clear Health has a detailed and proactive process to promptly address network gaps because we know from experience that network gaps are high on the list of reasons for member dissatisfaction and voluntary disenrollment. Our Gap Committee is our frontline team responsible for monitoring gaps in the network and assuring that network deficiencies are resolved. The Gap Committee includes representatives from Member Services, Grievance and Appeals, Medical Management, Quality Management, Health Services, Provider Relations, and Delegation Oversight.

Each of these departments track and trend member or provider barriers obtaining access to covered services, whether it is appointment availability or a lack of a necessary specialty type in the network. We track and trend claims and encounter data for peaks and valleys that could indicate a provider is at capacity and identify those that are being under-utilized for special investigation into why Clear Health members are not being seen at expected rates for that provider type. We identify issues and determine root causes through the analysis of Quest Analytics data and review of the Provider Network Verification files for ratio analysis.

Each department brings the results of their review of network issues, access challenges, and member and provider complaints to the Gap Committee meetings. We review, aggregate, and analyze data from all of these departments. Short- and long-term interventions are developed and we prioritize the implementation of each strategy is prioritized based upon the number and type of members impacted, as well as the urgency of the need for the services/provider.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

We maintain minutes of each meeting that document estimated resolution dates for the issue and the individual accountable to support for future follow-up. Each Gap Committee meeting results in a prioritization list that is assigned to the Provider Relations department and a recruitment list is provided to each Provider Network Manager. Recruitment updates are reported back to the Gap Committee or to the workgroups by Provider Relations. Recruitment difficulties in high-impact areas are escalated to our Regional Vice President of Provider Solutions for assistance.

The Gap Committee reports network findings, performance metrics, corrective action plans (CAPs), and all other pertinent information to the Quality Management Committee (QMC). Our QMC meeting, led by our Health Services and Quality departments, addresses potential access to care concerns. When members report access issues or complaints about providers, the source department tracks and trends these issues and reports them to the Gap Committee. The Gap Committee reports them to the Quality Management department (and these are included in the Provider's recredentialing review).

5. DELEGATION AND OVERSIGHT OF PROVIDER NETWORK FUNCTIONS

Clear Health views subcontractors as valued partners in delivering the highest quality services to enrollees (members), providers, and the Agency. We work hard to select top-level qualified subcontractors who can best serve our members through a comprehensive vetting process.

5.1. Clear Health Is Responsible for Subcontractor Performance

Clear Health retains sole responsibility for fulfilling SMMC Contract requirements. We are fully accountable for our subcontractors' performance, and will continue our successful Subcontractor Oversight Program. Clear Health will continue to oversee, monitor, supervise, and enforce Contract compliance, as well as promote frequent, open, and effective communication that emphasizes delivery of quality services to members.

Our dedicated Florida-based Vendor Delegation Oversight Group (VDOG) oversees and monitors subcontractor performance. Led by our Staff VP of Operations and System Solutions, VDOG includes four full-time dedicated staff. The VDOG team has support from executive leadership and departments across Clear Health, including Provider Relations, Compliance, Regulatory, Operations, Utilization Management, Member Services, Grievance and Appeals, and Medical Management.

VDOG assigns an Account Manager to each subcontractor to conduct day-to-day management, as well as oversight and review of subcontractor performance using tools such as the monthly Key Performance Indicator (KPI) report.

The Account Manager works in conjunction with Provider Relations to monitor the subcontractor's network development and ongoing network management efforts to confirm continued compliance with AHCA access and availability requirements.

For example, we receive a weekly add/termed provider report from each subcontractor in addition to their monthly full roster submissions. The weekly add/terms provider reports allow us to update our systems to have the most updated provider directory for our members.

EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

In the event we have any concerns of gaps within the subcontractor networks, the VDOG team will immediately bring those gaps to the attention of the subcontractor and request for an updated roster to fill the gap or an action plan outlining efforts being taken to fill the gap. If the subcontractor is unable to fill the gap, we ask them to submit a waiver with all details of attempt to fill their gap.

Due to the unique nature of administering pharmacy benefits, the Pharmacy Performance Oversight Council will continue to monitor the performance of Clear Health's pharmacy subcontractor. This assures performance meets all regulatory and accreditation standards (such as NCQA, CMS, URAC, State and federal regulations).

Third Party Vendor standards are established and must be met to continue participation in our network. Monthly meetings are held with each subcontractor to address any issues at the time and/or develop intervention strategy to remedy the situation. VDOG addresses member complaints and grievances with all of the subcontractors in order to better serve the health plan population. Participation and support are items reviewed as part of our Network Development Plan on a yearly basis.

Clear Health engages our delegated subcontractors with any changes that are or will be implemented. Our delegated subcontractors are required to meet the same standards as the health plan including network adequacy and education. Our subcontractors have established a series of provider trainings as well as other initiatives to improve the communication and knowledge of their providers.

Clearly defined expectations and consistent monitoring of performance against them is a key component of our Subcontractor Oversight Program. Clear Health executes written agreements with each subcontractor that detail the specific scope of services required, performance standards, service level agreements, and reporting responsibilities. The agreements also specify the actions Clear Health will take to address inadequate or substandard performance, such as development of a CAP, use of sanctions, and termination. If at any time performance does not meet requirements, we take action and work closely with the subcontractor toward a resolution and a return to complete and ongoing compliance.

We outline specific service level agreements for each function we delegate to the subcontractor. service level agreements are never less stringent than those required by AHCA in the SMMC Program Scope of Services. If AHCA modifies a standard, we will amend the subcontractor agreement to reflect the change.

Clear Health also at times requires subcontractors to meet service level agreements for areas that do not have a corresponding AHCA requirement. For example, Clear Health requires our transportation subcontractors to meet a 95 percent on time performance metric, a standard that is not a current AHCA requirement.

5.2. Pharmacy Oversight Activities

Responsibility for regular PBM oversight lies with the national Pharmacy Services Compliance and Audit team. Although our pharmacy subcontractor is delegated network credentialing and management functions, Clear Health determines the strategy and makes all oversight decisions. We review pharmacy network adequacy reports to assure compliance with access standards.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

The team receives regular monthly and quarterly reports including data files from the PBM. Assigned business reviewers evaluate reports and data files to determine if the PBM's performance complies with requirements and service level agreements. They review each function either monthly or quarterly, depending on the function, and identify deficiencies or contractual gaps. Functions reviewed include:

- Claim processing accuracy
- Eligibility processing
- Network access
- Prompt payment
- State or federal provider exclusions/sanctions
- Call center performance
- Network audits
- Fraud, waste, and abuse activity
- Drug utilization review
- Delegated functions such as drug recalls

CAPs are implemented to address contractual issues, regulatory/compliance issues, or standing unresolved issues needing resolution. CAPs are formally requested and bi-weekly meetings are held with PBM to review CAP status and discussion of criteria for closure.

5.2.1. Compounding Pharmacies

In order to ensure members have access to compounded prescriptions when they need them, our pharmacy subcontractor's retail networks include many local pharmacies that have compounding capabilities. In addition Express Scripts has contracted with select sterile compounding pharmacies.

Our pharmacy subcontractor's supply chain team ensures that our retail networks continue to meet contract obligations, including the availability of compounding pharmacies. This team evaluates SMMC requests to add specific pharmacies to the network and can provide special reporting, such as identifying pharmacies that offer compounding services.

Our pharmacy subcontractor's Compound Management Program evaluates every ingredient within a compound prescription claim against a list of over 1,000 bulk powders that are targeted within this program, which represent over 95 percent of all compound medication spend. To determine whether a compound is covered or excluded from coverage, Express Scripts' program evaluates every ingredient within a compound prescription, cross matching it to our exclusion and inclusion list.

Our pharmacy subcontractor's highest priority is providing uninterrupted service to members. Their regional home delivery pharmacies provide complete back-up/contingency and redundant capabilities in the event of a disaster at any pharmacy site. Order routing capabilities allow the dispensing of medication from any pharmacy in the national network. In the event of a failure at one home delivery pharmacy, prescription information is easily routed to other pharmacies for fulfillment without significant processing interruption.

EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Their dispensing process allows automatic sorting and isolation of packages by destination ZIP code or shipping carrier, facilitating alternate delivery methods. Express Scripts' maintains relationships with several shipping carriers, reducing shipping carrier failures. The shipping carriers work closely with our pharmacy subcontractor during a natural disaster such as a hurricane, flood, or wildfire to determine alternate delivery or pick-up locations, minimizing delivery disruptions.

The Accredo pharmacy provides prescription compounding for specialty products in a limited capacity. The vast majority of our product portfolio does not require compounding. However, in the rare instance that a specialty medication requires compounding, we will evaluate to determine if we can compound in-house or coordinate with a pharmacy that can provide services.

5.2.2. Oversight Audits

Pharmacy subcontractor oversight includes conducting two formal audits each year. Audits help assure compliance with the Pharmacy Benefits Management (PBM) Services Agreement and State, federal, NCQA, URAC, and Medicaid regulations applicable to PBM functions. The team collaborates with other national business units, including the Reliability Team and pharmacy regulatory mandates subject matter experts, to determine the scope of the audit. Audits are conducted by national staff and/or an external auditing firm. Audit activities may include:

- Developing audit scope in collaboration with the business areas and receiving management approval
- Creating and/or revising audit tools
- Monitoring audit progress and PBM participation/cooperation
- Determining audit deficiencies and opportunities for improvement; if applicable, reaching an agreement with applicable business area and creating a final report
- Collaborating with legal on final audit report
- Collecting PBM documentation for audit deficiencies, tracking until resolution, coordinating information with applicable business and approval for closure, presenting to the Pharmacy Performance Oversight Council for closure

Oversight audit results and CAPs resulting from audits are reported to Clear Health's Compliance Officer.

5.2.3. Pharmacy Oversight Committees

Pharmacy subcontractor oversight and monitoring includes two main committees: the Pharmacy Performance Oversight Council and the Joint Compliance Committee (JCC).

The Pharmacy Performance Oversight Council monitors the overall performance of all delegated functions related to providing pharmacy operational/clinical service solutions and confirms that performance meets all applicable health plan, regulatory, and accreditation standards (such as

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

NCQA, CMS, URAC, State, and federal regulations). The Pharmacy Performance Oversight Council meets at least four times each year and includes representatives from key areas, including UM, Medical Directors, Clinical, Appeals/Grievances, Delegation, Finance, Pharmacy Operations, and EDOM). The Pharmacy Performance Oversight Council was established to:

- Review and analyze performance metrics and information
- Provide recommendations to improve member quality of care and service
- Review and approve PBM oversight audit reports
- Review and approve the PBM's annual UM program, UM work plan, and UM annual report
- Review and approve CAPs
- Supply quarterly reports maintaining linkage between service and clinical
- Assess activities to verify that contract, accreditation, and regulatory requirements are met

The JCC meets every two weeks with the pharmacy subcontractor to discuss new and existing mandates as well as legal, regulatory, and contractual requirements; approve implementation plans to comply with these requirements; and to discuss any legal, contractual, or compliance concerns with the subcontractor and their legal team. If agreement on or resolution to an issue cannot be obtained in the JCC, the issue is escalated.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The adequacy of the respondent's methodology for identifying and resolving barriers and network gaps; including ongoing activities or network development based on region-specific identified gaps and future needs projection.
2. The adequacy of the respondent's plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long-term interventions.
3. The extent to which the respondent's plan includes strategies for measuring the time in-between when services are authorized and when they are received.
4. The extent to which the respondent's update of its network development and management plan is informed by multiple data sources (including complaints, grievances, etc.).
5. The extent to which the respondent's draft network development and management plan addresses the delegation of provider network functions to subcontractors and the oversight of these operations.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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Clear Health Alliance

**DRAFT ANNUAL NETWORK DEVELOPMENT AND
MANAGEMENT PLAN
Region 1**

Prepared by: Provider Relations department

Effective Date:

Revised:

Submitted: 2017

**2017 ANNUAL NETWORK DEVELOPMENT AND
MANAGEMENT PLAN**

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Annual Network Plan

The mission of Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health) is to expand and simplify access to coordinated health care services for enrollees (members) and beneficiaries in government-sponsored programs. We will enable members to achieve optimal health through an outstanding network of providers and high-touch, local customer service delivered with the highest level of respect and service.

As Florida's largest HIV/AIDS specialty plan, Clear Health has extensive experience and qualifications in contracting and servicing networks designed to meet the special needs of this population. We recognize that to develop and maintain a high quality network to serve the HIV/AIDS Medicaid population our company must have the respect and trust of the community.

We know from experience that an integrated provider engagement model is critical to ongoing success. Everyone at Clear Health shares responsibility for interacting with providers in a way that drives superior results and outcomes. All areas within our organization (such as Member Services, Utilization Management, Case Management, Pharmacy, Claims, Quality Management, HEDIS®, and Medical Economics) work with providers to make sure they have the information, tools, and ongoing support necessary to achieve the best outcomes for our members and reduce providers' administrative burden. Across Florida, we support providers with timely communications, effective and informative one-on-one training, user-friendly technical assistance, actionable data and analytical support, and proactive issue resolution to foster continuous improvement and high-quality care.

We understand that a network of high-quality providers is key to improved member outcomes, positive member experience, and appropriate utilization of services. We have designed our engagement model to move providers along the value-based continuum, providing support to advance them through the array of value-based services.

We have developed a provider recruitment strategy and message of inclusivity and collaboration, and have actively provided education and support for the providers who serve our population. Clear Health has built an extensive HIV/AIDS Medicaid network in Florida, establishing close relationships with primary care providers (PCPs), specialists, county health departments, Federally Qualified Health Centers (FQHCs), Regional Health Clinics (RHCs), and teaching institutions. We have been able to recruit PCPs and specialists in infectious disease, cardiology, dermatology, rheumatology, gastroenterology, and endocrinology who have experience in treating patients with HIV disease to become Medicaid providers and contract with us.

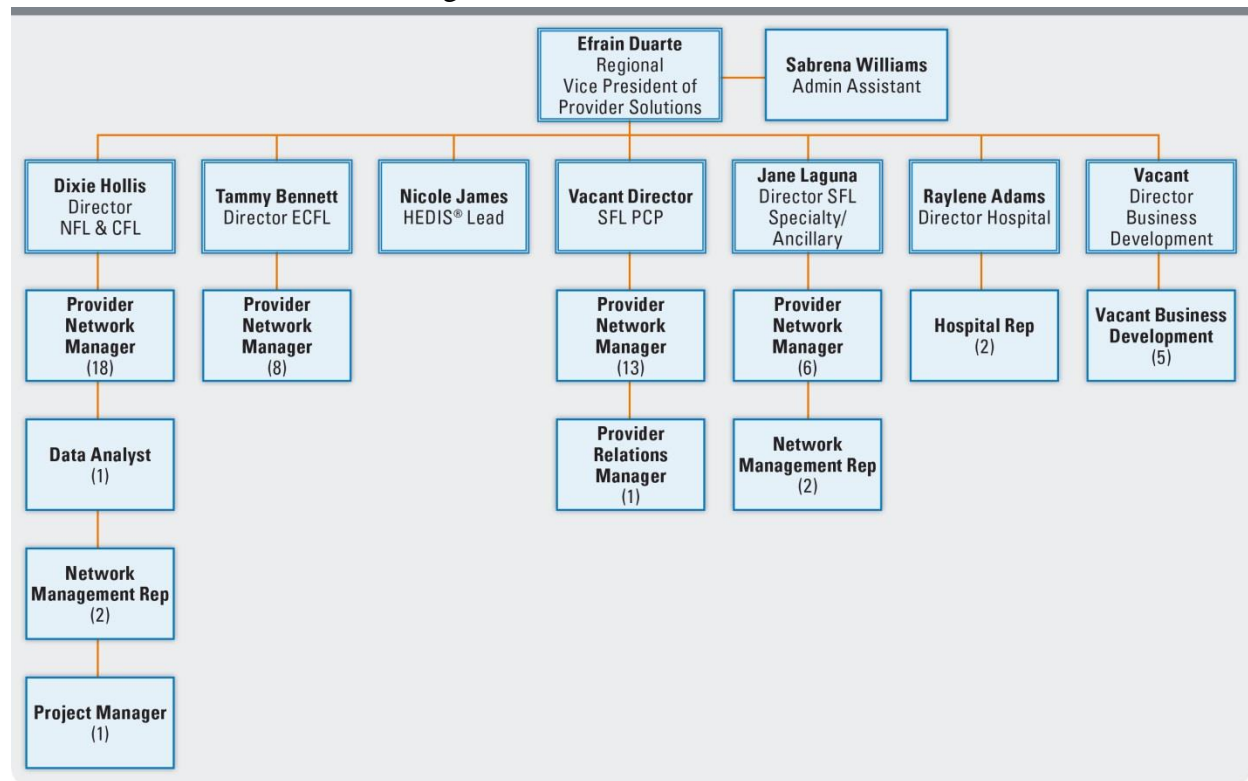
We have developed an intimate understanding of the unique needs of members with HIV/AIDS and the providers needed in their treatment and care. We allow family practice, general practice, pediatric, internal medicine, and infectious disease providers to serve as PCPs. An obstetrician may also serve as a PCP for a pregnant member, if that obstetrician meets criteria for HIV expertise and is willing to participate as a PCP. This broader definition has enabled us to lower member-to-provider ratio requirements to facilitate more frequent and more comprehensive interaction with the members.

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We provide an enhanced level of support to network providers we designate as red ribbon providers. They have specialized HIV/AIDS training and are designated by a red ribbon beside their names in our provider directory, which informs members of their additional specialized HIV/AIDS care and treatment competency. Our red ribbon program is nationally recognized and a testament to our person-centered model of service and support.

Clear Health has established a Network Development and Management Plan (“Annual Network Plan”). It demonstrates our processes for developing, maintaining, and monitoring the Medicaid provider network. We will continue to submit the plan to the Agency every year by September 1.

Our Florida Provider Relations organization chart is included below



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Provider Relations Approach

Clear Health’s collaborative provider engagement strategy transforms health care delivery, creates an integrated system of care, and drives improved access and health outcomes for our members. Our success is anchored by our local, hands-on approach. We meet providers where they are and have been trusted partners through changes in programs, policy and benefits, demographics, cultural needs, and public health initiatives. Our provider engagement model brings us together with our providers by leveraging data, insights, and technology for a common objective – delivering the right care at the right time in the right place.

We embed Provider Network Managers in the regional communities, meeting face-to-face with providers to build trusting, open communication, and develop collaborative relationships. They

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collaborate with providers to improve the effectiveness and efficiency of their practices and identify opportunities to improve care and service. By analyzing quality metrics, utilization trends, and reports for care opportunities, Provider Network Managers help providers coordinate care and create action plans to manage costs and improve quality, performance, and our members' experience while encouraging them to adopt practice management strategies that work for top-performing peers.

Our network management strategy, with its focus on reducing administrative burden and allowing providers more time to take care of our members, includes the following:

- On-demand technical assistance to help providers succeed, such as proactively contacting them if we identify possible submission errors through ongoing claims review
- Proactive education, delivered by a team of professionals focused on Medicaid products, that addresses the specific needs of providers in our network
- Assistance for providers at the point-of-care through actionable information using a variety of delivery methods to help manage members' care, including notifying providers of care gaps through online clinical alerts; providing periodic gaps in care reports for their assigned members; and providing access to our Case Management System that displays HEDIS[®] care alerts, prescriptions, lab results, and more to help identify and address barriers to care and services
- Sound reimbursement practices, including prompt and accurate claims payment and innovative incentive programs that reward providers for improvements in quality measures, leading to improved outcomes
- Practices to simplify and minimize administrative burden, including technology solutions such as online claims and prior authorization submission
- Ongoing collaboration with providers to improve member outcomes
- Educating PCPs on identifying members with behavioral health (BH) needs, including Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Across Florida, we collaborate with network providers and support them with timely communications, effective and informative one-on-one training, user-friendly technical assistance, and proactive issue resolution to foster continuous improvement and high-quality care. Our regionally based Provider Relations staff is located in local communities throughout the state. They know their local communities and the providers in those communities, and they are able to meet face-to-face to build trust, open communication, and collaborative relationships.

A. Processes to Develop, Maintain and Monitor Network

Clear Health maintains an appropriate provider network sufficient to provide adequate access to all services covered under the SMMC MMA Contract. We build our network to reflect the health care needs of our Florida members and our development approach reflects our understanding of the population's unique characteristics as described below.

1. Development

- Clear Health considered the following elements (as required by 42 CFR 438.206) when we established the provider network:

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1. The anticipated number of members
 2. The expected utilization of services, taking into consideration the characteristics and health care needs of the specific Medicaid population represented
 3. The numbers and types (in terms of training, experience, and specialization) of providers required to deliver the covered services
 4. The numbers of network providers who are not accepting new members
 5. The geographic location of providers and member, including distance
 6. Travel time, the means of transportation ordinarily used by members and whether the location provides physical access for Medicaid members with disabilities
- Clear Health developed our plan for each region by determining network gaps. We use various means to regularly monitor the network and identify any barriers and gaps in care. Our Gap Committee is the primary method for reporting identified gaps in the network and making sure they are resolved. Our Directors are responsible for resolving network gaps and are accountable for any delays. The Gap Committee meets quarterly with department representatives from Member Services, Medical Management, Quality Management, Health Services, Provider Relations, Grievances and Appeals, and Delegation Oversight
 - Each of these departments tracks and trends member or provider disputes with access to covered services, whether it is appointment availability or a lack of a necessary specialty type in the network. We also track and trend claims and encounter data to identify peaks and valleys that could indicate a provider is at capacity and identify those underutilized to investigate why Clear Health members are not seen at expected rates for that provider type. Data from all of these sources is aggregated and prioritized based upon the impact, number of affected members, and urgency of the requested services. Documented minutes of each GAP Committee meeting include accountable individual and estimated dates for issue resolution for follow-up. Gap Committee meetings result in a prioritized list for the Provider Relations department and, when necessary, a recruitment list for each Provider Network Manager. Provider Relations reports recruitment updates to the Gap Committee and difficulties in high-impact areas are escalated to the Regional Vice President of Provider Solutions for resolution assistance.
 - In addition, we consider the wishes of current providers in our network. When new providers join our network, we ask for their preferred referral specialists and providers and proactively add those to the recruitment list. This preserves the new provider's established referral patterns and supports continuity of care for assigned members. Additionally, as the Provider Network Manager meets regularly with providers, we continue to request information on referral specialists to keep current with changes and new providers who may have started practice in the community.

2. Maintaining

To maintain our network, Clear Health reviews data from various sources and takes action based on provider or membership changes, including:

- When members report access issues or complaints about providers, they are tracked and trended by the source department, reported to the Gap Committee and Quality Management (QM) department, and included in the providers' recredentialing review.

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- When Clear Health recognizes a network gap, we identify prospects in the affected area and work to close the gap and address the barrier by negotiating a contract with nearby providers of that specialty as a long-term intervention. During the contracting and negotiation process, we will execute a letter of agreement (LOA) or single-case agreement to meet the needs of members in that region who may require those specialty services. This is a short-term intervention, because our ultimate goal is to fully contract and credential the providers.
- Clear Health monitors any future membership changes and our capacity to provide covered services. We are also responsive to new gaps and adjust network recruitment strategies accordingly.

3. Monitoring

- Adequacy reports and Quest Maps are presented quarterly to the Gap Committee, and more frequently as an ad hoc report when a major network change occurs
- The Gap Committee performs an annual formal network analysis (Annual Network Plan) based on estimated membership for the upcoming year. This analysis includes reports from directors. Reports reflect any new trend identified in the market, gaps, and the closure of any gaps or issues identified in the previous year's Network Development Plan
- Clear Health takes into account the accessibility and availability of our contracted ancillary providers, such as Beacon (BH), DentaQuest (dental), ESI (pharmacy), EyeQuest (vision), contracted hospitals, and specialty providers. This is accomplished through the review of member and provider complaints, Quest Analytics access reports, and quality management and utilization reports
- In addition, Clear Health meets regularly with contracted ancillary providers to review their performance and service standards. Our Director of Statewide Ancillary Contracting and the Subcontractor Oversight Director are included in these meetings.
- The Subcontractor Oversight team is responsible for the contracts and service overviews of all subcontractors. Ancillary providers and subcontractors are held to the same standards that Clear Health is required to uphold. Compliance with standards is determined via pre-delegation audits and annual audits thereafter. Standards must be met to continue participation in our network. We hold monthly meetings with each subcontractor to address deficiencies, concerns, and issues, and discuss intervention strategies, as necessary, to remedy the situation.

Provider Relations employees diligently monitor network adequacy, anticipates future needs, and promptly identify gaps to make sure that members have access to care and we continue to meet AHCA standards. We use our proven techniques to monitor and evaluate our network and seek input from various sources (members, providers, AHCA, and other stakeholders) to make sure our members have access to care when and where they need it.

We identify gaps in our provider network and collaborate with the AHCA to improve access, encouraging providers to enroll as Medicaid providers. We submit regular and ad hoc provider network reports in accordance with AHCA requirements.

Other Data Sources Used to Monitor Access to Care

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In addition to Quest Analytics reports, we use a number of other data sources to monitor access to care and quality of services including:

- **Secret shopper phone calls** are used to collect data from providers in our network regarding appointment availability and access to care, including hours of operation and after-hours availability. We document provider responses to confirm compliance, identify potential quality improvement opportunities, and make sure our system contains accurate information for the provider directory
- **Routine appointment waiting times.** We also consider routine appointment waiting times. Every quarter, we survey a statistically sound sample across our network to identify appointment standards and access to services for PCPs, specialists, and BH providers
- **Member services data** identifies potential compliance issues. For example, if we receive repeated calls regarding a provider's inaccessibility, we contact the provider to investigate
- **Quality of Care and access concerns** are investigated as part of our Continuous Quality Improvement (CQI) program. We review the outcomes of Quality of Care reviews, including Peer Review Committee actions
- **HEDIS® scores.** The HEDIS® hybrid process enables collaboration with providers to improve access and outcomes. Our staff reviews medical records for documentation, access to care, and quality of services during provider visits
- **Administrative data review and annual comprehensive analysis of access and availability** includes analysis of administrative complaints, after-hours availability, survey information, appointment access statistics, provider help line reports, Quest Analytics access reports, grievance and appeals data, and provider satisfaction survey results. The analysis includes data from various departments, such as Provider Contracting, Operations, Medical Management, and Quality Management
- **Grievance and appeals data** identify trends at an individual provider level
- **Member satisfaction surveys.** Each year, our Quality Management department engages a qualified organization to administer the most current version of the CAHPS survey that queries members on access to care and other key questions

Any findings of provider non-compliance with access and availability standards will result in interventions, focusing on helping improve performance. We may work with providers to extend their office hours or expand their practices, or we may recalibrate the member-to-PCP assignments to maximize our network capacity.

B. Network Design by Region and County for the General Population

Clear Health is a Medicaid Specialty Plan for people living with HIV/AIDS. Our network includes all Florida regions, except Region 4.

When developing and reviewing the network in each region, Clear Health considers the member population type, its culture, language needs, members' limited resources and education, as well as the availability of providers in the region and access to them. This member population is

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composed of Medicaid-eligible children and adults of all ages, which include low-income families, persons with limited resources, Aged, Blind, and Disabled persons, and others.

The population requires specialty provider types with the education and experience serving and treating individuals diagnosed with HIV/AIDS, related disease complications, and co-morbidities. The population also requires BH providers with experience treating individuals with HIV/AIDS and Medicaid.

There are regions in Florida with limited access to certain providers, requiring Clear Health to develop strategies that include access to providers in adjacent regions. This may exceed travel time and distance access standards required in the Contract, and require transportation to these providers.

Clear Health currently serves approximately 9,500 members in our active regions (as of August 2017). The regions vary between very rural and urban areas, with some regions having a mix. The recruitment and contracting was a challenge in regions with rural counties and much easier for the larger urban areas. By having contracts with providers in the larger urban area, we identified patterns of care to enable a member to obtain services when none are available in their area.

Region 1

Region 1 includes Escambia, Okaloosa, Santa Rosa, and Walton Counties.

Our statewide network for the following identified providers includes:

- Cardiologists (pediatric and adult): 1,102 providers
- Pulmonologists (pediatric and adult): 402 providers
- Endocrinologists (adult): 244 providers
- Internists (adult): 1,043 providers
- Psychiatrists (pediatric and adult): 799 providers
- OB/GYNs (adult): 925 providers
- Licensed mental health clinicians (pediatric and adult): 1,880 providers

Our network for Region 1 also includes:

- Physical therapy (pediatric): 39 providers
- Speech-language pathology services (pediatric): 24 providers
- Occupational therapy (pediatric): 26 providers
- Private duty nursing services (pediatric): 57 providers
- Intermittent skilled nursing (pediatric and adult): 12 providers
- Early intervention services: 64 providers
- Specialized therapeutic foster care: 1 provider
- Compounding pharmacies: 1 provider

Provider recruitment efforts are ongoing. We anticipate contracting with all available providers prior to rollout. We will continue to deploy innovative strategies in rural areas, including

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encouraging providers to open additional locations; extend the hours of established practices; and use mid-level practitioners, BH coaches, and other physician extenders to increase capacity. We will implement telemedicine solutions where appropriate to support the population. Below we describe our process for identifying and mitigating network gaps.

Early Intervention and Specialized Foster Care

Early intervention and specialized foster care are currently accessed through Florida's Early Steps System. Clear Health network providers are experienced in early intervention and specialized foster care services. In fact, our network providers currently render services through Florida's Early Steps System. They understand the needs of medically complex infants and toddlers.

Our network is capable of offering services to the family and child in the community and is designed to maximize participation and development. We are able to meet these specialized needs in the office or home through our provider network and home health services. Beacon offers specialized therapeutic services through Community Mental Health Centers CMHCs. We continue to recruit additional providers to make sure our network has all the necessary capabilities to meet the needs of this population.

Private Duty Nursing and Intermittent Skilled Nursing

Regionally, there are no gaps for home health. The challenge in the more rural areas is for home health nurses to be able to cover the travel distance between members.

We have collaborated with home health providers in our network to increase capacity to mitigate this issue. We have worked hard to establish ongoing, preferential relationships with home health providers. These relationships, which foster a higher level of service and availability, include frequent and open communication. In many cases, it has resulted in enhanced levels of staffing at the home health agency. We offer additional compensation to support home health providers and make sure members get the care they need when they need it.

Clear Health focuses on MMA provider training, network expansions, delivering member access to care, and provider encounter data collection and submission. This last year, we continued the focus on improving processes for measuring our provider network performance. With the availability of prior years' claims data experience and two full MMA years of HEDIS® data, Clear Health was better equipped to review collected encounter data and establish network provider performance measures. Using this data and provider-specific performance measures, we identified providers who performed better than their peers in care management, health outcome measures, HEDIS® quality measures, CHCUP scores, medical record reviews, and other measures such as re-admission rates, emergency department (ED) visits, and cost saving.

This past year, Clear Health set higher benchmarks and gave providers tools and strategy training aimed at improving health outcomes.

Inpatient Census Report. We learned that giving providers a daily inpatient report increased the rate of timely follow-up visits after admission, expedited and addressed the treatment of high-

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risk conditions, and prevented readmission. Providers need to know when their members receive inpatient care. One successful initiative is the delivery of an inpatient census report that informed PCPs of a facility admission for members assigned to them. We found that keeping providers informed of inpatient care is critical to overall care of the member and improving health outcomes. Clear Health implemented the automatic delivery of the inpatient census report to high-volume PCPs and we are in the process of rolling this out to the remaining PCP network.

PCP Panel Report. Clear Health continued to deliver the PCP Panel report through our provider portal. This report provides PCPs a list of members in their panel and their contact information. We expect providers to perform outreach to all members and schedule an appointment for a health screening and evaluation.

HEDIS® Dashboard Report. Clear Health continued to send the HEDIS® Dashboard report, providing PCPs with their performance measure rates. This report helps providers identify the procedures to be rendered to the members on their panel.

PCP Capitation Reports. This year, Clear Health identified a gap between our fee-for-service and capitated providers. The percent of encounters received from capitated providers was very low. To mitigate the issue, we sent high-volume providers their capitation reports and checks together to make sure PCPs were aware of our members to improve the health of everyone in their panel.

While consistently maintaining our contractual network requirements, Clear Health strives to continue to foster close relationships with providers who demonstrate quality care, good utilization patterns, better quality outcomes, and cost savings.

Overall, the Clear Health network is very tightly knit because of the sensitivity in treating people with HIV/AIDS. Our case management team has developed relationships with community resources and clinics in each county and has thoroughly identified the pattern of care for each member. They communicate closely with organizations to identify new providers moving into the area that can deliver services to our members.

Section J of the Network Development and Management Plan provides additional details on network status.

C. Evaluation of Prior Year

Below is a description of the evaluation of the prior year's plan, including an explanation of the method used to evaluate the network and reference to the success of proposed interventions and/or the need for re-evaluation:

1. Clear Health uses Quest Analytics reports to determine availability and evaluate the network. The Quest Analytics Software includes the MMA Contract-defined access standards to make sure the network is reviewed against AHCA standards. We also conduct a PCP wait time survey for the purpose of accessibility analysis.

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2. Clear Health reviews individual provider performance measure data upon recredentialing, as well as member complaints, risk management issues, quality reviews, and other key indicators identified in credentialing policies and procedures.
3. Section J of the document provides details of the prior year and Section K provides supporting reports.

D. Description of the Current Status of the Network

1. How Members Access Services

Members receive covered Medicaid and expanded services through our network of providers, specialists, facilities, and ancillary providers. They are able to locate participating providers using the following methods:

- A printed directory available to each member at no charge by calling the Member Services line or accessing the member website
- A provider directory available on the member website, searchable by name, specialty type, county, and zip code
- A call to the Member Services line to request assistance or a printed copy of the directory
- A call to a Case Manager or Disease Manager (when enrolled in a case or disease management program) for help locating a provider and arranging care
- The ID card that identifies the name of members' PCPs and phone number to call should the member have any questions about accessing care
- New member welcome calls upon becoming Clear Health members, making sure they have a PCP, as well as explaining how to access care when needed. This process also helps us identify members who would benefit from case or disease management
- An after-hours Nurse help line where members can interact with a nurse who helps them with advice and recommendations for seeking treatment aided by decision support software
- Opportunities for members to communicate with us at all approved community outreach events, as well as through our Mobile Medical Units staffed by licensed providers

In addition, PCPs receive training and education during onboarding that reviews how members access services. PCPs also receive a list of specialty and ancillary providers so they may assist members in the selection, when necessary.

2. Analysis of Timely Access to Services

On an annual basis, Clear Health conducts PCP wait time and after-hours surveys to monitor network accessibility. We conduct initial audits in the spring and re-audits of noncompliance in the fall. For those in a Case or Disease Management program for medically complex cases, the Case Manager will help schedule the member's first visit. We also provide PCPs a monthly roster of new members they can use to initiate contact to schedule their first visit.

The status of the network is monitored quarterly through review of Quest Analytics reports and analysis of their trends and data. Reviews of Internal Ratio network reports and Agency Ratio network reports occur every other week to assure ongoing compliance with MMA contract

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requirements. (In the annual submission to the State, we will include our Current Network Status report.)

3. Partners

Relationships between the various levels, focusing on provider-to-provider contact and facilitation for PCPs, specialists, hospitals, as well as BH providers, assisted living facilities (ALFs), and home health agencies.

During the recruitment and network maintenance process, determining the relationship between the PCPs, specialists, and facilities within an area is crucial to identifying patterns of care. As mentioned above, when a new physician joins our network, we request a list of preferred referral specialists and facilities and proactively add them to the recruitment list. Not only does this help maintain established referral patterns in the area, it also supports continuity of care for members. The local Provider Relations team meets regularly with network providers to stay current with changes in the area and facilitate relationships between all entities involved with the provision of care to our members.

4. Communication Tools

The assistance and communication tools provided to PCPs when they refer members to specialists and the methods used to communicate availability of this assistance to the providers.

We give all providers a provider handbook when they join the network. Clear Health has a website and provider portal, both used to furnish resources necessary for delivering care to our members. We send fax blasts and policy updates on an ongoing basis to communicate new information or remind providers of a process or change. These communications are typically also available on the website. We advise providers of all available resources during initial training, ongoing education, and through their assigned Provider Network Manager. Each year, we send providers a CD with updated documents for their review and a reminder to visit our websites.

E. Current Barriers and Network Gaps

1. The Methodology Used to Identify Barriers and Network Gaps

Clear Health uses various methods to regularly monitor the network and identify barriers and gaps in care. As mentioned earlier, the Gap Committee is the primary means of reporting identified gaps in the network and confirming that they are resolved. Directors are responsible for resolving the network gaps and held accountable for any delays. Experience has shown that network gaps are one of the primary reasons for member dissatisfaction and voluntary disenrollment. As a result, we have a detailed and proactive process to address network gaps with a heightened sense of urgency.

The quarterly Gap Committee meetings incorporate all departments that interact with network providers and members, such as Member Services, Health Services, Grievances and Appeals, and Provider Relations. The different departments bring results of their reviews of network issues, access challenges, and member and provider complaints to the meetings. We review, aggregate, and analyze data from all of these departments to identify issues and determine the root causes. We develop interventions to resolve issues and gaps and prioritize the

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implementation of each strategy based upon the number of impacted members, as well as the urgency of need for the services or provider. Meeting minutes track anticipated completion dates, responsible parties, required follow-up, and final resolution of issues.

2. Accommodating Additional Members and Assuring Access Standards Compliance

If our membership exceeds our current network's capacity, we use several methods to deliver access to the services members need, including:

- Communication to current network providers about their ability to service more members
- Coordinating transportation for members to see necessary specialty providers that are not available in their area
- Recruiting out-of-network providers to participate in our network
- Referring members to out-of-network providers for care via a single-case agreement

3. Immediate Short-term Interventions to Address Network Gaps

To resolve a gap or barrier using a short-term intervention, Provider Network Managers outreach to a qualified provider or specialist able to offer the needed services and work to negotiate a letter of agreement (LOA) or a single case agreement. We provide education on how to interact with Clear Health while the member is under his or her care.

4. Long-term Interventions to Fill Network Gaps and Resolve Barriers

A long-term intervention would consist of closing a gap or barrier by negotiating a contract with a qualified provider or specialist in the county or region able to offer the services needed.

We make sure member needs are met and covered services are provided, even if we are unable to deliver the service within our provider network. We will cover medically necessary services in an adequate and timely manner by using providers and services that are not in our network. We maintain a standard process to resolve these issues in an expedited manner.

Our process includes communication of the issue and resolution time requirements to the team, as well as an escalation to senior management if it appears the issue will not be resolved prior to the deadline. The Regional Vice President of Provider Solutions is ultimately accountable for resolution in a timely manner.

Various departments may identify issues and each department has a method to escalate to the appropriate Provider Relations staff. The issue is communicated verbally and in writing. The Provider Relations Director assigns a representative to negotiate a single-case agreement or LOA, guaranteeing reimbursement of services to out-of-network providers while we are unable to provide the medically necessary covered services within our network. If it appears that the issue will not be resolved in a timely manner, it is escalated to the Vice President of Provider Relations for resolution. Issues that cannot be resolved are escalated to the President and CEO and Chief Medical Officer.

In addition to the measures taken to coordinate care for the member, we also coordinate and facilitate transportation when needed.

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5. Outcome Measures/Evaluation of Interventions to Fill Network Gaps and Resolve Barriers

We monitor and evaluate interventions using an interdisciplinary model that includes all necessary departments. All information is reported to the Gap Committee that develops performance measures and monitors progress until resolution. Each measure and outcome is specific to the issue, region/county, and line of business. The Gap Committee considers issue indicators when developing outcome measures, evaluation, and time frames.

6. Projection of Changes in Future Capacity Needs, by Covered Service

The Provider Relations department reviews membership changes, projects growth, and reviews our capacity to provide covered services using internal ratios and MMA contractual requirements to confirm compliance with network adequacy. The team is also charged with developing ongoing network recruitment strategies based on current gaps, as well as enrollment projections. The Gap Committee reviews adequacy reports quarterly or ad hoc when a major network change occurs. In addition, the Gap Committee performs a formal network analysis annually and prepares a Network Development and Management Plan based on estimated membership for the coming year. This annual analysis includes Quest Analytics reports that identify network gap issues from tracking and trending done during the previous year. The Network Development and Management Plan also takes into account the ease in which care is provided to members by network ancillary providers (such as BH, dental, and specialty providers) by monitoring the number of member and provider complaints, reviewing utilization data to confirm that members are being seen, and assessing willingness to work with the plan through interactions and meeting requests correspondence.

7. Ongoing Activities for Network Development Based on Identified Gaps and Future Needs Projection

Each Gap Committee meeting results in a prioritization list that is assigned to the Provider Relations department and a recruitment list for each Provider Network Manager. Provider Relations reports recruitment updates to the Gap Committee each month and escalates recruitment difficulties in high-impact areas to the Vice President for resolution.

F. Committees

The Gap Committee promotes communication and coordination among internal departments pertaining to network development and adequacy. The committee consists of representatives from Member Services, Quality Management, Health Services (including utilization, case, and disease management), Grievances and Appeals, and Provider Relations, with each presenting on behalf of his or her department. Issues are tracked and trended, and short- and long-term interventions are developed and monitored to completion. The Gap Committee reports network findings, performance metrics, corrective action plans (CAPs), and all other pertinent information to the Quality Improvement Committee and Compliance Committee.

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G. Description of Coordination with Outside Organizations

Clear Health maintains a community presence by working closely with local organizations. We support our relationships with these partners through frequent outreach and visits to offer pertinent health care information and resources. During these visits, we focus on methods to inform members of their health care options, provide educational materials, and offer updates of various community events. Our objective for outreach is creating an open forum to obtain feedback from the community in the form of questions, concerns, and suggestions pertaining to situations they may be encountering. This enables us to better address members' concerns and offer further support to our community.

Clear Health works closely with community organizations that also service our members. We contract with Rural Health Clinics (RHCs), FQHCs, and County Health Departments (CHDs). We also have an agreement with the Statewide Healthy Start Coalition to provide outreach and educational services to our pregnant members. In addition, we work closely with the Florida Assertive Care Teams (FACT) and the PAC AIDS Waiver programs to provide care for our most vulnerable members. We refer them to these and other identified community organizations to assist with the coordination of additional non-Medicaid covered and wrap-around services available to them.

While working with community organizations, we are also able to obtain leads on providers who serve the population for recruiting opportunities.

H. Continuity of Care Waiver

A. Per the MMA Contract, if Clear Health is able to demonstrate to the Agency's satisfaction that a region as a whole is unable to meet network requirements, the Agency may waive the requirement at its discretion in writing. However, as soon as additional service providers become available, we shall augment its network to include such providers in order to meet the network adequacy requirements.

Clear Health is committed to providing a complete network for each of its MMA regions. In certain situations, such as rural counties where providers may not be available, we will approach AHCA to request a waiver. We will also make all attempts to accommodate the member with providers in adjacent regions and provide transportation when needed.

In addition, following the implementation of the MMA Program, the Agency began issuing quarterly Facility/Group/Organization Waivers applicable to specific regions and counties. We monitor the providers, facilities, groups, and organizations in each region and county to make sure that we contact any new qualified entities that come into the market and add them to our network when possible.

B. If Clear Health is unable to provide medically necessary services to a member through its network, we will cover these services in an adequate and timely manner by using providers and services that are not in the Clear Health network for as long as needed to provide the medically necessary services.

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As mentioned previously in this document, we make sure the needs of members are met and covered services are provided, even if we are unable to provide the service within our provider network. In those cases, we will cover the services in a timely manner using providers and services outside of the network. We have a standard process to resolve these issues in an expedited manner.

Our process includes communication of issue and resolution time requirements to the team, as well as an escalation process to senior management if it appears the issue will not be resolved prior to the deadline. The Regional Vice President of Provider Solutions is ultimately accountable for resolution in a timely manner.

Issues may be identified within various departments and each has a method to escalate to the appropriate Provider Relations employee. The issue is communicated verbally and in writing. The Provider Relations Director assigns a representative to negotiate a single-case agreement or LOA, guaranteeing reimbursement of services to out-of-network providers while we are unable to provide the medically necessary covered services within our network. If it appears that the issue will not be resolved in a timely manner, the issue is escalated to the Regional Vice President of Provider Solutions. Issues that cannot be resolved are escalated to the President and CEO and Chief Medical Officer.

In addition to the measures taken to coordinate care for the member, Clear Health will also coordinate and facilitate transportation when needed.

I. Regional Network Change Requirements

A. Clear Health has procedures to address changes in the network that negatively affect members' ability to access services, including access to a culturally diverse provider network.

In the annual submission to the State, we will include our most recent policy for handling and reporting regional network changes.

B. Clear Health will provide the Agency documentation of compliance with access requirements at any time there has been a significant change in regional operations that would affect adequate capacity and services, including the following:

1. Changes in Managed Care Plan services
2. Enrollment of a new population

In the annual submission to the State, we will include our most recent policy for handling and reporting regional network changes.

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C. Clear Health will notify the Agency within seven business days of any adverse changes to its regional provider network. An adverse change is defined as follows: For MMA, adverse changes to the composition of the network that impair access standards as specified in the MMA Exhibit.

In the annual submission to the State, we will include our most recent policy for handling and reporting regional network changes.

D. Significant changes in regional network composition that the Agency determines negatively impact member access to services may be grounds for Contract termination or sanctions as determined by the Agency and in accordance with Section XI, Sanctions.

In the annual submission to the State, we will include our most recent policy for handling and reporting regional network changes.

If at any point during our regular network analysis we identify a change that affects the ability of members to access services, we will immediately notify the Agency. The notification will include information on how we will accommodate the members impacted by the change and make sure covered services will continue to be rendered, including access to a culturally diverse provider network and translation services. We report adverse changes to the Agency within seven days when the change causes more than five percent of members in the region to change their PCP or when there is a decrease in the total number of PCPs by more than five percent. We also provide an impact analysis to the Agency whenever changes in services are made, when there are adverse changes, and upon request.

J. Regional Network Analysis

1. Challenges and Barriers

Region 1- Hospital or Facility with Birth/Delivery Services and Hospice

Some of the major challenges and barriers involve sensitivity about the members we serve and how they impact other patients or clients. Providers in some of these areas feel they do not have adequate resources and time to handle our members. This issue is more evident in many of these rural counties since there are limited or no providers. There are many providers who have refused to contract with us because of the potential risk. We continue our efforts to contract with providers to develop and maintain a complete and comprehensive network.

Our network meets or exceeds the provider capacity ratios in all specialties except respiratory therapy (RT). Our network is currently lacking in RT therapy in each county. The cause of this gap, as has been described to the Agency in the past, is that therapists work for facilities and will not contract independently with health plans. As they are considered part of medical staff, Medicaid ID and National Provider Identifier (NPIs) are not always available for this provider type. We continue efforts to contract respiratory therapists.

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(In the annual submission to the State, we will include our SMMC Network Waiver Request Report).

2. Out of Network Usage

Clear Health manages and reviews out-of-network usage on a monthly basis and reports trending analysis to the Gap Committee every quarter. A review of the first three quarters of 2017 demonstrates low utilization of out-of-network providers. With membership less than 5,000, we averaged 29.1 LOAs for the year. There was no identified trend of LOA providers because services were approved as needed for all members. Integrated Home Care Services, Inc., (IHCS) a durable medical equipment, infusion therapy and home health provider, accounting for over 50 percent of our LOA volume. This was a result of contractual changes between providers in our network and IHCS.

Clear Health adds data to previous months' data to identify any high or low indicators. (In the annual submission to the State, we will include our LOA Statistics Report as reported to the Gap Committee).

3. Network Adequacy

Region 1 includes Escambia, Okaloosa, Santa Rosa, and Walton Counties.

Our statewide network for the following identified providers includes:

- Cardiologists (pediatric and adult): 1,102 providers
- Pulmonologists (pediatric and adult): 402 providers
- Endocrinologists (adult): 244 providers
- Internists (adult): 1,043 providers
- Psychiatrists (pediatric and adult): 799 providers
- Obstetricians/Gynecologists (adult): 925 providers
- Licensed mental health clinicians (pediatric and adult): 1,880 providers

Our network for Region 1 also includes:

- Physical therapy (pediatric): 39 providers
- Speech-language pathology services (pediatric): 24 providers
- Occupational therapy (pediatric): 26 providers
- Private duty nursing services (pediatric): 57 providers
- Intermittent skilled nursing (pediatric and adult): 12 providers
- Early intervention services: 64 providers
- Specialized therapeutic foster care: 1 provider
- Compounding pharmacies: 1 provider

Clear Health uses Quest Analytics to determine time and distance network adequacy based on the ratio and time and distance requirements per specialty required under the Contract. Traditionally, ratio and time and distance analysis were generated from software called Geo Networks. Although Geo Networks and Quest perform the same functions, we could not replicate the Agency's result using Geo Networks. To adequately monitor contract requirements,

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we purchased Quest Analytics, the same software currently used by the Agency and CMS, allowing consistent monitoring and reporting of our networks. We run analysis bi-weekly and reported every quarter to the Gap Committee and before a significant provider termination to confirm adequate coverage.

Requests for waiver are submitted to the Agency using the approved template, including detail around ratio and time and distance waiver requests and details on geographic and provider make-up of the area. (In the annual submission to the State, we will include our SMMC Network Waiver Request, Gap Committee Minutes, and Quest analysis).

4. Member Experience

The Grievance and Appeals department also provides analysis to the Gap Committee. A review of 2017 complaints and grievances did not identify trends specific to any provider type. The highest percentage of Medicaid grievances is for access to care at 36.9 percent, due partially because of dissatisfaction with Medicaid limits. This is consistent with the highest percentage of appeals, which are for Medicaid deny, and limit authorization. Unfortunately, although we educate members on the reasons for denial, it leads to grievances and perceived issues with quality of customer service.

Our Member Advisory committee (MAC) assures a mechanism is in place for obtaining member input into our QI Program and its priorities. This includes receiving member feedback on the provider network and their satisfaction with the network. In the past year, the MAC did not present any network concerns to the Gap Committee. The MAC meets at least annually for each line of business. (In the annual submission to the State, we will include our Medicaid Grievance and Appeals Log).

In addition, Clear Health makes sure that National **Standards** for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) measures are met for the member population with emphasis on languages. Clear Health currently meets the language requirements for our population. Our monitoring and results report provides information over the past year. (In the annual submission to the State, we will include our Cultural Competency report.)

The MAC assures provider offices are maintained in line with facility requirements. Providers must receive a passing site visit prior to initial credentialing and maintain compliance, which is verified no less than every three years.

5. Provider Complaints

Provider complaints are presented and analyzed each quarter at our Gap Committee. Depending on the issue, short- or long-term interventions are discussed.

A review of the provider complaints received in the second quarter of 2017 demonstrated an increase in the number of complaints related to claims payment and service authorizations. A review of the complaints did not reflect any significant trends as to the cause of this increase, because there were multiple complaint types. We continue to monitor provider complaints related to claims and authorizations. (In the annual submission to the State, we will include our monthly Provider Complaint report.)

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6. Provider Survey

Clear Health greatly improved our provider satisfaction survey method in 2016. We increased distribution of surveys by 70 percent with the help of a new subcontractor, Morpace. This allowed us to obtain valuable and actionable data to create effective action plans. We list a few of the initiatives below, and we include action plans as part of our supporting documents.

The survey was distributed to 1,000 providers. We conducted the annual survey using a mixed mode methodology (mail, telephone, and Internet). The initial mailing in March 2017 consisted of a cover letter, self-addressed envelope, and survey. The letter informed providers of the option to complete the survey online. A second survey was mailed in April 2017 to all providers who had not returned the original survey. In May 2017, provider offices that had not responded to the survey were called and the survey conducted telephonically. Two hundred and fifty-seven surveys were completed for a response rate of 25.7 percent. Morpace conducted a key driver analysis that identified items with the most significant impact on provider satisfaction and dissatisfaction. The results were presented to the Gap Committee who used the key driver analysis identify items needing an action plan.

The provider satisfaction survey tool measures the following:

- Claims processing and provider reimbursement
- Utilization Management
- Quality Management
- Disease Management
- Provider services
- Communication and technology
- Continuity and coordination
- Provider help line
- Complaint resolution
- Provider enrollment process

The results and analysis of the surveys were shared with the Provider Relations, Health Services, Claims, and Credentialing departments. Results were also presented to the Gap Committee, Quality Improvement Committee, and Board of Directors.

Strengths

Strengths are those items that have a high impact on providers' satisfaction and small room for improvement. The following five measures received the highest satisfaction ratings in the 2017 Provider Satisfaction Survey:

- Satisfaction with provider orientation and training process
- Satisfaction with the timeliness of information to coordinate care
- Satisfaction with the knowledge of the Provider help line staff
- Satisfaction with the helpfulness of the complaint resolution staff
- Satisfaction with the accuracy of information to coordinate care

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Opportunities

Opportunities are areas that have the highest impact on the provider's overall satisfaction with and have the highest room for improvement. These items include:

- Rate the quality and effectiveness of general provider communications
- Rate the quality and effectiveness of the provider handbook
- Rate the quality and effectiveness of the provider newsletters
- Rating of the quality of case management services regarding continuity and coordination of care

We created a detailed action plan to address opportunities for improvement. (In the annual submission to the State, we will include our Provider Satisfaction Action Plan.)

7. HEDIS®

Clear Health prepares a full set of HEDIS® measures annually using the analysis and reporting of data collected through medical record review, claims, and encounter data (such as laboratory, pharmacy, and health care utilization). Network providers share health care data with us so that we can generate accurate and complete reports. As part of this annual data collection, the Quality Improvement department requests access to medical records and charts to abstract specific HEDIS® information.

Following NCQA technical specification, the HEDIS® Roadmap is the tool used to describe how information collection practices affect HEDIS® data reporting. The Roadmap provides preliminary information for the contracted auditor to conduct the audit.

We contract with a CMS and AHCA approved NCQA-certified HEDIS® audit firm or auditor.

HEDIS® reports are certified by the HEDIS® auditor, and the auditor must certify the actual file submitted to AHCA and CMS. The HEDIS® auditor is responsible for ensuring the HEDIS® production process adheres to the regulatory agencies requirements and specifications. The auditor is available to assist with the HEDIS® Roadmap development and completion. Onsite visits by the auditor to Clear Health occur at least annually.

Clear Health annually evaluates the HEDIS® and CAHPS results to determine the effectiveness of the Quality Improvement Plan, the quality of our network providers, and to identify opportunities for improvement, implement corrective actions and interventions such as provider and member education and outreach, and development of Performance Improvement and Quality Improvement projects.

We report the results of the evaluation and any interventions to the Quality Management Committee and Board of Directors.

Clear Health collects, analyzes, and reports quality performance measures as defined by the Agency. We also collect internal service performance data that measures the quality of service delivered to all members and providers. This includes data related to Member Services line phone metrics and problem resolution timeframes, member and provider complaints, grievances and appeals, utilization rates, authorizations, referrals, and claims processing time standards.

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These measures are reported, tracked, and trended through our quarterly Quality Improvement Committee meetings.

Clear Health also collects the following information:

- Access to care (such as Quest Analytics reports, appointment availability surveys, service and benefit utilization rates, and timeliness of referrals or treatment)
- Improvement in the member's health status such as quality of life indicators, depression scales, or chronic disease outcomes
- Comprehensive health assessment that includes accuracy of acuity stratification, safety indicators, or timeliness of initial assessments or annual reassessments
- Implementation of an individual plan of care (rate of participation by multi-disciplinary team members and beneficiaries in care planning)
- Use and adequacy of a provider network having targeted clinical experience via claims review, pharmacy claims, and diagnostic reports
- Delivery of add-on services and benefits that meet the specialized needs of the most vulnerable members (such as frail, disabled, or near the end-of-life)
- Provider use of evidence-based practices and or nationally recognized clinical protocols
- Effectiveness of communication, such as call center utilization rates, rates of beneficiary involvement in plan of care development, analysis of member or provider complaints

In the event of an ongoing failure by a provider to meet our health information standard, the provider-specific data is incorporated into the provider re-credentialing and re-contracting processes (or earlier, if necessary). During the HEDIS® session, 90 percent of providers were able to provide records to support the required measures. Please refer to the Provider Interventions section below that illustrates the steps taken by our Provider Relations team to outreach to the providers about required metrics and importance of capturing data.

We evaluate the results of the HEDIS® and CAHPS annually to determine the effectiveness of our disease management programs and case management activities. This evaluation process is part of a comprehensive system to track all quality improvement data and results to track member outcomes and experience of care.

We will develop and apply strategies to address the results. We may implement quality improvement strategies that include feedback to providers, regular prioritization of measures, and goals to ensure that the quality measures are appropriate for the member population.

The results of the evaluation and any interventions implemented are reported to the QMC and Board of Directors.

To allow members to be able to perform a reliable comparison of performance among different managed care plans, we publish HEDIS® measures results on our website.

(In the annual submission to the State, we will include our Quality Evaluation.)

An intervention process was identified to send providers their scores; it is currently being rolled out to the network.

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8. Provider Specific Performance Monitoring

Clear Health monitors the quality and performance of each network provider. At the beginning of the Contract period, we will notify all network providers of the metrics we use to evaluate performance and determine continued participation in the network.

We monitor the quality and performance of participating providers, including the use of nationally accepted performance measures (HEDIS®) and use certified software to extract data and develop provider profiles by provider and measure.

In addition to HEDIS®, we use other measures of access to care and services, disease management and monitoring measures, as well as preventive services. We also address provider performance issues, including contract termination, when necessary.

Clear Health performs ongoing activities to monitor and improve provider performance, promote education, as well as promote improvements in the quality of care and services delivered by providers in our network.

We maintain two essential provider monitoring processes: Peer Review and Medical/Case Record Review.

In addition to the Peer Review and the Medical/Case Record Review, we perform the following provider monitoring activities:

- Provider profiling using HEDIS® accredited performance measures
- “Secret shopper” calls to providers
- Investigation and tracking potential Quality of Care concerns through complaint and occurrence reporting
- Monitoring access, availability, and cultural competence
- Monitoring continuity and coordination of care
- Monitoring appropriate utilization of services
- Promoting member safety
- Monitoring of subcontractors
- Member satisfaction survey and complaint analysis

9. Provider Interventions

Each month QM provides the Provider Relations department with a list of members who have not had a child health check-up in compliance with the periodicity schedule, sorted by enrollment date. Provider Network Managers discuss results from this report with providers, focusing on providers who have large lists of non-compliant members. We encourage providers to contact non-compliant members and attempt to schedule well-child visits.

We include provider education on CHCUP and dental screenings in the provider handbook and newsletters, as well as performed during onsite visits by Provider Network Managers and medical record reviewers. We send fax blasts to providers to remind them about non-compliant members and correct CHCUP coding requirements.

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10. Appointment Access Times and After Hours

We conduct an Appointment Availability Survey quarterly and submit results to the Agency by February 1. The QI department audits using calls to PCP offices to verify compliance and provides the Provider Relations department with providers who need intervention or education because they are not meeting one or more standards. Failure to comply when re-audited may result in termination.

Providers were audited to determine the accessibility and availability of appointments for members. The Appointment Availability Survey was administered in two waves: PCPs and BH providers (8/17/16 through 8/30/16) and pediatricians (9/8/16 through 9/19/16). The following appointments types were assessed:

- (1) Urgent care
- (2) Routine sick care
- (3) Well care
- (4) Initial visit routine care
- (5) Follow-up routine care
- (6) Non-life threatening emergent care
- (7) Wait time

Interviewers utilized a prepared script that identified Clear Health during the call. The script included scenarios for each type of appointment and was tailored for the type of provider.

Interviewers listed multiple choice response options to help guide schedulers' answer format. Morpace compared the response to Clear Health's standards to determine compliance for each appointment type.

Telephone calls were placed during normal business hours: 8:30 a.m. to 5:30 p.m. EDT.

After-hours Surveys were conducted 8/17/16 through 8/26/16 weekdays between 5:30 p.m. and 9:00 p.m. Morpace surveyed a random sample of providers in the Florida providers in our network. Noncompliant providers from 2015 may be included in the random sample. Noncompliant providers from 2015 were re-surveyed in 2016, either as a part of the random sample or through census dialing all remaining noncompliant providers after the random sample quotas was achieved. Prior to dialing, Morpace "cleaned" the database so that there would be only one record for each phone number even though other providers shared the same number. After the survey was conducted, Morpace extrapolated the After-hours Survey data collected to all remaining providers at the same number. Because of this extrapolation, the total number of providers after extrapolation is greater than the actual number of surveys conducted.

In 2016, the Provider Appointment Access and After Hours Survey results performance standard of greater than 90 percent was met. (In the annual submission to the State, we will include analytics from a Gap presentation.)

11. Delegated Vendors

Clear Health retains sole responsibility for fulfilling SMMC Contract requirements. We are fully accountable for our subcontractors' performance, and will continue our successful Subcontractor Oversight Program. Clear Health will continue to oversee, monitor, supervise, and enforce

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Contract compliance, as well as promote frequent, open, and effective communication that emphasizes delivery of quality services to members.

Our dedicated Florida-based Vendor Delegated Oversight Group (VDOG) oversees and monitors subcontractor performance. Led by our Staff Vice President of Operations and System Solutions, VDOG includes four full-time dedicated staff. VDOG has support from executive leadership and departments across Clear Health, including Provider Relations, Compliance, Regulatory, Operations, Utilization Management, and Medical Management.

VDOG assigns an Account Manager to each subcontractor to conduct day-to-day management, as well as oversight and review of subcontractor performance using tools such as the monthly Key Performance Indicator (KPI) report.

The Account Manager works in conjunction with Provider Relations to monitor the subcontractor's network development and ongoing network management efforts to confirm continued compliance with AHCA access and availability requirements.

For example, we receive a weekly add/termed provider report from each subcontractor in addition to their monthly full roster submissions. The weekly add/terms provider reports allow us to update our systems to have the most updated provider directory for our members.

In the event we have any concerns of gaps within the subcontractor networks, VDOG will immediately bring those gaps to the attention of the subcontractor and request for an updated roster to fill the gap or an action plan outlining efforts being taken to fill the gap. If the subcontractor is unable to fill the gap, we ask them to submit a waiver with all details of attempt to fill their gap.

Due to the unique nature of administering pharmacy benefits, the Pharmacy Performance Oversight Council will continue to monitor the performance of Clear Health's pharmacy subcontractor. This assures performance meets all regulatory and accreditation standards (such as NCQA, CMS, URAC, State, and federal regulations).

Subcontractor standards are established and must be met to continue participation in our network. Monthly meetings are held with each subcontractor to address any issues at the time or develop an intervention strategy to remedy the situation. Participation and support are items reviewed as part of our Annual Network Plan.

Clear Health engages our subcontractors with any changes that are or will be implemented. Our subcontractors are required to meet the same standards as network providers including network adequacy and education. Our subcontractors have established a series of provider trainings as well as other initiatives to improve the communication and knowledge of their providers.

Clearly defined expectations and consistent monitoring of performance against them is a key component of our Subcontractor Oversight Program. Clear Health executes written agreements with each subcontractor that detail the specific scope of services required, performance standards, service level agreements (SLAs), and reporting responsibilities. The agreements also specify the actions Clear Health will take to address inadequate or substandard performance, such as development of a CAP, use of sanctions, and termination. If at any time performance

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does not meet requirements, we take action and work closely with the subcontractor toward a resolution and a return to complete and ongoing compliance.

We outline specific SLAs for each function we delegate to the subcontractor. SLAs are never less stringent than those required by AHCA in the SMMC Program Scope of Services. If AHCA modifies a standard, we will amend the delegation agreement to reflect the change.

Clear Health also at times requires subcontractors to meet SLAs for areas that do not have a corresponding AHCA requirement. For example, Clear Health requires our transportation subcontractors to meet an on-time performance metric, a standard that is not a current AHCA requirement. In addition, Clear Health sent subcontractors a survey to make sure they were addressing and reporting Access and Availability according to Contract requirements. All subcontractors explained their process and addressed compliance requirements. We will use the document in upcoming audits as part of the subcontractors' annual review.

We requested the following information:

1. Explain how you identify network gaps time/distance standards and availability when panels are closed
2. What strategies will you deploy to increase provider capacity to meet member needs where network gaps have been identified?
3. Describe how you ensure members receive timely access to services by measuring the time from when services are authorized to when they are received
4. What recruitment strategies and retention efforts are planned for each provider type and include quality and performance metrics used to determine provider's success?
5. What methodology is used to identify and resolve barriers for network gaps? Please also include strategies used to support ongoing monitoring activities for your provider network
6. How do you meet the needs of the member if you are unable to provide the service within your provider network? Please include your approach for long-term and short-term solution
7. What is the average wait time for an urgent appointment?
8. What is the average wait time for a routine appointment?

(In the annual submission to the State, we will include information on our vendors/subcontractors).

12. Telemedicine

Telemedicine services can play an important role in providing members with ready access to both physical health (PH) and behavioral health (BH) services. Telemedicine is used to support health care when the provider and member are physically separated. Telemedicine can also play an important role in expanding access for members in rural areas of Florida where certain specialties might not exist, as well as those in more urban areas of the state for after-hours access to care as an effective alternative to unnecessary use of the emergency department (ED), and for expanding access for members with limited mobility.

Clear Health will cover telemedicine consistent with Florida state regulations and Medicaid program requirements with respect to the provision of services via telemedicine. We will

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administer our telemedicine program in accordance with the telemedicine coverage provisions specified in the AHCA Standard Contract, including but not limited to the requirements related to technical safeguards, HIPAA, provider training, member choice, and fraud and abuse. We will comply with the telemedicine requirements specified in Attachment B, and will follow Florida Medicaid billing and reimbursement policies, as well as limitations, and restrictions on the provision of telemedicine.

Clear Health's telemedicine strategy is multi-faceted and designed to increase access to care in the above specialties as well as other services that support achievement of the Agency's goals. Our objective is to provide quicker and easier access to primary care, BH, and specialty services through telemedicine, and to address barriers related to travel, thereby reducing potentially preventable events (PPEs) and improving member health outcomes. Our strategies are designed to provide a comprehensive telemedicine solution and include:

Specialty Teleconsults. Through our strategic partnership with GlobalMed, we will address the lack of adequate access to specialty consultations in rural areas and regions with our innovative pediatric and adult specialty telemedicine consultation solution. We will offer access to telemedicine consultations with locally-based Florida-licensed in-network providers for primary care, and various specialties including cardiology, pulmonology, endocrinology, internal medicine, and licensed mental health clinicians and psychiatrists. We will use a two-way audio/video communication with a secure internet connection from a video-enabled device such as a computer, tablet, or smart phone and/or facilitated presentation site with integrated diagnostic equipment. Patients will have telemedicine access to specialist consultations from PCP offices and other provider-facilitated presentation sites. This capability will support multiple participants, allowing the patient, PCP, and specialist to all participate simultaneously in the telemedicine visit. The member could also engage in a provider visit from the comfort of their home making this process convenient for them. We will offer scheduling for specialty consultations at blocks of time during the week for various specialties and engage with our network providers and members to educate and create awareness of appointment availability. We will also establish strategically located and facilitated community-based outreach center (CBOC) presentation sites in rural regions and areas of the state where access to a PCP location is limited.

LiveHealth Online. Through LiveHealth Online (LHO), we will offer our innovative member-direct access solution for urgent care telemedicine. LHO facilitates online access through two-way audio/video technology to Florida-licensed, board-certified physicians covering primary care specialties (such as family practice, general practice, pediatricians, internal medicine, and emergency medicine) for consultations on clinically appropriate conditions (such as a cough, fever, or flu). Members can access services through a secure internet connection or an application on their smart phone.

Telemonitoring. Through our strategic partnership with Telemedcare America (TMC) and First Quality Home Care (FQHC) we are developing a pilot to provide telehealth monitoring to members with the goal of reducing utilization and cost. The goals of this pilot program focus on improving outcomes and reducing costs for a selected group of 100 members who suffer from chronic conditions of congestive heart failure (CHF), chronic obstructive pulmonary disease

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(COPD), and diabetes, for a six month period. Members will be monitored on an integrated model of service facilitated by TMC and FQHC in order to reduce hospitalizations and maintain control of chronic diseases through specific protocols.

K. Reports

In our submission of our Annual Network Plan to the State, we will include the most recent versions of reports and policies.

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D. PROVIDER EXPERIENCE

MMA SRC# 12 – Provider Credentialing (Statewide):

The respondent shall describe its proposed process to credential and recredential providers (including subcontractors' processes, if applicable), including credentialing timeframes, internal continuous quality improvement initiatives for recredentialing, transparency for providers on their application status and the steps the respondent or its subcontractors will take to ensure the respondent and the Agency have accurate provider demographic information in-between credentialing cycles.

Response:

Credentialing network providers is an important component of our contracting and quality management process. We use it to confirm that all our contracted providers and organizations are qualified to provide services and deliver the best possible care to our enrollees (members). We have the systems, employees, and policies and procedures in place to accurately and promptly credential and re-credential the full spectrum of providers in compliance with AHCA. While all providers are required to undergo credentialing, we give particular focus to providers serving in the primary care role for our members with HIV/AIDS. We include an Education/Training Attestation for participation as an HIV/AIDS PCP as part of the credentialing packet to assure competence with treating the population.

While we understand the importance of a thorough credentialing process, we also understand the importance of minimizing providers' administrative burden and providing clear communication during the credentialing process. Our turnaround time statistics and provider satisfaction ratings are evidence of our success. Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance (Clear Health) significantly exceeds the industry standard of credentialing in 120 days with consistent performance of 95 percent of clean credentialing files completed within 45 days. In 2016, they received a satisfaction rating of 93 percent when providers were asked to rate our provider credentialing process.

1. CREDENTIALING AND RECREDENTIALING PROCESS

Clear Health retains sole responsibility for fulfilling Contract requirements. Our Florida team is fully accountable for meeting all credentialing requirements and will continue to oversee, monitor, supervise, and enforce Contract compliance locally. Our Provider Network Managers will continue to provide hands-on support to providers through the entire credentialing process; it is a best practice we will be bringing forth to our combined organization.

We received feedback from our providers that credentialing was an issue for them and that they often felt lost in the process once they submitted their application. In response to our providers, we implemented a process that has resulted in our high satisfaction scores. A Provider Network Manager supports the provider through the entire credentialing process.

Providers submit their credentialing packets directly through mail, email, or in person to a Provider Network Manager. The Provider Network Manager reviews the packet against a standard

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checklist and follows-up with the provider to rectify any incomplete items prior to submission. This step has resulted in an 85 percent increase in processing clean credentialing applications. The Provider Network Manager maintains contact and provides updates to the provider throughout the process so that the provider's credentialing process is transparent.

Providers can submit our proprietary application or a Council for Affordable Quality Healthcare (CAQH) application. The Provider Network Manager reviews the information for completeness and accuracy. For example, if a provider submits documentation into the CAQH Universal Credentialing DataSource® and attests to its accuracy, we are able to review the application for completeness or ask for additional information if the provider failed to fully complete the application. We also help non-traditional providers complete credentialing applications as we typically credential beyond the required provider types to include any provider who provides direct care and services and is not facility- or hospital-based.

We regularly review and update our comprehensive credentialing policies and procedures in accordance with NCQA standards, federal, and Agency requirements. We continually refine our processes and incorporate new resources and tools to simplify and expedite the credentialing and re-credentialing process to make sure it is as easy as possible for providers by reducing their administrative burden. We have streamlined the credentialing and contracting processes through our participation with the Council for Affordable Quality Healthcare (CAQH) Universal Provider DataSource® initiative. Clear Health is enrolled with CAQH's various products including primary source verification and ongoing monitoring. We will continue to collaborate with CAQH and support its efforts to integrate additional solutions that simplify the credentialing application processes.

Our regionally based Florida Provider Relations team makes onsite visits to providers' offices to review and assist them through the credentialing process. Our goal is to facilitate transparency in the credentialing process to providers, assisting providers and office managers in navigating the process and assuring a point of contact to reach out to for questions/concerns. We also provide other resources to assist providers, such as our Credentialing Quick Tips, documents which provide clear and concise instructions on each step of the process.

1.1. Preventing Discrimination in Provider Selection

Our credentialing policies and processes comply with 42 CFR 438.214(c), and we do not discriminate against a health care professional solely on the basis of license or certification or a health care professional who serves high-risk populations or who specializes in the treatment of costly conditions. Clear Health partners with providers who serve high-risk populations as demonstrated through our Clear Health Alliance product to find effective cost and clinical methods to treat patients.

1.2. Credentialing Committee

Our Chief Medical Officer (CMO), in conjunction with the National Credentialing Committee, is responsible for setting clinical competence and conduct criteria for the entire provider network via this policy making body. Our CMO is a member of Anthem's (our ultimate parent company) national Credentials Committee. Locally, we have a Florida Credentialing Committee, which includes no less than two participating Florida licensed physicians, one of whom practices in the

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specialty type most frequently used by members. These physicians also operate within the scope of the credentialing program.

1.3. Types of Providers Credentialed and Re-credentialed

We credential and re-credential individually licensed providers who are contracted in our provider network to provide services. We credential or re-credential facilities or organizational providers who have oversight of staff working within such place of service. The organizational provider is responsible for credentialing and re-credentialing all network providers in accordance with NCQA, federal, and Agency standards.

Our credentialing and re-credentialing processes meet and exceed NCQA accreditation requirements, as well as federal and Agency credentialing guidelines. For example, we credential and re-credential organizational facilities extending beyond NCQA requirements, such as renal dialysis centers and nursing home facilities. Our credentialing and re-credentialing processes monitor quality of care and patient safety for providers and facilities and make sure our provider network is qualified and able to provide the best care possible to our members by eliminating preventable potential quality of care issues.

1.3.1. Red Ribbon Providers

Participation as an HIV/AIDS red ribbon designated PCP requires that the provider attest that they meet the criteria to care for our members in one of the following ways:

- AAHIVM HIV specialist credentialed by the American Academy of HIV Medicine
- Board certified in the field of infectious disease and, if not certified in the past year through the American Board of Medical Specialties, has clinically managed a minimum of 25 patients in the preceding 12 months and successfully completed a minimum of 10 hours of continuing medical education (CME), with at least five hours related to antiretroviral therapy in the past year.
- Recognition by the Florida/Caribbean AIDS Education and Training Center as having sufficient clinical experience and additional on-going training in HIV/AIDS to be considered a specialist
- Meet the criteria of an HIV-qualified physician as defined by the HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America or demonstrates experience as an HIV qualified provider set by AHCA standards

If a provider chooses the last option listed above, they must complete a questionnaire that demonstrates continuous professional development by meeting defined qualifications as follows: in the immediately preceding 36 months, provided continuous and direct medical care or direct supervision of medical care to a minimum of 25 patients with HIV AND in the immediately preceding 36 months, successfully completed a minimum of 40 hours of Category 1 continuing medical education addressing diagnosis of HIV infection, treatment for HIV disease and co-morbidities, and/or the epidemiology of HIV disease, and earned a minimum of 10 hours per year, OR in the immediately preceding 12 months, completed recertification in the subspecialty of infectious diseases with self-evaluation activities focused on HIV or initial board certification in infectious diseases.

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In the 36 months immediately following certification, newly certified infectious diseases fellows should be managing a minimum of 25 patients with HIV and earning a minimum of 10 hours of category 1 HIV-related CME per year, OR providers must demonstrate experience as an HIV-qualified provider by showing evidence of continuous development through clinical, behavioral, or case management of at least 20 HIV-infected patients in the past two years with a minimum of eight contact hours annually of HIV-specific continuing medical education (CME) that includes information on the use of antiretroviral therapy.

We identify providers meeting criteria in our directories with a red ribbon and designation that "Provider is an HIV PCP" as a footnote on each page.

1.4. Initial Professional Provider Credentialing

Our credentialing process uses our proprietary application or the Uniform Credentialing/Re-credentialing Provider Application through the CAQH Universal Provider DataSource® to capture all required data elements. It is compliant with NCQA and consistent with federal and Agency requirements.

We conduct Primary and Secondary Source Verification on the information submitted by the provider in accordance with NCQA accrediting standards and federal and Agency requirements. Policies and procedures guide our credentialing process. The process includes assessment of the applicant's training and education to training requirements established by the Credentialing Committee. If a practitioner fails to meet training requirements, we notify the provider of the educational requirement, advise the provider of the committee decision, and thank the provider for their application. We query and obtain information from the following:

- The National Practitioner Databank to determine if any disciplinary actions have been taken against the applicant in addition to any settled/closed malpractice cases
- The Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (LEIE) database
- System for Award Management (SAM) — the official federal system that consolidates the capabilities of EPLS, CCR/FedReg, and ORCA
- Various Florida Department of Health Licensing Boards as applicable
- Equivalent licensing boards for out-of-state providers and other applicable licensing entities
- Hospital Privileges
- Provider Identifiers
- Quality Competence

Our requirements meet and exceed NCQA standards, providing us an excellent framework to assess the clinical competence of each network provider and to make sure we apply standards consistently. We conduct site visits as required for any facility that does not have an accreditation

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or Medicare survey or that is identified on the Health Resources and Services Administration shortage designation list. In addition, Clear Health makes sure providers are eligible to participate in the Medicaid program.

Our policies and procedures comply with Florida and federal laws and regulations, including 42 CFR 438.214 and 42 CFR 1002.3.

Our credentialing process also includes a site visit for several provider types. Site reviews are required for all PCPs (which include Family Practice, General Practice, Pediatrics, Internal Medicine, and Infectious Disease PCPs), Women's Health Care Providers, OB/GYNs, Assisted Living Facilities, Adult Family Care Homes, and Adult Day Health Care Providers. Beacon, our Behavioral Health subcontractor, performs site visits for High Volume Behavioral Health Providers.

Once our Credentialing department receives a provider's credentialing application, a Provider Network Manager will schedule an office site visit. The provider must have a review score of 100 percent to pass the review for the initial credentialing application process. In the event the provider does not receive a passing score, Clear Health implements a corrective action plan. We work with the provider to develop the plan and resolve issues. The Provider Network Manager will revisit the provider within 60 days to make sure all deficits have been corrected. Failure to comply will result in termination.

1.5. Exclusion and Debarment Screening

Clear Health has established processes to make sure excluded providers are not included in our network. Clear Health frequently processes the lists of providers currently excluded by state and federal governments. Our subcontractors and providers must comply with all federal requirements (42 CFR 1002) on exclusion and debarment screening as well. Clear Health requires that all tax reporting provider entities billing or receiving Medicaid funds through our Contract screen all owners and employees against the federal exclusion databases such as OIG, LEIE, and SAM.

To support credentialing standards during credentialing and between re-credentialing cycles, we have an ongoing monitoring program to verify continued compliance with credentialing standards. Clear Health utilizes this method to assess and address any issues of substandard professional conduct or competence, including fraud, waste, and abuse issues, for providers and facilities/hospitals. We review our providers initially, monthly, and during re-credentialing against OIG, LEIE, and SAM. Provider contracts also contain language indicating any individual employed under the provider involved in providing services to the member must not be sanctioned by any state or federal databases. As part of the federal requirements, we also screen any individual identified as having five percent or greater interest in the provider practice monthly as documented on the Disclosure of Ownership Form. The Program Integrity department reviews reports from various sources, including:

- OIG, LEIE, and SAM
- Federal Medicare/Medicaid Reports
- Office of Personnel Management
- Office of Contracting and Procurement
- State Licensing Boards/Agencies

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- State Exclusion List
- Medicare Opt-out Lists
- CAQH Ongoing Monitoring
- Health plan functional areas, as appropriate

We also consider any other verified information received from appropriate sources.

Monthly screening assures a timely response to sanctions or actions. Clear Health immediately takes action to remove the provider from our network. If we identify this sanction or action at the time of receipt of the initial credentialing application, we notify the provider that he or she is ineligible to participate in our network.

When we identify a network provider by these sources, we use formal criteria to assess the appropriate response, which may include review by the Credentialing Committee, by the CMO, and/or legal counsel. If Clear Health identifies any potential quality of care issues via its various departments, we report practitioners to the appropriate authorities.

1.6. Reporting

Policies and procedures guide our process for reporting serious quality deficiencies resulting in suspension or termination of a practitioner to the appropriate Florida and federal authorities, including the Secretary of Health and Human Services and the Inspector General of Health and Human Services, National Practitioner's Database, and state agencies. Internally we utilize weekly and monthly reporting and tracking tools via Bridger, which is a software utilized to review sanctions received from various exclusion websites. The review is nationwide; each state receives monthly updates with actions taken and notices sent to providers.

1.7. Re-credentialing

Our re-credentialing program complies with the federal, State, and NCQA standards. Our process includes re-verification of required elements including re-verification of licensure(s), sanctions, certifications, clinical privileges, and competence, as reviewed by malpractice history and license history, as well as health status that could affect the practitioner's ability to serve our members. We conduct re-credentialing at a minimum every 36 months, unless an event triggers a re-review — such as a medical director request following a quality of care complaint. The process follows the initial credentialing process outlined above and includes other information such as a review of member and provider complaints and medical records quality. We present additional information on re-credentialing in our response to Section 4 below. We review and incorporate the following performance information into the re-credentialing process, as applicable:

- Member grievances and appeals
- Member satisfaction surveys regarding provider experience
- Results of quality reviews
- Utilization management
- Quality improvement and medical management activities
- Other plan-specific data as available and applicable, including medical record audits
- Re-verification of hospital privileges and current licensure, if applicable
- Provider Complaints

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2. TIMEFRAME FOR PROCESSING CREDENTIALING APPLICATIONS

Clear Health significantly exceeds the industry standard of credentialing in 120 days with consistent performance of 95 percent of clean credentialing files completed within 45 days. We are able to achieve reduced turnaround time due to our efficient system integration with various primary data sources that allow downloading of data from industry leading solutions such as CAQH and alleviate the data entry delay, while making sure all documents are primary and/or secondary source-verified according to established standards. We leverage our contract and credentialing software system to assist in the data collection process, review, and tracking. In addition, we have implemented a series of operational processes such as checklists, business rules, and administrative form improvement to assure we receive complete documentation at the time of credentialing. We assist providers by streamlining our process and simplifying administrative process to expedite credentialing process.

Clear Health has developed the Provider Administration department, geared toward assisting the Provider Network Manager to complete the credentialing packets. Provider Network Managers also serve as the liaison to our national organization to make sure of proper and timely follow-up. We review all credentialing applications for completeness within four business days. The Credentialing staff then completes a checklist that identifies the missing information and forwards that to the assigned Provider Network Manager to contact the provider to obtain the missing information. Provider Relations leadership and Provider Network Managers receive a weekly report notifying them of pending documentation for each provider. If we do not receive additional documentation from the provider or the Provider Network Manager within 45 days, we deactivate the file and send it back to the Provider Network Manager for closure. The provider can reapply, but they must complete a new credentialing application for the verifications and attestations to be timely per our standards.

3. KEEPING PROVIDERS INFORMED THROUGHOUT THE CREDENTIALING PROCESS

As described above, a Provider Network Manager supports the provider through the entire credentialing process. This enhanced level of support for providers throughout the credentialing process reduces administrative burden as it means less rework and resubmission of applications on the provider end. Clear Health offers a toll-free Provider Services line in which the Provider can call to inquire about their credentialing status. The provider may also communicate with the Provider Administration department via email. Additionally, our high-touch model between the Provider Network Manager and the Provider facilitates lines of open communication and allows the provider to reach out to their Provider Network Manager for status as well.

4. INCORPORATING ADDITIONAL INFORMATION INTO THE RE-CREDENTIALING PROCESS

Our re-credentialing program complies with the Code of Federal Regulations, NCQA, and AHCA standards. Our process includes re-verification of required elements including re-verification of licensure(s), sanctions, certifications, clinical privileges, and competence, as reviewed by malpractice history and license history, or health status that could affect the practitioner's ability to serve our members.

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We report quality deficiencies as well as disciplinary actions from hospitals, other health care entities and governmental agencies or notice of impairment of a provider to the Quality Management department, which in turn initiates the process of Peer Review. In cases where the patient's health is not subject to imminent danger or the provider's ability to practice has not been curtailed by the Board of Medicine, prior to initiating the suspension/termination process, the Peer Review and Quality Improvement committees take action and place the provider on a Corrective Action Plan to improve the provider's performance. Actions to improve performance include education, supervision, curtailing member assignments, ability to meet data-based targets determined by infraction, and reduction of privileges. We initiate the suspension/termination process when efforts to improve performance have not brought about the desired effect. We forward recommendations from the Peer Review and Quality Management to the Credentialing Committee for review and action on the participating status of the provider.

We track providers due for re-credentialing electronically as our system assists with monitoring and tracking. A re-credentialing packet is sent to identified providers approximately eight months prior to the re-credentialing due date. This packet requests standard information and a copy of the provider's most current State licensure(s), professional liability insurance, and other applicable supporting information, including an updated Disclosure of Ownership Form. We ask providers to respond to this written request within 30 days, and we make no fewer than three attempts to each provider asking for this information. If we do not receive information from the provider, we make a second attempt by phone and fax. After an unsuccessful second attempt is made by the Credentialing department, a Provider Network Manager supplements this outreach effort through direct contact with the provider and office staff in order to facilitate the process.

While we close a provider's file for failure to respond after three attempts, our Provider Network Managers will continue to attempt to remove any barriers to completion of the re-credentialing application. For example, if the provider is on leave of absence, we have policies to temporarily close the provider's current credentialing status, update the provider's record in our system so that the provider does not show as available to members, and set a reminder to reach out to the provider upon return from leave of absence.

We conduct primary-source verification in accordance with NCQA and AHCA requirements once we receive all information and provide the information to the CMO and/or Credentialing Committee. After reviewing the information and supporting documentation received, we include an assessment of any available provider performance criteria. The elements we select for review may vary by provider type and the availability of information.

Any historical recommendations from the Peer Review Committee and other departments are included in the re-credentialing process and discussed by the Credentialing Committee. The Credentialing Committee reports to the Quality Management Committee, which in turn reports to the Board of Directors. We provide regular reports to both committees for oversight.

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The Credentialing Committee may make a recommendation including but not limited to reducing privileges, providing education and mentoring, suspending privileges, instituting a probationary period for another re-credentialing event; or recommending termination from the network. Our Legal department is notified of any adverse actions against a provider for the proper notification to the National Provider Database, the Office of the Inspector General, Medicaid Program Integrity, and AHCA. Our Legal department reports to the State Board of Medical Examiners as applicable.

5. INCORPORATING THE AGENCY'S STREAMLINED CREDENTIALING CAPABILITY

Clear Health Provider Network Managers are available to assist providers at each stage of the process of joining our network. Florida requires providers to register with the State prior to including them in our network (online directory and PNV submission to the State). As they meet with potential providers, Provider Network Managers explain how easy it is to register with the State and walk them through the process, explaining all required elements including the submission of prints for background screening via the State's Limited Enrollment Process and Provider Enrollment process. The Provider Network Manager follows up with the provider and provides guidance as they move through the State's process as well as on how to contact the State for resolution of any issues. Once the State registration process is complete, the Provider Network Manager continues to support the provider throughout the credentialing application process.

We are incorporating information on the Limited Enrollment Process into trainings that potential providers can access for instructions on how to enroll with the State. We have previously sent fax-blast to non-participating providers received through claims data for further promotion of this capability. We have also incorporated a bulletin into the Explanation of Payment (EOP) remittance notice that is sent to all providers which references the Agency's website and various methods to enroll.

5.1. Delegated Entities

At times, we elect to delegate credentialing and re-credentialing activities to another entity to reduce provider administrative burden. We delegate credentialing to our subcontractors including Beacon Health Options (BH), Health Network One (therapy services), DentaQuest (dental services), EyeQuest (optometry and ophthalmology services), AIM Specialty Health (radiology), HearUSA (audiology and hearing services), and Chiro Alliance Corporation (chiropractic services). We also delegate credentialing to several of the larger health systems in the State.

We include a description of our delegation oversight responsibilities and an overview of the delegation process in our quality improvement program as well as our policies and procedures. All delegates undergo an initial pre-delegation audit, complete with file audit and policy and procedures review, followed by a committee review and recommendation. Once delegated, each must submit weekly updates (additions, terminations, and changes) and undergo annual re-assessments. We document activities and responsibilities associated with delegated activities in the subcontractor's written agreement. The agreement requires the subcontractor and medical groups to provide reports related to the performance of their delegated activities and other obligations under the agreement, including training. We comply with NCQA standards for delegation oversight.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

6. PROVIDER DEMOGRAPHIC OR PARTICIPATION STATUS CHANGES

Provider data is the foundation for many critical program processes, including our Provider Directory, claims processing/payment, and encounter data submission to the Agency. Clear Health will continue to leverage the established and proven systems, processes, and best practices currently employed in Florida as well as those used by our affiliates to create and maintain accurate provider data. Clear Health utilizes various vendors, such as Availity and Morpace, to assist in making sure accurate provider demographic information.

We capture and maintain in our system sufficient information on SMMC Providers to support Provider payment. We also maintain information to do the following:

- Generate IRS 1099 forms (including maintaining the provider's name, address, and federal identification number)
- Meet all federal and Agency reporting requirements through capturing, storing, and maintaining comprehensive, current, and accurate provider data
- Review re-credentialing data for updates
- Cross-reference State and federal identification numbers and maintain multiple numbers for the provider to support processes to identify and report excluded providers via Bridger. Our exclusion processes use Tax Identification and Social Security Numbers, National Provider Identifier (NPI), name, date of birth, and state Medicaid ID number

Prior to and during the implementation process, we will review all available documentation (the ITN, our Proposal, and report formats) and document all provider data requirements. A thorough understanding of the output requirements for provider data (required fields, field formats, and field values) will continue to guide configuration of data entry validations and quality review checks to promote ongoing compliance with AHCA requirements and quality measures.

6.1. Maintaining Provider Data

Clear Health's Core Operations System maintains comprehensive information on all of our program network providers. Provider data is fully integrated with other system components to support activities such as claims processing/payment, compliance reporting, and Provider Directory management. Maintaining a single, integrated source of provider information enables us to deliver data integrity and consistency. We continually assess the quality of our provider data and have active outreach programs designed to verify the information in our systems. Working closely with our Florida Provider Relations team, our national Provider Data Management (PDM) department will maintain accountability for ongoing data accuracy of Provider information. PDM tightly controls changes to Provider data to protect its accuracy and maintain compliance with Contract requirements. PDM has established teams, systems, and processes to support Clear Health in creating and maintaining complete, accurate provider data for our SMMC Program. Clear Health is able to leverage national initiatives around data (such as Availity) in addition to local plan initiatives, assuring we receive the most up to date information. In addition, Clear Health assures the following:

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

- Accurate Provider Set-Up. Strict processes and Provider data edits and audits validate accurate set-up in our system and accurate entry of changes
- Regular Data Audits and Inspection. Review activities confirm ongoing data accuracy and reliability
- Identification and Reporting of Inaccurate/Outdated Information. We use multiple methods to capture inaccurate/outdated information from members, providers, and employees
- Claims Support. PDM reviews claims that pend because of provider data validation. PDM uses a document management workflow system to accept, route, and track requests, including adding providers, modifying their information (such as address, phone, languages spoken, office hours, office accessibility, and panel status), and terminating them. Workflow logic routes requests to work queues based on factors, including market and complexity, enabling an employee with the required skills and expertise to respond quickly and accurately
- Weekly monitoring of the Provider Master List (PML) for Medicaid ID's

6.2. Accurate Provider Set-Up and Entry of Changes

To complete the provider set-up in our system, our Florida Provider Relations team will collaborate with the PDM. The Provider Relations team submits completed service forms through our workflow system and PDM enters these into our system, taking steps to assure completeness and accuracy of provider entry and set-up in our system.

Based on specific AHCA requirements documented in the Contract, we customize desk-level procedures and checklists by provider type to make sure that we capture all required information during the application process. For new providers, PDM returns forms missing required information (according to business rules). Entry screens apply a series of data entry edits designed to prevent keying errors in fields such as telephone number, NPI, and Medicaid ID number. Edits also flag potential duplicate providers for review. Changes to provider data will follow a similar process.

Each month, the PDM Quality team audits a random sample of provider data (entry of new providers and changes to existing ones). The process validates keying accuracy as well as adherence to processes. Employees promptly correct any identified issues and take steps, such as modifying documentation or educating and training staff, to prevent a recurrence. In addition, Morpace sends out a survey requesting demographic information updates from our provider network, which our PDM department processes.

For all new providers and existing providers with changes to identification numbers and license status, PDM Quality checks the exclusion/sanction databases using the new information. This check is in addition to the exclusion database checks that we perform every 30 days to confirm that excluded providers are not in our network.

EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

6.3. Regular Data Audits and Inspection

Clear Health performs provider data accuracy review using NCQA guidelines as well as federal and State requirements. PDM proactively monitors the ongoing accuracy of data so that it is available to operational processes (such as claims processing), as well as our members through our Provider Directory. Ongoing activities to confirm data accuracy and completeness include the following:

- **Third-Party Evaluation.** PDM performs a periodic evaluation of provider information using a third-party tool, ProviderPoint from LexisNexis, that specializes in provider data accuracy. ProviderPoint uses advanced analytics to mine a vast data repository compiled from their clients, public sources, subscriptions, and outbound provider calls. ProviderPoint evaluates provider data against the repository and returns suggested changes accompanied by a confidence level. PDM updates our systems when suggested changes of certain data elements (telephone and fax numbers, license and DEA number date ranges, and gender) have a 90 percent or greater confidence level.
- **Provider Relations Data Review.** Our Florida Provider Relations team also plays a critical role in validating the integrity and accuracy of provider data, especially that which affects our online Provider Directory or claims payment. The team leverages the best practices of our affiliates to implement a regular data review program, using methods such as verification sheets during Provider visits, mailings, or online survey tools. They evaluate and update the approach (including frequency and methods) as necessary to maintain a high level of provider data accuracy.

PDM regularly evaluates audit practices to identify opportunities to strengthen the integrity and accuracy of Provider data.

6.4. Identifying and Reporting Incorrect/Outdated Provider Information

Clear Health encourages members, providers, and employees to identify and report incorrect or outdated Provider Directory information. In addition to internal quality checks, PDM accepts data change requests from a variety of sources, including:

- Florida Provider Relations employees through day-to-day interactions with providers or regular data quality checks
- Florida Case Management and Care Coordination employees identify incorrect provider services while coordinating care
- Self-service tools on our provider portal, enabling Providers to update demographics and practice information
- Provider calls to our Provider Services line
- Member calls to our Member Services line to report provider data problems

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Changes that come from providers or Provider Network Managers go to PDM for entry. Changes entered through the provider portal will be updated directly in our system, with some exceptions. We route provider data issues reported by members to the PDM Quality team for research and outreach to the provider as necessary. We complete changes submitted to PDM within 30 days.

6.5. Monitoring Subcontractors

Our Delegation Oversight Department has processes in place to assure that our subcontractors report provider demographic or participation status changes to us in-between credentialing cycles. We require our subcontractors to submit information on new and terminated providers weekly. We also require them to submit a roster of all providers monthly. We use this information to monitor providers in our subcontractor's networks and to identify those who are not qualified such as sanctioned or ineligible providers. Should we identify non-qualified providers, we contact our subcontractor and request they be removed from the network. Subcontractor providers must meet the same credential requirements as Health Plan providers, including the requirements that they are eligible to render services to Medicaid members.

Evaluation Criteria:

1. The adequacy of the respondent's description of its credentialing and recredentialing criteria, certified credential verification organization processes, and utilization of a third party credentialing vendor.
2. The extent to which the respondent's timeframes for processing credentialing applications is more expeditious than the industry standard processing timeline of one hundred twenty (120) days.
3. The adequacy of the respondent's approach to providing transparency to providers throughout the credentialing and recredentialing processes, including how providers will be informed at each step of the application process.
4. The extent to which the respondent uses information from provider complaints, monitoring, and recommendations from its Quality Improvement Committee in its recredentialing process.
5. The extent to which the respondent and its subcontractors incorporate the Agency's streamlined credentialing capability (via promotion of limited enrollment) in its credentialing and recredentialing processes.
6. The extent to which the respondent outlines steps the respondent and its subcontractors will take to ensure provider demographic or participation status changes are reported to the plan in-between credentialing cycles.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 13 – Value Based Purchasing (Regional):

- a. The respondent shall describe the continuum of value-based purchasing (VBP) contractual arrangements available for providers, delineated by primary care, specialty care and hospital-based care.
- b. The respondent shall describe the volume of contracts it expects to implement or maintain through a VBP arrangement each year for each of the next five (5) Contract years, delineated by primary care, specialty care and hospital-based care.
- c. The respondent shall include specific outcomes it expects to see throughout the life cycle of the VBP continuum, delineated by primary care, specialty care and hospital-based care.
- d. The respondent shall describe specific VBP arrangements it intends to implement and/or maintain in an effort to promote the Agency's goals, delineated by primary care, specialty care and hospital-based care.

Response:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

[REDACTED]

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EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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EXHIBIT A-4-b

MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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EXHIBIT A-4-b

**MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)**

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The extent to which the respondent has provided the continuum of value-based purchasing arrangements available to network providers, delineated by primary care, specialty care and hospital-based care.
2. The extent to which the respondent has provided specific percentages of overall contracts, delineated by primary care and specialty care and hospital-based care, that it intends to implement or maintain through some type of VBP arrangement for each of the five (5) Contract years, including a rationale for the intended percentages.
3. The extent to which the respondent describes how its VBP arrangements incentivize quality improvement, including specific outcomes it expects at each stage on the continuum.
4. The extent to which the respondent describes how its VBP arrangements incorporate goals or incentives for reduction of potentially preventable events.
5. The extent to which the respondent describes how its VBP arrangements incorporate goals or incentives for improvement of birth outcomes.
6. The extent to which the respondent provides a breakdown of specific VBP strategies employed with its current network of primary care providers.
7. The extent to which the respondent describes the approach in sharing specific data elements with providers under a VBP arrangement and the level of respondent support offered to providers to ensure progression along the continuum of VBP arrangements.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)**

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

E. DELIVERY SYSTEM COORDINATION

MMA SRC# 14 – General HEDIS Performance Measures Experience (Statewide):

The respondent shall describe its experience in achieving quality standards with populations similar to the target population described in this solicitation. Include in table format, the target population (TANF, ABD, dual eligibles), the respondent's results for the HEDIS measures specified below for each of the last two (2) years (CY 2015/ HEDIS 2016 and CY 2016/ HEDIS 2017) for the respondent's three (3) largest Medicaid Contracts (measured by number of enrollees). If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one of three (3) states for the last two (2) years.

The respondent shall provide the data requested in **Exhibit A-4-b-2**, MMA Performance Measurement Tool (10-2-2017) to provide results for the following HEDIS measures:

- Childhood Immunization Status (Combo 3);
- Well-Child Visits in the First 15 Months (6 or more);
- Immunizations for Adolescents (Combo 1);
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life;
- Adolescent Well Care Visits;
- Frequency of Ongoing Prenatal Care ($\geq 81\%$ of expected visits); and
- Timeliness of Prenatal Care.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Based on the ITN requirements, we have submitted HEDIS data for Amerigroup, the Simply legacy plan in Florida with the largest Medicaid membership. Additionally, Amerigroup's membership is more comparable to that of the population from which the Medicaid 50th percentile is derived than the HEDIS® results for Clear Health. Because of its specialized nature, Clear Health is not one of Simply's largest three contracts by membership. In addition, we are reporting results for our two largest affiliate Medicaid contracts, New York and Texas, based upon the number of Medicaid members served by each contract.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1. EXPERIENCE ACHIEVING QUALITY STANDARDS

Simply and our affiliate health plans currently serve more than 6.5 million beneficiaries of state-sponsored health plans in 19 states and the District of Columbia. We collect and report HEDIS® and state performance measures in each of these states. Simply has collected and reported HEDIS® and state performance measures in Florida since we began operations there over 14 years ago, and today we collect and report all required measures to the National Committee for Quality Assurance (NCQA) and Agency for Health Care Administration (Agency).

Simply is further sharpening our focus on quality by bringing together the best practices and innovative solutions of three Florida health plans that have recently merged to become one entity. Our Chief Medical Officer and Quality Management leadership spearhead our Quality program, bringing more than 40 years of combined experience in performance improvement programs and HEDIS® reporting. As a result of this experience, we continue to achieve high marks for performance, as demonstrated in our HEDIS® 2016 and 2017 scores described below and in Exhibit A-4-b-2.

**** RESULTS & SUCCESSES:** Simply's legacy plan, Amerigroup, scored well above the statewide average for HEDIS® 2016 across all 11 components of the Keeping Kids Healthy Quality Indicator and all three components of the Pregnancy-related Care Quality Indicator published in Florida's Medicaid Health Plan Report Card on the State's website, FloridaHealthFinder.gov. Quality of Care Indicators are a set of measures used to report the performance of health plans. Data for these measures came from HEDIS® and were designed for use by Medicaid consumers. ******

Health plan ratings, shown as stars, are assigned to each health plan for each indicator based on the plan's score for the indicator. Plans are assigned between one and five stars, based on the health plans ratings for the associated measure. The designation of stars is denoted below:

- 5 stars – Best: at or above 50 percent of all Medicaid health plans' scores
- 4 stars – Good: better than at least 40 percent of all Medicaid health plans' scores
- 3 stars – Fair: better than at least 25 percent of all Medicaid health plans' scores
- 2 stars – Poor: better than at least 10 percent of all Medicaid health plans' scores
- 1 star – Very Poor: worse than 90 percent of all Medicaid health plans' scores

**** RESULTS & SUCCESSES:** For HEDIS® 2016 scores, we were one of three plans to receive the highest number of 5 stars (seven in total) on 11 components of the Keeping Kids Healthy Quality Indicator and one of three plans to receive a 5-star rating for each component of the Pregnancy-related Care Quality Indicator. We were the only plan to score this well in both Quality Indicators (combined). ******

Per the directions, the following is our experience focusing on the seven HEDIS® measures in this submission requirement.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1.1. Florida Experience Achieving Quality Standards

In the HEDIS® 2016 and 2017 submissions, Simply's legacy plan, Amerigroup, led the state at the NCQA Quality Compass 90th percentile for Frequency of Ongoing Prenatal Care (≥ 81 percent of expected visits) and exceeded the Medicaid 60th percentile for HEDIS® 2016 in all but one measure (Immunizations for Adolescents (Combo 1)).

Childhood Immunization Status (Combo 3) rates of 77.08 percent for HEDIS® 2016 and 80.09 percent for HEDIS® 2017, which exceeded the National Medicaid 75th percentile for HEDIS® 2016 scoring, and the National Medicaid 90th percentile for HEDIS® 2017. For HEDIS® 2016, we reported higher rates (ranging up to 15 percentage points) than all other health plans reporting this measure.

Our Well-Child Visits in the First 15 Months (six or more) rates for HEDIS® 2016 (72.43 percent) and HEDIS® 2017 (71.30 percent) exceeded the Medicaid National Mean (2016) and the Medicaid 75th percentile in both reporting periods. We performed higher than any other health plan reporting HEDIS® 2016 (except our legacy plan, Better Health, which was 1 percentage point higher).

Our Immunizations for Adolescents (Combo 1) rates (72.92 percent and 72.69 percent) exceeded the Medicaid National Mean for HEDIS® 2016, exceeded the Florida Medicaid Mean for HEDIS® 2017, and Amerigroup was the third highest scoring plan that reported on this measure for HEDIS® 2016.

Our Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life rate for HEDIS® 2016 (78.78 percent) and HEDIS® 2017 (76.16 percent) exceeded the Medicaid National Mean in both reporting periods. We were at the Medicaid 60th percentile for HEDIS® 2017, exceeded the Medicaid 75th percentile for HEDIS® 2016, and, along with one other plan, had the fourth highest score in the state on this measure for HEDIS® 2016.

Our Adolescent Well Care Visits rate for HEDIS® 2016 (55.75 percent) exceeded the Medicaid National Mean and the National Medicaid 60th percentile. In 2017, the score for this measure improved by more than 4 percentage points (59.72 percent) and is at the National Medicaid 75th percentile. We had the third highest score of the 12 Florida health plans reporting this measure for HEDIS® 2016.

Frequency of Ongoing Prenatal Care (≥ 81 percent of expected visits) rate 76.24 percent in HEDIS® 2016, exceeded the statewide average (60 percent), the Medicaid National Mean, and the 90th percentile. Compared to other health plans, we led the state, performing better than all other health plans reporting for HEDIS® 2016. We also exceeded the HEDIS® 2017 statewide average (61 percent), the Medicaid National Mean, and the 60th percentile for HEDIS® 2017.

Timeliness of Prenatal Care rates improved slightly between HEDIS® 2016 (86.12 percent) and 2017 (86.54 percent). We exceeded the Medicaid National Mean, the 60th percentile for HEDIS® 2016, and the 50th percentile for HEDIS® 2017. We had the third highest score of the Florida health plans reporting on this measure for HEDIS® 2016.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1.2. New York Experience Achieving Quality Standards

Our affiliate's Medicaid contract with New York began in January 2005 and currently serves 380,224 members. The most recent contract was executed in March 2014 and extends through February 2019. The current contract covers the TANF, ABD, and Medicaid expansion populations. For measurement year 2016, New York met 20 out of 41 state-specified targets and earned more than \$16 million in performance-based incentives.

Childhood Immunization Status (Combo 3) rates (76.39 percent and 73.09 percent) exceeded the Medicaid National Mean and the Medicaid 75th percentile for HEDIS® 2016. The rate for HEDIS® 2017 exceeded the Medicaid National Mean and Medicaid 50th percentile for HEDIS® 2017.

Well-Child Visits in the First 15 Months (6 or more) rates for HEDIS® 2016 (66.30 percent) and 2017 (63.95 percent) exceeded the Medicaid National Mean and Medicaid 60th percentile for HEDIS® 2016 and exceeded the Medicaid National Mean and 50th percentile for HEDIS® 2017.

Immunizations for Adolescents (Combo 1) rates (72.92 percent and 71.30 percent) exceeded the Medicaid Florida Mean in both reporting years and the National Medicaid mean in HEDIS® 2016.

Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life rates (86.03 percent and 85.81 percent) for HEDIS® 2016 and 2017 respectively exceeded the Medicaid National Mean and 90th percentile for HEDIS® 2016 and 2017.

Adolescent Well Care Visits rates for HEDIS® 2016 and 2017 (68.68 percent and 70.41 percent) exceeded the Medicaid National Mean and 90th percentile in both reporting years.

Frequency of Ongoing Prenatal Care (≥ 81 percent of expected visits) rates (65.19 percent and 63.10 percent) exceeded the Medicaid National Mean and Medicaid 60th percentile in HEDIS® 2016 and 50th percentile for HEDIS® 2017.

Timeliness of Prenatal Care rates improved slightly between HEDIS® 2016 (87.38 percent) and 2017 (89.82 percent). Rates exceeded the Medicaid National Mean each year and the 75th percentile for each reporting year respectively.

1.3. Texas Experience Achieving Quality Standards

Our affiliate's current contract for Texas Medicaid was executed in September 2011 and extends through August 2018 (currently serving 646,398 members). The initial Medicaid contract with Texas began in 1996. The current contract covers the TANF, CHIP and ABD populations. Texas Medicaid reports by product within the contract and has currently suspended their quality-related withhold program due to methodological concerns. The state of Texas aspires to the Medicaid 75th percentile as the goal for comparison of Texas rates.

Childhood Immunization Status (Combo 3) rate (72.45 percent and 74.54 percent) exceeded the Medicaid National Mean during both reporting years and the Medicaid 50th percentile for HEDIS® 2016 and the Medicaid 60th percentile for HEDIS® 2017.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Well-Child Visits in the First 15 Months (six or more) rate for HEDIS® 2017 (62.50 percent), improved almost 11 percentage points, exceeding the Medicaid National Mean and the Medicaid 50th percentile.

Immunizations for Adolescents (Combo 1) rates (83.91 percent and 82.64 percent) exceeded the Medicaid National Mean in both reporting years, and exceed the 75th percentile for HEDIS® 2016 and the 60th percentile for HEDIS® 2017.

Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life rates for HEDIS® 2016 (78.78 percent) and 2017 (81.48 percent), exceeded the Medicaid National Mean and the Medicaid 75th percentile for both reporting years.

Adolescent Well Care Visits rates for HEDIS® 2016 (70.05 percent) and HEDIS® 2017 (69.95 percent) exceeded the Medicaid National Mean by more than 20 percentage points in 2016 and achieved the Medicaid 90th percentile in both reporting years.

Frequency of Ongoing Prenatal Care (≥ 81 percent of expected visits) rates (78.77 percent and 75.23 percent) exceeded the Medicaid National Mean both reporting years and achieved Medicaid 90th percentile for HEDIS® 2016 and 75th percentile for HEDIS® 2017.)

Timeliness of Prenatal Care rates (87.97 percent for HEDIS® 2016 and 83.56 percent for HEDIS® 2017) exceeded the Medicaid National mean both reporting years and Medicaid 75th percentile and 50th percentile respectively.

2. THE EXTENT THE RESPONDENT EXCEEDED THE NATIONAL MEAN AND APPLICABLE REGIONAL MEAN FOR EACH QUALITY MEASURE.

See Attachment MMA SRC# 14-1: Exhibit A-4-b-2 MMA Performance Measurement Tool. This MMA Performance Measurement Tool shows our calendar year 2015 and 2016 rates for each of the seven HEDIS® measures requested in this solicitation.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for the HEDIS performance measures included in this submission requirement.
2. The extent to which the respondent exceeded the national mean and applicable regional mean for each quality measure reported and showed improvement from the first year to the second year reported.

Score: This section is worth a maximum of 70 raw points with component 1 worth a maximum of 10 points and component 2 worth a maximum of 60 points as described below:

Exhibit A-4-b-2, MMA Performance Measurement Tool (10-2-2017), provides for forty-two (42) opportunities for a respondent to report prior experience in meeting quality standards (seven (7) measure rates, three (3) states each, two (2) years each).

For each of the seven (7) measure rates, a total of 5 points is available per state reported (for a total of 105 points available). The respondent will be awarded 1 point if their reported plan rate exceeded the national Medicaid mean and 1 point if their reported plan rate exceeded the applicable regional Medicaid mean, for each available year, for each available state. The respondent will be awarded an additional 1 point for each measure rate where the second year's rate is an improvement over the first year's rate, for each available state.

An aggregate score will be calculated and respondents will receive a final score of 0 through 60 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 105 points, the final score will be 60 points (100%). If a respondent receives 95 (90%) of the available 105 points, the final score will be 54 points (90%). If a respondent receives 10 (10%) of the available 105 points, the final score will be 6 points (10%).

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EXHIBIT A-4-b-2
MMA SRC# 14 - MMA PERFORMANCE MEASUREMENT TOOL (10-2-2017)

INSTRUCTIONS:

Respondents should submit calendar year 2015/HEDIS 2016 and calendar year 2016/ HEDIS 2017 performance measure data for the selected HEDIS measures for the respondent's three (3) largest Medicaid contracts (measured by number of enrollees).

If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one (1) of three (3) states for the last two (2) years.

The performance measures that respondents are required to report on can be found on the Performance Measure Group B tab.

Use the drop-down box to select the state for which you are reporting and enter the performance measure rates (to the hundredths place, or XX.XX) for that state's Medicaid population for the appropriate calendar year.

EXHIBIT A-4-b-2
MMA SRC# 14 - MMA PERFORMANCE MEASUREMENT TOOL (10-2-2017)

RESPONDENT NAME: **Simply Healthcare Plans, Inc., D/B/A Clear Health Alliance**

Group B						
	State #1:	Florida	State #2:	New York	State #3:	Texas
HEDIS Performance Measure	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate
Adolescent Well-Care Visits	55.56	59.72	68.68	70.41	70.05	69.95
Childhood Immunization Status - Combination 3	77.08	80.09	76.39	73.09	72.45	74.54
Frequency of Ongoing Prenatal Care - ≥ 81% of expected visits	76.24	70.77	65.19	63.10	78.77	75.23
Immunizations for Adolescents - Combination 1	72.92	72.69	72.92	71.30	83.91	82.64
Timeliness of Prenatal Care	86.12	86.54	87.38	89.82	87.97	83.56
Well-Child Visits in the First 15 Months of Life - 6 or more visits	72.43	71.3	66.30	63.95	51.62	62.50
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	78.78	76.16	86.03	85.81	78.78	81.48

Total Points	84
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EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 15 – Failure to Meet HEDIS Measures (Statewide):

In addition to providing HEDIS measure data, describe any instances of failure to meet HEDIS or Contract-required quality standards for the measures listed below and actions taken to improve performance. Describe actions taken to improve quality performance when HEDIS or Contract-required standards were met, but improvement was desirable.

- Childhood Immunization Status (Combo 3);
- Well-Child Visits in the First 15 Months (6 or more);
- Immunizations for Adolescents (Combo 1);
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life;
- Adolescent Well Care Visits;
- Frequency of Ongoing Prenatal Care ($\geq 81\%$ of expected visits); and
- Timeliness of Prenatal Care.

Response:

Clear Health has an established Quality Management (QM) program and staff with experience in improving quality performance in a meaningful way for Medicaid enrollees (members) with HIV/AIDS in Florida. Our QM program includes internal monitoring to evaluate ongoing performance and effectiveness of delivery of services for this population and addresses any issues identified. By investing in the data tools that support the reporting and monitoring of performance, as well as in the design and application of strong interventions to successfully remediate all improvement opportunities, our organization is able to reach and exceed performance standards. Our experience and strict discipline with performance monitoring provides the best opportunity and positions us to continue to improve quality for our members in the most meaningful way. Through our annual evaluation of program trends and demands, we assess case/disease management effectiveness, service delivery (for example, monitoring preventive screenings), member and provider complaints, and satisfaction survey results. Implementing these and other indicators of current performance allows us to identify areas of service and operations that require immediate corrective action plans as well as areas where we meet standards but continued improvement is desired, ultimately improving the quality and health outcomes for members.

Quality is fundamental to everything we do. Achieving better member outcomes is not the responsibility of one program or specific employee, but is the result of quality being infused throughout all departments in our organization. These outcomes are a culmination of efforts of our Customer Care Representatives who offer support and resources to our members, Provider Network Managers who provide actionable data and targeted education to providers, Claims Processors who ensures providers are paid in a timely and accurate manner, Utilization Management (UM) and Case Management (CM) teams who ensure our members are offered appropriate support, and our Pharmacy team who proactively meets with providers to discuss best practices in prescribing. Additionally, we have developed a Performance Ratings team responsible for overseeing the accuracy of data, understanding and identifying trends, and communicating data gaps throughout the organization and to providers in our network to make sure we successfully remediate all performance measures not being met and improve those that are at or above the desired benchmark.

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MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1. ABILITY TO IMPROVE QUALITY AND SUCCESSFULLY REMEDIATE WHEN PERFORMANCE MEASURES ARE NOT MET

Clear Health carefully monitors all measures benchmarked under the 50th percentile (the Agency for Health Care Administration's (Agency) expected minimum standard). We submit Performance Measurement Action Plans to the Agency presenting how all metrics below the State thresholds will be remediated. We analyze the prior year's results to identify root cause barriers to performance, as well as to track current members via monthly year-to-date HEDIS® monitoring.

Because Clear Health is a Specialty Plan designed for members with a diagnosis of HIV or AIDS, the risk profile of our members is significantly different from the overall Medicaid population. Therefore, comparing our membership's rates of many clinical measures to the overall (healthier) Medicaid population does not accurately reflect the quality results our Clear Health plan has achieved. As noted in the Agency's Report Card, viewers are cautioned when reviewing the ratings for Specialty Plans, because these plans serve people with certain diagnoses or conditions, and the ratings compare performance to plans that may be serving healthier people. In addition to these issues, several of our performance measures have historically been negatively affected by the algorithm assigning non-eligible Medicaid enrollees into our Specialty Plan and associated delays in disenrollment. While our case management and Member Services staff are well equipped to assist and support members without an HIV/AIDS diagnosis, these members are reticent (and often refuse) services as a way to prevent any association with an HIV/AIDS-related plan and the stigma associated with an implied diagnosis of HIV/AIDS. This is particularly true when the members are children.

Based on the ITN requirements for MMA SRC 14 and MMA SRC 15, we have submitted HEDIS® data for the legacy Simply plan in Florida with the largest Medicaid membership, which is Amerigroup. Additionally, Amerigroup's membership is more comparable to that of the population from which the Medicaid 50th percentile is derived than the HEDIS® results for Clear Health. Clear Health is not one of Simply's largest three contracts by membership due to its specialized nature.

Although the ITN instructions precluded submission of Clear Health's specific HEDIS® results, we recognize the Agency's intention to learn about quality improvement interventions and capabilities present in our Clear Health Specialty Plan. Therefore, in this SRC response, interventions utilized by the unified Simply will be described as such, and interventions relevant solely to our Clear Health plan will be clearly identified as applicable. Interventions related to all measures are described below and in Table 15-1 Performance Improvement Intervention Matrix in Attachment MMA SRC# 15-1. Our Simply legacy plan reported year-over-year improvements for six of the seven measures identified above, ranging from 1.31 percentage points to 23.98 percentage points. Five of the seven measures identified above did not score above the 2016 Quality Compass 50th percentile in HEDIS® 2016. Subsequently, four out of the five measures that had not scored above the 50th percentile made significant improvements compared to the previous year, resulting in three measures achieving the 75th percentile, two measures achieving the 60th percentile, and two measures remaining below the 50th percentile.

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The following focuses on the five measures that did not score above the 50th percentile in HEDIS® 2016 and our actions to improve performance:

- Childhood Immunization Status (Combo 3)
- Immunizations for Adolescents (Combo 1)
- Adolescent Well Care Visits
- Frequency of Ongoing Prenatal Care (≥ 81 percent of expected visits)
- Timeliness of Prenatal Care

Similarly, in our Clear Health membership, five of the seven measures listed for which year-over-year data exists (two measures failed to have sufficient numbers of eligible members) did not meet the target rate of the NCQA 50th percentile in HEDIS® 2016. While four of the five measures improved between HEDIS® 2016 and HEDIS® 2017, only one exceeded the 50th percentile.

1.1. Interventions Targeting Access to Preventive Care

As part of our overall strategy to improve access to care for all members, we engage with members who are overdue for a preventive visit and their assigned Primary Care Providers (PCP). Members are contacted through multiple initiatives to encourage them to obtain preventive care services, immunizations, and follow-up care from their PCP. As soon as a Florida Medicaid enrollee becomes a Clear Health member, we begin tracking services received and gaps in care to promote the timely and effective completion of services. Our tracking tools enable us to closely monitor access to preventive services and adherence to medications. We use this information to send reminders about upcoming or missed screenings to members and targeted education to providers. Interventions are described below and in Table 15-1 Performance Improvement Intervention Matrix in Attachment MMA SRC# 15-1.

1.1.1. Member Outreach

We acknowledge the importance of providing members with frequent preventive care information through a variety of mechanisms. Our new member welcome packet includes information about their PCP, the importance of developing a relationship with their PCP, and how to access a Customer Care Representative for assistance selecting, changing, or making an appointment with their PCP. In the case of a Clear Health member, they might select an infectious disease specialist as their PCP. Additionally, we utilize this opportunity to encourage and assist members to access preventive services. Information about well-child visits and immunizations is included in our new member welcome packets for members between birth and the age of 18. We also send members annual birthday reminders. Within 45 days of a members' birthday, we send member households an annual Preventive Health Reminder about recommended, age-appropriate, well-care and preventive services. The reminder card also instructs the family to call the toll-free Member Services line with any questions or needs for assistance in scheduling an appointment.

Upon enrollment, all members or their parents or guardians receive a welcome call that includes an initial health risk assessment. If the member is not current on well-child visits or vaccinations, or their parent or guardian does not know the immunization status, we provide information on the recommended immunizations for the age of the child and offer to help schedule a PCP appointment. We also remind callers to our toll-free Member Services line and Nurse help line about the importance of preventive services, and we assist members to obtain needed care. For

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our Clear Health members, we have designated Customer Care Representatives to assist these members. These representatives have been provided additional training to ensure they are able to assist our members with HIV/AIDS efficiently and effectively.

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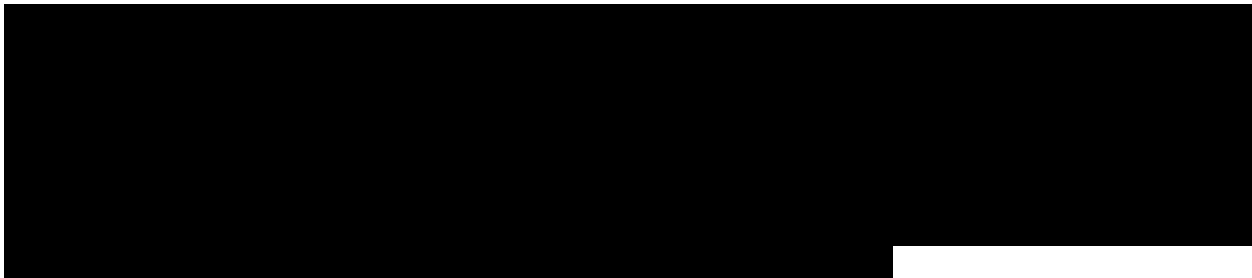
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1.1.5. Alternative Service Locations

We are committed to removing barriers to care and we design strategies to overcome them by meeting the members where they are. We have found that offering designated office hours and alternative service locations is the best way to help members access preventive services. We support them through targeted initiatives such as school-based clinic services, Clinic Days, mobile clinics, and our mobile units. In addition to these options, we contract with home visiting physician providers who can provide preventive care visits to members who are homebound.

School-based Clinic Services: We currently partner with providers of school-based services in three counties (Orange, Pinellas, and Miami-Dade) and we are the only health plan collaborating with schools in the Miami-Dade area. Our outreach focuses on connecting our adolescent members with well-child and immunization services in the school-based setting.



Mobile Clinics: We collaborate with providers with mobile clinics who will go into the neighborhoods where our members reside. The mobile clinics are staffed by practitioners who have a practice in the member's community and can serve as the member's PCP. The mobile clinics are an extension of the PCP's main office, usually a Federally Qualified Health Center or academic medical center. A wide array of services is provided to the members, including well-child visits, immunizations, adult well-care visits, and any prescriptions needed for chronic illnesses such as asthma. We understand children's dental services will not be covered by the health care plans in the coming Contracting period; however, we think it is important to note that our mobile dental clinics have been very successful closing dental gaps in care for our members. Additionally, we use this opportunity to educate and connect members to their PCPs for well-child exams and immunization gaps in care.

Mobile Units: Simply owns and operates mobile units currently used at community events to provide educational information. Our mobile units distribute educational information about a number of health-related topics, including adult well-care visits, immunizations, well-child exams, mental health and substance abuse, bullying, domestic violence, and many other topics.

See Table 15-1 Performance Improvement Intervention Matrix in Attachment MMA SRC# 15-1 for a summary of all interventions.

** RESULTS & SUCCESSES: In 2016, we served more than 1,500 members through our combined alternative service location initiatives that addressed medical service needs and more than 230 members' dental service needs. In 2017, we have already provided medical care to more than 1,000 members and dental care to almost 400 members through alternative service locations. **

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1.2. Improved Well-child Visit Rates

Through the numerous strategies described above, Simply demonstrated year-over-year improvement between HEDIS® 2016 and 2017 for two of the three Well-Child measures that did not achieve the 50th percentile in HEDIS® 2016. In HEDIS® 2017, Simply's rates for the Adolescent Well-Care Visits measure improved over 16 percentage points achieving the 75th percentile, and the rates for the Childhood Immunization Status (Combo 3) improved over 1.3 percentage points exceeding the National Mean but falling just below the 50th percentile. Despite our ability to increase the rate of adolescents who received a well-child visit, our score for Immunizations for Adolescents did not improve and remained somewhat below the 50th percentile.

1.3. Interventions Targeting Birth Outcomes

Clear Health understands that early and ongoing prenatal care is essential to improving birth outcomes. Early identification of pregnant members is vital to providing timely prenatal care. An analysis by Florida Medicaid's Bureau of Medicaid Data Analytics of 169,375 pregnant women aged 10 to 60 (cohort) in Florida's Medicaid program between August 1, 2014 and July 31, 2015 found that the majority of women (76 percent) obtained their first prenatal visit in the same month or the month following their first service identifying the member was pregnant. Only eight percent waited longer than two months past identification. While guidelines recommend that women begin prenatal visits as early as possible and at least seven months prior to delivery, 70 percent of the cohort had their first prenatal care visit later than the recommended seven months prior to delivery (published Autumn 2016). Once women are aware of their pregnancy, the majority seek prenatal care in a timely manner.

Analyses completed by the Family Data Center within the University of Florida's College of Medicine, and presented in the Florida Medicaid Maternal & Child Health Status Indicators Report (2011-2015) consistently (five-year trend) shows that women eligible for Florida Medicaid due to pregnancy (SOBRA) have lower rates of inadequate prenatal care compared to women eligible for Florida Medicaid through all other eligibility avenues/criteria. Women eligible through SSI have the highest rates of inadequate prenatal care. These findings have led us to seek strategies to identify and engage pregnant members as soon as possible.

1.3.1. Member Outreach

As part of our overall strategy to identify pregnant members within the first trimester and promote compliance with medical guidelines for frequency and timeliness of prenatal and postnatal visits, we employ a variety of measures to identify pregnant members. In addition to using the enrollment file that identifies women as eligible for Medicaid through SOBRA, we have implemented a bi-directional data sharing agreement with the Healthy Start Coalition to enable the expeditious identification of pregnant members.

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At times, locating members can be a challenge. For this reason, we utilize our close working relationship with the Healthy Start Coalition, referring members for outreach. As additional measures, and in recognition of the special risks for pregnant women with HIV, we engage our Managed Care Coordinators and Outreach Care Specialists from our Member Outreach Team for any ongoing efforts as needed. This reduces duplication while ensuring that all avenues are exhausted to bring these members into care.

- **Maternal Postpartum Outreach Program (MPOP):** MPOP is an all-inclusive (member, provider, and data collection) outbound call outreach program focused on improving access to care and ensuring the timeliness of a mother's visits with a provider after delivery of her baby. Outreach is completed by providing experienced compassionate outreach care specialists and a state-of-the-art web-based system to assist members with postpartum visits, refer at-risk members to care providers and community resources, and educate members about recommended newborn check-ups and Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Program components include:

- **MPOP System:** A state-of-the-art web-based system that identifies moms who have just delivered a baby and may need assistance with scheduling their postpartum visit, and captures all components of the outreach process (appointments, mailings, outreach attempts)

- **Outreach Care Specialists:** Experienced Outreach Care Specialists attempt to contact new mothers assigned in the MPOP system to assist with appointment scheduling, appointment reminder (5 days prior to the mom's postpartum appointment), and appointment coordination and verification (contact OB provider to schedule an appointment for moms and verify mom kept her postpartum appointment)

Upon identification of a pregnant member, an obstetrical (OB) risk screening tool is completed by either the automated My Advocate program, or the OB Case Manager to determine the member's need for further assessment for OB case management services. All pregnant members with HIV/AIDS are stratified as high-risk for OB case management. While the OB Case Manager is primary, a Managed Care Coordinator will co-manage as needed. Frequency of contact is, at minimum, monthly, and focuses on adherence to antiretroviral therapy (ART) in addition to normal high-risk OB protocols.

An OB Case Manager follows all pregnant members from initial identification through all phases of their pregnancies. The OB Case Management program involves coordination of pregnancy monitoring (laboratory testing, utilization of emergency services and hospitalizations, and use of medications), self-management, support, and provider services.

- **OB Practice Consultants** - Provider education and collaboration efforts are enhanced by OB Practice Consultants, who are Registered Nurses who meet regularly with providers to build and maintain a coordinated approach to caring for women before, during, and after pregnancy. OB Practice Consultants also provide information on providers' HEDIS® performance for measures that focus on maternity care. Our OB Practice Consultants are based out of Miami, Orlando, and Tampa.

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**** REAL STORY:** High-risk OB Case Management Helps Mother Deliver Healthy Baby Girl
When Carmen, our OB Case Manager, offered 36-year-old new member Krysten high-risk OB case management services based on her HIV status, she was reluctant to discuss her status, but she accepted help managing her pregnancy. Happily, although Krysten had not sought prenatal care in the first months of her pregnancy, she welcomed Carmen to coordinate services and referrals for her, including to WIC, Healthy Start, and an OB/GYN. Carmen also worked with the Orange County Department of Health Ryan White case manager to coordinate education on prenatal and post-partum care, nutrition, baby feeding, and the signs and symptoms of preterm labor and post-partum depression.

Carmen was there for Krysten throughout her pregnancy, answering her questions, providing support, and reinforcing the importance of medication, lab work, and appointment compliance to keep her and her baby healthy. By keeping her appointments and taking her medications, Krysten avoided complications including preterm labor and transmitting the virus to her full-term baby girl, Andrea. In addition, she kept her OB/GYN follow-up and pediatrician appointments too. Krysten expressed her gratitude to Carmen. ******

Ensuring we are able to connect with our pregnant members who are homeless requires additional effort. We have recently secured access to the Homeless Management Information System (HMIS), a local information technology system that collects client-level data and data on the provision of housing and services to homeless individuals and families, and persons at risk of homelessness. This system enables us to use the client tracker, a valuable application that helps us locate members experiencing homelessness. This application identifies shelters and other organizations that are currently providing services or that recently provided services to a member. Through the HMIS client tracker, we will monitor our membership characteristics and service needs, and use the system to help us locate members experiencing homelessness on a timely basis. We will use service need information collected through the HMIS as another source of information to help us identify services currently being provided to our members who are or have been homeless, so that we can identify and fill service gaps and make sure that member needs are being met.

1.3.2. Programming and Tools

The Taking Care of Baby and Me® program addresses maternal and newborn health risks by ensuring members have access to the information, care, and support needed to stay healthy before, during, and after pregnancy. The program assures that our members have access to appropriate obstetrical, medical, and behavioral health care services. We engage members in care management as advocates for their own health care and by assisting with the essential elements of personal responsibility and health care that lead to a healthy pregnancy and newborn.

- My Advocate – To effectively screen for risk factors and engage our members during and after pregnancy, Simply employs My Advocate, a multi-channel communication program that provides health education by phone, text message, smartphone app, or online to pregnant members. In addition to promoting healthy habits, My Advocate:
 - Allows members to complete our High-Risk OB Screener by phone or online to determine level of risk and need for case management or care coordination services

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- Alerts OB Case Managers and Managed Care Coordinators to reach out to members when they experience a change in risk level
- Allows members to ask questions and get a prompt callback from an OB Case Manager

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1.4. Improved Performance Related to Birth Outcomes

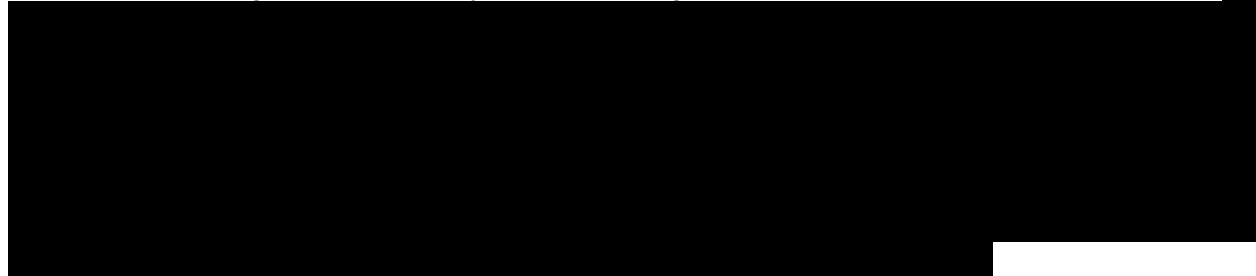
Simply demonstrated significant year-over-year improvement for both measures related to birth outcomes described in this Submission Requirement Component. Our rates for the Frequency of Ongoing Prenatal Care measure improved over 23 percentage points, and our rates for the Timeliness of Prenatal Care improved over 14 percentage points between HEDIS® 2016 and HEDIS® 2017. These improvements resulted in both scores achieving the 60th percentile in HEDIS® 2017.

2. ABILITY TO IMPROVE QUALITY WHEN STANDARDS WERE MET

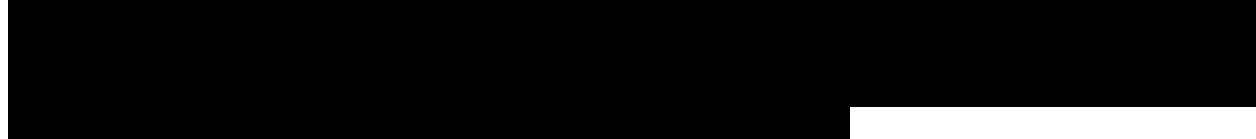

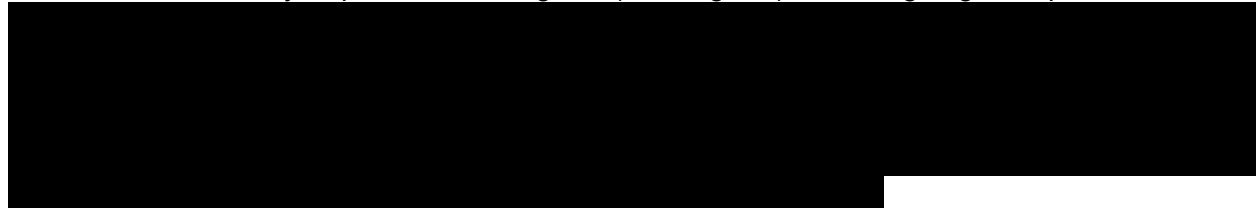
Clear Health is committed to excellence in the quality of care and services provided to members, and to the competence of our provider network. We are dedicated to improving member satisfaction, improving the health status and quality of care for our members, providing expanded

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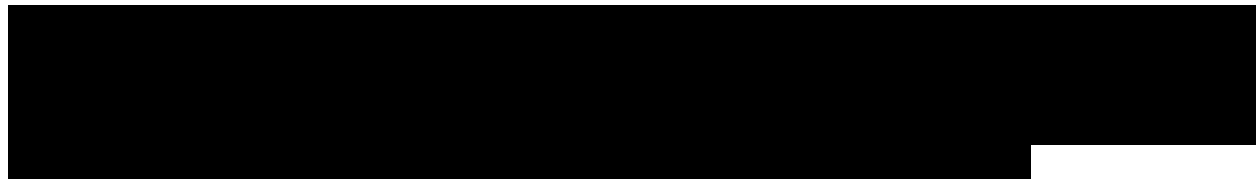
benefits, improving member safety, and assuring member access to medical services.



Clear Health's Quality Improvement Program (QI Program) is an ongoing, comprehensive, and



The following focuses on the two measures that scored above the 50th percentile in HEDIS® 2016 but where improvement was still desired:

- Well-Child Visits in the First 15 Months (6 or more)
 - Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
- 
- 

2.1.1. Member Outreach

We provide members with frequent preventive care information through a variety of mechanisms:

- New member welcome packet including information about their PCP, the importance of developing a relationship with their PCP, how to access an appointment with their PCP, and information about well-child visits and immunizations is included in our new member welcome packets for members between birth and the age of 18.

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- Annual birthday reminders. Within 45 days of a member's birthday, we send member households an annual Preventive Health Reminder about recommended, age appropriate, well-care and preventive services.
- Welcome call. Upon enrollment, all members or their parents or guardians receive a welcome call that includes an initial health risk assessment, information on the recommended immunizations for the age of the child, and assistance scheduling a PCP appointment (as needed).
- Member Services line and Nurse help line. We remind callers of our toll-free Member Services line and Nurse help line and the importance of preventive services, and assist members as needed to access care.

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[REDACTED]

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[REDACTED]

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[REDACTED]

[REDACTED]

2.2. Continued Improvement of Well-child Visit Rates

Simply achieved the 50th and 75th percentile for the measures Well-Child Visits in the First 15 Months (6 or more) and Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life, respectively, in HEDIS® 2016. Between HEDIS® 2016 and 2017 we demonstrated year-over-year improvement of more than 7.5 and 2 percentage points (respectively), yielding achievement of the 75th percentile for both measures in 2017.

Evaluation Criteria:

1. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way and to successfully remediate all failures for the HEDIS performance measures included in this submission requirement.
2. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way even when HEDIS or Contract-required standards were met, but improvement was desirable, for the HEDIS performance measures included in this submission requirement.

Score: This section is worth a maximum of 10 raw points with each component worth a maximum of 5 points each.

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MMA SRC# 16 – HEDIS (Data Sources) (Statewide):

The respondent shall describe:

- a. The extent to which it has used the following standard supplemental data sources for its HEDIS and other performance measures:
 - Laboratory result files;
 - Immunization data in State or county registries;
 - Transactional data from behavioral healthcare vendors; and
 - Current or historic State transactional files in a standard electronic format.
- b. The extent to which it has used supplemental data from electronic health record vendor systems and data from certified eMeasure vendors for HEDIS and other performance measures.
- c. The extent to which it has experience reporting HEDIS measures collected using Electronic Clinical Data Systems.

Response:

Clear Health uses the national expertise and resources of our Health Care Analytics (HCA) Data Management team and the local expertise of our Florida-based Business Intelligence team to collect, analyze, measure, and report HEDIS®, CAHPS®, and any locally-defined performance measures. Our national office's support enables us to invest in and use industry-leading hardware and software with economies of scale. Our Florida-based team makes sure that State-specific data (such as immunization records and local laboratory data) and data required for Florida-specific measures is collected and used in the calculation of performance measure rates. Clear Health's Business Intelligence team has more than 10 years of HEDIS® management experience and is fully dedicated to collecting, calculating, and reporting HEDIS® and Agency-required performance measures. Our ultimate parent company, Anthem, Inc. (Anthem) makes more than 150 HEDIS® submissions, annually, to the National Committee for Quality Assurance (NCQA). This is one of the largest contributions of data in the country. Anthem submits data for 20 Medicaid markets including Florida and multiple entities, including separate reporting for Florida's Medicaid and Florida Healthy Kids programs. We routinely use supplemental data sources in all health plan types to calculate performance measure rates.

1. EXPERIENCE AND ABILITY TO USE STANDARD SUPPLEMENTAL DATA SOURCES FOR HEDIS® AND OTHER PERFORMANCE MEASURES.

Clear Health understands the success of the Statewide Medicaid Managed Care (SMMC) program is largely measured by the quality scores of contracted health plans. Clear Health has the experience, expertise, and proven ability to earn top quality scores. We are committed to collecting and using all available data sets required to calculate and report performance measures that reflect the quality of care provided through the SMMC program. We collect and use all standard supplemental data sources needed for HEDIS®, Child and Adult Core Set measures requested by CMS, and Agency-defined performance measures according to standards specified in the most recent version of NCQA's HEDIS® Technical Specifications

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(such as Data Collection Methods and Data Sources), the Agency Report Guide, and the Agency Performance Measure Specifications Manual. We use supplemental data for all measures for eligible population identification and compliance measurements. The Health Care Analytics (HCA) Data Management team has process ownership and assists the health plan's Business Intelligence team in planning and executing annual data collection. The process defines the reporting population, the hybrid or administrative measure project design, year-round data management, and year-round enrollee (member) and provider outreach. Data collected from these efforts is imported into the HEDIS® warehouse, proofed, and pulled into the certified software vendor warehouse. Audited data is used in administrative measures, medical record projects, and CAHPS® sample generation.

Clear Health uses a HEDIS® certified software vendor (Inovalon) to load and store all data used for HEDIS® reporting and auditor approval, including NCQA certified national auditors and state/federal regulatory auditors for all data extraction processes. Our HEDIS® warehouse contains information from paper and electronic claims, encounter data, enrollment, and provider files maintained in our transaction systems or internal data warehouses. Data sources are inclusive of medical records from chart review, electronic medical record data feeds, paper/electronic claims and encounter data, subcontractor data (e.g., vision, dental, pharmacy, behavioral health, and laboratory result data), state pharmacy files and state registries (maintained in multiple repository sites), and state Fee-for-Service/historical encounter files.

We have automated lab data exchanges with national providers, including Quest Diagnostics (Quest), Laboratory Corporation of America (Labcorp), and Bio-Reference Laboratories, and carry out extensive efforts at the local level to collect additional lab data to enhance completeness. To verify that we are obtaining sufficient supplemental data from local repositories, we conduct a Florida-specific data utilization analysis, then implement data acquisition and/or sharing agreements accordingly. Additionally, as a part of our overall quality improvement processes, the HEDIS® data team works closely with our certified HEDIS® audit firm to make sure all data sources are collected and used accurately to identify services and eligible members. This process assures the resulting performance measure rates accurately reflect our high performance.

In Florida, we receive laboratory files from our laboratory service provider (Quest) and behavioral health (BH) files (837 claims data encounter files) from our BH subcontractor (Beacon Health Options) daily and complete a validation process to determine if the files have already been received. If a file is deemed new, we flag the data appropriately (e.g. EMR data is flagged as supplemental data) and validate the row count and consolidate the member ID with our Core Operations System (COS). Files that pass the validation process are stored in our Florida-based data warehouse until they are sent to our HEDIS® software vendor (monthly in one single file per subcontractor). We have a comprehensive process to clean data from each data source. The certified HEDIS® software is used to calculate all HEDIS® scores. The process includes de-duplicating data about the same service from multiple data sources and using data from the correct source based on NCQA's specified hierarchy (for instance, claims data overrides supplemental data for the same service) and purpose (for instance, auditor reviewed and approved supplemental data is only allowed to be counted as numerators and exclusions).

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Clear Health shares immunization data with the Florida's State Health Online Tracking System (SHOTS) immunization registry on a quarterly basis. Immunization encounter data is sent to the Florida Department of Health (DOH) in the State-specified format via a Secure File Transfer Protocol (SFTP) site. Clear Health also requests immunization data from the DOH periodically. Toward the end of the year, we match immunization data more frequently to accurately track important immunization-related measures (such as Childhood Immunization Status, Immunizations for Adolescents) and take action to close gaps in care in partnership with members and providers. When Clear Health receives data from the Florida SHOTS registry indicating a vaccination was received, we submit it to our HEDIS® software vendor to be reconciled with members who meet criteria to be included in one or more measures.

We receive historic State transactional files in standard electronic format on a daily basis. After validating the data, we consolidate the member ID with data in our COS and store the data in our Florida-based data warehouse. We send all historical data to our HEDIS® software vendor monthly. Historic data provides immunization and screening data not found in other registries and is one of many sources used to calculate rates for Childhood Immunization Status, Lead Screening in Children, and Immunizations for Adolescents. It also helps complete our members' records on care received before their enrollment with Clear Health, which otherwise would be represented as a gap. For instance, newborns and pregnant women may not become Clear Health members until several weeks or months after enrolling in Florida Medicaid. State-provided historical claims and encounter data enable us to capture services rendered prior to enrollment in our health plan, including the first Well-Child Visit and/or prenatal visits. These are vital for the Well-Child Visits in the First 15 Months of Life and Timeliness of Prenatal Care HEDIS® measures. We are able and willing to collect additional data from supplemental data repositories, to calculate and report additional performance measures as directed by the Agency.

As depicted in Figure 16-1 HEDIS® Data Flow in Attachment MMA SRC# 16-1: Data Sources, we use all available data sources to collect, maintain, and utilize data to generate HEDIS®, Adult and Child Core Set Measures, and Agency-defined measures. We use sophisticated tools, data review processes, and policies and procedures to verify data accuracy and completeness.

2. EXPERIENCE AND ABILITY TO USE SUPPLEMENTAL DATA FROM ELECTRONIC HEALTH RECORD VENDOR SYSTEMS AND FROM CERTIFIED EMEASURE VENDORS.

The HEDIS® Data Management team began incorporating Electronic Health Record (EHR) data from provider groups in 2014 and currently has more than 100 provider groups participating throughout the nation. Supplemental data from these provider EHRs has been incorporated into our HEDIS® process and we are able and willing to implement this with our Florida providers.

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To make the EHR linkage process more efficient and scalable, we are exploring opportunities to use data aggregators. Additionally, we are creating a national supplemental data management team to streamline the process for data intake from provider groups. We use advanced technology such as Alteryx to ensure we have a comprehensive data quality review from data intake to data processing and feeding to the HEDIS engine. This initiative will also ensure we have a scalable work flow to process a significant increase in volume of EMR data sources from provider groups. Our national data management team, comprised of staff with diverse expertise, will centralize operations, improve efficiency, and make sure the same high quality standards are applied consistently. The centralization will also benefit providers by reducing their administrative reporting burdens. The new process will enable network providers who see members in Medicaid, Medicare, and commercial products to submit data once rather than separately. We are also in the process of engaging new technology to automate data loading and quality processes.

We support NCQA's eMeasure Certification (eMC) program for organizations that develop, license, and sell quality-measure reporting software that calculates electronic clinical quality measures (eCQMs). eCQMs help organizations track and monitor the quality of care delivered by providers who use electronic data. We understand that certified data, in the approved Quality Reporting Document Architecture (QRDA) format, can be used as supplemental data and used for calculating HEDIS® measures at the health plan level. Additionally, health plans can use eMCs to reduce the number of costly chart reviews and after 2019, patient centered medical homes (PCMHs) will be required to submit measurement data from NCQA-certified sources through the eMC program.

One of our national data management team's goals will be aligning our supplemental data collection and management processes with those of NCQA's EHR initiatives, including eCQMs.

3. EXPERIENCE AND ABILITY TO REPORT HEDIS® MEASURES USING ELECTRONIC CLINICAL DATA SYSTEMS (ECDS).

Per NCQA, Electronic Clinical Data Systems (ECDS) are plan-based networks of data containing a member's personal health information and experience records (such as screening tool results) within the health care system. ECDS also support other care-related activities through various interfaces that include evidence-based decision support, chronic disease management, and outcome reporting. These data are structured to consistently execute automated quality measurement queries and provide results to the team responsible for members' care. For example, scores from depression screening tools (such as the Patient Health Questionnaire (PHQ-9)) can be used to track members' experience over time. Health plans that establish a network of interoperable ECDS foster a person-centered, team-based approach to improving health care quality.

ECDS is a relatively new domain of measurement and is not currently being reviewed by NCQA auditors during pilot testing. While testing ECDS, we learned that structured data on quality from EHRs, clinical registries, HIEs, administrative claims systems, and other sources are intended to be made available to clinicians at the point of service to enable better management. The design is best suited for integrated delivery systems.

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Our New York affiliate health plan partnered with the New York state Medicaid agency to pilot ECDS and test these new capabilities. The targeted measure involved use of the PHQ-9 screening tool for clinical depression. Repeating the PHQ-9 over time and entering scores into the ECDS makes it possible to track whether a member's depression is improving or worsening. We identified all Medicaid members within the state who had the diagnosis to qualify for the measure, and providers conducted PHQ-9 screening as appropriate. The plan shared results with the state after the pilot concluded at the end of 2015. As is the case with some pilots, the state did not elect to continue ECDS development in the New York Medicaid program. Clear Health, with the experience and support of our national team, is willing and able to consult with the Agency on a potential pilot for use of ECDS systems in Florida.

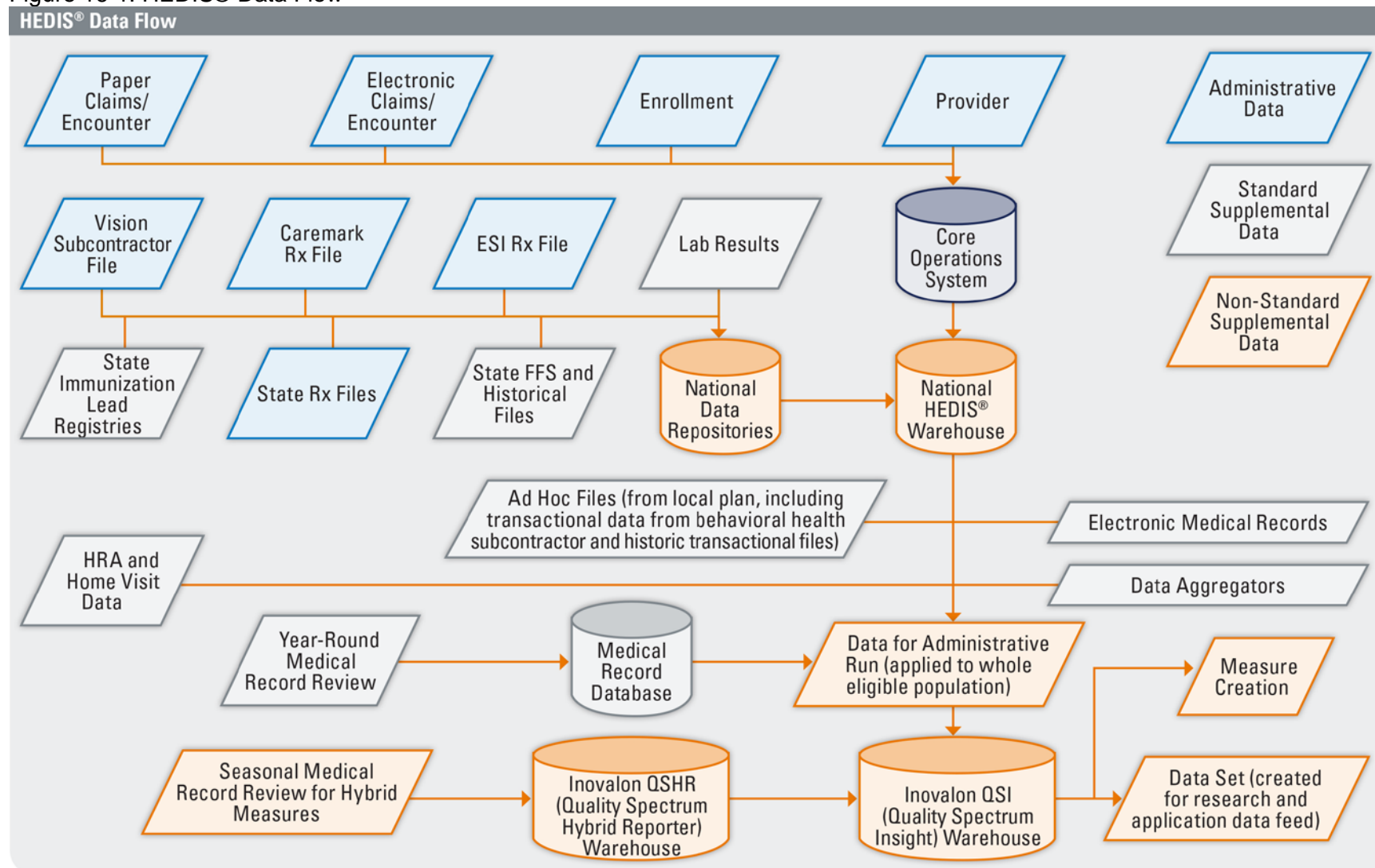
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Evaluation Criteria:

1. The extent to which the described experience demonstrates the ability to use standard supplemental data sources (lab result files; immunization data in State or county registries; transactional data from behavioral healthcare vendors; and current or historic State transactional files in a standard electronic format) for HEDIS and other performance measures.
2. The extent to which the described experience demonstrates the ability to use supplemental data from electronic health record (EHR) vendor systems and data from certified eMeasure vendors for HEDIS and other performance measures.
3. The extent to which the described experience demonstrates the ability to report HEDIS measures collected using Electronic Clinical Data Systems (ECDS).

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

Figure 16-1. HEDIS® Data Flow



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MMA SRC# 17 – Coordination of Carved Out Services (Statewide):

The respondent shall describe its approach to coordinating services that are not covered by the respondent, but are covered by Florida Medicaid either through the FFS delivery system (e.g., behavior analysis services, prescribed pediatric extended care) or through a prepaid dental plan.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Clear Health brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). Clear Health draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations while maintaining our unique community-based approach to addressing the specific needs of members with HIV/AIDS.

Clear Health is committed to working proactively with our enrollees (members), providers, sub-contractors, and AHCA to assure members receive all their covered services to promote their health and quality of life. Our deep experience in communities and understanding of local agencies, programs, and community resources facilitate our partnerships and streamline reciprocal referral processes so that we all work toward common goals. We will continue to leverage our role and relationship with members, caregivers and providers to promote engagement in all appropriate programs and advance recent gains in access.

1. PROCESS FOR RECIPROCAL REFERRAL FOR NEEDED SERVICES

Proactive identification and coordination of carved-out services is built into the standard operating procedures of our case management program for Clear Health. All members are assigned a Case Manager (called a Managed Care Coordinator to differentiate from the case management services of partner organizations) who collects information on current services, participation in additional programs, and physical and behavioral health (BH) needs through a comprehensive assessment process and builds a person-centered plan of care. The plan identifies the need for any non-covered or carved-out services and referrals for additional assessment or service provision in the appropriate setting. Our experience teaches us that in most situations these services are offered by community-based organizations, State agencies, and providers, including those administering carved-out benefit programs. Throughout the member's enrollment with Clear Health, the Managed Care Coordinator will continually assess eligibility for additional programs to serve member needs. Our staff coordinates referrals to facilitate access to all needed care and services, including those that address the social determinants of health our members may be facing.

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With member or representative permission, the Managed Care Coordinator will collaborate directly with service providers to assure the plan of care is cohesive and complementary and the member is receiving all appropriate benefits in a coordinated fashion. The Managed Care Coordinator may also facilitate the application process for these services by providing assistance to the members or caregivers, such as support to identify and gather all required information, counseling them on how to talk to their providers about service needs, and calling to make appointments for additional services if appropriate.

For example, we have a reciprocal referral process for members who need additional sedation for carved-out dental services in an outpatient setting: the dental benefits manager helps to identify and coordinate the services with the dental provider and our Managed Care Coordinator who then coordinates with the the medical facility to complete authorization for the sedation. Likewise, our Managed Care Coordinators coordinate with vision services to deliver appropriate ophthalmology services when providers refer for cytomegalovirus retinitis follow-up to prevent blindness in immune-compromised members. For pediatric members with Prescribed Pediatric Extended Care (PPEC) services, our Pediatric Managed Care Coordinators collaborate closely with the PPEC service providers to identify and arrange wraparound services as appropriate, including private duty nursing, transportation, and home care services to improve member health and quality of life. We also coordinate closely with Medicaid Certified School Match Programs for pediatric members with medical needs, integrating school-based services into the overall plan of care. For all carved-out services, Managed Care Coordinators continually monitor enrollment, member compliance with scheduled appointments, progress, and outcomes, and document them as a part of our integrated Case Management record.

Clear Health Customer Care Representatives also actively support members to access carved-out services. As noted below, our staff receives comprehensive training on the Florida Medicaid benefits and carved-out services and uses that information to address member questions and concerns when they call. For members who require or express an interest in pursuing a carved-out benefit, it is standard operating procedure for the Customer Care Representatives and Managed Care Coordinators to make a referral to an appropriate agency and assist the member, as needed, to make the appointment or secure the benefit. Clear Health staff facilitate access to carved-out services, including arranging transportation when appropriate. If our staff have difficulty arranging an appointment for a service carved out of managed care, we will contact Florida Medicaid's Recipient and Provider Assistance to find a solution to meet the member's needs.

We are committed to continuing to partner with AHCA to maintain high levels of access and utilization of pediatric dental care among our members during the transition to a carved-out service. We will proactively communicate to our member families about the importance of routine preventive dentistry for adults and children during welcome calls and other opportunities, and will make connections to the State program to facilitate access. We plan to build on the success of our Mobile Dental pilot with Miami-Dade Health Department, including expanding from four to six locations in Miami and adding proactive outreach to adults and kids needing dental care. This year, the Mobile Dental Clinics (on a Department of Health vehicle) provided dental care to 65 of our members and services were reimbursed by DentaQuest.

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2. ENGAGING AND EDUCATING ENROLLEES IN UNDERSTANDING THE DIFFERENCES IN BENEFITS IN MEDICAID DELIVERY SYSTEMS

We work hard to assure that our members are aware of the comprehensive benefits available through our plan, as well as benefits that they may be eligible for through other programs in Florida Medicaid. This includes communication of benefit information at enrollment through the welcome call, the introductory member packet, and via the member website. We list all our plan benefits in the member information, as well as additional program and benefits for which they may be eligible. Members can also contact our Customer Care Representatives or Managed Care Coordinators at any time with questions about benefits. When members express confusion about carved-out benefits, the case is referred to our case management department for follow-up. Our team members will contact the member to understand the point of confusion, offer clarity on the benefit packages, and assist with coordination of the services or claims processes as needed to make sure our member receives all necessary services without delay.

Another way to assure that our members are given the correct information about benefits and receive all covered services without delay is to educate providers about them. Our Provider Relations team works with network providers to promote clarity on covered benefits and other services available to our members through the MMA plan and other Florida Medicaid programs. Our new provider orientation includes an overview of the benefit package for our Medicaid beneficiaries, as well as an overview of benefits available through other Medicaid programs. For example, when orienting PCPs to our program, we discuss the Vaccines for Children program, provide education on maintaining an adequate vaccine supply, and provide instructions to bill Medicaid Fee-for-Service (FFS) directly for immunizations. We will work with DentaQuest and contracted dental providers to see that they are clear on services available through the pediatric dental carve-out and the billing procedures to prevent delays in care for our pediatric members.

3. PROCESS FOR ENSURING OUR STAFF AND SUBCONTRACTORS ARE AWARE OF BENEFITS AVAILABLE IN OUR PLAN AND OTHER FLORIDA MEDICAID PROGRAMS

Training for all staff at member- and provider-facing departments and subcontracted entities is an important part of our strategy to assure that there is comprehensive understanding about benefits in the Medicaid programs and processes to secure appropriate services to support members.

3.1. Training for Clear Health Staff on Benefits

All new Clear Health employees undergo a comprehensive classroom training program upon hire, developed in partnership with instructional designers on our Organizational Development team. The classroom program includes training on our benefits, the benefits of other Florida Medicaid programs available to our members, and processes for obtaining those benefits. Staff in our Member Services, Provider Relations, Case Management, and Utilization Management departments receive additional training on the utilization management process, criteria and their application, as well as strategies to support members through benefits management processes.

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We also offer refresher trainings on benefits annually, with additional training on State program updates through employee handbooks, transmittals, and fee schedule changes. Our Case Management System contains the most up to date information on benefits and carved-out services and is updated regularly. Information on benefits is at the fingertips of all member facing staff, including Grievance and Appeals Associates, Customer Care Representatives, Utilization Management Associates, and Managed Care Coordinators.

3.2. Training on Benefits by Subcontracted Entities on Benefits

As a part of our Subcontractor Oversight Program, Clear Health will assure compliance with training requirements on covered and carved-out benefits to promote clarity, accurate communication with members and providers, and to confirm that there is no inappropriate cost-shifting or duplication of services. We will confirm that each Subcontractor has a robust training program for staff in place that reviews covered benefits and carved-out services in the Florida Medicaid program, including review of the training curriculum as a part of our routine oversight process. For example, DentaQuest, our dental network and utilization management subcontractor, has processes in place to train staff and providers initially and on an on-going basis on benefits included in different programs, including Medicaid and Florida Healthy Kids. Their Customer Services Representatives easily identify member and provider participation in plans, assuring they provide accurate information in response to questions.

All member- and provider-facing materials will be approved by AHCA and Clear Health to assure compliance with carved-out benefit training expectations.

Evaluation Criteria:

1. The extent to which the respondent describes effective and efficient processes for reciprocal referral for needed services.
2. The adequacy of the respondent's approach to engage and educate enrollees in understanding the difference in benefits covered by the respondent and those that are available through other Medicaid delivery systems.
3. The extent to which the respondent's description includes a process for ensuring respondent's staff and subcontractors are aware of and effectively communicate the appropriate information on services available through other Medicaid delivery systems.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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MMA SRC# 18 - Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Jose is a 15-year old male. He is diagnosed with bipolar disorder and is currently hospitalized under the Baker Act; this is his third psychiatric admission under the Baker Act in the past year. Up until six (6) months ago, Jose lived with his mother and two younger siblings, but he moved in with his father after his behavior declined and his mother was unable to protect herself and his siblings from Jose's angry outbursts and verbal and physical aggression. His father is physically disabled from a work injury, and he is concerned about managing Jose upon release, as Jose's behavior at home and school has significantly declined. At school, Jose is currently failing and has a notable number of absences and office referrals for altercations. Jose was diagnosed two months ago, during his second psychiatric admission, with bipolar disorder. Jose has been prescribed a low dose of Seroquel daily, but he does not take it consistently because of the side effects. He experiences drowsiness, dry mouth, and nausea. In his current admission, his laboratory testing results showed evidence of thyroid dysfunction. The hospital social worker assisted the family in completing and submitting a referral for Statewide Inpatient Psychiatric Program (SIPP) services, but the SIPP provider informed the social worker that authorization was denied. Jose's father has called the plan's enrollee help line for assistance with completing an expedited appeal. Jose was involved in outpatient therapy for the past six weeks. There have not been any adjustments to his medications to date. Jose has been enrolled in Medicaid since he was 5-years old. He has been enrolled in his health plan since July 2014.

The respondent shall describe its approach to coordinating care for an enrollee with Jose's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

- a. New Enrollee Identification;
- b. Health Risk Assessment;
- c. Care Coordination/Case Management;
- d. Service Planning;
- e. Discharge/Transition Planning;
- f. Disease Management;
- g. Utilization Management; and
- h. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan. Clear Health recognizes that enrollees (members) and their families may experience crisis situations, and need rapid, intensive support to help them navigate the health care system. Our staff is qualified and well-trained to quickly intervene and provide one-on-one

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support to members, their families, and others on the multidisciplinary care team. We are flexible in how we engage members and always place them at the forefront. Our person-centered approach engages members based on where they are in recovery and recognizes them as the primary contributors of their care, including identifying goals, motivations, and driving development of their plans of care to address their physical, behavioral, social, and spiritual needs. We use trauma-informed approaches and embrace strategies such as motivational interviewing. We team with our providers, local government resources, community resources, and faith-based partners to wrap supports around members.

**** Addressing the Needs of Members and Their Families in Crisis ****

When Jose's father contacts our Member Services line, he receives assistance from a Customer Care Representative and files an expedited appeal, which is upheld the following day. Given Jose's history of HIV via perinatal transmission, he has already been assigned a Managed Care Coordinator, Lorenzo, since enrollment. Lorenzo is a licensed social worker with experience working with children and adolescents who have behavioral health conditions, is bilingual in Spanish, and has worked closely with SIPP and the Psychiatric Facility, as well as the Child and Adolescent Crisis Unit (less restrictive level of care) in Jose's area. Lorenzo has closely worked with the behavioral health (BH) community available to Jose and is familiar with the supports that might be recommended. He has received extensive training on HIV/AIDS as part of his past work experience and more recently through his employment with Clear Health. Having worked primarily with Jose's mother, Lorenzo reaches out to Jose's father (Jose's new legal guardian following his move) to discuss his recent request for SIPP and case management, and to arrange a face-to-face meeting the following day near where Jose's father works.

When they meet, Lorenzo talks to Jose's father at length about Jose's current admission, the appeal and decision, and the available options for discharge. He listens to Jose's father talk about his experience and the challenges the family has faced in addressing Jose's condition and in coping with his outbursts, even though Jose has been in outpatient therapy for the past six weeks prior to admission. He relates that Jose has not had any changes to behavioral medications to date and was born with HIV and confirms that the family has been receiving services through the Children's' Diagnostic and Treatment Center, a leading provider of primary care services for women and children living with HIV/AIDS, since shortly before his birth.

Through the case management program, Lorenzo is aware that Jose's HIV is under control as he and his mother are both compliant with medical appointments and labs, and Jose is taking antiretroviral therapy as prescribed. Lorenzo acknowledges the stressful situation, conducts a caregiver assessment and applauds Jose's father for taking the step to meet him and to work together to help Jose and his family get the services and supports they need. Lorenzo talks to Jose in detail about the options and alternative levels of care as well as the community resources available that may help Jose leave the facility as that is his primary concern at this time. Lorenzo also plans to provide Jose's father with emotional support options during the next meeting.

Lorenzo encourages Jose's father to consider therapeutic BH on-site services (TBOS), discussing in detail what these services entail and explaining that the purpose of these services is to help adolescents under 21 who have complex needs, like Jose. Lorenzo makes sure that Jose's father fully understands all the choices he has. Lorenzo reviews Jose's plan of care, and Jose's father agrees to consider TBOS.

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Lorenzo scheduled a peer-to-peer discussion with Jose's treating provider, a Plan Medical Director, to review the case and treatment options. After the conversation, everyone was in agreement that TBOS along with comprehensive case management, and community resources was not only a reasonable option but preferable. The treating provider acknowledged that he would stay engaged with Jose's care and follow the progress using this treatment plan. The provider was appreciative of Lorenzo's dedication to Jose's wellbeing and complimented the outpatient approach that was suggested.

Lorenzo explains that he will help with Jose's discharge by making sure his medications are in place and Jose's labs, thyroid dysfunction results and medications are reviewed by Jose's PCP (an HIV specialist) and his BH providers to make sure everything is in place before Jose leaves the hospital. Lorenzo assures Jose's father that Jose will have a follow-up appointment within seven days of his discharge with his providers, and that Lorenzo will help arrange transportation. Lorenzo talks to Jose's father about the need to develop a crisis plan for Jose. Lorenzo also makes sure Jose and his family have important contact information, including how to call Lorenzo and how to contact Clear Health's Member Services line, the Mental Health Crisis phone number, and local mental health provider clinic information.

Before the end of their meeting, Lorenzo arranges to meet with Jose and his father within five days (on the anticipated discharge date) to complete the comprehensive health assessment. He explains this process in detail to Jose's father and talks to him about what he wants to accomplish, his hopes for Jose's health, and the goals he'd like to achieve. Lorenzo explains to Jose's father how they'll work together to make sure Jose's preferences, goals, and desired health outcomes are met and that the plan of care will help identify the key supports structure, services, and care coordination to facilitate a safe transition for Jose.

During the next few days, Lorenzo reviews Jose's history and current admission in Clear Health's Integrated Rounds to obtain input regarding Jose's medical concerns, such as his adverse reaction to his medication and his thyroid dysfunction. The pediatric medical director explained that a common side effect of Seroquel is thyroid dysfunction and suggests a consultation between PCP and psychiatrist for possible medication adjustments and potential changes to the treatment plan. The team reviews strategies and approaches that Lorenzo can use to engage Jose, his father, and other family members. They also identify anticipated challenges and risks, and how to mitigate them. Using the feedback from this team, including Clear Health's pharmacist, pediatrician, and pediatric psychiatrist, Lorenzo develops a revised plan of care for Jose and his father to review in their next meeting. The plan of care helps ease Jose's whole-person transition through identification of services and social supports.

Lorenzo consults with the BH provider Jose sees for outpatient therapy, his current inpatient providers, and reaches out to other community agencies involved, such as the community mental health center that administer TBOS. Lorenzo also provides Jose's father with information about local National Alliance on Mental Illness programs, such as the Family Support Group and Family-to-Family program, a 12-week course for family and friends of individuals with mental illness, to assist them in caregiving, coping and problem-solving. Jose's father agrees to consider these but would like to hold off. Lorenzo also contacts Jose's PCP and with him, identifies an endocrinologist based on the family's preferences (location and language) to evaluate any potential thyroid issues contributing to Jose's symptoms.

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Lorenzo monitors Jose's admission and transition from the inpatient facility with his Clear Health care team members so that he will be able to determine if any adjustment is needed to Jose's care plan. Lorenzo remains in touch with Jose's father throughout the admission and transition to confirm that all services and follow-up appointments are coordinated (PCP, Psychiatrist, Endocrinologist, and TBOS) and to address any other issues that arise.

Jose is discharged in five days and Lorenzo meets with Jose and Jose's father to complete the assessment. He listens very closely to Jose and Jose's father discuss their situation and to understand Jose's personal goals, strengths, what is important to him, with whom he is connected in his community, and his readiness for change (as reflected on his Patient Activation Measure). Lorenzo makes sure to talk to Jose and his father about any cultural concerns and preferences they have and to discuss any issues or perceived stigmas related to Jose's bipolar diagnosis in addition to his HIV. Jose expresses interest in attending weekly support groups for teens with HIV at the Children's Diagnostic Center and this is added to his plan of care. Jose's father agrees to take him for his first group in two weeks. Lorenzo also reached out to Jose's mother to follow up with her and Jose's siblings. He let them know there are great family therapy resources available if the needed help as well.

Throughout the assessment process, Lorenzo is respectful of Jose's choices and provides information that he and his family can understand and use to inform his choices. Lorenzo explains that Jose and his father may choose a multidisciplinary team supplemented with Clear Health clinicians and supports, who help identify the care and services needed to meet Jose's goals. Together they collaborate to finalize the plan of care and Lorenzo ensures their understanding of all follow-up appointments scheduled and transportation available.

With Jose and his father's informed consents, Lorenzo schedules a time to meet again and review progress on Jose's plan of care. Throughout this process, as well as after the plan of care has been developed, Lorenzo continues to stay in close contact with Jose and his father, and helps them understand Jose's rights as a member and enhance his ability to manage his personal health information.

Lorenzo makes sure the person-centered plan of care is finalized, understood and approved by Jose and his father, and updated within 5 days of the initial meeting. He also sees that all services are authorized, coordinated, and initiated as soon as necessary. Throughout this process, Lorenzo works with Jose and his father to help Jose tell his own story and develop a recovery plan in his own voice, sharing important information about himself and his recovery goals. Lorenzo requests permission to include Jose's recovery plan in his plan of care for use by the multi-disciplinary team. With the correct signed consent in place, Lorenzo gives providers information on Jose's diagnoses, medication history, side effects, strategies that have or have not worked, and person-centered components of his plan of care, including strengths, motivations, and recovery goals.

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1.a. IDENTIFY MEMBERS WHO NEED CARE COORDINATION

In addition to member self-referral, Clear Health uses a multimodal approach to identify members who have complex conditions, need care coordination, and who may benefit from interventions. Through initial screeners, the comprehensive health Assessment, provider referrals, our Utilization Management team, and predictive modeling; we identify members, no matter where they live, who may benefit from any of our clinical programs – including our Case Management and Disease Management programs. In addition, our predictive modeling tool, the Chronic Illness Intensity Index (CI3) helps us proactively monitor and mine utilization data to identify members with high rates of utilization who may be at risk for ED, inpatient, medication adherence issues, and other key health factors. Among our suite of predictive modeling tools, we will identify members who need more intensive support, such as when a member has three ED visits within a 60-day period.

Previously, at the time of Jose's initial enrollment and his two prior admissions, Clear Health Case Management contacted Jose's mother (guardian of record) to offer care coordination and case management services that Jose's mother accepted. At the time of each of the admissions, Lorenzo as well as a member of our field-based Case Management team attempted to meet Jose's mother, face-to-face, but she declined. Lorenzo reached out to Jose's providers to provide care coordination and review Jose's benefits throughout these outreach attempts and admissions. Jose's case was coordinated for utilization management, transition services in the community, and discharge planning. Clear Health continued to monitor Jose's utilization and reached out regularly to offer enhanced case management and support services, but Jose's mother preferred to try to keep his care within her family support system at the time. With the most recent admission, Jose's father, his new legal guardian, submitted a request for SIPP services to Clear Health; the request was denied due to lack of medical necessity and Jose's father was notified of his right to appeal. Lorenzo reaches out to Jose who is made aware of how to reach backup case management during regular business hours as well as on evenings and weekends.

Lorenzo also contacts the Clear Health Transition Case Manager assigned to Jose's current facility to obtain updated information about Jose's transition plan. Lorenzo will share this information with Jose's father and will use this information in developing Jose's plan of care to help decide with his outpatient BH provider for a rapid post-discharge appointment and incorporates this information in Jose's personal health care record.

1.b. THE ASSESSMENT PROCESS

Our comprehensive health assessments target each member's physical, behavioral, cognitive, functional, and social needs for case management and care coordination services. Information obtained from assessments includes screening and assessment of current and past substance use, as well as questions regarding healthy behaviors, physical and behavioral health, history of medical and behavioral health, comorbidities, depression screening, and treatment history (including interventions that the member found to be effective and those that were not helpful). We have also developed a specialized recovery-oriented health risk assessment for members who have a serious mental illness that includes evaluation for co-occurring disorders.

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This information is maintained in the member's personal health record within our Case Management System. This system also includes all of Jose's utilization (ED visits, outpatient and inpatient services, authorization data, pharmacy), plans of care, and notes and interactions with Jose's Case Manager, Lorenzo. Lorenzo also attaches information gleaned from Jose's Individualized Education Plan, provided by his father during the assessment, as well as treatment plans from the inpatient facility, discharge plans and information gathered from coordination with Jose's current treating providers (such as results of psychosocial assessments), and information from the most recently submitted SIPP application.

To assure the development of a comprehensive, person-centered plan of care, Lorenzo arranges a face-to-face meeting with Jose and his father to conduct an assessment and capture their goals, preferences, and desired health outcomes. Following Jose's father's approval, Lorenzo initiates the tasks identified in the plan of care.

Lorenzo reviews the following sources of data/information as part of the assessment process to inform Jose's plan of care:

- School- and family-based support structures in place, including Jose's family dynamics and stability related to the current changes in his home situation (moving from his mother's house to his father's)
- Review of school issues, including the numerous recent absences and altercations that have occurred
- Review of the Individual Education Plan to identify barriers or needed changes
- Current or past involvement in the legal system, including Department of Juvenile Justice
- Transportation needs to get to school and medical and behavioral care appointments

Lorenzo also assesses Jose's ongoing BH and support needs, including his anger issues and reluctance to attend school or take his recently prescribed psychiatric medication, Seroquel. Lorenzo evaluates compliance with Jose's participation to identify barriers, challenges to care, and requests a review of current medications and side effects by the Clear Health pharmacist to identify alternative solutions. Lorenzo also looks for any evidence in Jose's treatment record that medication side effects have been discussed and planned for, to identify BH or substance use disorders in his family history, and to assess his intellectual functioning, including autism and Asperger's Syndrome.

As discussed above (1.a.) the timeframes for assessments and follow ups. The Plan follows NCQA or AHCA guidelines, whichever is more stringent.

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1.c. RISK STRATIFICATION PROTOCOL

Clear Health uses our proprietary Chronic Illness Intensity Index (CI3) for risk stratification. Its predictive modeling algorithms show the relative-risk ranking of members regarding their likelihood to consume significant medical service resources in the future. These members often have complex medical issues, high service utilization, intensive health care needs, and have higher IP and/or ED usage. All clinical data is entered into a reporting system, where it is synthesized to identify and stratify members by severity and risk level. Once stratified, our clinical team accesses the information to identify opportunities for outreach, education, enhanced access, and care coordination to identify members with comorbid medical or mental health and substance use disorders, assess their conditions, and implement interventions. Utilization and chronic condition data are claims-driven and based on the prior 12-month history.

Given Jose's past BH and medical history (with his HIV under control), he was originally classified as moderate risk. With these recent admissions, he is elevated to high risk. As part of our case management risk stratification protocol, our CI3 predictive model measures clinical risk and the likelihood of inpatient admission or emergency services use. Jose has a high score on all predictive models, indicating his risk for continued or new admissions and ED usage.

While predictive modeling puts Jose in the highest risk stratification, Lorenzo may also modify this level upon review of information obtained during the assessment process, such as social determinants of health influences, including ongoing school issues, legal system involvement, environmental concerns, substance use (if any), and any other medical problems noted. Because this information supports Jose's increased risk stratification, Lorenzo keeps the high-risk stratification in our Case Management System.

1.d. IDENTIFYING SERVICE NEEDS AND MAKING REFERRALS

Clear Health's guiding principle is and will continue to be person-centered care and service planning across the member's system of care, optimizing but never duplicating services. Our Care Coordinators coordinate personalized care and service supports across the full continuum of care to address the member's needs holistically (across physical health, behavioral health, and social supports).

While Jose is inpatient, Lorenzo uses the facility's and Clear Health's discharge plans to see that recommended services, including outpatient follow-up care, is assessed and coordinated, and that medication and BH authorizations are in place. Outpatient services recommended for Jose include TBOS or targeted case management. Lorenzo reviews both options with Jose and his father. He explains that these services will help Jose learn problem-solving skills, BH strategies, normalization activities, and other services that will help maximize his strengths and reduce behavior problems related to his mental health condition. Jose's BH challenges are significantly impacting his ability to interact and live within his family home and community. His challenges at school and at home — which led to his third admission to a psychiatric facility under the Baker Act — has likely put him under greater distress, which may evoke greater challenges upon his discharge. Lorenzo also verifies and makes referrals for any non-covered services identified (such as school-based programs) and works with community providers to coordinate them.

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Lorenzo also checks with the pharmacy benefit manager regarding discharge medications and to obtain a one-time medication prior authorization and coordinates with the treating provider on necessary prior authorizations going forward. Lorenzo also closely coordinates with our Utilization Management staff to make sure prior authorization is obtained for TBOS and targeted case management services and included in our Case Management System.

Jose needs a service array to help him manage his health issues. To assist in the transition, and promote long-term best health outcomes, Clear Health provides the following wrap-around services:

- Case Management — Lorenzo serves as Jose's Managed Care Coordinator and coordinates care, provides access to resources, and develops and oversees implementation of a person-centered plan.
- Therapeutic Behavioral Onsite (TBOS) Services — TBOS for children and adolescents are designed to assist high-risk children to prevent a more intensive and restrictive behavioral health placement. Coverage must include the provision of these services outside of the traditional office setting.
- Crisis Stabilization — This acute care service, offered 24/7, provides brief, intensive mental health residential treatment services. This service meets the needs of individuals who are experiencing an acute crisis and who, in the absence of a suitable alternative, would require hospitalization.
- Outpatient BH services — A continuum of services, including peer support services and teen HIV support groups, designed to offer the least restrictive level of treatment to each patient. The program offers a structured therapeutic setting to individuals who have had an acute exacerbation of their psychiatric illness which severely interferes with multiple areas of their daily functioning including vocational, social and/or educational functioning.
- Medical services – PCP referral to coordinate laboratory evaluation of thyroid condition and potential referral to pediatric endocrinologist and potential of (a) make sure that bipolar diagnosis is correct in the context of thyroid dysfunction; (b) make sure that management with Seroquel is the best option considering thyroid dysfunction; and (c) coordination for the management of the thyroid dysfunction and the BH condition. In addition, the member will be screened periodically for drug-induced diabetes.
- School-based services (non-covered) — Lorenzo refers Jose and his father to the Broward County School system, which can assist them with development and implementation of an IEP and 504 plan.

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1.e. INTERVENTIONS AND STRATEGIES TO FACILITATE COMPLIANCE WITH THE PLAN OF CARE

Through regular, monthly contact (or more frequent as gaps are needed or as identified by the member) our Managed Care Coordinators reach out to members and review their progress towards the goals they've identified. The Managed Care Coordinator uses the member's personal health record, which is updated daily with utilization and claims data and identification of upcoming preventive screenings or changes in risk stratification, to remain current with the member's utilization and care gaps.

To assure compliance with Jose's plan of care and consistent with his and his father's desired outreach (telephonic vs. face-to-face, given their privacy concerns), Lorenzo conducts follow-up calls with them to remind them of post-discharge follow-up appointments. He verifies that Jose has transportation to and from the appointments, and that he and his father know what information to bring to these appointments, and helps them prepare a list of questions to ask the providers. Lorenzo also makes sure that Jose has access to needed well-child visits and that an appointment is scheduled with the endocrinologist Jose and his father select with input from his PCP to further evaluate Jose's thyroid issues.

For Jose and others like him who are living with HIV and behavioral diagnoses, the teenage years can be some of the most challenging as they develop social networks, find their first jobs, and eventually move out on their own. Lorenzo reviews the benefits of peer support programs with Jose and his father and, following their agreement, works to connect Jose with a peer support group that meets in a nearby town to help encourage him to adhere to his treatment plan and achieve his goals.

Our case management processes assure that Managed Care Coordinators have appropriate training, support, tools and supervision to make sure that each member receives the right care, at the right time and right place. As part of the collaborative case management process, Lorenzo consulted with his supervisor to verify and make sure the plan of care for Jose considered and addressed all barriers.

1.f. DISCHARGE AND AFTERCARE PLANNING PROTOCOLS

Discharge planning begins upon notification of an acute inpatient, observation status, rehabilitation or skilled nursing facility admission. Early identification and planning of the member's transition of care needs is essential in providing quality discharge needs and in making sure that the member is discharged to the appropriate level of care to prevent readmissions and unscheduled transition of care. Clear Health's Transition of Care team works with the member, Clear Health Concurrent Review nurses, attending physician, hospital staff, and all ancillary service providers to complete all discharge needs for members and identifies any ongoing care needs to coordinate with the designated Managed Care Coordinator.

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Prior to discharge, Lorenzo discusses the prepared discharge and treatment plans (hospital, Clear Health, and provider) with Jose and his father using evidence-based motivational interviewing techniques. He reviews the recommended follow-up care, peer support, and community-based resources available to Jose post-discharge, and makes sure that Jose has post-discharge access to the services he needs, including necessary medication authorizations, and that TBOs and targeted case management services are scheduled.

Jose's transition (discharge) plan is initiated at the point of his admission. The Clear Health Transition Case Manager assigned to his hospital determines that he is a Clear Health member and, upon review of his personal health record in the Clear Health Case Management System, notes that his mother had refused pediatric case management and support services during the past admissions. The Transition Case Manager works closely with the facility staff and has frequent contact to evaluate member progress. Maintaining this close working relationship with hospital team members enables proactive identification of needs, supporting care, and service coordination planning for Jose's transition. The Transition Case Manager works with the hospital to develop a comprehensive plan that considers Jose's recovery goals, as well as medical, behavioral, social supports, strengths and addresses risks to prevent readmission.

Lorenzo and the Clear Health Transition Case Managers make sure Jose understands his transition plan and condition, and knows that the appropriate supports and services are in place (including medications, transportation, and any other barriers identified).

1.g. COORDINATION WITH OTHER INSURERS, PROVIDERS, AND COMMUNITY PARTNERS FOR NON-COVERED SERVICES

Through our care planning processes, we identify and address our members' care and service needs across the full continuum of care (physical health, behavioral health, functional, and psychosocial). We recognize that members sometimes have needs that may not be met through our existing provider network or may not be a covered service. To help these members remain in the community, we engage all existing community resources to provide solutions. Because our Managed Care Coordinators know the local area, they access community supports and actively engage community-based organizations, advocacy groups, faith-based organizations, and other community resources to develop creative solutions for services that are not a covered benefit.

Based on the assessment, Lorenzo determines that Jose is not comfortable with his current BH provider. Lorenzo works with Jose and his father to identify another provider who has an established relationship with his PCP and speaks Spanish.

With Jose's and his father's permission, Lorenzo contacts the new BH provider for an appointment and provides a copy of Jose's plan of care. Lorenzo also makes sure that Jose's new BH provider is identified in the Clear Health systems. As the primary contact for Jose's care, Lorenzo coordinates all his follow-up appointments and services, making sure he has access to his PCP, an endocrinologist or other specialist referrals (as identified by his treating providers), and supporting coordination of non-covered services. Lorenzo also coordinates with the regional Managing Entity to assure seamless care across all of Jose's BH needs.

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Lorenzo works to make sure Jose's school-based needs are addressed and appropriate accommodations made. He works with Jose's school to assure completion of a new Functional Behavior Assessment to update his current Individual Education Plan/504 plan. Lorenzo also identifies local community-based resources that could benefit Jose and discusses them with Jose and his father, including the local Boys and Girls Club for after-school activities.

Lorenzo makes sure all of these actions and coordination activities across providers and referral services are documented in Jose's personal health record, including any follow ups resulting from the referrals. All services and care coordination are conducted in accordance with Jose's preferences and goals.

If Jose had other insurance, such as coverage through his mother's commercial policy, the Plan would confirm what services were covered under that policy and coordinated services such as targeted case management, which is a Medicaid-covered service unlikely to be covered under a commercial plan.

1.h. PROVIDER CAPACITY ASSESSMENT

Lorenzo, through care coordination, identifies network providers Jose and his father can select for referred care and services. If Lorenzo is unable to find a network provider, he will work with the provider network team to identify others for a single case agreement to connect Jose with his necessary services.

Clear Health's Provider Relations team makes sure that providers in the plan of care are credentialed accordingly and have the capacity to serve the member. Upon making a referral for service, the Clear Health Case Management team communicates Jose's needs with service providers he has identified to see that they are able to meet his needs. All referrals include Jose's detailed symptoms and behaviors at the time of referral to facilitate the best pairing. Should referral applications not be available, Lorenzo calls providers directly to see that Jose's needs can be met in a timely, and sufficient manner. Our expansive provider network includes providers that have enhanced training to meet the needs of specialty population such as those with behavioral health conditions. Our network also includes providers that are diverse and meet different cultural and linguistic needs as well.

1.i. STRATEGIES THAT PROMOTE MEMBER SELF-MANAGEMENT AND TREATMENT ADHERENCE



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To promote self-management for Jose's care, Lorenzo works to:

- Engage directly with Jose if he is intellectually able, and with his father's permission, to empower him to take control in his ongoing care needs
- Make sure that prescribing clinicians are aware of and work to address barriers to medication adherence for his psychotropic medications, and thyroid medication if needed, as well as monitor side effects that may deter medication adherence, including educating his family regarding higher risk of suicidal ideations for young adults on certain psychotropic medications.
- Discuss with Jose and his father the importance of medication adherence, and the benefits of appropriately taking prescribed medications for all of his medical conditions
- Refer Jose to age-appropriate support groups to discuss his HIV and other conditions with peers or other professionals
- Refer Jose's father and other family members to support groups (through NAMI and Federation of Families)
- Identify community organizations in addition to his Ryan White HIV/AIDS care provider that are related to Jose's interests in sports or other activities in order to increase engagement in positive, prosocial, structured activities

1.j. APPLICATION OF UTILIZATION MANAGEMENT PROTOCOLS

Clear Health's comprehensive Utilization Management (UM) program includes well-defined protocols for UM activities that are tailored to meet the needs of our members. We promote the delivery of care and services in a culturally competent manner within the context of members' cultural beliefs, behaviors, practices, disabilities, and language preferences. We use the guidelines and protocols to provide a framework for decision making that also considers social determinants, geographic location such as rural versus urban, and how those circumstances may impact access to care.

Our fully integrated UM program is compliant with NCQA standards and includes defined protocols for the following components:

- UM program structure and responsibilities
- UM staff qualifications and training
- Medical necessity criteria and Level of Care Guidelines including selection, approval, adoption, and resulting implementation
- Medical necessity review procedures (prospective, concurrent, and retrospective)
- Integrated care rounds
- Service authorization, adverse determination, and appeals procedures

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- Transition planning and coordination (initial and continued stay)
- New technology assessment
- Integrated pharmacy management
- Quality committee structure and responsibilities
- Quality oversight and improvement activities

Clear Health applies our Level of Care Guidelines to make sure members receive the most clinically effective, appropriate, and least restrictive services based on their unique needs, goals, and circumstances to support their recovery and community living. We recognize that the care continuum is fluid and members may enter treatment at any level then move to more or less intensive settings or levels of care. At each level of care, our goal is to provide access to individualized treatment. Our Utilization Management (UM) guidelines reflect evidence-based treatment protocols for children, adolescents, and adults. We use our BH policy, BH clinical guidelines, as well as guidelines from the American Society of Addiction Medicine, in conjunction with State coverage policy, to assess medical necessity of services.

To complement these guidelines, we conduct UM and Case Management rounds. For members, such as Jose, we include the participation of pediatric psychiatrists in these rounds to assure the clinical team (both physical and behavioral health) are aware of Jose's progress, impending discharges, and any community-based issues prior to admission and discharge. The coordination across teams and the participation of pediatric psychiatrists provides an opportunity for the Managed Care Coordinator to seek clinical/medical input in real time to support Jose's changing needs. The combination of coordinating care based on our medical necessity criteria and constant evaluation of Jose's current circumstances will best promote continuity in care and make sure it is fluid enough to meet his changing needs.

In supporting Jose, TBOS and TCM will require authorization. Clear Health utilizes a multi-layered approach to ensure members' information is secure, services are authorized accurately, and the member receives supports and services as quickly as possible. Decisions on authorizations are made within seven days, but an expedited authorization may be filed and a decision rendered within two days. Clear Health uses medical policy and clinical guidelines in conjunction with State coverage policy to assess medical necessity of services. Lorenzo monitors these authorizations and sees that they are completed in a timely fashion.

To assure continuity of care, Lorenzo works closely Jose's multi-disciplinary team and our Medical Directors to develop and implement a plan to effectively support his complex needs through the transition from the hospital to his father's house. Lorenzo uses our well-defined continuity of care processes to coordinate proactively with community partners as needed, so that Jose's services and supports work in concert with ongoing medical or behavioral health care to improve clinical and functional status, and to make sure he can remain safely remain in the community.

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1.k. STRATEGIES TO INTEGRATE MEMBER INFORMATION ACROSS THE PLAN AND SUBCONTRACTORS

Jose's information is integrated across the Plan's data platforms and the plan has data exchange processes to assure that each delegate has needed information, balancing compliance with HIPAA regulations while providing the vendor with the minimum necessary information needed to provide care. All delegates receive enrollment files and other pertinent medical data relevant to their delegated functions. For example, we regularly share with our delegated pharmacy benefits manager member diagnosis data to allow them to auto-adjudicate authorizations. Further, the PCP, has access through the provider portal to the utilization and case management history for the member.

Beacon, our subcontractor for BH utilization management and network management of our BH providers, is responsible for authorizing Jose's BH services. Lorenzo works closely with the Beacon UM nurse co-located in the Clear Health Case Management department to see that authorizations are entered and to find network providers for BH services to meet Jose's needs. All authorizations and providers are included in our Care Management System with timely data feeds. Throughout Jose's care planning, Lorenzo works closely with Beacon to see that his care is integrated in the necessary systems to assure continuity of care. He monitors that services are authorized and communicates frequently with Beacon to assure fully coordinated care.

2. WORKFLOW

As illustrated in our workflow, provided as Attachment MMA SRC# 18-1: Workflow, Clear Health meets all State-required time frames across the care planning process.

3. INNOVATIVE AND EVIDENCE-BASED PROCESSES TO ENHANCE COMMUNICATION AMONG SERVICE PROVIDERS AND SUBCONTRACTORS

Clear Health supports providing access to actionable medical and BH information to our multi-disciplinary team through our Case Management System. We support a shared plan of care approach where clinicians work together, through access to a member's physical and BH assessments, service authorizations and other clinical data, claims history, and gaps in care, to support coordination of all members' care and service needs. The system includes an online dashboard emphasizing utilization of wellness and emergency services that is available to all providers. Providers can send us secure referrals and information by email or fax. They can also send a provider-to-provider secure email (if their system permits) or transfer information among providers in a secure manner. Clear Health's Case Managers make sure that participating providers have the appropriate signed consents in place to coordinate care.

Lorenzo uses Clear Health's Case Management System to track Jose's plan of care and his and his family's engagement in services. The system is used to view Jose's use of health, pharmacy, and emergency services. The information helps inform ongoing activities to support Jose in his recovery.

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4. APPROACHES THAT SUPPORT CARE DELIVERY IN THE MOST APPROPRIATE AND COST-EFFECTIVE SETTING AND AVOIDS UNNECESSARY OR ED USE

Our program uses industry best practices, such as screening in health care settings and schools, motivational interviewing and engaging Peer Support Specialists, to supplement traditional clinician outreach. Our Managed Care Coordinators work to address the health status, health literacy, and engagement of members through targeted interventions and case management, education, self-management principles, and harm reduction. We engage providers, community partners, and others (such as Peer Supports) to make sure members have frequent in-person contact. During conversations with members, we determine their readiness to change, encourage them to identify strengths and needs from their own perspective, and participate in the development of their plan of care. This evidence-based and person-centered engagement methodology enhances the probability that members will develop self-directed plans of care with achievable goals. Our fully integrated program takes every aspect of a member's life into account. We work with members to address social determinants of health and support needs, such as housing, employment, commitment to preventive care, and needs in other life domains that can compromise sustained recovery. Following the processes resulted in redirection of Jose from SIPP to community-based services that keep him at home.

5. EXPERIENCE SERVING ENROLLEES WITH COMPLEX MEDICAL NEEDS AND IMPROVING HEALTH OUTCOMES

To proactively identify members with complex needs, we use a predictive modeling system that synthesizes member demographic and claims data, such as diagnoses, pharmacy, hospitalizations, ED encounters, and expenditures, to predict future outcomes. This enables us to identify and prioritize outreach to members with mental health, SUD, and other chronic health conditions, including those with the greatest need for ongoing services and likelihood to be admitted to the hospital in the near future. Using this information, we will identify a designated Managed Care Coordinator who is 'matched' to the member's primary needs, PH, BH or LTSS, based on training and licensure and is located in their geographical area whenever possible. All of our staff has received extensive cross-training to be able to provide for the member's needs, and has access to the full clinical support team in Clear Health, with expertise in pediatrics, adolescents, infectious disease, nutritional, disease management, and physical, LTC and behavioral health needs.

Studies have found that half of the individuals who develop serious mental illness had symptoms by age 14, and children are more at risk of relapse and readmission than adults. Our guiding principle for children with serious mental illness or serious emotional disturbance is they are best served at home, going to school, and participating in other age-appropriate activities whenever possible. Helping a child with serious mental illness or emotional disturbance is difficult for the entire family, so supporting the family is critically important. In our work with members, we understand the importance of supporting the family and the child's natural supports with education, community support, and respite options. We work with pediatricians to make sure they have the tools and training needed to provide screening and brief intervention to identify children and adolescents with serious mental illness, emotional disturbance, or SUD. We encourage providers to make referrals so children have timely access to wraparound and other community and/or faith-based services and supports. Likewise, we consider it important to team with local organizations working with the schools to promote screening and prevention activities and assure

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community collaboration. Families may lack access to important diagnostic services that are the foundation for development of effective service plans and Individual Educational Plans (IEPs). We support access to psychological testing to help identify appropriate interventions and facilitate access to services from the Developmental Disabilities Administration. Clear Health offers providers training on evidence-based practices in working with children and adolescents who have serious mental illness or emotional disturbance, and help them connect parents to relevant educational materials.

Our integrated, strengths-based, person-centered case management program considers the specialized needs of our members who have complex needs, including their physical, behavioral health (mental health and substance use disorder), pharmacy, and social and community support needs. We have extensive experience in the development of tailored complex case management programs for members with unique, complex, chronic, and co-occurring needs who require higher levels of interventions such as Jose. Our integrated approach provides access, responsiveness, and effectiveness in the system of care by supporting the following:

- 1) Identification of members with potential or current specialized or complex health care needs through early screening, comprehensive assessments, and predictive analytics
- 2) Risk stratification for each member based on a multi-faceted consideration of information
- 3) Placement of members into case or disease management programs based on needs assessment
- 4) Development of an integrated plan of care that addresses physical, behavioral health/substance use disorder, pharmacy, social, and home- and community-based needs for members as they transition across all settings and incorporates both covered Medicaid benefits and services as well as those not covered by Medicaid that would benefit the member
- 5) Reciprocal referrals and information sharing with PCPs/specialists and community based Ryan White providers with HIV expertise
- 6) Formation of multidisciplinary treatment team for members in complex case management as needed to support them and provide consistency and continuity of contact with their familiar support system, as well as the expertise of a broader team of specialists as their needs evolve
- 7) Care coordination support to improve member access to needed services, including scheduling appointments, arranging transportation, conducting appointment reminder calls, following up to verify service initiation and member progress, and making appropriate service adjustments and incorporating those into the plan of care
- 8) Ongoing evaluation of our case management program, including reviewing, tracking, monitoring, adjusting, and analyzing for outcomes, quality metrics, and improvement
- 9) Emphasis on disease prevention, chronic condition management, and increasing member engagement with recommended treatment protocols
- 10) Establishment of community-based relationships

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11) member education to enhance understanding of health care conditions and prescribed treatment

12) Encouragement for members to develop their capacity to self-direct their care

13) Collaboration with other state and community entities to ensure truly integrated care and prevent duplication of service.

6. COORDINATED HEALTH CARE INTERVENTIONS DESIGNED TO ACHIEVE COST SAVINGS

Our members in case management frequently identify as having two or more conditions. In fact, throughout our health plan, 62 percent identify as having three or more. Achieving cost savings while optimizing health outcomes requires a member-centric, integrated approach. Our members work closely with qualified and trained Case Managers (Managed Care Coordinator) to make sure they are receiving the most appropriate level of care. Our model has proven successful. In a 2016 case study, we found that after receiving case management services for at least 90 days, members used health resources more efficiently and required less emergent care, thus reducing costs while improving outcomes. One such outcome was significantly greater: reduction in avoidable ED visits and inpatient admissions. Overall, members demonstrated a 39 percent reduction in non-emergent ED visits.

We recognize that members, like Jose, can often experience a range of physical health issues that can adversely affect their health, have co-occurring physical health and behavioral health diagnoses, and experience significant life changes or move across different systems of care. Together, these factors can create challenges to accessing the appropriate integrated care and services needed. Our Managed Care Coordinators deeply understand the Florida health care system and know how to link members with the providers, community resources, and stakeholders they need to support their safety, permanency, and wellbeing. Our tiered model of clinical interventions address the care continuum from birth to end of life. It is both flexible and responsive to changes in support needs, such as increasing or decreasing intensity or complexity. We collaborate with local and State-based stakeholders, including members and their families, advocates, network providers, community-based organizations, and State agencies to assure access to and coordination of the full continuum of care. Regardless of age, ability, or need, we emphasize care connections – our Case Management System helps us connect our members with the right providers to get the right care at the right time at the most appropriate level of care. This approach brings high quality, cost effective care to each member.

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7. INNOVATIVE AND EVIDENCE-BASED STRATEGIES TO INTEGRATE INFORMATION ACROSS ALL SYSTEMS/PROCESSES INTO ITS WORKFLOWS

Our care coordination/case management workflows use a variety of innovative, evidence-based strategies to integrate information across all processes and systems, beginning with our members' real-time personal health record. Through our advanced Case Management System, each member's personal health record contains updated utilization and claims history along with any "red flags" to alert our Managed Care Coordinators about upcoming or overdue preventive health screenings. All of our health plan staff who interact with the member have access to this system, so they can offer seamless, integrated assistance in coordinating care and making sure the members' needs are addressed (such as scheduling appointments or arranging transportation). Our system also allows individuals who are part of care management or care coordination to enter tasks, send letters, or connect directly with members based on the information in the personal health record.

As part of our medical necessity reviews, our Case Management System incorporates Clear Health's evidence-based criteria and Level of Care guidelines and enables our clinical and Utilization Management staff to document medical necessity reviews of preauthorization requests. UM reviewers can easily access critical information and use it to make the most appropriate Level of Care determinations. The system captures the exact criteria used in a clinical decision, the date and time of the review, and the updated information in the member's personal health record systematically so that all information stays up-to-date to promote integrated care. Our Case Management System is also connected to our calendar system so that our Managed Care Coordinators can easily schedule screenings, assessments, and follow-up meetings with the multi-disciplinary team.

Another key part of our clinical workflows is our comprehensive assessments. These include innovative branching logic, which guides our Managed Care Coordinators into areas for deeper details or to conduct additional assessments, such as high-level behavioral health screening (which might trigger an additional behavioral health assessment) or comorbid chronic conditions that will trigger additional disease-specific assessments. All of this information is retained with our Case Management System, allowing our Managed Care Coordinators to fully address a member's total health care needs.

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Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:
 - a. Identification processes for enrollees with complex health conditions or who are in need of care coordination;
 - b. Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
 - c. Application of the respondent's case management risk stratification protocol;
 - d. Identification of service needs (covered and non-covered) and a description for service referral processes that the plan has in place;
 - e. Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;
 - f. Application of discharge and aftercare planning protocols that facilitate a successful transition;
 - g. Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;
 - h. Description of the assessment of provider capacity to meet the specific needs of enrollees;
 - i. Identification of strategies that promote enrollee self-management and treatment adherence;
 - j. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
 - k. Application of strategies to integrate information about the enrollee across the plan and various subcontractors when the respondent has delegated functions.
2. The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process.
3. The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).
4. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.
5. The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.
6. The extent to which the respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.

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7. The extent to which the respondent describes innovative strategies to integrate information across all systems/processes (e.g., prior authorization data synching up with the claims system) into its workflows.

Score: This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.

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Table 18-1. Workflow

Day	Description
	Jose has been a member since July 2014. Lorenzo is his assigned Managed Care Coordinator. Given Jose's past BH and medical history (with his HIV under control), he was originally classified as moderate risk. With these recent admissions, he is elevated to high risk. At the time of each of his recent admissions Lorenzo reached out regularly to offer enhanced case management and support services, but Jose's mother preferred to try to keep his care within her family support system at the time and refused. Jose has recently moved in with his father since his decline in behavior.
July 2017	Jose has shown behaviors indicating he may be a danger to himself or others and is hospitalized a third time under the Baker Act.
Day 1	The hospital social worker assists Jose's father in completing and submitting a referral for Statewide Inpatient Psychiatric Program (SIPP) services.
Day 2	Jose's SIPP request was denied based upon lack of medical necessity. The UM coordinator notes Jose's file and the recent repeated attempts to engage in enhanced case management and support services and discusses the case to Lorenzo, a Managed Care Coordinator who lives in Jose's community.
Day 2	Jose's SIPP denial also triggers a Transition Behavioral Health (BH) Managed Care Coordinator to be assigned to his case immediately. The Transition Managed Care Coordinator contacts Jose's father to begin the process of getting Jose wraparound services in the community. Jose's father expresses discontent with the denial. The Transition BH Managed Care Coordinator notes Jose's personal health record and indicates that Lorenzo, will be contacting him. Later that day Jose's father calls the Member Services line to inquire about filing an expedited appeal. The Customer Care Representative explains that he can verbally file an expedited appeal, completes the request, and informs Jose's father that he will hear back within 72 hours on the results of his expedited appeal.
Day 2	Member Contact: Lorenzo calls Jose's father to review the SIPP denial and alternative options available for Jose and his father. He reviews the benefits of therapeutic BH on-site services (TBOS) with Jose's father, who is agreeable. Lorenzo schedules a face-to-face meeting with Jose and his father near where Jose's father works at a time and date requested by Jose's father. During the call, Lorenzo also informs Jose's that while the results of the appeals process are pending, there are alternatives treatment options. Lorenzo also reviews the alternative level of care recommendation that was provided with the denial, which Jose's father declines pending the outcome of the appeal. Lorenzo stresses to the father the urgency to meet regarding Jose's situation, regardless of the result of the appeal, and Jose's father agrees to meet the following day as planned.
Day 3	The expedited appeal is reviewed by a BH Medical Director who was not involved in the original decision and upheld. The member is contacted on the same day by telephone to notify of the outcome. An appeals resolution letter is sent explaining all further member rights.
Day 3	Comprehensive Health Assessment: Lorenzo meets with Jose's father to discuss the current admission, the appeal and decision as well as Jose's treatment and available options including Therapeutic Behavioral On-site Services (TBOS). Lorenzo reviews Jose's plan of care and Jose's father agrees to consider TBOS. Lorenzo explains that he will help with Jose's discharge by making sure his medications and his BH providers are in place before Jose leaves the hospital. Lorenzo assures Jose's father that Jose will have a follow-up appointment within seven days of his discharge, and that Lorenzo will help arrange transportation. Lorenzo talks to Jose's father about the need to develop a crisis plan for Jose. Lorenzo conducts a caregiver assessment and also makes sure Jose's father has important contact information, including how to call Lorenzo and how to contact Clear Health's Member Services line, the Mental Health Crisis phone number, and local mental health provider clinic information. Before the end of their meeting, Lorenzo arranges to meet with Jose and his father in five days to complete the comprehensive health assessment with Jose and his father together.

Day	Description
Day 4	Care Coordination/Case Management: Lorenzo discusses Jose's case during internal rounds, with participation from a Clear Health pediatric medical director who suggests a consultation between PCP and psychiatrist for possible medication adjustments and potential changes to the treatment plan to help address Jose's needs. The team reviews strategies and approaches that Lorenzo can use to engage Jose, his father, and other family members. They also identify anticipated challenges and risks, and how to mitigate them. Using the Lorenzo develops a revised plan of care for Jose and his father to review in their next meeting.
Day 5	Care Coordination/Case Management: To address Jose's medication compliance, Lorenzo has a Clear Health psychiatrist review Jose's case with his PCP. After running labs, they determine that the Seroquel prescription should be replaced with a medication that is long acting and has fewer side effects. Lorenzo consults with the BH provider Jose sees for outpatient therapy, his current inpatient providers, and reaches out to other community agencies involved, such as the community mental health center that administer TBOS. Lorenzo also calls Jose's father with information about local National Alliance on Mental Illness programs, such as the Family Support Group and Family-to-Family program, a 12-week course for family and friends of individuals with mental illness, to assist them in caregiving, coping and problem-solving.
Day 6	Care Coordination/Case Management: Lorenzo identifies endocrinologists in Jose's area for Jose and his father to select to evaluate any potential thyroid issue.
Day 8-20	<p>Care Coordination/Case Management: Lorenzo participates in Jose's transition from the facility and assures that all activities are integrated with Jose's plan of care. Lorenzo meets with Jose and his father to complete a comprehensive health assessment. They discuss Jose's short- and long-term goals, concerns about reintegrating in the community, his issues with prescribed medications, and his current providers. They discuss his family, living situation, education, and friends. He also refers to school system to develop a new Individualized Education Plan for Jose who would like to try virtual learning.</p> <p>Additional alternative providers and supports that are available to Jose and his father are also discussed. Throughout the assessment, Lorenzo helps Jose and his father to identify service providers that they would like to see incorporated in his plan of care. Lorenzo obtains Jose and his father's approval and together they finalize the plan of care with Lorenzo arranging to return to review progress towards plan of care goals and they identify a time and date that works for Jose's father in two-weeks. The plan is shared with multi-disciplinary team members agreed on by Jose and his father.</p> <p>Lorenzo calls Jose's father on day 13 (within 5 days of discharge) to confirm PCP, endocrinologist and new BH provider appointments were attended.</p> <p>Lorenzo visits again on day 20 (two-week post discharge follow-up) and finds that Jose is improving and engaged in therapy (TBOS).</p>
Day 29	Care Coordination/Case Management: Lorenzo follows up with a call and discusses with Jose's father compliance with medications and treatment and is told he is really doing well since his medications have been adjusted and thyroid medication added. Also the IEP has been completed and he has returned to school with special services.
Day 30 and Ongoing	Care Coordination/ Case Management: Lorenzo calls to follow up on Jose's health status and provides appointment reminders. He will continue to follow up with the family monthly as Jose is still considered high risk.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 19 - Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Jane is a 57-year old female with Type II diabetes mellitus and hypertension. Jane is compliant with her treatment plan, which consists of the following prescribed drugs: Insulin and Lisinopril. She is also compliant with her follow-up appointments with her specialists. She lives alone, but receives support from her eldest daughter who lives nearby. Jane thought she timed her follow-up visit with her endocrinologist adequately to allow sufficient time to receive a new prescription for all drugs; however, Jane realizes she only has enough insulin to last through the doses for tomorrow. Her appointment with Dr. Seem, her endocrinologist, is in two weeks. Jane calls her doctor's office who informs her that they have no availability to see her today or tomorrow and Dr. Seem will not write a new prescription without examining Jane since it has been four months since her last appointment. Jane decides to call her health plan's member hotline for assistance.

The respondent shall describe the approach for handling Jane's call and how the respondent would help Jane obtain her medication.

Response:

Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance (Clear Health) understands the importance of access to prescribed medications for members like Jane, to help them better self-manage their chronic conditions. In the response below, we present how our Case Management processes and staff work to make sure Jane has access to the services and support to address her needs, goals, and preferences.

Following Jane's story, we outline our activities to meet each of the Evaluation Criteria.

**** Obtaining Required Medication In A Timely Fashion ****

After Jane realizes she's out of insulin and not able to see her endocrinologist soon, she finds the number to Clear Health's Member Services line and calls. Andrea, one of our qualified and trained Customer Care Representatives, answers and talks to Jane to see how she can help. Andrea asks Jane questions to find out how much insulin Jane has left and how Jane typically gets her supply of insulin. She asks Jane where her pharmacy of choice is located and also makes sure Jane has the means to get there. Andrea checks the Case Management System to verify the status of prescriptions and sees that Jane does not have any refills on her insulin authorized.

Fully understanding the issue, Andrea gets to work right away to help Jane get the insulin she needs. First, Andrea calls Jane's endocrinologist, Dr. Seem. Jane speaks directly to Dr. Seem, explaining the current situation and requesting a new, temporary prescription to meet Jane's immediate insulin needs until the office can see Jane for an appointment (in two weeks). Andrea also asks if there is any way to get Jane in sooner. Dr. Seem reiterates what he told Jane, that cannot write a new prescription, but says he is willing to issue a temporary one. He also agrees to fit Jane in to the schedule for an appointment in one week.

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Next, Andrea follows up with Jane's other specialist and pharmacy to verify the prescription has been processed. Once all of this is in place, Andrea calls Jane back to let her know her prescription is ready and can be picked up. Andrea double checks to make sure Jane wants to pick up her prescription (rather than home delivery) and has the transportation to get there before her supply is fully depleted.

Andrea takes the time to talk to Jane about the benefits and services available that may help her. She tells Jane how to get assistance with making appointments and the various options available for prescriptions (including home delivery). Since Jane is not currently receiving case management, having declined previously, Andrea also discusses this option with Jane, explaining how a designated Case Manager (Managed Care Coordinator) could be a valuable partner in helping Jane manage her health.

Andrea talks to Jane about the other options available, for future need, such as refill reminder options as well as the assistance that Andrea or another Representative can do to help assist Jane in making appointments, if needed. Jane really likes the idea of a Managed Care Coordinator to help her stay on track and agrees to be enrolled in case management to assist with her chronic health conditions, including well controlled HIV Disease. Andrea lets Jane know a Managed Care Coordinator will be in touch within 48 hours or two business days. Andrea notates this in the Case Management System and sends an electronic referral.

Based on Jane's history and condition, she is assigned the Managed Care Coordinator, Tom, for active case/disease management who can best assist her. The following day, Tom calls Jane to introduce himself and talk to Jane about case management. He talks at length with Jane about her situation and asks questions to understand her preferences, goals, and any barriers she feels exist to managing her condition. He also explains the comprehensive health assessment process and schedules a time to complete one with Jane that is convenient for her. Once the assessment is complete, Tom identifies several areas where Jane can use her benefits to help with her current self-management. Together, they create a plan of care with steps to help her meet her goals:

- Tom enrolls Jane in the Clear Health HIV/AIDS Case Management program to assist her with accessing resources and education that may reduce health risks. He develops and oversees implementation of a person-centered plan addressing all of her chronic health conditions including HIV Disease, Type II diabetes mellitus, and hypertension.
- Tom educates Jane by providing her with informational materials and reminders in the mail about her current medical conditions. These materials will help her strengthen her self-management skills and identify and prevent any complications that may arise, such as increased risk of heart attack, stroke, and complications from poor circulation.
- Tom provides information on healthy habits Jane can adopt, such as maintaining a blood pressure target of less than 130/80 mmHg to reduce her cardiovascular risk and delay progression of possible kidney disease, as well as a healthy diet and the need for daily foot checks.
- Tom arranges for Jane to meet a Clear Health Nutritional Case Manager to explore dietary changes she could make to help control her diabetes.

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- Tom arranges automatic mail order through a Clear Health subcontractor for Jane's testing supplies; he explains how to order these in the future to her.
- Tom enrolls Jane in the Clear Health Healthy Behaviors program for Weight Management as she has identified this as one of her goals.



- Tom provides Jane his direct phone number and gives her information on how to reach Clear Health's case management department in the event that she has an urgent need.

1.a. TRAINING FOR CALL CENTER STAFF AND INTERNAL ESCALATION PROCESS

In Clear Health's experience, cases like Jane's are typically quickly resolved in our Member Services department and referred to case management for identification purposes and ongoing support. Our Customer Care Representatives are available 24/7. They are thoroughly trained through our comprehensive orientation process and ongoing training to address high-impact and urgent inquiries, such as Jane's need for insulin or other diabetic supplies and medications. Member Services training includes specific protocols to follow for resolution, including proactive escalation, coordination with case or utilization management, and how to effectively partner with primary care providers (PCPs), specialists, and pharmacies. Training focuses on making sure the representatives are especially sensitive to any calls regarding medications, serious medical conditions, and medical needs of minors. Our continuous training programs incorporate the use of recorded calls to coach team members and use real-life scenarios as case studies so that our representatives are well prepared to handle these types of calls.

We use a layered internal control process to help our Customer Care Representatives best support members like Jane and reduce the risk of future urgent or emergency care. First, in concert with the high-level of training already discussed, all Clear Health representatives are supported by a network of Operations Experts and Managers who can assist them in identifying the best course of action for a member's specific situation. Second, Clear Health's call tracking and reporting system has the functionality to identify urgent calls, and route them to a senior representative or manager for review. In this case, due to Jane's urgent need for critical medication, her call is routed automatically to a Manager. If the Manager determines that the initial representative is unsuccessful in resolving the issue (for instance, the provider stated he would phone in a prescription, but it is not yet shown as filled), the case is referred to Clear Health's Resolution team.

The Resolution team handles complex issues for members and seeks to resolve them as quickly as possible. In Jane's case, this means following up with Jane's specialist and pharmacy to make sure the prescription is called in and processed without issue, and confirming the best way for Jane to receive her prescription in a timely manner (either by picking it up, arranging transportation for her, or coordinating home delivery options).

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1.b. SUPPORTING CARE DELIVERY IN THE MOST APPROPRIATE AND COST-EFFECTIVE SETTING AND AVOIDING UNNECESSARY OR ED USE

Our Managed Care Coordinators work to address the health status, health literacy, and engagement of members through targeted interventions and case management, education, self-management principles, and harm reduction. During conversations with members, we determine their readiness to change, encourage them to identify strengths and needs from their own perspective, and participate in the development of their plan of care. This evidence-based and person-centered engagement methodology enhances the probability that members will develop self-directed plans of care with achievable goals, and avoid unnecessary emergency department use. To make sure members can thrive in their home or setting of choice, our fully integrated program takes every aspect of a member's life into account. We work with members to address social determinants of health and support needs, such as housing, employment, commitment to preventive care, and needs in any of life's domains that can compromise sustained recovery.

For every member, we tailor our approach and interventions to fit his or her needs, recognizing that each individual is unique. In Jane's case, we use approaches to support her and make sure she has the services she needs to maintain her health and avoid unnecessary emergency room use, such as the following:

- Making sure the Jane is fully informed about her condition and understands the impact that exercise, food, and daily insulin have on her blood sugar levels.
- Reviewing Jane's current tools for monitoring her blood glucose and determining if a new device is needed.
- Coordinating a referral from Jane's physician to her Durable Medical Equipment (DME) provider to arrange for test strips to be shipped to Jane at her home for the next 12 months.
- Following up after visit her physician visit and again after receiving her new prescription, to make sure she has a prescription and resources in place for the next 12 months to receive insulin.
- Arranging additional appointments and transportation as needed. For example, Tom notices Jane has not had an annual eye exam for her diabetic retinal exam (DRE) and helps set this up for her.

Our members in case management frequently identify as having two or more conditions. In fact, throughout our health plan, 62 percent identify as having three or more. Achieving cost savings while optimizing health outcomes requires a member-centric, integrated approach. Our members work closely with qualified and trained Case Managers (Managed Care Coordinators) to make sure they are receiving the most appropriate level of care. Our model has proven successful. In a 2016 case study, we found that after receiving case management services for at least 90 days, members used health resources more efficiently and required less emergent care, thus reducing costs while improving outcomes. One such outcome was significantly greater: reduction in avoidable ED visits and inpatient admissions. Overall, members demonstrated a 39 percent reduction in non-emergent ED visits.

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1.c. INNOVATIVE AND EVIDENCE-BASED PROCESSES TO ENHANCE COMMUNICATION AMONG DEPARTMENTS AND SUBCONTRACTORS

We integrate member information through our robust data platform and our established data exchange processes, so that all parties involved have access to the necessary information to fully coordinate care. We balance this by using strict safeguards to maintain HIPAA compliance and to only provide necessary information to those who need it. This is an especially sensitive issue for our member living with HIV/AIDS.

All delegates receive enrollment files and other pertinent medical data relevant to their assigned functions. For example, we regularly share with our delegated Pharmacy Benefits Manager member diagnosis data to allow them to auto adjudicate authorizations. Further, our provider portal allows primary care and specialty providers access to the member's utilization and case management history to better coordinate care. Each member has a personal health record, which is accessible by all Clear Health staff engaged in case management and care for that member.

Our care coordination/case management processes incorporate a variety of innovative, evidence-based strategies to integrate information across all systems and communicate easily with all involved, beginning with our members' real-time personal health record. Through our advanced Case Management System, each member's personal health record contains updated utilization and claims history along with any "red flags" to alert our staff about upcoming or overdue preventive health screenings. For instance, Andrea (our Customer Care Representative) notices a red flag alert in the system that Jane may have missed an annual checkup with her PCP, which prompts Andrea to ask Jane about this and help her make an appointment.

All of our health plan staff who interact with the member have access to this system, so they can offer seamless, integrated assistance in coordinating care and making sure the members' needs are addressed (such as scheduling appointments or arranging transportation). Our system also allows individuals who are part of case management to enter tasks, send letters, or connect directly with members based on the information in the personal health record. As part of our medical necessity reviews, our Case Management System incorporates Clear Health's evidence-based criteria and level of care guidelines and enables our clinical and utilization management staff to document medical necessity reviews of pre-authorization requests. UM reviewers can easily access critical information and use it to make the most appropriate level of care determinations. The system systematically captures the exact criteria used in a clinical decision, the date and time of the review, and the updated information in the member's personal health record so that all information stays up-to-date to promote integrated care.

EXHIBIT A-4-b MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Another key part of our clinical workflows is our comprehensive health assessments. These include innovative branching logic, which guides our Managed Care Coordinators into areas for deeper details or to conduct additional assessments, such as high-level behavioral health screening (which might trigger an additional behavioral health assessment) or co-morbid chronic conditions that will trigger additional disease-specific assessments. All of this information is retained with our Case Management System, allowing our Managed Care Coordinators to fully address a member's total health care needs. In Jane's case, the comprehensive health assessment will include additional questions related to her diabetes and hypertension, to make sure we identify any knowledge gaps and education opportunities.

Our Case Management System is also connected to our calendar system so that our Managed Care Coordinators can easily schedule screenings, assessments, and follow-up meetings with the multi-disciplinary team.

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:
 - (a) Training for call center staff that illustrates the ability to triage cases of this nature, including the internal escalation process available to call center staff.
 - (b) Description of the interventions and strategies that would assist Jane in avoiding a visit to urgent care or the emergency department to receive a new prescription.
 - (c) Evidence of the integration between and among all relevant departments, including subcontractors if applicable, to facilitate a seamless resolution.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
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MMA SRC# 20 – Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Emma is four-years old. She currently lives in a pediatric nursing facility. At the age of two she was admitted to PICU following a respiratory arrest during an acute illness. A further complication of her condition led to her requiring a tracheostomy to support her breathing. Following an acute exacerbation of her condition, she is now unable to breathe without the support of her ventilator when she is tired, asleep, or unwell. She is fully ventilated overnight. Her difficulties are compounded by complex seizures. Emma's doctor says Emma needs to have nurses or health care assistants with her at all times to monitor her ventilation. Emma's most recent developmental screening indicates the presence of an intellectual disability. Emma's condition has stabilized, but her mother is concerned about agreeing to bring her home permanently. Her mother is the sole income for their home, which includes three older siblings and Emma's maternal grandmother. Emma's grandmother is retired, and her ability to help the family is limited by severe rheumatoid arthritis.

To be discharged to her home, Emma's physician has ordered a custom wheelchair that must be individually fabricated and assembled. Her physician also ordered an electronic tablet to provide cognition exercises for Emma. The tablet has a cognition exercise application that reduces the likelihood for any seizure activity that may occur with other similar tablets. Florida Medicaid does not cover the tablet nor the wheelchair, which includes a part that will make it easier for Emma to hold the tablet. Her mother is unable to bear the costs for these special service items. Further orders for Emma's transition to home care are:

- *Continuous pulse oximetry monitoring.*
- *Apnea monitor when she is not on the ventilator.*
- *A backup generator for the ventilator if the power goes out in the home.*

Emma is a new enrollee. Prior to her enrollment, all services were provided through the Medicaid FFS delivery system.

The respondent shall describe its approach to coordinating care for an enrollee with Emma's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

- a. New Enrollee Identification;
- b. Health Risk Assessment;
- c. Care Coordination/Case Management;
- d. Service Planning;
- e. Discharge/Transition Planning;
- f. Disease Management;
- g. Utilization Management; and
- h. Grievance and Appeals.

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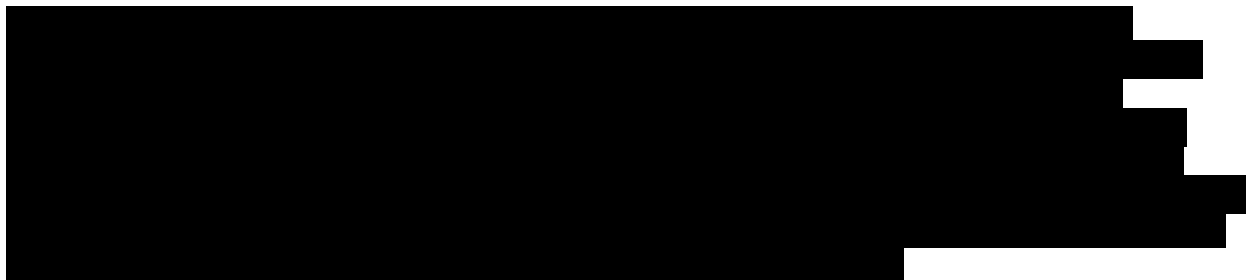
Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

Emma is a four-year-old female who requires a person-centered plan of care and is a new member to Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance (Clear Health). Clear Health is dedicated to assuring continuity of care for our pediatric members with complex conditions. Our Pediatric Case Managers are well versed in partnering with providers and family members to support a holistic approach to maintaining the comprehensive coordination of medical, nursing, behavioral health, community resources, services and interventions needed to support these children and their families in their setting of choice. These specialized staff, known as Managed Care Coordinators, are distinct from the Case Managers that many of our members may have through Ryan White-funded HIV/AIDS service organizations. Our goal is always to restore, maintain, and promote the health status of the child through partnership with the child's providers, family, and caregivers through a personalized plan of care that will address member- and family-identified service needs, coordination, and treatment of the child's chronic and severe conditions, functional limitations, and the child's physical, behavioral and psychosocial health needs.

**** Providing Care and Support for our Most Vulnerable Members ****

Clear Health receives notification of Emma's transition from Medicaid Fee-for-Service (FFS), through a continuity of care call from the Medicaid FFS Case Manager. Emma is assigned a Managed Care Coordinator, Barbara, based on Emma's age, location (pediatric nursing facility), and Barbara's extensive background working with children with complex needs including the HIV Disease that Emma was born with. Barbara reviews Emma's history and plan of care with the Medicaid FFS Case Manager in preparation for Emma's transition to Clear Health. She notes Emma has multiple physical health needs and services, including tracheostomy care, ventilator care, 24-hour Private Duty Nursing, mobility needs, continuous pulse oximetry, apnea monitor, complex seizure disorder, and an intellectual disability that will require a specialized team of health care professionals to assist her.



Barbara calls Emma's mother to introduce herself, welcome her, get to know more about Emma's current situation, describe the case management process, and initiate the comprehensive health assessment. During the call, Barbara explains Emma's benefits and schedules a time to complete the comprehensive health assessment within the week. Emma's mother asks for the visit to be conducted at the facility in two days, after her work hours so that

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it does not interfere with her job. She requests that Emma's favorite nurse and aide both be present for the assessment.

Emma's personal health record includes all information that has been received to date including pharmacy information and initial authorization data. Barbara supplements this with the information she has obtained from the nursing facility, from her initial outreach, and the information obtained from the Medicaid FFS Case Manager. Barbara contacts Emma's PCP and specialists to introduce herself as Emma's Managed Care Coordinator and ask for dates and times of availability in anticipation of the need for a multi-disciplinary team meeting.

Barbara meets Emma's mother as previously scheduled and conducts a comprehensive health assessment designed for pediatric members. Through the assessment process, Emma's mother discusses Emma's long term health goals, her desired outcomes, and preferences for her care. Barbara discusses Emma and her mother's psychosocial, spiritual, and cultural preferences and communication options for Emma. Throughout this process, Barbara verifies information that she has already obtained to determine if the current care is optimal, and to establish of Emma's plan of care at the nursing facility, and for a safe transition home.

Emma's mother shares her concerns about caring for Emma, as well as her three older siblings, so Barbara also discusses placement choices at length with Emma's mother, making sure that Emma's mother fully understands the residential options that may be available for Emma. She discusses the Freedom of Choice form with Emma's mother and obtains her signature, once she indicates she prefers to transition Emma home rather than to a group home or remaining in the nursing facility. Barbara explains that she will complete the person-centered plan of care for Emma's mother's review within the next week, and that she has already authorized the continuation of Emma's current services. As agreed upon, Barbara also shares the plan of care with the nursing facility for their feedback, and reaches out to Emma's providers to obtain their feedback as well.

Barbara and Emma's mother spend time discussing Emma's anticipated care needs, her concerns, and the responsibilities of continuing care for Emma during her current stay, her transition home, and post transition in the home. Barbara coordinates and convenes a multi-disciplinary team meeting to develop a transition plan and to discuss placement alternatives to be discussed with Emma's mother. Barbara communicates available options that Emma's mother will have to support Emma's care and service needs, reviewing the benefits of each option carefully and making sure that Emma's mother understands what each entails. Emma's mother reviews this information with Barbara and the multi-disciplinary team, and together they identify a transition plan that will help Emma and her family to feel confident in her safe transition home and continued care and service needs in the home.

Once the comprehensive health assessment is completed and Emma's health and services needs are identified, Barbara completes the development of the person-centered plan of care and coordinating the multi-disciplinary team review of the document. Emma's mother, PCP, specialists, and pediatric nursing facility staff review Emma's plan of care, which includes Emma's current services and support needs, any Medicaid reimbursable services she may need, as well as non-covered benefits that will need to be coordinated.

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To encourage her ongoing participation, Barbara shows Emma's mom's how she can access, review and provide feedback on Emma's plan of care through Simply's online platform. Barbara will discuss the plan of care as part of her regular contact with Emma's mom, which will begin as daily exchanges for the first week that Emma is home, followed by weekly contacts for the next month.

Following Emma's mother's approval, Barbara initiates the tasks identified in the plan of care. To ensure a successful transition to Emma's family home, Barbara works with the pediatric nursing facility discharge staff, Emma's assigned nursing facility nurse, Emma's mother, Emma's PCP and specialists, subcontractors, and service providers identified in Emma's plan of care to finalize her transition.

Barbara works closely with the Nursing Facility Discharge Planner to review all orders and clinical documentation and includes the Clear Health Utilization Management (UM) department for authorization of service. For those items that are not covered through Emma's Medicaid benefits, but are ordered by her provider as medically necessary, Barbara facilitates a review of Emma's case and care needs with the Clear Health Medical Director. This includes reviewing the equipment recommended by her provider that is not covered under Florida Medicaid, such as the custom wheelchair and tablet. Barbara makes sure that all documentation necessary for Medical Director review, including a Functional Mobility Assessment (FMA) for the proposed custom wheelchair, is included in Emma's case file.

After gathering all of the information for each of the requested services, Barbara is able to approve all the Medicaid covered services for Emma's transition based on Medicaid Coverage Policies and Clear Health Medical Policies and Clinical Guidelines. All requested Medicaid non-covered services are sent to the Pediatric Medical Director for review of medical necessity as per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) protocols. The Medical Director reviews all clinical information and associated medical policies and guidelines for medical necessity and approves the custom wheelchair for Emma as medically necessary regardless of coverage by Medicaid. The Medical Director has a question regarding the medical necessity of the tablet ordered and places a call to the ordering physician to obtain a better understanding of its use as part of the treatment of cognitive deficits and minimization of seizure activity. The pediatric neurologist explains the clinical rationale for the request. Our Medical Director determines that in this specific case, it is medically necessary, approves the request and documents the conversation with the pediatric neurologist, including the rationale for medical necessity, in the medical record.

Barbara provides Emma's mother with a list of community resources, including sponsor programs or foundations that offer community outreach assistance for children with complex needs and their family/caregivers. Emma and her mother are already enrolled in a Ryan White-funded agency providing services to women and children with HIV/AIDS and Barbara is in touch with the pediatric infectious disease provider that has been following Emma there as well. Barbara gives Emma's mother information on accessing our expanded benefit, Community Resource Link, which provides a reliable source of information about the wide range of programs and services available for members. The online tool is easy to use and promotes increased personal responsibility and self-management by educating members about all locally available supplemental supports and services they may not be aware of. Barbara uses her Clear Health iPad to demonstrate this benefit to Emma's mother.

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As part of the transition plan, Emma's mother participates in caregiver training at the facility. Caregiver training for Emma consists of management of the home ventilator and respiratory circuit, suctioning, responding to ventilator alarms, interpretation of pulse oximetry, understanding symptoms of seizure and administration of anti-epileptic medication, positioning, transferring from bed to chair, skin care, and other tasks required to maintain Emma's health and well-being at home. Universal precautions are followed at all times. Emma's mother performs return demonstration of all required tasks prior to discharge. She is also educated in the importance of adherence with medication, physician follow-up visits, routine tracheostomy changes and ventilator maintenance.



1.a. IDENTIFICATION PROCESSES FOR ENROLLEES WITH COMPLEX HEALTH CONDITIONS

In addition to member self-referral, Clear Health uses a multi-modal approach to identify members who have complex conditions, need a person-centered plan of care, and who may benefit from interventions. Through initial screeners, the comprehensive health assessment, provider referrals, our Utilization Management (UM) team, and predictive modeling; we identify members, no matter where they live, who may benefit from any of our clinical programs – including our case management and disease management programs. In addition, our predictive modeling tool, the Chronic Illness Intensity Index (CI3) helps us proactively monitor and mine utilization data to identify members with high rates of utilization who may be at risk for ED, inpatient, medication adherence issues, and other key health factors. Among our suite of predictive modeling tools, we will identify members who need more intensive support, such as when a member has three ED visits within a 60-day period.

Clear Health maintains enhanced case management processes for enrollees (members) like Emma, who are under 21 and receiving services in a skilled nursing facility. The health plan would receive notification of Emma's transition from Medicaid FFS, though a continuity of care call from the Medicaid FFS Case Manager. In the event that the Case Manager from Emma's previous plan does not call, she would be identified through the indicator on the Provider Network Verification file from the state. As a failsafe, if the Provider Network Verification

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indicator is missing, Clear Health has developed a weekly report to identify members under the age of 21 years living in a nursing facility or receiving Private Duty Nursing services. Upon identification, Emma would be immediately enrolled in our Enhanced Care Coordination program.

1.b. THE ASSESSMENT PROCESS

During the first 30 days of enrollment the member receives a new member welcome packet that includes an HRA form. Welcome calls are also made to the member during this period which includes discussion of the HRA form, the opportunity to complete the form on the phone or mail it back to the plan.

Once referred to case management – either through the CI3 predictive risk modeling score, member or provider request, or Member Services referral – the Managed Care Coordinator reviews all of the member's information available and makes an initial member contact attempt within 72 hours. During the first 14 days of the referral, at least three contact attempts must be made and a "please contact us" letter to engage members, like Emma and her mother, in case management.

During the initial contact, the Managed Care Coordinator completes the comprehensive assessment. If a member is unable to complete the assessment, our Managed Care Coordinator schedules one at the member's earliest convenience, not to exceed 14 days from the first contact.

Clear Health uses a variety of information to assess the member's total health care needs (physical, behavioral, functional, cognitive, social, and occupational). Using structured tools, Managed Care Coordinators conduct the in-depth clinical assessment in which we gather information, including:

- General health
- Emergency department use and hospitalizations
- Medications
- Health care utilization
- Functional capacity
- Preventive care history

Our comprehensive assessment comprises more than 20 potential clinical areas that help Managed Care Coordinators, like Barbara, identify potential risk factors and areas of need. It also includes specialized assessment modules for each member's specific conditions (including physical, behavioral, functional, social, and psychological health) using branching logic.

Due to her experience with these complex members, Barbara reviews all of the information in Emma's personal health record and transition plan with an eye on what might be missing, noting provider names, services currently being utilized, and identifying other service or care needs that Emma may have. Through the Clear Health Case Management System, all of this information is captured in Emma's personal care record. Barbara incorporates all additional information and questions in the tools and notes attached to Emma's case. Barbara uses this information and incorporates it in her discovery process to avoid redundancy and confirm accuracy of information throughout the process.

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When Barbara conducts the comprehensive health assessment, she will utilize an assessment that has specifically been designed for pediatric members. Her trauma-informed training will help her communicate with Emma's family as they have likely experienced a great deal of trauma related to Emma's health and service needs, including her HIV infection as well as her most recent hospitalization, and there may be adjustment issues once Emma is home. Barbara will be sure to include the service and care providers that Emma's mother identified to address her concerns about supporting Emma at home as well as caregiver supports that they approved in the plan of care. Barbara will also encourage Emma's mother to remain adherent with her own HIV treatment and plan of care during this time. Barbara will also arrange for a home assessment to be conducted prior to Emma's discharge in order to identify modifications necessary to facilitate Emma's safe transition home; these services will also be included within the plan of care.

1.c. RISK STRATIFICATION PROTOCOL

Clear Health uses our proprietary Chronic Illness Intensity Index (CI3) for risk stratification. Its predictive modeling algorithms show the relative-risk ranking of members regarding their likelihood to consume significant medical service resources in the future. These members often have complex medical issues, high service utilization, intensive health care needs, and have higher IP and/or ED usage. All clinical data is entered into a reporting system, where it is synthesized to identify and stratify members by severity and risk level. Once stratified, our clinical team accesses the information to identify opportunities for outreach, education, enhanced access, and case management to identify members with co-morbid medical or mental health and substance abuse disorders, assess their conditions, and implement interventions. Utilization and chronic condition data are claims-driven and based on the prior 12-month history.

Members under the age of 21 living in a skilled nursing facility or receiving Private Duty Nursing services are automatically enrolled into the Clear Health enhanced plan of care program as one of our highest risk populations. Emma is categorized as Risk Level 3 (the highest level) and is enrolled in this program due to her medical complexity, age, current and previous level of care, and ongoing support needs. Emma's mother receives ongoing contact, at least monthly but often more frequently during changes in the member's condition or change in service needs, and support to make sure she receives individualized, coordinated care equal to her medical and support needs.

1.d. IDENTIFYING SERVICE NEEDS AND MAKING REFERRALS

Clear Health's guiding principle is and will continue to be person-centered care planning and service across the member's system of care, optimizing but never duplicating services. Our Managed Care Coordinators coordinate personalized care and service supports across the full continuum of care to address the member's needs holistically (across physical health, behavioral health, and social supports).

We incorporate algorithms and clinical practice guidelines into our Case Management System and tools that can assist Barbara in developing Emma's plan of care. These tools help identify preventive screenings and treatment for Emma's complex medical condition. Once the comprehensive health assessment is completed and Emma's health problems and needs are identified, Barbara begins the process of developing the person-centered plan of care and

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coordinating the multi-disciplinary team review of the document. Emma's mother, PCP, HIV and other specialists, and pediatric nursing facility staff review Emma's plan of care, which includes Emma's current services and support needs, any Medicaid reimbursable services she may need, as well as non-covered benefits that will need to be coordinated. Using the data and information collected during the assessment, Barbara works with Emma's mother to review and finalize the person-centered plan. Following Emma's mother's approval, Barbara initiates the tasks identified in the plan of care.

Emma's complex medical support needs will require a highly coordinated, comprehensive plan of care and services to make sure she is able to lead a meaningful life at home with her family. Clear Health is well positioned to serve Emma with our robust Medically Complex Pediatrics program, which was recognized as a finalist for the Dorland Health Case in Point Platinum Award in 2016 under Simply Healthcare Plans (of which Clear Health is D/B/A).

Through the comprehensive health assessment, Barbara noted that Emma's natural home environment has both emotional and financial stressors. She identifies care activities and service coordination for Emma's family to consider in order to safely transition both Emma and her family, including arranging in-home Private Duty Nursing. She also notes that Emma's mother is reluctant to bring the child home permanently given her concerns for Emma's continued safety and her own health. She knows that this transition will require careful planning with the pediatric nursing facility and Emma's family in order to meet Emma's medical care and service needs.

Barbara contacts the pediatric nursing facility, with whom she has established relationships to discuss Emma's transition and discharge planning. She asks for Emma's plan of care, current status, PASRR I and PASRR II forms and the DCF form filed upon Emma's admission, and updates Emma's personal health record with this information. She also creates a follow up task for herself to assure the DCF forms are similarly submitted upon Emma's discharge from the facility. She verifies that the services identified on the PASRR assessments are included in Emma's plan of care and being provided while in the facility. Barbara authorizes continuation of Emma's stay at the facility in order to assure continuity of care.

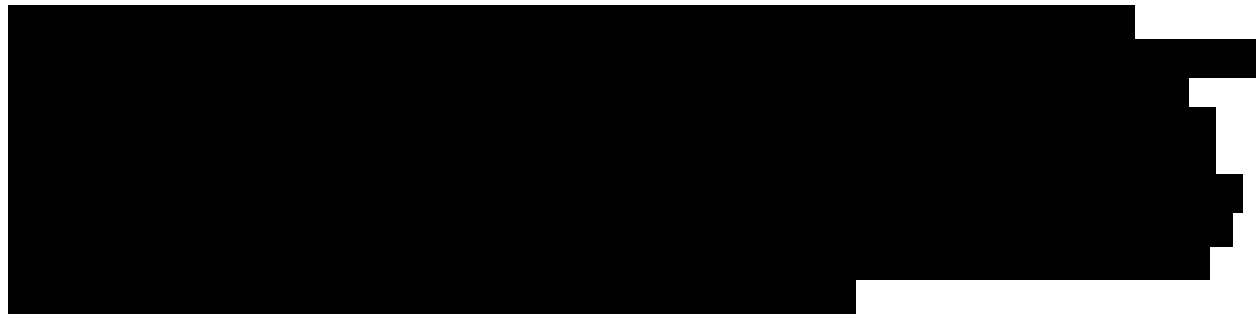
Barbara's also reviews Emma's Freedom of Choice form and makes a note to herself to review this with Emma's mother prior to Emma's transition to a less acute setting or her home.

Given Emma's and her family's recent desire to transition care settings, as well as the other potential risks to her physical and behavioral health, Emma will receive an array of services, including:

- Private Duty Nursing – Emma has complex physical health needs, including tracheostomy care, utilization of a ventilator, and seizures. Emma is unable to perform Activities of Daily Living/Instrumental Activities of Daily Living (ADLs/IADLs) on her own. Due to Emma's medical complexity, she requires 24/7 Private Duty Nursing.
- Durable Medical Equipment (DME) – Emma will require the following pieces of durable medical equipment:
 - Ventilator and supplies

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- Custom wheel chair (non-covered)
 - Tablet for cognitive development, enhanced to minimize risk of seizure activity (non-covered)
 - Apnea monitor
 - Continuous pulse oximetry
 - Back-up generator
- Speech & Occupational Therapy – Speech and occupational therapy will assist Emma in improving motor, cognitive, sensory processing, communication and play skills.
 - Assistance with scheduling well-child visits, specialist visits, dental visits and coordinating the visits with the siblings' visits. Sedation dentistry is available for Emma if deemed necessary. Barbara will need to coordinate the dental services through the State's subcontractor for dentistry as pediatric dental services are provided through Medicaid FFS.
 - Explore options on how to meet Emma's educational needs with Emma's mother including home schooling and Prescribed Pediatric Extended Care (PPEC).
 - Transportation – Transportation services will allow Emma to attend medical appointments, and to accommodate the potential equipment needs she has during transport.



1.e. INTERVENTIONS AND STRATEGIES TO FACILITATE COMPLIANCE WITH THE PLAN OF CARE

Through regular, monthly contact (or more frequent as gaps are needed or as identified by Emma's mother) our Managed Care Coordinators reach out to members and review their progress towards the goals they've identified. The Managed Care Coordinator utilizes the member's personal health record which is updated daily with utilization and claims and identification of upcoming preventive screenings or changes in risk stratification, to remain current with the member's utilization and care gaps.

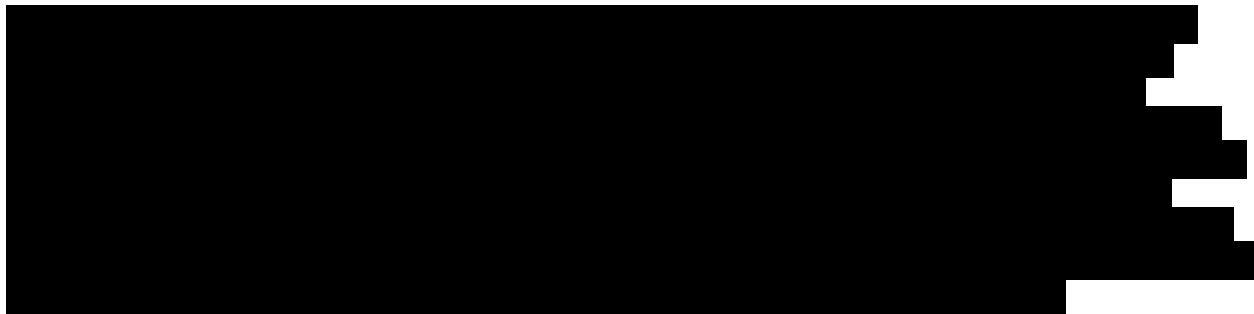
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Barbara will demonstrate use of and assist Emma's mother in accessing Emma's plan of care through our on-line platform, which allows users to securely review and provide feedback on the plan of care thereby encouraging ongoing participation in the plan of care. She advises Emma's mom that they will discuss the plan of care as part of their regular contacts. Barbara also suggests daily contacts for the first week that Emma is at home, followed by weekly contacts for 3-4 weeks. She explains that as Emma's mom becomes more comfortable and feels that the plan of care is sufficient, they can decrease the contact to monthly which they will maintain unless there is a change in the member's condition or Emma's mom feels the plan of care requires an adjustment.

1.f. DISCHARGE AND AFTERCARE PLANNING PROTOCOLS

Discharge planning begins upon notification of an acute inpatient, observation status, rehabilitation or skilled nursing facility admission. Early identification and planning of the member's transition of care needs is essential in providing quality discharge needs and in making sure that the member is discharged to the appropriate level of care to prevent readmissions and unscheduled transition of care. Clear Health's Transition of Care team works with the member, Clear Health Concurrent Review nurses, attending physician, hospital staff, and all ancillary service providers to complete all discharge needs for members and identifies any ongoing care needs to coordinate with the designated Managed Care Coordinator.

To assure a successful transition to Emma's family home, Barbara works Emma's multi-disciplinary team, which includes the pediatric nursing facility discharge staff, Emma's assigned nursing facility nurse, Emma's mother, Emma's PCP and HIV specialists, subcontractors and service providers identified in Emma's plan of care to finalize a comprehensive, coordinated transition plan 30 days prior to Emma returning home. The transition plan will include all services and supports necessary for continuity of her current care and services, as well as required care and services for post transition in her home. Barbara also incorporates the services and supports identified as a result of the home safety assessment.



Barbara arranges a multi-disciplinary team meeting to review the transition plan and Emma's plan of care, make any required modifications and approve the final plan of care with the agreement of Emma's mother.

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1.g. COORDINATION WITH OTHER INSURERS, PROVIDERS, AND COMMUNITY PARTNERS FOR NON-COVERED SERVICES

Through our case management processes, we identify and address our members' care and service needs across the full continuum of care (physical health, behavioral health, functional, and psychosocial). We recognize that members sometimes have needs that may not be met through our existing provider network or may not be a covered service. To help these members remain in the community, we engage all existing community resources to provide solutions. Because our Managed Care Coordinators know the local area, they access community supports and actively engage community-based organizations, advocacy groups, faith-based organizations, and other community resources to develop creative solutions for services that are not a covered benefit.

The multi-disciplinary team meeting, as described above, brought the PCP and specialists together with Emma's mother and will continue to meet every six months or more often, as needed, based on any significant changes in Emma's condition or significant life changes. Barbara walks the mother through the process of registering Emma on the special needs registry of the local office for emergency operations center.

1.h. PROVIDER CAPACITY ASSESSMENT

Clear Health's Provider Relations department continuously monitors our provider network to make sure that all contracted providers in the plan are credentialed accordingly and have the capacity to serve our members. Upon making a referral for service, the Clear Health case management team communicates the member's needs with service providers they have identified to see that they are able to meet his needs and have available appointments. All referrals include the member's detailed symptoms and behaviors at the time of referral to facilitate the best pairing. Our expansive provider network includes providers that have enhanced training to meet the needs of specialty population, such as those with HIV. Our network also includes providers that are diverse and meet different cultural and linguistic needs.

Clear Health assess provider capacity and member satisfaction with the services our providers deliver. In Emma's case, services will include home health, DME, and access to our network of specialists, including pediatric pulmonologist and neurologist that can meet her unique needs. Barbara makes sure that Emma has an emergency plan in place, which will identify specific providers. Barbara works in tandem with Provider Relations to make sure Emma's services and care needs are addressed with the appropriate providers who can meet her needs (and will verify the appropriate authorizations are in place). Barbara makes sure that everything is ready for Emma prior to and after her provider visits.

In Emma's circumstance, she was established with specialists through Medicaid FFS and continued with her providers through her transition period. Emma's pediatric neurologist was not in-network with Clear Health. Clear Health's Provider Network Manager contacted the neurologist to initiate a single case agreement at the rate he is currently being paid. In addition, the representative requested a meeting to discuss contracting with the Clear Health provider network.

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1.i. STRATEGIES THAT PROMOTE MEMBER SELF-MANAGEMENT AND TREATMENT ADHERENCE

As part of developing the person-centered plan of care, our Managed Care Coordinators include health education to improve upon member health literacy, build member advocacy and self-management skills, and to encourage treatment adherence. For example, families of members like Emma, receive care education using evidence-based guidelines, including coaching by the Managed Care Coordinator as well as printed materials and access to online resources.

As part of the transition plan, Emma's mother participates in caregiver training for Emma at the facility. Caregiver training consisted of management of the home ventilator and respiratory circuit, suctioning, responding to ventilator alarms, interpretation of pulse oximetry, understanding symptoms of seizure and administration of anti-epileptic medication, positioning, transferring from bed to chair, skin care, and other tasks required to maintain Emma's health and well-being at home. Emma's mom performs return demonstration of all required tasks prior to discharge.

Emma's mother is instructed in the importance of adherence with medication, physician follow-up visits, routine tracheostomy changes and ventilator maintenance. Further, Emma's mother is educated to notify the Managed Care Coordinator immediately upon any missed home health visits or changes in treatment plan. The Plan calls the HHA weekly to make sure there were no home health visits missed.

In order to provide optimal support for ventilator home management, Clear Health has contracted with a home ventilator tele monitoring subcontractor. This subcontractor offers home support through tele monitoring of various ventilator parameters which trigger alerts for interventions. Interventions include, but are not limited to: physician notification, reeducation of caregivers, and emergency response. This remote ventilator monitoring program also includes a 24/7 RN hotline, RN-based case management, and a proven algorithm that reduces unnecessary hospital readmissions.

1.j. APPLICATION OF UTILIZATION MANAGEMENT PROTOCOLS (I.E., IDENTIFICATION OF THE CRITERIA THAT WILL BE UTILIZED, PROCESSES TO ENSURE CONTINUITY OF CARE, ETC.)

Clear Health's comprehensive Utilization Management (UM) program includes well-defined protocols for UM activities that are tailored to meet the needs of our members. We promote the delivery of care and services in a culturally competent manner within the context of members' cultural beliefs, behaviors, practices, disabilities, and language preferences. We use the guidelines and protocols to provide a framework for decision making that also considers social determinants, geographic location such as rural versus urban, and how those circumstances may impact access to care.

As reflected in our responses above, Clear Health applies State criteria, the Plan's medical policy and its clinical utilization guidelines to assess medical necessity of requested services. EPSDT requirements are satisfied by assessing all services (both covered and non-covered) for medical necessity for children under the age of 21. Services are never denied solely on the grounds of non-coverage.

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Upon enrollment with our health plan we make sure of continuity of care by providing a 60-day continuity of care period and honoring all authorizations provided by previous plans. Services may be continued beyond the 60-day continuity of care period when members are participating in an active treatment plan. We will engage in single case agreements with out-of-network providers at the rate they were previously paid to manage the member. We also attempt to contract with these providers based on network needs.

Barbara will work closely with the Nursing Facility Discharge Planner to review all discharge orders and clinical documentation; she includes the Utilization Management Department to coordinate necessary authorizations for service. For those items that are not covered through Emma's Medicaid benefits, but are ordered by her provider and are medically necessary, Barbara will facilitate a review of Emma's case and care needs with the Clear Health Medical Director. This includes reviewing the equipment recommended by her provider that is not covered under Florida Medicaid, such as the custom wheelchair and tablet. Barbara makes sure that all documentation necessary for Medical Director review is included in Emma's case file.

After gathering all of the information for each of the requested services, Clear Health's UM Department is able to approve all the Medicaid covered services for Emma's transition based on Medicaid Coverage Policies and internal Medical Policies and Clinical Guidelines. However, all requested Medicaid non-covered services are sent to the Pediatric Medical Director for review of medical necessity as per EPSDT protocols. The medical director reviews all clinical information and associated medical policies and guidelines for medical necessity and approves the custom wheelchair for Emma as medically necessary regardless of coverage by Medicaid. When Medical Directors have a question regarding the medical necessity of the Tablet ordered, they will directly place a call to the ordering physician to obtain a better understanding of its use as part of the treatment of cognitive deficits and minimization of seizure activity. In Emma's case, the pediatric neurologist will explain the clinical rationale for the request. The Clear Health Medical Director will then determine that in this specific case, it is medically necessary, and will approve the request and document the conversation with the pediatric neurologist, including the rationale for medical necessity, in the medical record.

1.k. INTEGRATING INFORMATION ABOUT THE ENROLLEE ACROSS THE PLAN AND VARIOUS SUBCONTRACTORS WHEN THE RESPONDENT HAS DELEGATED FUNCTIONS

Emma's information is integrated across our data platform, and we have data exchange processes to assure that each delegate has the necessary information, balancing compliance with HIPAA regulations while providing the information needed to provide care. All delegates receive enrollment files and other pertinent medical data relevant to their delegated functions. For example, we regularly share with our delegated Pharmacy Benefits Manager member diagnosis data to allow them to auto adjudicate authorizations. Further, the PCP has access through the provider portal to the utilization and case management history for the member. In addition, each member has a personal health record, which is accessible by all Clear Health staff engaged in the plan of care and service coordination for that member.

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Our pharmacy subcontractor, Express Scripts (ESI) can also identify missed prescription fills through reporting. Barbara can view Emma's medication history as part of her routine case management activities. If she sees that Emma's caregiver is not filling her medications she will work with her to resolve any barriers. In Emma's case, transportation was a challenge due to her ventilator dependence. Barbara arranges for Emma to be transported by ambulance to attend all provider visits.

2. WORKFLOWS/NARRATIVE DESCRIPTIONS.

As illustrated in our workflow, provided as Attachment MMA SRC# 20-1: Workflow, Clear Health meets all State-required time frames across the case management process.

3. INNOVATIVE AND EVIDENCE-BASED PROCESSES TO ENHANCE COMMUNICATION AMONG SERVICE PROVIDERS AND SUBCONTRACTORS

Clear Health supports providing access to actionable medical information to our multi-disciplinary teams. We support a shared plan of care approach where clinicians work together, through access to a member's physical and behavioral health assessments, service authorizations and other clinical data, claims history, and gaps in care, to support coordination of all members' care and service needs. The system includes an online dashboard emphasizing utilization of wellness and emergency services that is available to all providers. Providers can send us secure referrals and information by email or fax. They can also send a provider-to-provider secure email (if their system permits) or transfer information among providers in a secure manner.

Barbara uses Clear Health's shared plan of care to track information and input from the multi-disciplinary team, obtain information and share input with Emma's mother, and maintain family engagement. The system is used to view Emma's use of health, pharmacy, and emergency services. The information helps inform all involved of ongoing activities to support Emma in her transition to living in the community with her family.

4. SUPPORTING CARE DELIVERY IN THE MOST APPROPRIATE AND COST-EFFECTIVE SETTING AND AVOIDS UNNECESSARY OR EMERGENCY DEPARTMENT USE

Our program uses industry best practices to supplement traditional clinician outreach. Our Managed Care Coordinators work to address the health status, health literacy, and engagement of members through targeted interventions and case management, education, self-management principles, and harm reduction. We engage providers, community partners, and others (such as Peer Supports) to make sure members have frequent in-person contact. During conversations with members, we determine their readiness to change, encourage them to identify strengths and needs from their own perspective, and participate in the development of their plan of care. This evidence-based and person-centered engagement methodology enhances the probability that members will develop self-directed plans of care with achievable goals. Our fully integrated program takes every aspect of a member's life into account.

Emma's transition to home includes wraparound services designed to support Emma and Emma's caregivers to prevent unnecessary hospitalization, ED visits, and to assure that Emma stays at home, which is her family's preference.

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5. EXPERIENCE IN PROVIDING SERVICES TO ENROLLEES WITH COMPLEX MEDICAL NEEDS AND PROVIDING STRATEGIES THAT IMPROVE HEALTH OUTCOMES

To proactively identify members with complex needs, we use a predictive modeling system that synthesizes member demographic and claims data, such as diagnoses, pharmacy, hospitalizations, ED encounters, and expenditures, to predict future outcomes. This enables us to identify and prioritize outreach to members with mental health, SUD, and other chronic health conditions, including those with the greatest need for ongoing services and likelihood to be admitted to the hospital in the near future. Using this information, we will identify a designated Managed Care Coordinator who is 'matched' to the member's primary needs, PH, BH or LTSS, based on training and licensure and is located in their geographical area whenever possible. All our staff has received extensive cross-training to be able to provide for the member's needs, and has access to the full clinical support team in Clear Health, with expertise in pediatrics, adolescents, infectious disease, nutritional, disease management, and physical, LTC and behavioral health needs.

In May 2016 Simply Healthcare Plans (d/b/a Clear Health) was recognized for our work with medically complex children by Decision Health. This award recognizes professionals and organizations that demonstrate success in the overarching healthcare continuum. Honoring programs such as the medically complex children program that best educate and empower individuals, improve adherence and wellness, manage quality of care, and contain healthcare costs. We have been serving medically complex children in Florida since the Plan's inception both in the home and the skilled nursing facility setting. Additionally, through our affiliates, we serve medically complex children across 19 other state Medicaid programs.

6. COORDINATED HEALTH CARE INTERVENTIONS DESIGNED TO ACHIEVE COST SAVINGS

Our integrated, strengths-based, member-centered Case Management program considers the specialized needs of our members who have complex needs, including their physical, behavioral health (mental health and substance abuse disorder), pharmacy, and social and community support needs. We offer tailored complex case management programs for members with unique, complex, chronic, and co-occurring needs who require higher levels of interventions. Our integrated approach provides access, responsiveness, and effectiveness in the system of care by supporting the following:

- 1) Identification of members with potential or current specialized or complex health care needs through early screening, comprehensive assessments, and predictive analytics
- 2) Risk stratification for each member based on a thorough consideration of information
- 3) Placement of members into case or disease management programs based on needs assessment
- 4) Development of an integrated plan of care that addresses physical, behavioral health/substance abuse disorder, pharmacy, social, and home- and community-based needs for members as they transition across all settings and incorporates both covered Medicaid benefits and services as well as those not covered by Medicaid that would benefit the member

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- 5) Reciprocal referrals and information sharing with PCPs/specialists and community based Ryan White providers with HIV expertise
- 6) Formation of multi-disciplinary treatment teams for members in complex case management as needed to support them and provide consistency and continuity of contact with their familiar support system, as well as the expertise of a broader team of specialists as their needs evolve
- 7) Case management support to improve member access to needed services, including scheduling appointments, arranging transportation, conducting appointment reminder calls, following up to verify service initiation and member progress, and making appropriate service adjustments and incorporating those into the plan of care
- 8) Ongoing evaluation of our case management program, including reviewing, tracking, monitoring, adjusting, and analyzing for outcomes, quality metrics, and improvement
- 9) Emphasis on disease prevention, chronic condition management, and increasing member engagement with recommended treatment protocols
- 10) Establishment of community-based relationships
- 11) Member education to enhance understanding of health care conditions and prescribed treatment
- 12) Encouragement for members to develop their capacity to self-direct their care
- 13) Collaboration with other state and community entities to establish truly integrated care and prevent duplication of service
- 14) Co-management of physical and behavioral health issues.

Our members in case management frequently identify as having two or more conditions. In fact, throughout our health plan, 62 percent identify as having three or more. Achieving cost savings while optimizing health outcomes requires a member-centric, integrated approach. Our members work closely with qualified and trained Case Managers (Managed Care Coordinators) to make sure they are receiving the most appropriate level of care. Our model has proven successful. In a 2016 case study, we found that after receiving case management services for at least 90 days, members used health resources more efficiently and required less emergent care, thus reducing costs while improving outcomes. One such outcome was significantly greater: reduction in avoidable ED visits and inpatient admissions. Overall, members demonstrated a 39 percent reduction in non-emergent ED visits.

We recognize that members, like Emma, can often experience a range of physical health issues that can adversely affect their health, have co-occurring physical health and behavioral health diagnoses, and experience significant life changes or move across different systems of care. Together, these factors can create challenges to accessing the appropriate integrated care and services needed. Our Managed Care Coordinators understand the Florida health care system and know how to link members with the providers, community resources, and stakeholders they need to support their safety, permanency, and well-being.

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Clear Health's programs support members at every age and every stage. Our tiered model of clinical interventions address the care continuum from birth to end of life. It is both flexible and responsive to changes in support needs, such as increasing or decreasing intensity or complexity. We collaborate with local and State-based stakeholders, including members and their families, advocates, network providers, community-based organizations, and State agencies to assure access to and coordination of the full continuum of care. Regardless of age, ability, or need, we emphasize care connections – our Case Management System helps us connect our members with the right providers to get the right care at the right time.

In 2014, Clear Health implemented a unique, evidence-based, high-touch program to manage medically complex children in collaboration with a board-certified pediatrician and case management experts. The program featured enhanced identification with predictive modeling analytics with enhanced engagement with the member. In 2016, as part of the integration of the Anthem Florida plans this best practice was implemented across the merged entity. This resulted in close to \$300,000 per month in savings across the combined entity from reduced admissions, readmissions, avoidable hospitalizations and other avoidable ancillary costs.

7. INNOVATIVE STRATEGIES TO INTEGRATE INFORMATION ACROSS ALL SYSTEMS/PROCESSES

Our case management workflows use a variety of innovative, evidence-based strategies to integrate information across all processes and systems, beginning with our members' real-time personal health record. Through our advanced Case Management System, each member's personal health record contains updated utilization and claims history along with any "red flags" to alert our Managed Care Coordinators about upcoming or overdue preventive health screenings. All of our health plan staff who interact with the member have access to this system, so they can offer seamless, integrated assistance in coordinating care and making sure each member's needs are addressed (such as scheduling appointments or arranging transportation). Our system also allows individuals who contribute to case management to enter tasks, send letters, or connect directly with members based on the information in the personal health record.

As part of our medical necessity reviews, our Case Management System incorporates Clear Health's evidence-based criteria and level of care guidelines and enables our clinical and UM staff to document medical necessity reviews of pre-authorization requests. UM reviewers can easily access critical information and use it to make the most appropriate level of care determinations. The system captures the exact criteria used in a clinical decision, the date and time of the review, and the updated information in the member's personal health record systematically so that all information stays up-to-date to promote integrated care. Our Case Management System is integrated with our Core Operations System where all authorization data is synched in order to make sure accurate claims payment. Our Case Management System is also connected to our calendar system so that our Managed Care Coordinators can easily schedule screenings, assessments, and follow-up meetings with the member and/or caregiver.

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Another key part of our clinical workflows is our comprehensive assessments. These include innovative branching logic, which guides our Managed Care Coordinators into areas for deeper details or to conduct additional assessments, such as high-level behavioral health screening (which might trigger an additional BH assessment) or co-morbid chronic conditions that will trigger additional disease-specific assessments. All of this information is integrated and maintained in our Case Management System, allowing our Managed Care Coordinators to fully address a member's total health care needs.

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Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:
 - a. Identification processes for enrollees with complex health conditions or who are in need of care coordination;
 - b. Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
 - c. Application of the respondent's case management risk stratification protocol;
 - d. Identification of service needs (covered and non-covered) and a description for service referral processes that the respondent has in place;
 - e. Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;
 - f. Application of discharge and aftercare planning protocols that facilitate a successful transition;
 - g. Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;
 - h. Description of the assessment of provider capacity to meet the specific needs of enrollees;
 - i. Identification of strategies that promote enrollee self-management and treatment adherence;
 - j. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
 - k. Application of strategies to integrate information about the enrollee across the plan and various subcontractors when the respondent has delegated functions.
2. The extent to which the respondents' workflows/narrative descriptions include timeframes for completion of each step in the care planning process.
3. The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).
4. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoid unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.
5. The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.
6. The extent to which the respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.

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7. The extent to which the respondent describes innovative strategies to integrate information across all systems/processes (e.g., prior authorization data synching up with the claims system) into its workflows.

Score: This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.

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**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
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F. OVERSIGHT AND ACCOUNTABILITY

No SRCs in this Category for MMA.

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EXHIBIT A-4-b
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G. STATUTORY REQUIREMENTS

MMA SRC #21 – Provider Network Agreements/Contracts Statewide Essential Providers (Statewide)

The respondent shall submit **Exhibit A-4-b-3**, Provider Network Agreements/Contracts Statewide Essential Providers, to demonstrate its progress with executing agreements or contracts with Statewide Essential Providers by submitting **Exhibit A-4-b-3**:

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health) has submitted Attachment MMA SRC# 21-1: Exhibit A-4-b-3, Provider Network Agreements/Contracts Statewide Essential Providers, which demonstrates our progress with executing agreements or contracts with Essential Providers across Florida. We partner with Essential Community Providers because they maintain the appropriate geographic presence, the established trust of our enrollees (members), a keen awareness of the diverse needs of the population, and access to key local resources available within their communities.

Essential Community Providers are at the core of our network development strategy due to our like-minded focus on serving low-income and underserved populations. We collaborate with Essential Community Providers because we actively support their role in caring for these most vulnerable members of the population—and because this support is so clearly linked to improving the health outcomes of our members.

We are confident of our ability to contract with all Essential Community Providers as we already have current contracts with 22 of 23 (95.7 percent) of the Essential Community Providers identified by AHCA., including:

- Tampa General Hospital
- Shands Teaching Hospital
- Shands-Jacksonville
- Jackson Memorial Hospital, Jackson Health System
- Sacred Heart Hospital
- Winnie Palmer Hospital at Arnold Palmer Medical Center, Orlando Health
- NEO: All Children's Hospital OB: Bayfront Medical Center St. Mary's Medical Center
- OB: Bayfront Medical Center
- St. Mary's Medical Center
- Broward General Medical Center
- Memorial Regional Medical Center
- Lee Memorial Health System
- University of Florida College of Medicine
- University of Miami School of Medicine
- University of South Florida College of Medicine
- University of Central Florida College of Medicine
- Nova Southeastern University College of Osteopathic Medicine
- Florida International University College of Medicine

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- All Children's Hospital
- Miami Children's Hospital
- Nemours Children's Health System
- Shriners Hospitals for Children

As AHCA notifies us of newly identified Essential Community Providers, we will contact them in-person or by telephone to introduce Clear Health, answer any questions they might have, and begin the contracting process.

**EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)**

Evaluation Criteria:

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0% - 25%	10
25.1%- 50%	20
50.1%- 75%	30
75.1% or greater	40

Score: This section is worth a maximum of 40 raw points based on the above point scale.

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EXHIBIT A-4-b-3

MMA SRC# 21 - PROVIDER NETWORK/CONTRACTS STATEWIDE ESSENTIAL PROVIDERS (STATEWIDE) (10-2-2017)

General Instructions:

Each Respondent shall complete the Managed Medical Assistance Agreements/Contracts scoring template worksheet. The respondent is required to submit the total number of agreements/contracts with Statewide Essential Providers by using column 'b' on the worksheet.

MMA Statewide Essential Providers Scoring Workbook Explanation:

Statewide Essential Providers List		
Tampa General Hospital Shands Teaching Hospital Shands-Jacksonville Jackson Memorial Hospital, Jackson Health System Sacred Heart Hospital Winnie Palmer Hospital at Arnold Palmer Medical Center, Orlando Health NEO: All Children's Hospital OB: Bayfront Medical Center St. Mary's Medical Center Broward General Medical Center Memorial Regional Medical Center- Lee Memorial Health System University of Florida College of Medicine University of Miami School of Medicine University of South Florida College of Medicine University of Central Florida College of Medicine Nova Southeastern University College of Osteopathic Medicine Florida State University College of Medicine Florida International University College of Medicine All Children's Hospital Miami Children's Hospital Nemours Shriners Hospitals for Children		
Statewide Essential Providers Scoring Template Fields		
Field	Respondent Data Entry Required?	Description
Service Provider Type	No	Statewide Essential Provider
*Agreements/Contracts	Yes	Agreements/Contracts count shall be entered by Respondent
Statewide Essential Count	No	Total number of available statewide essential providers (see Statewide Essential Providers list above)
%	No	The number of agreements/contracts Respondent entered in column 'b', divided by the total number of Statewide Essential Providers and converted to a %
Score	No	Specific statewide essential provider type score

*Agreements and Contracts to be completed by the respondent

EXHIBIT A-4-b-3
MMA SRC# 21 - PROVIDER NETWORK/CONTRACTS STATEWIDE
ESSENTIAL PROVIDERS (STATEWIDE) (10-2-2017)

Enter Respondent Name Below
Simply Healthcare Plans, Inc., D/B/A Clear Health Alliance

EXHIBIT A-4-b-3
MMA SRC# 21 - PROVIDER NETWORK/CONTRACTS STATEWIDE
ESSENTIAL PROVIDERS (STATEWIDE) (10-2-2017)

SRC Score
40

Service Provider Type	Agreements/Contracts	Statewide Essential Count	%	Score
Statewide Essential	22	23	95.7%	40

EXHIBIT A-4-b-3
MMA SRC# 21 - PROVIDER NETWORK/CONTRACTS STATEWIDE
ESSENTIAL PROVIDERS (STATEWIDE) (10-2-2017)

Percentage of Agreements/Contracts	Points
0.0%	0
1.0%	10
25.1%	20
50.1%	30
75.1%	40

EXHIBIT A-4-d SPECIALTY SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

RESPONDENT NAME: Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance

A. RESPONDENT BACKGROUND/EXPERIENCE

SPECIALTY SRC#1 – Specialty Experience (Statewide):

The respondent, including respondent's parent, affiliate(s) or subsidiary(ies), shall provide a list of all current and/or recent (within five (5) years of the issue date of this solicitation [since July 14, 2012]) contracts for managed care for the proposed specialty population. If the respondent does not have experience with the provision of managed care to the proposed specialty population, the respondent shall not submit a response to this SRC. The respondent shall provide the following information for each identified contract:

- a. The specialty population served;
- b. The name and address of the client;
- c. The name of the Contract;
- d. The specific start and end dates of the Contract;
- e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services;
- f. The use of administrative and/or delegated subcontractor(s), their scope of work;
- g. The annual contract amount (payment to the respondent) and annual claims payment amount;
- h. The scheduled and actual completion dates for contract implementation;
- i. The barriers encountered that hindered implementation (if applicable) and the resolutions;
- j. Accomplishments and achievements;
- k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid); and
- l. Whether the contract was capitated, fee-for-service or other payment method.

For this SRC the respondent shall not include subcontractor experience.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

We are excited to bring our collective knowledge and resources to the important and highly successful work of Clear Health in providing comprehensive, person-centered care to our specialty population – individuals with HIV/AIDS.

Through a Medicaid contract with AHCA, Clear Health first began managing a comprehensive provider network serving HIV/AIDS enrollees (members) in February 2012. In our five years serving HIV/AIDS members, Clear Health has become a national leader in managed medical assistance to individuals with a diagnosis of HIV/AIDS. We currently serve more than 9,300

EXHIBIT A-4-d SPECIALTY SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

members across Florida making us the largest HIV/AIDS specialty plan in the state and the nation. Services include integrated behavioral health and physical health care, dental, vision, pharmacy, and transportation services.

In developing this HIV/AIDS specialty plan, Clear Health worked closely with the University of Miami, a renowned expert in HIV/AIDS care and research. The University helped develop protocols for quality, compliance, and care, and provided an introduction to former NBA basketball star, Earvin “Magic” Johnson (Magic), who was so impressed by our commitment to not only the HIV/AIDS members but also the TANF, ABD, and dual eligible populations, that he became a plan spokesperson and an active participant in setting strategic direction for the program. Magic chairs Clear Health’s Strategic Advisory Group, which makes recommendations regarding improvements to quality, operations, and community partnerships in conjunction with our Member Advisory Committee and the broader HIV/AIDS community and research experts.

Magic recently served as keynote speaker at the 17th Annual Center for AIDS Research Scientific Symposium. The symposium was sponsored by the University of Miami and organized by Dr. Margaret Fischl, a Clear Health provider and nationally renowned AIDS researcher. Through his direct input, leadership, and the efforts of the Magic Johnson Foundation, Magic has provided invaluable insight and an entrée to minority populations and communities that have historically been difficult to reach. Moreover, in his role as plan ambassador and community advocate, Magic visits with students in local schools, pastors in local churches, network providers, and our associates. In May of this year, he met with Florida lawmakers in Tallahassee, expressing support for our innovative efforts to serve Medicaid and Medicare members.

With our experience serving individuals with HIV/AIDS, we have become acutely aware of the need for and benefits of an HIV/AIDS specialty health plan. For instance, Clear Health offers a targeted, intensive case management outreach model designed to meet the unique needs and challenges of individuals with HIV/AIDS. Our integrated team approach, including providers, case managers (managed care coordinators) and clinical pharmacists, facilitates coordinated care with community-based organizations, Ryan White agencies, federally qualified health centers (FQHCs), and health departments. Our specialty health plan structure also includes a dedicated Clear Health member service unit and comprehensive provider network, including contracted infectious disease practitioners serving as primary care physicians (PCPs). In addition, we place a special emphasis on privacy and confidentiality for Clear Health members, given the stigma around HIV/AIDS that still exists in the community. Positive member outcomes and satisfaction, as described below, make the strongest case for our specialized approach to service delivery.

The net result is that Clear Health has become a national model and thought leader in the area of managed, specialized HIV/AIDS care. In addition to working with such providers as Dr. Margaret Fischl, who pioneered treatment through her work in helping to get the first HIV/AIDS drug approved, we continue to work on a consulting basis with Thomas Liberti. Mr. Liberti was the Bureau Chief for HIV/AIDS at the Florida Department of Health from 1997 to 2012, and spearheaded the design and implementation of one of the nation’s most comprehensive public health responses to the HIV/AIDS epidemic. With our experience, we serve as an expert resource to our affiliate plans in 19 other markets across the country and our other Florida contracts.

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Furthermore, we have become a highly-trusted source of tailored specialty health care among members and a reputable and dependable partner among providers and other stakeholders. Our Clear Health CAHPS® scores reflect high member satisfaction. In our 2016 member survey, 98 percent of respondents reported they were treated with respect, 95 percent were helped with their health services, and 95 percent stated that we helped them better understand their health.

In addition, and perhaps most importantly, our member health outcomes reflect our effectiveness in building a care model that is reflective of our commitment to developing comprehensive, specialized care for individuals with HIV/AIDS:

- In 2014, we initiated an innovative CD4 program focused on improving medication regimen compliance for members with low CD4 counts. Of the 716 members tracked since program inception, 250 are actively in monitoring and intervention, and 178 have stabilized or improved.
- HEDIS measures continue to improve for our members. For the Comprehensive Diabetes Care (CDC) measure, we observed a 12.7 percent increase in HbA1c testing from 2016 to 2017, a nine percent increase in diabetes retinal eye exams, and a 9.5 percent increase in medical attention for neuropathy. For the same time period, Clear Health fostered a 10.7 percent improvement in the Controlling Blood Pressure (CBP) measure, a 5.3 percent increase in Cervical Cancer Screening (CCS), and a 13.5 percent increase in Annual Dental Visits (ADV).
- Through an outreach partnership with Beacon Health Options, our behavioral health subcontractor, we increased behavioral health utilization among members. This resulted in reduced substance use disorder-related hospital admissions from approximately 14.0 admits per 1,000 members in January 2015 to less than 5.0 admits per 1,000 members in December 2016. We have also improved in the HEDIS measures related to follow-up visits 7 and 30 days after mental illness hospitalizations.

We recognize that the care and treatment of individuals with HIV/AIDS is multi-dimensional and to be successful it is critical to partner inside and outside the health care community. We foster affiliations with community-based organizations with aligned goals for education, improved access to care and health outcomes, and reduction of HIV transmission, and we are committed to removing barriers to service. For example, we recently partnered with county health departments to improve adherence to preventive dental care among members less than 21 years of age. A mobile dental clinic will be used to improve access to these dental services.

As the needs of our members evolved, we adjusted our HIV/AIDS specialty care. For instance, we increased our nursing capacity as we continue to serve more and more members who are frail and aging, as well as individuals with associated co-morbidities and complex polypharmacy needs. Today, more than half of the current staff is comprised of nurses.

In addition, we continue to add expertise to our experienced and skilled HIV/AIDS team. Many staff members, both nurses and non-nurses, have come to Clear Health with direct experience serving individuals with HIV/AIDS. We also contract with industry experts to reach the most difficult to engage members and to provide training and expert review to our staff and Medical Directors. Our manager for our HIV/AIDS Care Coordination Program, Ms. Alina Orozco, has more than 25 years of experience working with this population. Clear Health was recognized for its HIV program and asked to speak on using multidisciplinary interventions and predictive

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modeling for clinically challenged Medicaid populations at the 8th Annual Care Coordination Summit in 2016.

1. MEDICAID POPULATION SERVED BY THE MANAGED CARE CONTRACTS IS SIMILAR TO THE SPECIALTY POPULATION PROPOSED

Medical Assistance (MMA) services to individuals with HIV/AIDS as a specialty population in all 11 Florida regions (adding Region 4 to our existing service area in the 10 other Florida regions). Clear Health has been serving individuals with HIV/AIDS in Florida since February 2012, and as of August 1, 2017, we coordinate care for 9,365 individuals with HIV/AIDS under an AHCA contract.

In addition to serving individuals with HIV/AIDS in our existing Clear Health contract, Simply serves members with HIV/AIDS in our other Florida contracts, including our SMMC, Medicare Advantage, and Florida Healthy Kids (FHK) contracts. Within these contracts, we provide comprehensive managed medical assistance to more than 1,000 members with HIV/AIDS.

2. NUMBER AND SIZE OF MANAGED CARE CONTRACTS ACTIVE IN THE LAST FIVE (5) YEARS

As stated above, Clear Health has been providing HIV/AIDS specialty care through its AHCA contract since February 2012. This contract is described in detail below.

While our affiliate health plans currently do not have any specialty contracts exclusive to the HIV/AIDS population, they do coordinate specialized care programs for more than 13,000 individuals with HIV/AIDS in 14 other states. Our Clear Health efforts and achievements inform the HIV/AIDS specialty care offered through our affiliates, even as they refine their own service delivery models. For instance, when a member with HIV/AIDS enrolls with our affiliate in Indiana, continued services with a special emphasis on pharmaceuticals are immediately authorized. Members are enrolled in complex care management, and an individualized care plan is created. Outreach is conducted to previous providers and care managers, if applicable, to obtain past treatment records. Efforts go beyond treatment of the illness and address the holistic needs of the member, such as behavioral health care needs, housing and food security, and psychosocial support needs.

a. The specialty population served: Individuals with HIV/AIDS

b. The name and address of the client: Florida Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308

c. The name of the contract: Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) Program Contract FP030

d. The specific start and end dates of the contract: February 3, 2014 – December 31, 2018

e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services:

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Role: Clear Health establishes and manages the provider and subcontractor network for the provision and authorization of services, case and disease management, member services, and quality management, among other clinical and administrative services.

Scope of work: Clear Health is responsible for the provision of integrated physical and behavioral health services, dental, vision, pharmacy, and transportation. Provided below is a listing of services offered:

- Advanced registered nurse practitioner
- Ambulatory surgical center services
- Assistive care services
- Behavioral health services
- Birth center and licensed midwife services
- Clinic services
- Chiropractic services
- Dental services
- Child health check up
- Immunizations
- Emergency services
- Emergency behavioral health services
- Family planning services and supplies
- Healthy Start services
- Hearing services
- Home health services and nursing care
- Hospice services
- Hospital services
- Laboratory and imaging services
- Medical supplies, equipment, prostheses and orthoses
- Optometric and vision services
- Physician assistant services
- Physician services
- Podiatric services
- Prescribed drug services
- Renal dialysis services
- Therapy services
- Transportation services

Clear Health also offers the following expanded services to members:

- Primary care visits (non-pregnant adults)
- Home health care (non-pregnant adults)
- Physician home visits
- Prenatal/perinatal visits
- Outpatient services
- Over-the-counter (OTC) medication/supplies
- Adult dental services
- Waived copayments
- Vision services

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- Hearing services
- Newborn circumcision
- Adult pneumonia vaccine
- Adult influenza vaccine
- Post discharge meals
- Nutritional counseling
- Medically related lodging and food
- Home and community based services

f. The use of administrative and/or delegated subcontractor(s) and their scope of work:

- AIM Specialty Health – Utilization management, including radiology
- Anthem, Inc. – Administrative/support services, including utilization management
- Audiology Distribution, LLC D/B/A HearUSA, Inc. – Audiology and hearing services
- Beacon Health Options – Behavioral health services (utilization management and network)
- Chiro Alliance Corporation – Chiropractic services
- DentaQuest of Florida, Inc. – Dental services
- DentaQuest of Florida, Inc. D/B/A EyeQuest – Vision services
- Express Scripts, Inc. – Pharmacy services
- Health Network One, Inc. – Therapy services, including occupational, physical, and speech
- LogistiCare Solutions LLC – Non-emergent medical transportation (Regions 1 – 9)
- MCT Express, Inc. – Non-emergent medical transportation (Regions 10 and 11)
- Ride2MD, Inc. – Non-emergent medical transportation (All regions)

g. The annual contract amount (payment to the respondent) and annual claims payment amount:
Annual contract amount: \$272 million; annual claims amount: \$228 million.

h. The scheduled and actual completion dates for contract implementation: Scheduled dates of implementation: Regions 1, 7 and 9 by August 1, 2014; Regions 2 and 3 by May 1, 2014; Regions 5, 6 and 8 by June 1, 2014; Regions 10 and 11 by July 1, 2014; all implementations were timely and as required.

i. The barriers encountered that hindered implementation (if applicable) and the resolutions:

Clear Health encountered no barriers that hindered the timely implementation of this contract; however, there were challenges related to provider availability and resistance to managed care that we resolved prior to and during implementation. These were not unique to Clear Health.

Clear Health encountered reluctance on the part of providers already providing services to HIV/AIDS patients to contract with Clear Health as a Specialty Medicaid HMO. Our first concern was the potential impact this could have on member continuity of care due to the clinical imperative of adherence to a treatment regimen. Prior to implementation, our Provider Relations team identified providers already treating potential Clear Health members and secured letters of agreements from the non-participating providers to ensure coverage for this population. Extensive effort was made at the grass roots level to work with providers and advocacy groups to provide information and gain their trust in Clear Health. This resulted in the development of a comprehensive network that includes an extensive list of primary and specialty providers with expertise in the treatment of HIV/AIDS.

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i. Accomplishments and achievements:

Clear Health is extremely proud of the progress made in partnership with AHCA since initiating its HIV/AIDS specialty plan in 2012. We learned a great deal in this time and applied lessons learned to improve member outcomes and satisfaction. For instance, by combining our original Ryan White approach with our Medicare SNP model, we placed increased emphasis on initial contact and early assessment. Following triage, each member is assigned to a group to receive targeted interventions, communications, and outreach. We monitor engagement of care and CD4 counts as indicators of success. This approach resulted in system efficiencies and improved member outcomes:

- Decline in per member per month (PMPM) costs with improved Highly Active Anti-Retroviral Therapy (HAART) compliance. We reduced our pharmacy costs by \$100 PMPM since the inception of the contract. We attribute this to improved medication regimens, which specifically target overutilization and the elimination of multiple prescribers for individual members, among other strategies.

- Low potentially preventable admissions (PPA). Clear Health is the best performing HIV/AIDS plan related to PPA, as reported in the AHCA Quarterly Statewide Medicaid Managed Care Reporting, Spring 2017.

- Reduced all-cause 30-day hospital readmissions. Our readmission rate decreased from 31.0 percent in 2015 to 28.4 percent in 2016. We have also realized a reduction in substance abuse admissions per 1,000, which we attribute to providing appropriate outpatient services for members with substance abuse issues and follow-up after inpatient treatment utilizing intensive outpatient programs to enhance successful treatment and sobriety.

- Successful behavioral health HEDIS outcomes. Between 2015 and 2016, there was a 5.0 percent increase in Anti-Depressant Management Acute Phase (AMM) and a 6.7 percent increase in Follow up After Mental Health Hospitalization. These improvements in clinical management and follow-up coincided with decreases in preventable inpatient behavioral health services. For instance, in February 2016 there were 93.6 admits per 1,000 Clear Health members and 352.5 in-patient days per 1,000. By November 2016, there was a marked decrease in hospital utilization: 75.9 admits per 1,000 members and 239.8 days per 1,000 for behavioral health inpatient care.

- Over the past three years, we worked closely with behavioral health prescribing physicians in Region 11 to encourage generic prescriptions for members with serious mental illness (SMI). We have seen an annual increase in the generic prescribing rate of two percent, translating to a 26 percent reduction in the cost per prescription and PMPM for anti-psychotic drugs.

- In 2015, we submitted a three-year performance improvement project (PIP) to AHCA with the goal to increase HIV-related medical care visits and reduce the percentage of enrolled members with no medical visits during the measurement period. We are extremely pleased with our progress: a 17 percent improvement in HIV-related medical visits and a 49 percent reduction in members with no visits. In addition, compliance with HAART improved by 64 percent, reaching a rate of 94 percent in 2016.

- We expanded our provider network from 8,058 providers in 2014 to 11,199 providers in 2016 – a 39 percent increase.

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Provided below is a summary of other achievements and accomplishments under this Contract:

- Awareness and trust in the community

In the five years since its inception, Clear Health has become a highly-trusted source of HIV/AIDS health care in Florida communities. This trust was earned through consistent outreach, education, and engagement of members, providers, and subcontractors. In 2013, we approached NBA great Earvin "Magic" Johnson, arguably the most credible and well-known spokesperson for people living with AIDS, to represent Clear Health. He has since become an ambassador for the program, as well as an active participant in setting strategic direction for Clear Health. Importantly, he has helped us connect with and establish a trusting relationship with racial/ethnic minority communities disproportionately impacted by HIV/AIDS.

We have identified the needs and developed a specialty plan uniquely structured to manage care, treatment and expanded benefits that make a difference in the lives of the members we serve using a multi-disciplinary model that keeps the member in the center with the providers, plan, and the care coordinators collaborating to deliver high quality care and improved outcomes. We developed and continue to build strong relationships with health departments, teaching institutions, community-based centers including initiatives with district commissioners, leaders in the urban communities where the epidemic is widespread, and with the LGBTQ (Lesbian, Gay, Bi-sexual, Transgender, and Queer) community where infection rates continue to be the highest. Our team at Clear Health is multi-ethnic, multi-lingual, multi-lifestyle, and we have both professional and personal experience with HIV disease. We take pride in representing and reflecting the community we serve, and we are proud to be the leader in the HIV/AIDS Specialty Plan arena in Florida.

- An accessible and multi-disciplinary provider network

Clear Health has built an extensive HIV/AIDS Medicaid network in Florida, establishing close relationships with PCPs, specialists, health departments, FQHCs, and teaching institutions. With an expert staff and strong clinical leadership, (including physicians, pharmacists, nurses, and social workers) and our public health experience specific to HIV/AIDS, coupled with our strong relationship with advocacy groups, we have been able to recruit and contract with PCPs and specialists in infectious disease, cardiology, dermatology, rheumatology, gastroenterology, and endocrinology who have experience in treating patients with HIV disease. We have developed a provider recruitment strategy and message of inclusivity and collaboration and actively provided education and support for the providers who serve our population.

In addition, we have expanded our definition of primary care physicians to include infectious disease specialists. This allows these physicians to coordinate member care across disciplines, and this broader definition has allowed us to lower member-to-provider ratio requirements to facilitate more frequent and comprehensive interaction with the members. Providers with specialized HIV/AIDS training are designated with a red ribbon beside their name in the provider directory, informing members of their additional specialized HIV/AIDS care and treatment competency. This "Red Ribbon" program is nationally recognized and a testament to our patient-centered model of service and support.

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- Engaging and retaining members in care

We have seen steadily increasing enrollment since our program's inception as well as declining disenrollment. Of all the members who were able to disenroll (and enroll with another Medicaid program, if eligible), 66 percent of these elected to enroll (or stay) with Clear Health. We believe this is a result of our strong performance and the personal commitment of the Clear Health staff to the members we serve.

- Experience in our Leadership Team

Simply's Leadership Team, including Ms. Lourdes Rivas, President and CEO, Dr. Vincent Pantone, CMO, Ms. Suzanna Roberts, COO, Ms. Holly Prince, CFO, and Ms. Judi Peterson, Staff Vice President, have provided strong oversight, vision, and direction to Clear Health since its inception in 2012. For its part, Clear Health's management team has extensive experience in serving the targeted population as well as in the managed care industry:

— The Simply Medical Director, Dr. Vincent Pantone, has 13 years of clinical experience as a physician leader in the health care industry. Since his training at Montefiore Medical Center in New York City, he has retained a strong interest in improving access and coordination of care to underserved populations, including Medicaid-eligible individuals with HIV.

— The director for our HIV/AIDS Health Management Services, Ms. Elizabeth Ellsworth, CCM, has over 20 years of experience working with Medicaid programs. As a certified coach for motivational interviewing, she has developed many of the policies and programs that have enhanced the Clear Health case management model. She led the design of Simply's three Medicare Advantage special needs plans whose models of care were each recently awarded a perfect score by CMS. Many of the best practices from these models of care are shared with our HIV/AIDS case management.

— Our manager for our HIV/AIDS Care Coordination Program, Ms. Alina Orozco, RN has more than 25 years of experience working with this population, and our case management and care coordination team has 424 cumulative years of experience. The team operationalizes this experience and expertise by continuously developing and enhancing HIV/AIDS training and looking for new opportunities to educate community partners, in-house staff members, and others in topics such as co-occurring conditions and motivational interviewing.

— Dr. Alex Borges, PharmD is Staff Vice President of Pharmacy, Sales and Account Management at Simply. He has been a member of the Simply d/b/a Clear Health team since 2012 with over 12 years of experience serving the Florida Medicaid Community, including people living with HIV/AIDS. Dr. Borges has been crucial in designing an effective pharmacy program for our specialty population and worked closely with the team to develop appropriate interventions to increase medication adherence to anti-retroviral therapy.

k. Number of enrollees, by health plan type: 9,365 enrollees in Medicaid

l. Whether the contract was capitated, FFS or other payment method: Capitated

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3. RELEVANT EXPERIENCE OF MANAGED CARE CONTRACTS, OR OTHER CONTRACTS, ACTIVE IN THE LAST FIVE (5) YEARS

Since February 2012, Clear Health has had a contract with AHCA to provide HIV/AIDS specialty care to members in 10 of the 11 Florida regions (except Region 4). Through this contract, we have developed a service network offering geographically accessible, culturally competent physical and behavioral health services, dental care, vision, pharmacy, and non-emergency medical transportation. We currently have 9,365 members in this program, making us the largest HIV/AIDS specialty plan in Florida and in the nation. In addition, our ultimate parent company, Anthem, Inc., through its 14 other markets, provides specialized HIV/AIDS care to an additional 13,000 individuals.

4. ACCOMPLISHMENTS AND ACHIEVEMENTS SIGNIFICANT AND RELEVANT TO THE SPECIALTY POPULATION PROPOSED

Simply is proud of its progress in coordinating care for individuals with HIV/AIDS under its current HIV/AIDS specialty plan contract with AHCA. With this ITN, we propose to expand this care to all Florida regions (adding Region 4 in this bid).

The many accomplishments and achievements outlined in Section 2j above speak to our ability to create an effective and comprehensive network of care for individuals with HIV/AIDS. These accomplishments and achievements have led to positive health outcomes for our members, also referenced in Section 2j.

Evaluation Criteria:

1. The extent the Medicaid population served by the managed care contracts is similar to the specialty population proposed.
2. The number and size of managed care contracts active in the last five (5) years.
3. The extent to which managed care contracts, or other contracts, active in the last five (5) years, provided relevant experience.
4. The extent to which listed accomplishments and achievements are significant and relevant to the specialty population proposed.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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SPECIALTY SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

B. AGENCY GOALS

Specialty SRC#2 - Care Coordination and/or Case Management (Statewide):

The respondent shall propose care coordination and/or case management activities to meet the unique needs of the specialty population being proposed for this solicitation, including specific disease management interventions or special condition management relevant to the specialty population. The respondent (including respondents' parent, affiliate(s) or subsidiary(ies)) shall describe its experience in providing care coordination/case management for populations similar to the specialty population being proposed, including experience with disease management or other special condition management. The respondent shall describe proposed interventions, evidence-based risk assessment tools, self-management practices, practice guidelines, etc., relevant to the specialty population proposed. The respondent shall identify specific staff qualifications, training and/or experience for case management personnel related to the specialty population proposed. The respondent shall describe any other care coordination/case management activities the respondent proposes to meet the needs of the specialty population proposed.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Clear Health's care coordination and case management activities are vast and are tailored to the specific needs of each enrollee (member). Originally designed based on the Ryan White Act/Project AIDS Care (PAC) community program approach in a health care setting, the model evolved to embed an enhanced medical component and multidisciplinary approach. Our model ensures full coordination for all aspects of a member's care to include access to medical and specialty providers as well as expanded benefits (meals, transportation, eye care, and over-the-counter medications) and community resources. Through a multi-disciplinary team approach, members have access to the full range of services and supports they need to stay healthy.

1. EXPERIENCE PROVIDING CARE COORDINATION/CASE MANAGEMENT

Clear Health has been offering case management and care coordination services to members with HIV/AIDS since February 2012. We serve more than 9,300 members, many of whom receive case management services across 60 counties. We hold a Medicaid contract with AHCA with an HIV/AIDS specialty designation. In addition, we bring the combined experience of our merged entities; we have provided case and disease management services to Florida Medicaid members for more than 14 years. Our disease management programs address many disease states, including HIV/AIDS, recognizing that there is a wide range of health and social services coordination needs that are unique to this population. Our goal is to assure our

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members' continuity of care, promote self-management and health literacy, and to enhance their quality of life. Together, our Clear Health staff brings a combined 424 years of experience in care coordination and case management.

As the largest HIV/AIDS specialty plan in the state, Clear Health brings a team of medical experts and case management professionals who serve individuals diagnosed with HIV/AIDS. With their expertise and local knowledge, our clinical team understands the challenges, barriers, and needs of people and their communities, and the programs and education needed to inform and serve individuals and their families about how to live successfully with the disease and limit its spread.

Over the years serving this population, we have built upon the experience of staff in place from program outset and added more nurses and clinician support to serve an increasingly older population who have co-morbidities and multiple medications. Today, over half of our current staff are licensed nurses. Our Manager of Managed Care Coordination, Alina Orozco, is a licensed registered nurse with more than 25 years of experience working with individuals who have HIV/AIDS. In addition to case management, her experience includes HIV/AIDS treatment education, counseling and testing, as well as development of HIV prevention programs and training on a state and national level. Our Medical Director, Dr. Francisco Hernandez also brings 30 years of experience and our original Medical Director, Dr. Brian Palmer, continues to serve as a consultant (leading specific initiatives designed to reach the most challenging to engage members) as well as continuing to provide training and expert review to staff and our current Medical Directors.

In addition to the expert guidance and support of our Medical Director, our Managed Care Coordinators often consult with our in-house pharmacy team on drug formulary issues and identification of inappropriate, incomplete, or potentially adverse treatment regimens. Managed Care Coordinators and our Medical Director work with the pharmacy team to engage and discuss medications with the member and Primary Care Provider (PCP) as part of care coordination.

2. EXPERIENCE EFFECTIVELY PROVIDING CARE COORDINATION/CASE MANAGEMENT TO THE POPULATION PROPOSED

Our care coordination and case management staff (managed care coordinators) are not just highly qualified; many have dedicated a huge portion of their lives to improving the health of people living with HIV/AIDS. Our team at Clear Health is multi-ethnic, multilingual, and multi-lifestyle – they know this disease professionally and personally. Many have also been personally affected by the disease, while others have worked for community agencies or other organizations that see Clear Health members. We take pride in the fact that our staff reflects the community we serve. We were the first managed care plan in Florida to exclusively serve the HIV/AIDS population, and have worked extensively with the community, providers, teaching institutions, federally qualified health centers, renowned researchers, specialty pharmacies, and State agencies to develop best practices and partnerships that enable us to effectively provide care coordination and case management.

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Our care coordination and case management activities demonstrate results. We have low potentially preventable admissions and were the best performing specialty plan in this area, as reported in ACHA's Quarterly Statewide Medicaid Managed Care Report, Spring 2017.

From our experience, we know that one of the biggest risks for members with HIV/AIDS is remaining in care. These members often experience challenges related to mental health issues, substance use or addiction, unstable housing, and food insecurity in addition to chronic comorbidities and access to care. We designed our staffing model and our care coordination/case management model to both address the psychosocial and clinical challenges of these members as well as toward a vision of their future needs. A crucial component of this is our staff developing a deep level of trust with our members and truly understanding and empathizing with their experience. Our efforts to engage members and their families have shown results. For example, in 2015, Clear Health focused on a new three-year performance improvement project that focused on increasing compliance with HIV-related medical care visits and reducing the percentage of enrolled members with no medical visits during measurement period. HEDIS Highly Active Anti-Retroviral Treatment (HAART) improved 64 percent, with a 2016 rate of 93.85 percent in 2016. Results also found a 17 percent improvement in HIV-related medical visits and 49 percent reduction in members with no visits.

We have built a multi-disciplinary model that keeps members at the center; with providers, our Managed Care Coordinators, and others at our plan working collaboratively to deliver what we promise. We continue to build strong relationships with health departments, teaching institutions, and community-based centers (including initiatives with district Commissioners, leaders in African American churches where the epidemic is widespread and with the Lesbian, Gay, Bi-sexual and Transgender community, where the infection rates continue to be the highest).

To make sure our staff can effectively provide care coordination/case management to this population, they receive new hire training as well as ongoing training to stay up-to-date on HIV/AIDS treatment and community services available. New employees must complete a 12-hour course, developed by the University of North Carolina at Chapel Hill, on HIV/AIDS. It offers students an online learning course on HIV etiology, immunology, epidemiology, and impact on individuals and society. All Managed Care Coordinators must complete Motivational Interviewing techniques training to assist members through the stages of change and the nine-module course from the University of South Florida on Co-occurring Disorders. This training offers a comprehensive overview for counselors on topics related to assessing and treating individuals with co-occurring disorders – including prevalence, assessment issues, treatment guidelines and models – creating a continuum of care, adolescents, women, older adults, and persons within the justice system.

Our clinical staff subscribe to and regularly review top HIV treatment resources to remain abreast of new developments in care and treatment issues as well as to educate our members and refer them to reliable sources for information and support. Further, our staff stay highly engaged with the communities and members we serve. In 2015, Clear Health held the first Member Advisory Committee, and we've had these quarterly ever since. We have held over 20 meetings across the state, with over 300 Clear Health members attending in total.

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3. CARE COORDINATION/CASE MANAGEMENT ACTIVITIES RESPONSIVE TO THE SPECIALTY POPULATION PROPOSED

Our care coordination/case management activities are designed to improve the health status of our members with HIV/AIDS, as demonstrated through the following program objectives: increased knowledge of the disease process and associated complications; increased self-management; increased compliance with recommended clinical practice guidelines; and decreased utilization of services for hospital, emergency, and urgent care. Whenever possible, we engage individuals in case management and encourage them to be the active driver of their health care.

To assure we continue to provide care coordination and case management activities relevant to the members we serve, we routinely (at least annually) examine our top inpatient and outpatient diagnoses as well as the top 25 medical diagnoses. We use this data to make sure we are targeting prevalent issues in our programs and addressing chronic, co-morbid, and/or medical or behavioral health needs of our members. When we identify an area of need through these reviews, we quickly take steps to address it. For example, we recently hired a Nurse CM with experience in oncology to help address the increasing rates of cancer reported for members living with HIV/AIDS.

All members have access to our Member Services and Case Management telephone lines to request assistance when needed. We assign all members to a Managed Care Coordinator, who engages and assesses new members, seeks out those who are unable to be reached or challenging to contact, and monitors potential care coordination needs for those who have opted out of case and disease management. For those agreeing to participate in our case and disease management program, our Managed Care Coordinators comprehensively assess members and identify barriers to care to collaborate and develop an individualized plan of care with measurable goals toward improving health outcomes. They assist members with the coordination of medical, dental, and behavioral services as needed as well as coordination of services with Ryan White and other community based organizations. Although the PAC Waiver programs end this year, we will continue to collaborate with many of these agencies to serve persons living with HIV/AIDS, including on strategies to engage members who are homeless.

Our Managed Care Coordinators engage members and encourage their participation in their health care to improve self-management skills, keep their medical appointments, and adhere to their treatment plan. Our Managed Care Coordinators stay closely connected to members via ongoing telephonic and/or face-to-face communication. Our clinical team assists all members in achieving quality health outcomes using interventions, evidence-based risk assessment tools, self-management practices and practice guidelines, including the following:

- Assessing the acuity level and service needs of each member. The primary tool used to perform this assessment is our evidenced based HIV/AIDS Health Risk Assessment. In addition, we use disease specific, cultural, behavioral, caregiver assessments, and other assessments as applicable.
- Assuring that the member is assigned to an appropriate PCP
- Assuring that the member is assigned to an HIV specialist physician (as defined by the

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American Academy of HIV Medicine (AAHIVM) or recognized by the Florida/Caribbean AIDS Education and Treatment Centers (AETC), unless the member's PCP is an HIV specialist physician

- Developing in collaboration with member, PCP/specialists and/or others as requested by member, an individualized Plan of Care describing education, disease management, interventions, coordination, services to be provided and desired health goals
- Coordinating care through all levels of practitioner care (primary to specialist)
- Engaging in regular communication with members, their care providers, family and/or community agency case managers as needed via phone, mailing of educational materials, referrals to community programs, and home/hospital visits (members have access to a 24-hour triage service to avoid unnecessary emergency room and acute care services.)
- Coordinating referrals to behavioral health providers for members with mental health and/or substance abuse disorders
- Providing education to assist members in better management of their disease(s), as well as transmission prevention, risk-reduction services, and secondary prevention of associated conditions and illnesses
- Monitoring and promoting member adherence to physician treatment regimen, including medication compliance, recommended immunizations, tracking of CD4 count and other labs or readings as applicable (e.g., A1C, BP)
- Communicating and collaborating with members' PCPs, specialists and Ryan White and/or former PAC Waiver agency case managers to facilitate services not available through the regular Medicaid program and to request assistance with members that may be non-compliant/lost to care
- Providing outreach to locate and/or re-engage members who have been lost to care, including calls, letters, and referrals to an HIV-experienced outreach coordinator who specializes in locating these individuals and relinking them with services
- Communicating with Hospitalists, Concurrent Review Nurses, Social Workers, and others on behalf of our hospitalized members to assist with follow up care post discharge including home health, durable medical equipment, and home-delivered meals
- Coordinating support services (support groups, counseling, clinical trials, housing, substance abuse) with Ryan White and PAC Waiver case managers as well as other public or private organizations that provide services to HIV/AIDS clients, their families, and caregivers

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**** REAL STORY: Connecting Hard-to-reach Member to Services and Supports Improves Health and Quality of life**

Sometimes it helps when you have a history with someone. That's what Shay, our Managed Care Coordinator, thought when she saw Natalie's name on the new member roster. She had been Natalie's case manager under the Ryan White program at The Village in Miami, and knew she had a history of chronic homelessness, substance use, mental health issues, stroke, and criminal justice system involvement, in addition to HIV. Shay learned Natalie had been intermittently filling medications and attending medical appointments and could not be reached. As before, Natalie was hard to locate, so Shay referred her to one of our Outreach Care Specialists who located her at a women's shelter. By rekindling this trusted relationship, Shay was able to engage Natalie to take renewed interest in rebuilding her health and strength. She educated Natalie about her benefits, coordinated appointments with a PCP and psychiatrist, connected her to physical therapy, and helped her get approval for a motorized scooter. Natalie also began attending a support group at the clinic where her PCP and community case manager are located, is taking her HIV and mental health medications more consistently, and is accessing a local food bank to help meet her nutritional needs. Her health and quality of life have improved dramatically, and best of all, Natalie is now living in her own apartment with financial aid from a housing program for persons living with AIDs (HOPWA). **

To make sure our members receive the best possible care, we also offer a 24-hour Nurse help line and a focused outreach program to reach individuals who have not engaged in care after 60 days. We understand the importance of maintaining a steady drug-regimen for treatment effectiveness, and we also understand that the psychosocial factors of living with HIV/AIDS and related issues, such as poverty, can create barriers to treatment compliance. Our Managed Care Coordinators are committed to working with members on all their needs for improved outcomes.

We provide each member with care coordination/case management services, including HIV Disease education, treatment adherence support, coordination of plan health care services, and transportation. Managed Care Coordinators collaborate with local community resources that may assist members with special needs for additional supportive care such as food banks, legal, or housing assistance. Members are referred to HIV-experienced PCPs and specialists.

Each pregnant member will have an assigned OB Case Manager (primary), who with support from the Managed Care Coordinator, follows the member from pregnancy through birth and at least three months post-partum. The Managed Care Coordinator continues the relationship and case management when this period has ended with full insight into the care that has been provided and the member/baby's health status. The goal of the OB program for Clear Health Alliance members is to promote healthy pregnancy and delivery of HIV negative babies through the early identification of potential risk complications with appropriate referral and intervention.

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While the population of children within our health plan is small (under three percent) due to the improvements in therapy that significantly decreased rates of vertical transmission from mother to child, Clear Health still has a good number of children enrolled, who do not have HIV, but other serious illnesses, such as leukemia, or transplants. For these members, we provide our pediatric complex case management program, which consists of assessment, care planning, implementation, coordination and monitoring specific health care needs and includes components such as skilled nursing facility, private duty nursing, and home visits as appropriate.

Evaluation Criteria:

1. The extent of experience (e.g., number of contracts, enrollees or years) in providing care coordination/case management to similar target populations, including disease or special condition management.
2. The extent to which the described experience demonstrates the ability to effectively provide care coordination/case management to the population proposed.
3. The extent to which the care coordination/case management activities proposed are relevant to the specialty population proposed.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 10 points each as described below:

- (a) 10 points if the component is excellent;
- (b) 8 points if the component is above average;
- (c) 6 points if the component is average;
- (d) 4 points if the component is below average;
- (e) 2 points if the component contained significant deficiencies;
- (f) 0 points if the component was not addressed.

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Specialty SRC#3 – Quality Measures (Statewide):

The respondent shall propose quality management activities to address the needs of the specialty population(s) being proposed for this solicitation, including specific quality measures relevant to the specialty population(s). The respondent (including respondents' parent, affiliate(s) or subsidiary(ies)) shall describe its experience in quality management for population(s) similar to the specialty population(s) being proposed for this solicitation. Include experience with standardized measures, such as HEDIS and Contract-required measures, relevant to the specialty population(s) proposed. Identify specific quality measures relevant to the specialty population(s) the respondent proposes to collect and report to the Agency. Describe any other quality management activities the respondent proposes to improve performance. Describe any instances of failure to meet HEDIS or Contract-required quality standards and actions taken to improve performance. Describe actions taken to improve quality performance when HEDIS or Contract required standards were met, but improvement was desirable.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

Clear Health's goal is to ensure access, engagement, and quality of care for the Medicaid eligible population living with HIV/AIDS across all regions in the state. Our multi-disciplinary teams (MDTs) review each enrollee's (member's) individualized plan of care to determine the appropriateness and best care options to improve the member's health outcomes. We apply a comprehensive suite of quality measurements, including both HIV-specific indicators as well as dozens of cost-cutting measures focused on other aspects of our members' health and well-being. Clear Health focuses our resources on solving the issues that are most important to achieving high-quality health outcomes in partnership with members.

1. EXPERIENCE ACHIEVING QUALITY STANDARDS WITH SIMILAR TARGET POPULATIONS, INCLUDING HEDIS® OR CONTRACT REQUIRED MEASURES.

Since May 2014, we have provided services to people living with HIV/AIDS enrolled in our Clear Health plan across all of Florida with the exception of Region 4. We currently serve more than 9,300 members under Clear Health and more than 13,000 people living with HIV/AIDS across 14 of our affiliate plans. Clear Health has been using focused measures for people living with HIV/AIDS since 2012. Our Quality Management team regularly reviews our portfolio of quality measures, recommends quality measures specific to the needs of individuals with HIV/AIDS, and uses national best practice standards such as HEDIS® and Agency for Health Care Administration (AHCA) defined population specific measures to assure a full health spectrum in our quality program for people living with HIV/AIDS.

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Clear Health's MDTs use a multitude of strategies to engage members, such as motivational interviewing, person-centered planning, and Trauma Informed Care (TIC) models. Our Case Managers (Managed Care Coordinators) are locally based, familiar with the communities where our members reside, and educated to address issues including stigma, cultural considerations, race/ethnicity, age, poverty, behavioral health (BH), and homelessness. As part of our efforts to match members to the provider(s) who can make them feel comfortable and best meet their needs, we identify preferences and foster strong relationships within our provider network. For example, a member may prefer a provider of a particular gender or one who is knowledgeable about the LGBTQ community. By considering these factors and working closely with our members, we increase engagement and ultimately improve health outcomes.

**** INNOVATION:** Clear Health has enlisted Earvin "Magic" Johnson, HIV/AIDS advocate and NBA legend, as a spokesperson to educate the community and reduce stigma around HIV/AIDS. He has participated in 14 Clear Health events since 2012, with six of those in 2016 alone. He has brought his personal story and celebrity presence to an illness that calls for heightened community recognition. ******

We have the following four HIV-specific measures in place as part of our quality management activities and propose to continue them under the new contract:

- **HIV Visits (HIVV):** This measure is an important quality indicator because it demonstrates how well our members are engaged in ongoing treatment. Regular provider visits support medication adherence, monitoring of clinical indicators such as viral load, and better overall outcomes. Our Quality Department and Managed Care Coordinators work hard to improve HIVV rates through member outreach and assistance navigating the provider directory.

To help our members obtain care through the most appropriate provider type, we have a "Red Ribbon" designation on our provider directory that identifies the providers who have an Infectious Disease specialty. Even through these "Red Ribbon" providers are specialists in nature, for our Clear Health population they are considered Primary Care Providers (PCPs).

**** RESULTS & SUCCESSES:** The 2016 Clear Health Performance Improvement Project (PIP) on HIVV illustrates that a majority of members (76.39 percent) had at least two medical visits within the measurement year, an increase of 117 percent from the baseline measurement period. ******

- **Highly Active Antiretroviral Therapy (HAART)** – Medication regimen is a primary strategy for managing HIV, so this measure is key to understanding if our members are accessing HAART as recommended. Clear Health has developed highly detailed mechanisms to report and improve quality related to medication adherence.

**** RESULTS & SUCCESSES:** Our rate of HAART compliance is excellent, with 94 percent success in 2016-2017, a dramatic improvement in compliance from 57 percent in the prior year. ******

- **Retention in Care:** As part of the continuum of care for HIV/AIDS, we routinely measure the rate of our members continuing care, which is vitally important for maintaining good health and adherence to treatment.

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**** RESULTS & SUCCESSES:** The Clear Health model of member engagement has proven successful, as evidenced by 75.19 percent of our members being in care in 2016. This is an increase compared to the prior year in our own membership (64.43 percent) as well as significantly outperforming the Florida average (58 percent) and the national average (41 percent) on this metric. ******

- **CD4 Count:** A CD4 count is a blood test to determine the strength of the immune system as measured by the presence of a type of white blood cell. The normal range for CD4 cells is between 600-1500, while a CD4 count of less than 200 cells/mL indicates a severely compromised immune system and a clinical diagnosis of AIDS.

**** RESULTS & SUCCESSES:** Since it began in 2014, Clear Health's CD4 Project has stabilized or improved outcomes for 42 percent of the members not lost to follow-up (due to disenrollment, death, or inability to contact). Currently, approximately 250 members are being tracked and assisted through the CD4 Project. ******

We also track the following cost-cutting measures in our quality management program and will continue to do so under the new Contract:

- **Tobacco Cessation –** Tobacco use is well understood to be harmful, and its negative effects are magnified for people living with HIV. Clear Health has a Healthy Behaviors program with incentives that target smoking cessation. The program is newly supported by a texting feature to encourage completion of tobacco cessation milestones, and rewards members upon completion. We expect these new features to increase participation in the smoking cessation program.

**** RESULTS & SUCCESSES:** Clear Health member participation rates in our Smoking Cessation program increased from 15 percent in 2015 to 18 percent in 2016. ******

- **Follow-Up After Mental Health Hospitalization –** Serious behavioral health (BH) conditions are more common in Clear Health's membership than in the general Medicaid population, so we take special interest in connecting members to continued care once they leave a facility for mental health treatment. Specifically, addiction-related diagnoses and mental health disorders each affect more than 30 percent of Clear Health enrollees. The Clear Health MDT reviews every member who is admitted using comprehensive information obtained from the member, BH provider, labs, health records, Concurrent Review Nurse Case Managers, Managed Care Coordinators, and Outreach Care Specialists. The MDT follows members through treatment and provides support to address all issues that might impact their health with consideration for perceived stigma, culture, race/ethnicity, age, poverty, BH, and homelessness. This extended care has helped realize a significant shift away from inpatient BH services, reducing inpatient BH admissions as well as inpatient days per thousand. Please see Miguel's story at the end of this section.

**** RESULTS & SUCCESSES:** In 2016, Clear Health reduced inpatient behavioral health admissions per thousand from 93.6 to 75.9. Similarly, inpatient days per thousand decreased from 352.5 to 239.8. ******

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- **Plan All-Cause Readmission** – We track readmissions of all types very closely, since these represent opportunities for better coordination of care. To improve readmission rates, Clear Health implemented a telephonic and field-based transition of care (TOC) program and a field-based intensive case management program for individuals at highest risk for readmission. The member's Managed Care Coordinator contacts the member shortly before or after discharge to discuss the discharge plan they were given, ensure they understand and agree with the discharge plan, and explain the role of the TOC Managed Care Coordinator Nurse (TOC Nurse). The TOC Nurse calls or visits members to conduct assessments and uses a multidisciplinary approach to develop an ongoing plan of care with the member/family. Members are also screened for BH issues as part of our integrated care approach to improve outcomes. The Clear Health TOC Program incorporates best practices including the Coleman Model of care transitions. After the initial assessment, members at risk are encouraged to opt-in to the ongoing program as appropriate. If they agree, the field-based TOC Managed Care Coordinator Nurse will make additional home visits as needed and manage issues that would impact readmission or have a negative impact on the member's health. In addition to the TOC Nurse, members benefit from the continued support of their assigned Managed Care Coordinator who will continue to assist in the management of issues that may have a negative impact on the member's health or risk of readmission. Please see Renee's story at the end of this section.

**** RESULTS & SUCCESSES:** Our strategies have successfully reduced readmissions from 31.0 to 28.4 percent from 2015-2016 with increased support. ******

- **HEDIS®**

Clear Health and Simply's legacy organizations have dedicated an extensive amount of time and effort to improving clinical processes and outcomes as indicated by the dozens of individual measures in the NCQA HEDIS® set. Most HEDIS® indicators are not specific to HIV/ AIDS and/or may not be relevant to this population because of the nature of the measures (e.g. children measures, where the denominators are low and not reportable) but are important for general health. Clear Health Alliance achieved numerous year-over-year improvements from 2016 to 2017.

**** RESULTS & SUCCESSES:** Our HEDIS® successes at Clear Health include numerous year-over-year improvements, including Comprehensive Diabetes Care (CDC): HbA1c Testing (12.7 percent increase), CDC: Retinal Eye Exam (nine percent increase), and CDC: Medical Attention for Nephropathy (9.5 percent increase), Controlling Blood Pressure (10.7 percent increase), Annual Dental Visit (13.5 percent increase) and Follow-up After Mental Health Hospitalization (6.7 percent increase). ******

- **CAHPS®** – The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is the most widely used survey tool in the industry for monitoring member experience. We conduct CAHPS® surveys of our adult members annually and carefully analyze the results. In addition to the core survey, we include items MH1 through MH4 (related to Behavioral Health) and H.17 through H.20 (related to medical assistance with smoking and tobacco cessation) from the CAHPS® Health Plan Survey – Supplemental Items for the Adult Questionnaires. Clear Health's results indicate high levels of ongoing satisfaction with our health plan.

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**** RESULTS & SUCCESSES:** Clear Health achieved exceptionally high CAHPS® scores in 2017, indicating high levels of member satisfaction. Our results indicate 3 scores that matched the 100th percentile (Getting Care Quickly, Discussing Smoking Cessation Medications, and Flu Vaccine), 19 scores that exceeded the 90th percentile, and 6 scores that exceeded the 75th percentile. ******

**** SPOTLIGHT ON:** Supporting and Educating Member Leads to Medication Compliance
Fifty-six-year-old Robin became a Clear Health member in August 2014. Despite our encouragement and outreach, she was in denial of her condition and not taking her HIV medications. This led to frequent admissions and readmissions with a CD4 counts as low as 2. Her Managed Care Coordinator, Christina, worked with her, communicating in a non-judgmental way and establishing a rapport that helped build trust over time. When Robin was admitted with a CD4 count of 33, Christina talked with her about the benefits of enrolling in our Low CD4 Project, and Robin agreed.

Through continued education about the importance of medication compliance and the risk of opportunistic infections associated with not taking her medications, along with assistance in finding new providers, Robin slowly began to take her HIV medications as directed. The improvement to Robin's immune system has been dramatic, her last CD4 count was 756 with an undetectable viral load, and she has had only one hospital admission during 2017. ******

2. RELEVANCE OF QUALITY MEASURES TO THE SPECIALTY POPULATION(S)

We designed our QM program to improve the quality and safety of health care and services delivered to Clear Health members and promote an overall culture of quality throughout the organization. As Clear Health is a specialty plan for people living with HIV/AIDS, special attention is given to make sure quality activities and initiatives are specifically relevant to this population. For example, we use the four HIV-specific quality measures described above to track clinical indicators that are meaningful for people with HIV/AIDS.

We conduct both clinical and non-clinical Quality Improvement (QI) projects on an ongoing basis. We monitor and report core quality indicator metrics quarterly, with accountability generated by our quality committee structure. Our Quality Management Committee (QMC) reviews all measures and activities to ensure they are substantially relevant to improving the health, wellness, and quality of life for people living with HIV/AIDS. All rates deemed to be outliers are reviewed by the QMC and assigned a corresponding action plan to address issues identified. The QMC will follow up until the issue has been successfully resolved. Other specialized committees may take up specific issues, such as utilization management, that relate to improving quality.

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Clear Health currently performs four Medicaid Agency-approved Performance Improvement Projects (PIPs) for our population, but may change them as goals are reached or per contract requirements. This consists of a state-mandated collaborative PIP and additional PIP topics proposed and submitted by Clear Health for AHCA approval. All PIPs are designed to achieve, significant improvement to the quality of care and service delivery in areas that are expected to have a favorable effect on health outcomes and member satisfaction that are especially relevant to those living with HIV/AIDS. Topics for Clear Health's current PIPs include Preventive Dental Services for Children, HIV Medical Visit Frequency, Behavioral Health Screenings in Primary Care, and Member Satisfaction.

- Our HIV Medical Visit Frequency (HIVV) PIP aims to improve the percentage of members receiving two or more HIV-related outpatient visits at least 182 days apart within the calendar year. As discussed above, engagement in outpatient care is necessary for effective management of HIV. Since the implementation of the HIVV PIP in 2014, there has been significant improvement across all HIV measures, increasing the percentage of members with two or more visits, including the sub-measure that tracks visits with 182 days apart from zero in 2014 to 53.6 percent in 2016. There were improvements in all four categories measured.
- Clear Health is also working to increase rates of BH screenings by PCPs. The presence of several mental health and substance abuse diagnoses are known to be common among people living with HIV/AIDS. The relative frequency of these diagnoses in Florida appears lower than has been found in published studies. This suggests that members with mental health and substance abuse conditions may not be getting screened and diagnosed, or are not being diagnosed accurately, and therefore are not being referred for services that could improve their quality of life and enhance the effectiveness of medical treatment. In order to determine if screenings were being done but not coded correctly, we scheduled focus MRR reviews on BH screenings, which proved our hypothesis to be correct. Our interventions focus on provider education regarding accurate coding, member education regarding the importance of discussing BH with a provider, and system improvements to enhance internal reporting.
- Another PIP focuses on improving overall member satisfaction in the Clear Health population. The goal for this PIP is to increase the percentage of members who answer with an 8 or higher on the CAHPS® 5.0 Survey question, "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan"? Hearing from our members in face-to-face meetings throughout Florida has been instrumental in shaping our program so that it is both meaningful and effective for members. Clear Health's strong 2017 score on this measure places us in the top 20 percent of health plans nationally.

For each of its PIPs, Clear Health establishes a multi-disciplinary workgroup comprising internal staff, providers, and delegated vendors as applicable. We follow a formal QI process and all workgroup participants receive training on the QI process. Clear Health uses the PDCA (Plan-Do-Check-Act) cycle as its formal process. The core concept of the PDCA cycle is the use of short cycles of change to accelerate the rate of improvement. All PIPs achieve, through ongoing measurements and intervention, significant improvement to the quality of care and service delivery, sustained over time. We measure improvement by comparing a baseline measurement and an initial re-measurement following application of an intervention. Change must be statistically significant at a 95 percent confidence level and must be sustained for a period of

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two additional re-measurements for us to consider it a success. PIPs that have successfully achieved sustained improvement, as approved by the Agency, are considered completed. In such cases, we will continue to monitor the performance indicators as part of the QI program and select a new PIP topic for Agency approval.

In addition to measures embedded in PIPs, Clear Health will continue to monitor and improve a full complement of clinical and non-clinical quality measures that are specific to our members living with HIV/AIDS. Our approach includes HEDIS®, CAHPS®, utilization indicators, and operational metrics that are relevant to the population. Indicators are developed and compared to external benchmarks and/or internal performance goals. A broad range of indicators are established for essential departments and clinical programs.

For example, in analyzing 30-day hospital readmissions, Clear Health identified a link between BH diagnoses and members who are readmitted to the hospital within 30 days of a previous discharge. Workgroup efforts and interventions were then designed to address the specific needs of this specialty population. In response, Clear Health's Managed Care Coordinators hold complex case rounds monthly. The primary focus is on members who present complex and/or challenging care coordination issues, such as high risk due to BH conditions. The team discusses suspected barriers to treatment, co-occurring medical conditions, and identifies potential social and/or treatment limitations and potential solutions. Participation is cross-departmental and includes Managed Care Coordination staff, Medical Director(s), BH representation, and Clinical Liaison, providers, and BH Managed Care Coordinators.

3. QUALITY MANAGEMENT ACTIVITIES THAT IMPROVE QUALITY FOR THE POPULATION(S) PROPOSED IN A MEANINGFUL WAY

Our QI program was designed with the understanding that people living with HIV/AIDS have complex medical and social needs and encounter unique barriers to achieving optimal health. In response to our members, we operate many initiatives and activities specifically targeted to improve quality. Our approach is collaborative and we encourage active participation and input from providers, members, and employees to accomplish our quality improvement activities. We understand that the unique barriers to care among people living with HIV/AIDS may include HIV-related stigma, distrust of the health care system, homelessness/transience, difficulty accessing transportation, and limited knowledge about available services. Clear Health has developed a specific set of interventions to address our members' complex barriers to care and improve clinical outcomes.

Clear Health's additional QM activities relevant to the HIV/AIDS population include:

- All Clear Health members that accept case management – opt-in are assigned a Managed Care Coordinator who works directly with each member to engage and understand the member's needs and strengths. We also have a group of specially trained Customer Care Representatives to take calls from Clear Health members. This specialized staff has completed additional training in HIV/AIDS, cultural sensitivity, and potential comorbidities. The same team performs welcome calls to new Clear Health members so there is a sense of community and a cohesiveness to the member experience.

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- Accreditation: Clear Health is currently accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). AAAHC is a private, non-profit organization formed in 1979 to assist ambulatory health care organizations in improving the quality of care provided to patients. It accomplishes this by establishing, reviewing, and revising standards, measuring performance, and providing consultation and education. Clear Health is in the process of seeking NCQA accreditation.

**** RESULTS & SUCCESSES:** Clear Health received AAAHC accreditation spanning from January 30, 2016 to January 30, 2019. ******

- Multicultural Healthcare and Cultural Competency Plan (CCP) and Evaluation: In accordance with 42 CFR 438.206, Clear Health develops and implements a comprehensive written Cultural Competency Plan (CCP) describing our process to ensure that services are provided in a culturally competent manner to members. The CCP describes how Clear Health providers, employees, and systems effectively provide services to people of all cultures, races, ethnic backgrounds, sexual orientations, gender identities, socioeconomic status, disabilities and religions in a manner that recognizes values, affirms and respects the worth of the individual member, and protects and preserves the dignity of each. This is vitally important to the effective engagement and treatment of our members living with HIV/AIDS as culture plays a tremendous part in how they accept their diagnosis and participate in treatment. This Plan is updated annually and submitted to the Agency for approval each contract year. A summary of our CCP is available on our provider website and a hard copy is available to all by request.

**** TESTIMONIAL – Spotlight on NCQA Multicultural Health Care Distinction**
Part of the unified Simply, Amerigroup and our 15 affiliates are proud to hold NCQA Multicultural Health Care Distinction. “Earning Multicultural Health Care Distinction shows that an organization is making a breakthrough in providing excellent health care to diverse populations. I congratulate any organization that achieves this level of distinction. Eliminating racial and ethnic disparities in health care is essential to improving the quality of care overall.” - Margaret E. O’Kane, NCQA President ******

- We have a Disease Management (DM) Program for the entire Clear Health population. It is a system of coordinated health care intervention and communication. Our DM Program supports the provider/member relationship and plan of care; emphasizes prevention of exacerbations and complications using evidenced-based practice guidelines and empowerment strategies with the goal of improving the overall health of our members. The Program addresses co-morbid conditions and considers the whole health of the member. We develop and use a plan of treatment for each Program participant that is tailored to the individual member. Clear Health includes measurable goals and outcomes and sufficient information to determine if these goals are met. Clear Health members, with their Managed Care Coordinator, are regularly reviewing and updating each treatment plan at least annually.

- We provide Complex Case Management services to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help in navigating the system to facilitate appropriate delivery of care and services. Our goal is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner with comprehensive assessment of the member’s condition; determination of available benefits and resources; and development and implementation of a case management

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plan with performance goals, monitoring and follow-up. This focused management of a member's care has returned improved quality scores and better health outcomes for our members.

- Our Clear Health Member Advisory Committee (MAC) meetings are well attended by members. Staff from multiple departments attend MAC meetings to address member issues on the spot whenever possible, and the MAC also makes systemic recommendations to the health plan. For example, after listening to feedback from our members, we recognized the need for additional Clear Health MACs across the state. Various departments present at each meeting, such as QM, Member Services, Provider Relations, and Grievance and Appeals. Behavioral Health is a standard agenda item at all these meetings, as this is an important issue for our Clear Health members. The MAC membership also brings region-specific issues to these individual meetings, which resulted in mobile units being deployed to provide dental care in some of the areas where it was difficult for members to access those services. The MAC reports all feedback and results from the meetings to the QMC.

- Dress for Success: Clear Health partners with community resources that we know will benefit our members' efforts to achieve or sustain wellness, including supports for employment like Dress for Success. We partner with Dress for Success Palm Beaches to serve women from Palm Beach, Martin, St. Lucie, Hendry, and Northern Broward Counties through a mobile outreach unit. These counties account for nearly 5,000 square miles, and the total population of these areas is nearly 3 million, with women accounting for 51 percent of the overall population. Despite an improved unemployment rate, low-income single mothers continue to struggle to provide the basic necessities for their households and their children. With an historical rate of 57 percent employment for women utilizing Dress for Success' full scope of services, this mobile unit will provide outreach for suiting and training to women entering or re-entering the workforce who are not able to access services from Dress for Success' main location.

Dress for Success Worldwide provides a full continuum of services to offer long-lasting solutions that enable women to break the cycle of poverty. In addition to suiting and on-site coaching programs, Dress for Success Palm Beaches offers two distinct 10-week job readiness courses for women based on their age group. They also recently launched their new WAGE (Women Achieving Growth in Employment) program, geared toward enhancing job retention and growth for women already working.

Sponsoring Dress for Success Palm Beaches in their efforts to offer a Mobile Career Center will enable the next logical step in the life cycle of their organization, and bring job readiness and job retention programs into the community, with Clear Health members having access to priority appointments and training. Clear Health will work closely with Dress for Success Palm Beaches to bring the Mobile Career Center to approved venues, such as health fairs or other community events that may be accessible to our members.

- Clinical Practice Guideline (CPG) and Preventive Health Guideline Development and Review are adopted based on the health care needs of the member population and opportunities for improvement identified through the QM Program. These guidelines are reviewed, revised, and approved annually using nationally recognized evidenced-based literature. We adopt the latest antiretroviral regimen and treatments recommended by the U.S. Department of Health and Human Services and expert opinions from nationally recognized societies and organizations

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such as the American Diabetes Association, American Psychological Association, American Congress of Obstetricians and Gynecologists and National Heart Lung and Blood Institute. The guidelines are disseminated to members and providers via newsletter articles and via our website. We maintain written policies and procedures that reflect the current standards of medical practice and clinical guidelines adopted. As new practice guidelines are published and accepted by our Committees, the Medical Director introduces them and trains staff to ensure we are using the most up to date practice guidelines throughout our organization.

**** INNOVATION:** Clear Health has shared training and tools to help our infectious disease providers better understand the complex issues facing our members with HIV/AIDS and where standard treatment options may not be the best solution for this population. These trainings and tools are updated as needed to provide the most current information available. ******

- Our Early and Periodic Screening Diagnosis and Treatment (EPSDT) program strives to improve Child Health Check-Up (CHCUP) rates for children and adolescents in the Clear Health membership. We operate multiple concurrent improvement strategies: 1) Contacting providers who have the highest number of members missing visits or services, 2) Phone outreach and mailing to all new members to discuss the importance of child health check-ups and dental services and to offer assistance in making an appointment, 3) Managed Care Coordinators track engagement efforts and results with time dedicated each week to member outreach for children and adolescents who are overdue for services, 4) Managed Care Coordinators conduct home visits for members who can't be reached by phone or mail to complete assessments, schedule appointments, provide education, and coordinate other resources such as transportation, 5) Medical home visits are arranged for members who would like to complete a CHCUP visit but who cannot attend an office visit.

- Clear Health developed an HIV Cultural Competency training for our Managed Care Coordinators to help them understand how to best engage, educate, and monitor our members and address the indicators specific to this population. The training is offered on a regular basis to reinforce these important principles and updated as needed to provide the most current information available to best serve our members. Additionally we conduct annual training and highlight new guidelines, regimens, and strategies for caring for our members.

- Clear Health is supported by dedicated staff in QM who understand HIV/AIDS measurement issues and use best practices to address them. If necessary to improve quality, a workgroup or task force will be created in order to conduct a Root Cause analysis and implement the Plan-Do-Check Act model. The workgroup or task force will report its progress to the QMC until the resolution of the issue is achieved.

- Clear Health has appointed an experienced HIV/AIDS specialist to serve as a liaison between members and our Quality department. The HIV/AIDS Liaison reviews performance measures to determine what steps are needed to improve performance and to ensure Managed Care Coordinators meet required standards. The HIV Liaison and Quality team follow ER and hospital admissions dashboard reports in real time and look at all measures to actively intervene when any decline is indicated. Our Liaison is responsible for leading HIV/AIDS QI projects for Medicaid as well as coordinating and managing HIV/AIDS QI workgroups. The Clear Health HIV Liaison also coordinates the Member Advisory Meetings, training on cultural competency, HIV updates, and childhood wellness.

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- Clear Health is responding to the challenges of aging members with HIV/AIDS and other comorbid conditions. Older patients with HIV face higher rates of cardiovascular disease, diabetes, hypertension, impaired cognitive function, cancer, frailty, and behavioral health disorders. They may also face these issues at an earlier age than the general population. We have adapted our strategies to capture more clinical, social, and pharmacological interventions. We have focused on offering ongoing education to our infectious disease providers to enhance understanding of clinical guidelines and management of conditions that can be more complicated for people with HIV/AIDS, such as hypertension and high cholesterol.

- BH Care Services monitoring and improvement are integrated into the overall QMC and encompass state regulatory requirements as applicable. Areas of focus include access and availability of services, coordination of care (including coordination between medical and BH providers), disease management and case management services, and assessment of member experience with behavioral health care and services to ensure an integrated model of care. Clear Health uses BH HEDIS® measures and methodology as performance indicators for clinical improvement. Integrated operations include both behavioral health and medical personnel. Integration is further accomplished by BH practitioner representation on quality-related committees.

- Social Determinants of Health and Complex Needs: We incorporate data from multiple sources, including utilization data, health risk assessments, state agency aid categories, demographic information, Health Department epidemiology reports, and various other sources to ensure identification of members with complex health needs. This information helps drive program development, member, and provider education, and outreach programs. For example, according to The North America Housing & HIV/AIDS Research Summit Series, homelessness is both a cause and an effect of HIV infection. People coping with homelessness are at greater risk of becoming infected with HIV, and people living with HIV/AIDS experience higher rates of housing loss and instability. Clear Health tracks the percentage of members who were homeless or unstably housed during the measurement year. This data was collected through a review of Health Risk Assessments and members' addresses in the state eligibility file. It is important to note that homelessness is not easily captured – while some members' addresses are listed as Homeless or Shelter, others are identified by searching for specific shelter names and/or addresses, so although we capture most of those members who are homeless, housing status is still considered somewhat incomplete. In order to assist members who have been identified with unstable housing, the Clear Health Care Coordination team has developed relationships with community agencies that receive funds from The Housing Opportunities for Persons with AIDS (HOPWA) program and/or the Federal Emergency Management Agency (FEMA). They use a collaborative approach to assist members. Although AHCA no longer includes housing as a required performance measure, Clear Health still monitors the number of members with unstable housing and is currently participating in an initiative led by Anthem that focuses on specialty populations' non-clinical measures and their impact on health outcomes.

**** INNOVATION:** Clear Health will utilize our partnerships with key community organizations such as the former PAC waiver entities to facilitate our process of locating Clear Health's new members identified as homeless – as well as members that we have difficulty locating, contacting, and engaging in care. The PAC waiver entities we partner with will also work closely with our Managed Care Coordinators to be our local “feet on the street” – personally working with our members to help engage them in care. Our Managed Care Coordinators will continue

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to monitor member engagement and gaps in care, and will coordinate with these PAC waiver entities to further support our HEDIS® initiatives – helping us engage our homeless and/or difficult to contact members to make sure timely care and services are arranged and received.

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- Grievances and Appeals (2016 – Q1 2017): Since, 2016 all Clear Health Grievance and Appeals processes are in compliance with AHCA Service Level Agreements (SLAs). The Compliance Committee monitors and consistently reports to the QMC. There have been no EPSDT complaints or grievances presented to QMC. All Grievance and Appeals are resolved and trended to identify systemic issues that are then addressed at a higher level to prevent reoccurrence.
- Critical Incident Reporting for critical and adverse incident identification, tracking, analysis, and reporting to address/eliminate potential and actual quality of care and/or health and safety issues, in accordance with s.39.201 and Chapter 415, F.S. We report suspected unlicensed ALFs and AFCHs to the Agency and require providers to do the same pursuant to 408.812 F.S.
- Healthy Behaviors program: We encourage and reward healthy behaviors. Pursuant to Florida Statute 409.973(3), effective October 1, 2014, we have medically approved programs for Smoking Cessation, Weight Management, and Alcohol and Substance Abuse recovery. We have developed two additional programs for Maternity and Well Child Visits. We have a process in place to identify eligible members for these 5 programs and to secure the members' commitment to participation in these programs. We report on the Healthy Behaviors program in accordance with Section XIV, Reporting Requirements, and the Managed Care Report Guide. Data is submitted quarterly on each Healthy Behavior program, caseloads, and the amount and type of rewards/incentives provided for the Clear Health program.

In summary, Clear Health's quality management activities demonstrate meaningful improvement for members on a variety of measures. We have successfully reduced hospital readmissions from 31.0 percent to 28.4 percent from 2015-2016, reduced inpatient BH admissions per thousand from 93.6 to 75.9, and decreased inpatient days per thousand from 352.5 to 239.8. Our members' rate of HAART compliance is excellent with 94 percent success in 2016-2017. Several HEDIS® indicators have improved more than 10 percentage points year-over-year, including HbA1c Testing, Controlling Blood Pressure, and Annual Dental Visits. As our population consists of people with HIV/AIDS, one of our most significant improvements is the increased percentage of members with two or more HIV visits per year from 56 percent in 2014 to 76.39 percent in 2016. Lastly, Medicaid Health Plan Report Card for 2016 showed that Clear Health improved in two of the six categories followed for Quality of Care.

4. THE EXTENT TO WHICH THE RESPONDENT MET QUALITY MEASURE TARGETS, SUCCESSFULLY REMEDIATED ALL FAILURES OR ACHIEVED IMPROVEMENT TO OVERALL PERFORMANCE.

For the 2017 reporting year, Clear Health met or exceeded the State's goal on 12 out of 25 HEDIS® measures reported. Additionally, 19 of the measures showed year-over-year improvement from 2016 to 2017. Among the 12 measures for which Clear Health successfully exceeded the state's target of the NCQA 50th percentile are 7 measures that achieved the 90th

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percentile or higher, a significantly higher benchmark. Clear Health's 12 measures with strong performance include:

- Antidepressant Medication Management – Acute Phase
- Initiation and Engagement of Alcohol or Other Drug Dependence Treatment – Initiation Total
- Well-Child Visits - Ages 3-6
- Adult Access to Preventive Ambulatory Care
- Adult BMI Assessment
- Cervical Cancer Screening
- Child Access to PCP – Ages 12 to 24 months
- Chlamydia Screening
- Comprehensive Diabetes Care: HbA1c Testing
- Comprehensive Diabetes Care: Medical Attention for Nephropathy
- Medication Management for People with Asthma
- Annual Monitoring for Patients on Persistent Medication

Five of the requested measures were not reported due to insufficient denominators; all of these were measures focused on children and adolescents and the Clear Health enrollment in this age group is small. Fewer than three percent of Clear Health members are younger than 20 years of age.

Of the 13 reported measures where Clear Health did not achieve the State's goal, nine improved from the prior year's rates. One measure that progressed toward the state's target of the NCQA 50th percentile from 2016 to 2017 is Follow Up After Hospitalization for Mental Illness (7 - Day), which improved from 21.5 percent to 28.2 percent in 2017. One remediation strategy for this measure is our field-based Transition of Care (TOC) program, described above. All Clear Health members released after a BH hospitalization are assigned a TOC MCC Nurse. The member's Managed Care Coordinator will contact the member shortly after discharge to discuss the discharge plan they were given, ensure they understand and agree with the discharge plan, and explain the role of TOC Nurse. The TOC Nurse will visit members to conduct home assessments and use a multidisciplinary approach to develop an ongoing plan of care with the member/family. The Clear Health TOC Program incorporates best practices including the Coleman model of care transitions. In addition to the TOC Nurse, members benefit from the continued support of their assigned Managed Care Coordinator who will continue to assist in the management of issues that would have a negative impact on the member's health or risk of readmission.

Additionally, Clear Health observed improvement in the following measures:

- Adolescent Well Care: Improved from 45.5 percent to 46.0 percent in 2017.
- Annual Dental Visit: Ages 2 – 21: Improved from 26.7 percent to 40.2 percent in 2017.
- Breast Cancer Screening: Improved from 52.1 percent to 58.1 percent in 2017.
- Child Access to PCP: Ages 7 - 11: Improved from 0 percent to 66.7 percent in 2017.
- Postpartum Care: Improved from 43.6 percent to 48.8 percent in 2017.

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- Frequency of Prenatal Care: Improved from 44.5 percent to 47.7 percent in 2017.
- Comprehensive Diabetes Care: Eye Exam: Improved from 33.3 percent to 42.3 percent in 2017.
- Controlling High Blood Pressure: Improved from 32.6 percent to 44.3 percent in 2017.

Our Healthy Behaviors program addresses all measures listed above, encouraging members to seek preventative care or ongoing chronic health care monitoring. This is an evidenced-based program that is part of our overall strategy to connect members to Primary Care Providers or other consistent sources of care. We contact Clear Health members through multiple modes of communication to encourage them to obtain both preventive and follow-up services. Invitations to participate in the Healthy Behaviors program are provided to all newly enrolled members and annually as a part of our Preventive Health Reminder outreach efforts through each member's Managed Care Coordinator.

As soon as a Florida Medicaid member becomes a Clear Health member, we begin tracking services received and gaps in care to promote the timely, effective completion of services. Our tracking tools enable us to closely monitor access to preventive service and adherence to medications. We assign a Managed Care Coordinator to each member, who reminds them about upcoming or missed screenings as well as informing them about the Healthy Behaviors program that offers incentives for their efforts in meeting these goals.

Through participating in the Healthy Behaviors program, members can earn points that they can use to redeem a range of health-related gifts. The program includes milestones that are based on HEDIS® measures. Completion of each milestone currently earns the member a set number of points up to a total value of \$50 per program, which can be redeemed for items from an AHCA-approved list.

The four measures that did not show improvement from the previous year were:

- Child Access to PCP - Ages 25 Months - 6 Years
- Child Access to PCP - Ages 12 - 19 Years
- Timeliness of Prenatal Care
- Comprehensive Diabetes Care: HbA1c <8

As previously discussed, the enrollment of pregnant women, children, and adolescents in Clear Health is small (fewer than three percent of members are younger than 20) and this could have a statistical impact on these measures. The smaller a measure's denominator population, the more likely that change in the rate is due to chance instead of a true underlying change in care patterns. Moreover, the Infectious Diseases Society of America has recommended individualization of HbA1c targets for people living with HIV, meaning that eight percent may not be an appropriate threshold for all members. Some adverse consequences of more intensive glucose control have been observed in clinical trials, including increased severe hypoglycemia. Tighter control is more appropriate for younger, healthier patients, whereas looser control may be more appropriate for older patients with multiple comorbidities who are prone to hypoglycemia (Monroe, Glesby, Brown, 2014). The CDC also states that some HIV medications

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also predispose individuals to diabetes and dyslipidemia, while treatment options may be limited due to interactions with the agents used to treat co-occurring conditions.

Despite the methodological weaknesses in these metrics, Clear Health is committed to improving our rates and strives to meet the state's targets for all measures. Recently released results of the HEDIS performance data for 2016, which will appear in the fourth annual Medicaid Health Plan Report Card, show that Clear Health improved in two of the six categories – Pregnancy-related care and Living with Illness. A third measure, Keeping Kids Healthy was found to be not measurable/too small a population.

Our strategies for continued improvement include the Healthy Behaviors program, described above, and its incentives for members to receive preventive visits, engage in prenatal care, and manage diabetes. Additionally, each Clear Health member has a Managed Care Coordinator who ensures the member is aware of these important services and the resources available to them to support wellness and improved outcomes. For example, enrollment in one of our NCQA-accredited disease management programs may be beneficial for members with diabetes and/or members who are pregnant. To increase rates of children completing primary care visits, we will continue to execute our outreach and education efforts for parents/guardians and increase access through Clinic Days, school-based health centers, and telemedicine.

Clear Health's Managed Care Coordinators, in partnership with our Quality Management team and our specially trained Customer Care Representatives, will focus on improvement in these four areas while maintaining performance levels for other measures. We will review progress monthly to identify additional steps needed to make the necessary improvements.

Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, including HEDIS or Contract required measures.
2. The extent to which the quality measures proposed are relevant to the specialty population(s) being proposed for this solicitation.
3. The extent to which the quality management activities proposed demonstrate the ability to improve quality for the population(s) proposed in a meaningful way.
4. The extent to which the respondent met quality measure targets, successfully remediated all failures or achieved improvement to overall performance.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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C. RECIPIENT EXPERIENCE

Specialty SRC#4 Eligibility and Enrollment (Statewide):

The respondent shall propose detailed and specific criteria (age, medical condition and/or diagnoses) for the specialty population proposed in response to this solicitation. The respondent shall include proposed methods for identifying the specialty population proposed, including any data sources/system, specific medical codes for procedures (e.g. Current Procedural Technology (CPT), Healthcare Common Procedure Coding System (HCPC), International Classification of Diseases (ICD-10)) or diagnoses (e.g. ICD-10, Diagnosis Related Groups (DRG), American College of Gastroenterology (ACG)) associated with the population, clinical assessment and/or referral protocols required. The respondent shall identify the estimated number of recipients meeting the criteria for the specialty population proposed, along with the source or methodology for such an estimate.

Response:

Simply Healthcare Plans, Inc. (Simply), D/B/A Clear Health Alliance (Clear Health), is our HIV/AIDS specialty plan and is the respondent to this ITN. Simply brings together the best practices and innovative solutions of three Florida health plans that recently merged to become one entity. The merged entities are the original Simply, Better Health, Inc. (Better Health), and AMERIGROUP Florida, Inc. (Amerigroup). The unified Simply draws on the strength of each legacy organization's experience to elevate the performance of every area of our operations.

1. A CLEARLY DEFINED AND READILY IDENTIFIABLE TARGET POPULATION

Our HIV/AIDS specialty plan receives members who are either HIV positive, but asymptomatic, individuals with symptomatic HIV disease or individuals with CDC-defined AIDS identified via the State's HIV/AIDS algorithm. We propose using ICD-10 diagnosis codes available through claims data as the primary criteria to confirm the diagnosis for those individuals that were enrolled into the HIV/AIDS specialty plan.

The primary diagnosis codes clearly identifying individuals with a HIV/AIDS diagnosis include Z21 (asymptomatic HIV infection), B20 (symptomatic HIV infection and AIDS), and B97.35 (HIV-2 infection, rare in the US.) These diagnosis codes received from claims and encounter data or other sources are the primary mechanism for members to receive the appropriate designation of HIV/AIDS. In addition to the primary codes described, we use the State's HIV/AIDS algorithm, with data elements that include additional diagnosis codes, laboratory procedure codes commonly used with persons who have HIV/AIDS, and medications used to treat the condition to further verify diagnosis.

We recommend that the HIV/AIDS designation not be dropped once it is confirmed, even if no claims appear for an extended period. Since many factors can affect Medicaid eligibility and some members may temporarily leave the state or drop out of care voluntarily, the designation of HIV positive status should remain permanently; that is, never dropped from the client's record. Once confirmed, the HIV or AIDS diagnosis is not reversible.

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Upon review of the State's algorithm to determine HIV or AIDS status, we also believe that HIV medications to make the designation should be used as a secondary issue. Not all HIV positive individuals have current claims for HIV medications for various reasons (for example, participation in clinical trial), and some persons who are HIV negative may be taking components of an HIV regimen that is FDA approved for Hepatitis B or as an approved pre- or post-exposure prophylaxis. We recommend a review of all members with claims that include HIV medications. If there is not a diagnosis code associated with the client, additional investigation will be initiated by Clear Health. We have found that some members had the HIV/AIDS designation incorrectly because codes (in original or subsequent algorithms) related to exposure, testing, or medications did not accurately determine status. Because some members could have potential exposure requiring serial testing and possible use of antiretroviral medications for post exposure prophylaxis without the subsequent sero-conversion; there remains the possibility of designating the member inappropriately. Clear Health currently reports any member found not to have HIV to the state on a monthly basis as a contractual requirement of the MMA.

As part of a current review, Clear Health also recommends certain changes to the existing algorithm, including additional review for pediatric members who may have received designation inappropriately due to exposure (without subsequent infection). We do not recommend using prescription drug claims data to identify potential members for the specialty plan because some of these medications may be used to treat or prevent other conditions. We recommend that the HIV/AIDS designation, once created based on these specific diagnoses codes, remain the status for these members.

Clear Health has collaborated with the Medical Director of the Bureau of HIV/AIDS for the Florida Department of Health as well as our Medical Directors to review this criteria of identifying individuals with HIV/AIDS in an effort to streamline, improve, and clearly identify members with HIV/AIDS so they could be enrolled in the specialty plan. We value our partnership with the Agency, and will continue to work collaboratively to refine the State's HIV algorithm, as needed, so that it accurately identifies the potential members who are HIV positive and who are eligible to receive Medicaid services under the specialty plan.

In addition, we recommend that Medicaid Options enroll an individual who, self identifies with a diagnosis of HIV/AIDS and expresses a desire to be enrolled in the specialty plan. Upon enrollment, the individual will be assigned to the HIV/AIDS specialty plan and the plan will confirm with the member's PCP the HIV/AIDS diagnosis following the completion of the comprehensive health assessment. Our experience has shown that providers may not submit diagnosis codes in a manner that would enable those living with HIV/AIDS to be appropriately flagged in the State's system.

EXHIBIT A-4-d SPECIALTY SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

Clear Health complies with the AHCA contractual requirement under Managed Medical Assistance (MMA) to report members who we find do not have a diagnosis of HIV/AIDS based on assessment/claim review/provider attestation. We developed a utilization management policy and procedure for verifying eligibility to assure timely reporting of ineligible members. To date, we have reported over 600 members to the State via this monthly report. These members are reported monthly to the Compliance department for submission to the Agency via the Plan's Agency Contract Manager. In the case of minors, we will report members without the HIV or AIDS condition if the parent or legal guardian confirms via self-report that the member does not meet the criteria for enrollment in the specialty plan. We make every effort to review medical and pharmacy claims that may contradict the self-report of the parent or legal guardian. Absent such a claim, we will include the member on the Non-HIV Report for submission to AHCA. The report will include the Plan's name and Medicaid provider number; and members' full name, date of birth, and MID number.

2. A SPECIALTY POPULATION THAT DOES NOT EXCEED 10 PERCENT OF THE TOTAL POPULATION OF MMA ELIGIBLE RECIPIENTS.

Based on data available from the Agency, HIV/AIDS eligibles do not exceed 10 percent of the total Medicaid eligible population in any of the eleven regions.

As another data point, the prevalence of Persons Living with HIV/AIDS (PLWHA) by region and by county is available through the Florida Department of Health. In 2016, approximately 135,986 persons were living with HIV in the state of Florida. Estimates of individuals enrolled in Florida Medicaid at this time approaches 18,000 from available resources. The total Medicaid program has more than three million members. Therefore, the overall percent of MMA members eligible for the HIV specialty plan is less than one percent.

EXHIBIT A-4-d
SPECIALTY SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

Evaluation Criteria:

1. The extent to which the proposed criterion produces a clearly defined and readily identifiable target population.
2. The extent to which the proposed criterion results in a specialty population that does not exceed ten percent (10%) of the total population of MMA eligible recipients.

Score: This section is worth a maximum of 40 raw points as indicated below.

For Item 1:

- (a) 20 points if the proposed criterion produces a clear target population that is data driven and not dependent on assessment or referral;
- (b) 10 points if the proposed criterion produces a clear target population that is in any way dependent on assessment or referral;
- (c) 0 points if the proposed criterion does not produce a clear target population that can readily be identified.

For Item 2:

- (a) 20 points if the estimated size of the specialty population does not exceed ten percent (10%) of the estimated total population of MMA recipients;
- (b) 0 points if the estimated size of the specialty population exceeds ten percent (10%) of the estimated total population of MMA recipients.

**EXHIBIT A-4-d
SPECIALTY SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

D. PROVIDER EXPERIENCE

No SRCs in this Category for Specialty.

EXHIBIT A-4-d
SPECIALTY SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

E. DELIVERY SYSTEM COORDINATION

Specialty SRC#5 - PROVIDER NETWORK (Regional):

The respondent shall propose provider network standards that meet the needs of the specialty population(s) being proposed for this solicitation, including specific provider access ratios that exceed MMA standards for provider types relevant to the specialty population(s). The respondent (including respondents' parent, affiliate(s) or subsidiary(ies)) shall describe its experience in managing provider networks for population(s) similar to the specialty population(s) being proposed for this solicitation, including experience with provider contracting and performance measurement relevant to the specialty population(s) proposed. Identify specific requirements for provider contracts, credentialing, provider handbooks, etc., the respondent proposes for network providers serving the specialty population(s) proposed. Describe any additional provider services the respondent proposes to make available to the provider network serving the specialty population(s).

Response:

Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance (Clear Health) has managed a provider network serving the HIV/AIDS Medicaid population within the Region for four years. Clear Health alliance currently serves 233 enrollees (members) with 1,257 providers in Region 1. We focus our relationships with HIV clinics within the regions that are primarily Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), County Health Departments (CHDs), and/or community health centers. These clinics have an integrated model of behavioral health and primary care services.

1. EXPERIENCE SERVING THE PROPOSED POPULATION

Clear Health has been managing our provider network serving members with HIV/AIDS since February 2012. Clear Health has a Medicaid contract with the Agency with an HIV/AIDS specialty designation. We currently serve more than 9,300 people living with HIV/AIDS in 10 regions.

As Florida's largest HIV/AIDS specialty plan, Clear Health has extensive experience and qualifications in contracting and servicing networks designed to meet the special needs of our HIV/AIDS population. We recognize that to develop and maintain a high quality network to serve the HIV/AIDS Medicaid population, our company must have the respect and trust of the community. We began a very grass roots approach to engaging with providers in the community. This approach has been effective and as a result we have been able to engage not only providers who historically have been treating people living with HIV/AIDS, but we also were successful in engaging non-traditional providers like Medicare and Commercial to join our network. Our management team has a combined 105 years of experience serving the Florida Medicaid community and are experts in the industry.

EXHIBIT A-4-d SPECIALTY SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

Former NBA superstar, Earvin “Magic” Johnson, arguably the most credible and well known advocate for people living with HIV/AIDS, is a spokesperson for Clear Health. His passion for helping individuals with HIV/AIDS contributes to the bench strength of our organization. Adding to our experience in serving this population, we have partnered with a world-renowned HIV/AIDS research and teaching institution, the University of Miami, a Statewide Essential Provider.

To assure our network of Primary Care Providers (PCPs) meets member needs, we have expanded our definition of PCP to include family practice, general practice, pediatrics, internal medicine, and infectious disease providers. We designate providers with specialized HIV/AIDS training with a red ribbon beside their name in the provider directory, informing members of the provider’s additional specialized HIV/AIDS care and treatment competency. This “Red Ribbon” program is nationally recognized and testament to our patient-centered model of service and support. Other provider types may also specialize in HIV/AIDS.

Based on our experience in providing services to the specialty population proposed, we have identified that the following specialties are critical due to the most commonly seen comorbidities in the HIV/AIDS population: Infectious Disease, Cardiology, Hematology/Oncology, Dermatology, Pulmonology, Endocrinology, Gastroenterology, and Behavioral Health. We meet the required access standards in all regions for all of these specialties. Our experienced provider relations team recognizes the need to partner with FQHCs, CHDs, RHCs, and other key providers to serve these members.

Care and treatment of HIV/AIDS is multi-dimensional, and a big part of our success in this program has been our collaboration with more than just medical providers. Clear Health has created strong community partnerships and continues to foster relationships with the HIV/AIDS community. As a specialty plan, we foster affiliations with community-based organizations with aligned goals for education, empowerment, improved access to care and health outcomes, reduction of HIV transmission, and removing barriers to services.

Clear Health is proud of our strong performance including:

- Steady increases in enrollment since program inception
- Improvements in key HEDIS® scores, including HIV medical visits, 2015-2016
- Steady decline in pharmacy PMPM costs, substance abuse inpatient days/1000, all cause readmissions (PCR), 2015-2016
- Increased direct member contacts, completed assessments, and multi-disciplinary team meetings, percentage of members accessing behavioral health services
- Stable performance in general medical and mental health hospital admissions/1000, average length of stay for medical and behavioral health hospitalizations
- Key member and provider satisfaction rating dimensions improved, 2015-2016
- Internal case management satisfaction survey scores improved, 2015-2016

EXHIBIT A-4-d SPECIALTY SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

2. DEMONSTRATED EXPERIENCE MANAGING A PROVIDER NETWORK RELEVANT TO THE SPECIALTY POPULATION

Clear Health has built an extensive HIV/AIDS Medicaid network in Florida, establishing close relationships with PCPs, specialists, CHDs, FQHCs, RHCs, and teaching institutions. We have been able to recruit PCPs and specialists in infectious disease, cardiology, dermatology, hematology/oncology, behavioral health, gastroenterology, and endocrinology who have experience in treating patients with HIV disease to become Medicaid providers and contract with us. We have developed a provider recruitment strategy and message of inclusivity and collaboration and actively provided education and support for the providers who serve our specialty population.

Our ongoing recruitment efforts specifically target specialists who are experienced in working with people living with HIV/AIDS. It is our practice to work closely with our PCPs and determine who they most commonly refer members to so we can make every attempt to include those providers in our network. We have been successful in contracting with most physicians who have traditionally not accepted Medicaid enrollees from other plans and/or direct MediPass recipients.

Our proven experience demonstrates our ability to manage an HIV/AIDS network:

Our approach to provider engagement has changed the dynamics of traditional provider/health plan relationships by developing lasting provider partnerships. Leadership seeks out provider feedback and responds rapidly to improve both our network and internal processes. We support our high-performing network with value-based payment agreements. This provider engagement model supports increased high quality scores, improved member outcomes, and solid performance.

We provide an enhanced level of support to our red ribbon providers. These are providers with specialized HIV/AIDS training designated by including a red ribbon beside their name in our provider directory, informing members of the provider's additional specialized HIV/AIDS care and treatment competency. Our red ribbon program is nationally recognized and is a testament to our patient-centered model of service and support.

Our regionally based Provider Network Managers live and work in their local communities and have developed strong relationships with providers in each region. Our local and innovative approach, focused on supporting providers' growth capabilities and capacity to optimize member outcomes allows us to leverage our local presence to develop and refine strategies that address our members' needs. Our Provider Network Managers have extensive experience meeting the needs of providers servicing members with HIV/AIDS due to our experience across Florida. Our Provider Network Managers in Regions 1, 2, 3, 8, and 9 focus solely on meeting the needs of Clear Health providers. In our other regions, specifically 5, 6, 7, 10 and 11 we cross-train our Provider Network Managers to leverage the volume of our membership and the diversity of our products to manage an experienced network across all lines of business.

EXHIBIT A-4-d SPECIALTY SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

- We currently manage an extensive HIV/AIDS Medicaid network in Florida. We have identified, developed, and managed this unique specialty plan, building and maintaining strong relationships with CHDs, FQHCs, RHCs, teaching institutions, community-based centers, and leaders in the urban communities where the epidemic is widespread.
- Our management team has more than 105 years of experience in developing and maintaining Florida Medicaid networks. These networks, which include FQHCs, CHCs, and RHCs, all have experience with HIV/AIDS patients. Clear Health partners with the FQHC Escambia Community Clinics, which manage 27 percent of the region's Clear Health Alliance membership, and County Health Department Okaloosa. We have contracted with 20 FQHCs and 10 RHCs locations within the region. Clear Health also partners with Ryan White Programs and CHD Walton, an HIV specialty clinic, as options for our membership.
- Our management team has the trust and respect of HIV/AIDS providers and community organizations. We target providers to include in our network based on their involvement in the community working with HIV/AIDS. We continue to identify opportunities to partner with new HIV/AIDS specialty clinics to include in the network. For example, the Lee County Health Department just opened a new HIV/AIDS clinic and we contracted with them immediately upon their opening.
- Clear Health benefits from Simply's extensive Medicaid provider network throughout Florida.

3. PROVIDER CAPACITY RATIOS ASSURE THE ADEQUACY OF THE PROVIDER NETWORK

We propose a provider network standard of 1:750 for primary care providers (PCPs). This meets the MMA standard of 1:750 for PCPs and 1:6,250 for infectious disease specialists. Based on our experience in working with the specialty population, we recognize the importance of having a broader understanding of their unique needs and the providers they need in our network for their treatment and care.

We propose that providers from the following areas of medicine serve as PCPs: Family Practice, General Practice, Pediatrics, Internal Medicine, and Infectious Disease. We encourage providers who are not credentialed by the American Academy of HIV Medicine (AAHIVM) or recognized by the Florida/Caribbean AIDS Education and Treatment Centers (AETC) to do so, given our close working relationship with Dr. Jeffrey Beal, the Principal Investigator and Clinical Director for AETC. We have been successful in contracting with most providers who have traditionally not accepted Medicaid members from other plans or direct MediPass recipients.

An OB/GYN may serve as a PCP for a pregnant member if she meets criteria for HIV expertise and is willing to participate as a PCP. We view pregnancy as an emergent condition, and pregnant members receive the highest level of intervention and coordination. OB/GYNs in our network must understand the importance of mother-to-child transmission of HIV/AIDS and have experience in administering the protocols to reduce the likelihood of transmission.

EXHIBIT A-4-d SPECIALTY SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

We work to make sure that all pregnant women who are infected with HIV are offered the latest antiretroviral regimen recommended by the Department of Health and Human Services. OB/GYNs in our network must follow the Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States.

Based on our experience with our specialty population, we know that making certain specialties available in our network is critical due to the most common comorbidities in the HIV/AIDS population: Infectious Disease, Cardiology, Hematology/Oncology, Dermatology, Pulmonology, Endocrinology, Gastroenterology, and Behavioral Health. We meet the required access standards in all regions for each of these specialties. Our ongoing recruitment efforts specifically target specialists who are experienced in working with people living with HIV/AIDS. It is our practice to work closely with network PCPs and determine to whom they most commonly refer members, so we can make every attempt to include those specialists in our network.

In Region 1, we have 141 PCPs and nine infectious disease specialists (two infectious disease specialists have elected to act as PCPs) in our network who meet our stringent credentialing requirements for our 216 members living with HIV/AIDS in this region. We have administrative service agreements with the University of South Florida and the University of Miami and contract with their specialized PCP and specialist network, including infectious disease, serving our HIV/AIDS adult, adolescent, and pediatric members. We also have partnerships with two clinics specializing in HIV/AIDS.

Our network in Region 1 meets or exceeds the provider capacity ratios in all specialties except respiratory therapy (RT). Our network is currently lacking in RT in each county. The cause of this gap, the same as has been described to the Agency in the past, is that therapists work for facilities and will not contract independently with health plans. As they are considered part of medical staff, Medicaid ID and NPIs are not always available for this provider type. We continue efforts to contract respiratory therapists.

4. PROVIDER REQUIREMENTS PROPOSED ARE RELEVANT TO THE PROVIDER NETWORK SERVING THE SPECIALTY POPULATION

When bringing providers into our network, we look specifically for those who work with HIV/AIDS and have additional training in treating this population. We credential network providers and verify their status and additional training to confirm they have experience with this population. Once confirmed, we include the provider in our directory with a red ribbon beside their name. All red ribbon providers serve as a PCP for this population. We also permit infectious disease specialists to act as a PCP, and notate this with a red ribbon in our directory.

As mentioned previously, we have expanded our definition of PCPs to include Family Practice, General Practice, Pediatrics, Internal Medicine, and Infectious Disease. Based on our experience, we believe that these providers have the best understanding of the underlying condition of the member. We have lowered member to provider ratio requirements to allow for more frequent and more comprehensive interaction with members.

EXHIBIT A-4-d SPECIALTY SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

We credential and recredential providers in our network according to established criteria, which meet the Medicaid participation standards. While all providers are required to undergo credentialing, we give particular focus to providers serving in the primary care role for our members with HIV/AIDS. We require an Education/Training Attestation for participation as an HIV/AIDS PCP as part of the credentialing packet that includes the qualifications described below.

Participation as an HIV/AIDS-designated PCP requires that the provider attest that they meet the criteria to care for our members in one of the following ways:

- Be credentialed as an HIV specialist by AAHIVM
- Be board certified in the field of infectious disease. If not certified in the past year through the American Board of Medical Specialties, the provider must have clinically managed a minimum of 25 patients in the preceding 12 months and successfully completed a minimum of 10 hours of continuing medical education (CME), with at least five hours related to antiretroviral therapy in the past year
- Clear Health provides access to the Clear Health Training Academy. Our Training Academy is a powerful vehicle that fosters a robust, consistent, compliant, and comprehensive approach and provides a multitude of expert-developed, customized trainings, accommodating various formats, media, and schedules while offering providers the opportunity to earn CMEs and CEUs, allowing the provider to achieve a Red Ribbon status at no cost.
- Be recognized by the AETC as having sufficient clinical experience and additional ongoing training in HIV/AIDS to be considered a specialist
- Meet the criteria of an HIV-qualified provider as defined by the HIV Medicine Association (HIVMA) of the Infectious Diseases Society of America or demonstrates experience as an HIV qualified provider set by AHCA standards. If they choose this option, they must complete a questionnaire that demonstrates continuous professional development by meeting defined qualifications. In the immediately preceding 36 months, the provider must have provided continuous and direct medical care, or direct supervision of medical care, to a minimum of 25 patients with HIV.

Also, in the preceding 36 months, the provider must have successfully completed 40 hours of Category 1 CMEs addressing diagnosis of HIV infection, treatment for HIV disease and co-morbidities, or the epidemiology of HIV disease, and earning 10 hours per year. Alternatively, in the preceding 12 months, the provider must have completed recertification in the subspecialty of infectious diseases with self-evaluation activities focused on HIV or initial board certification in infectious diseases. In the 36 months following certification, newly-certified infectious diseases fellows should be managing a minimum of 25 patients with HIV and earning a minimum of 10 hours of category 1 HIV-related CME per year; or providers must demonstrate experience as an HIV-qualified provider by showing evidence of continuous development through: clinical, behavioral or case management of at least 20 HIV-infected patients in the past two years with a minimum of eight contact hours annually of HIV-specific CMEs that includes information on the use of antiretroviral therapy.

EXHIBIT A-4-d

SPECIALTY SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

5. ADDITIONAL PROVIDER SERVICES ARE RELEVANT TO THE PROVIDER NETWORK SERVING THE SPECIALTY POPULATION

Our Provider Network Managers are available to provide additional training on claims, billing, and procedural issues as needed. Providers, particularly PCPs, who serve a large volume of our members, receive more frequent on-site visits for enhanced support. We refer providers who require additional training on HIV/AIDS to our partner, the AIDS Education and Training Center (AETC), which conducts targeted, multidisciplinary education and training programs for health care providers treating persons living with HIV/AIDS. We partner with Dr. Jeffrey Beal, Principal Investigator and Clinical Director for AETC, to provide direction and education to providers who need or who would like to improve their HIV/AIDS treatment expertise.

Clear Health engages frequently with providers in our network to assure they provide access to care that meets our high quality standards and those that meet the needs of our members with HIV/AIDS. We collect and analyze performance measurement data regarding the services provided to our members, and we implement member and provider interventions if needed to exceed benchmark quality performance. Using provider profiles, we are able to identify providers who do not meet goals for adult immunizations, annual PCP visits, the percentage of members prescribed antiretroviral therapy, hospitalizations, and emergency department visits. We also monitor the clinical status of every member, including viral load and CD4 count, which are indicators that treatment is effective. If patterns of utilization or concerns about individual members emerge, our Provider Relations or Case Management staff or our Medical Director or Pharmacist reaches out to the provider to provide additional education. All Clear Health employees are available to support providers with technical assistance, consultation, and coordination of ancillary services and referrals to ensure timely access to services.

In addition, our pharmacy detailing program uses HIV/AIDS specialized Clinical Pharmacists to engage with provider outliers one-on-one at their office or via web conference. As drug costs rise, pharmacy benefits become more complex, over-utilization of high-risk medications increase, and polypharmacy and adherence issues impact member safety, we recently recognized the need to identify and alter unfavorable provider prescribing practices.

The program generates monthly and quarterly reports to identify medication outliers, frequent denials, providers who have not responded to previous interventions, and therapeutic areas of concern. Based on our analysis of the reports, our Clinical Pharmacists develop educational material targeted to specific providers and the latest therapeutic areas of concern. Our Clinical Pharmacists meet one-on-one with the provider to present our report analysis, comparative utilization metrics, educational materials, and list of specific interventions. These meetings complement more traditional pharmacy drug utilization review activities. In the meetings, the pharmacist also talks about members' medication history and prescriptions written by other prescribers. Our goal is to encourage and assist physicians in making medically appropriate and cost-effective clinical decisions.

For example, we encourage meaningful and actionable interventions by identifying:

- Brand to generic conversion opportunities
- Formulation optimization opportunities
- Member polypharmacy issues

EXHIBIT A-4-d SPECIALTY SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA

- High-risk medication utilization
- Instances of non-adherence or therapeutic duplication

We also close the drug pricing knowledge gap by educating the physician on market drug pricing and therapeutic claims comparisons. To reinforce our recommended interventions, we identify potential quality improvements and cost savings if the intervention is implemented.

Our Provider Network Managers focus on educating providers on our benefits, services, policies, and procedures to assure the provider and staff understand how to get access to care for their patients and provide continuity of care. All providers, including physicians and ancillary providers, and their staff receive training when contracted. We give them a provider handbook and training materials on CD to educate new staff and refer to it as needed. The provider manual includes the requirements for providing care in accordance with the most recent clinical practice guidelines for HIV/AIDS treatment. The manual also states that the provider must follow the Guidelines for the Use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents developed by the HHS Panel on Antiretroviral Guidelines for Adults and Adolescents – A Working Group of the Office of AIDS Research Advisory Council (OARAC). The manual also includes The Laboratory Monitoring Schedule for Patients Prior to and after Initiation of Antiretroviral Therapy, and policies and procedures on referring members for services in- and out-of-network. Referral guidelines for behavioral health and substance abuse services are also included. Beacon, our behavioral health vendor, includes most FQHCs and Community Mental Health Centers in our network. These providers are experienced in working with people living with HIV/AIDS.

We encourage all providers to attend the sensitivity training that we provide on how to work effectively with people living with HIV/AIDS.

All provider manual information is available to providers on the Clear Health website. We also offer a provider portal on the site, which providers can use to access member eligibility, claim status, referrals, and authorizations. Network providers may call the call center as needed for any questions they have.

EXHIBIT A-4-d
SPECIALTY SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA

Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) managing a provider network serving the proposed population(s).
2. The extent to which the described experience demonstrates the ability to manage a provider network relevant to the specialty population(s) proposed.
3. The extent to which the provider capacity ratios proposed ensure the adequacy of a provider network relevant to the specialty population(s) proposed.
4. The extent to which the provider requirements proposed are relevant to the provider network serving the specialty population(s) proposed.
5. The extent to which the additional provider services proposed are relevant to the provider network serving the specialty population(s) proposed.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

**EXHIBIT A-4-d
SPECIALTY SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA**

F. OVERSIGHT AND ACCOUNTABILITY

No SRCs in this Category for Specialty.

G. STATUTORY REQUIREMENTS

No SRCs in this Category for Specialty.

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EXHIBIT A-9
REGIONAL PREFERENCE HIERARCHY

RESPONDENT NAME: SIMPLY HEALTHCARE PLANS, INC. D/B/A CLEAR HEALTH ALLIANCE

The Agency shall award one (1) additional Contract in a region to each successful respondent who receives a Region 1 or 2 Contract award. The Agency shall award the additional Contract in the respondent's highest desired region of preference in which the respondent submitted a responsive reply and negotiates a rate acceptable to the Agency.

Respondents shall complete the Regional Preference Hierarchy Table below, to indicate its preference for receipt of additional Contract awards.

If the Regional Preference Hierarchy Table is left blank, the respondent indicates that it does not desire any additional region awards.

Respondents shall indicate the region(s) in hierarchy order (highest desire being 1 and lowest desire being 10).

REGIONAL PREFERENCE HIEARCHY	
Order Requested for Additional Award	By Region
1.	11
2.	10
3.	6
4.	7
5.	5
6.	9
7.	4
8.	3
9.	8
10.	2

Simply Healthcare Plans, Inc. D/B/A Clear Health Alliance.

Respondent Name



Authorized Official Signature

10-27-2017

Date

M. Lourdes Rivas

Authorized Official Printed Name

President and CEO

Authorized Official Title

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